



February 14, 2021 E-Newsletter

Alliance for Retired Americans Social Security Fairness Act GPO/WEP Fact Sheet

On January 4, 2021, **Representative Rodney Davis (R-IL) introduced the Social Security Fairness Act (H.R. 82)**, which would repeal the Social Security Windfall Elimination Provision (WEP) and the Government Pension Offset (GPO). The WEP and GPO provisions claw back the Social Security benefits of workers or their spouse or widow (er), if they worked for a period of time in jobs not covered by Social Security.

The Windfall Elimination Provision

The WEP reduces the Social Security benefits of a public sector worker who collects a pension from a job not covered by Social Security. Four percent of retired workers or nearly 2 million retirees were affected as of December 2019. These workers are retired federal, state and local government employees

who worked as teachers, police, firefighters, postal workers and general employees. While the WEP provision intended to reduce overgenerous Social Security payments, the adjustment formula has no way to differentiate between a high paid public sector worker and a low paid worker. The effect is that it reduces benefits disproportionately for lower-income households

The Government Pension Offset

The GPO reduces the spousal or survivors Social Security retirement benefits of a worker who collects a public pension from a job not covered by Social Security. The individual's Social Security spousal or survivors' benefits are reduced by two thirds of the amount of their



government pension. The reduction is recalculated each year, when the retiree receives a

cost-of-living increase in their pension, further reducing the benefit. In some cases, if two-thirds of the individual's government pension is greater than their spousal benefits, their Social Security spousal benefits are reduced to zero. As of December 2019, 707,879 Social Security beneficiaries had spousal or survivors benefits completely eliminated or partially reduced by the GPO. The GPO has a particularly harsh effect on moderate-and low-income pensioners, especially women, who represent eighty-three percent of those affected by the GPO and are more likely to fall into poverty as they age.

Some beneficiaries are subject

to both the WEP and the GPO. As of December 2018, 263,775 Social Security beneficiaries were affected by both the WEP and the GPO

Which public sector workers are affected?

- ◆ Many teachers in 15 states—Alaska, California, Colorado, Connecticut, Georgia, Illinois, Kentucky, Louisiana, Massachusetts, Maine, Missouri, Nevada, Ohio, Rhode Island and Texas
- ◆ Many state, county, city and special district employees around the country • Federal employees (hired before January 1, 1984) who are on the CSRS retirement system in every state
- ◆ Retirees in every state who worked in the jobs mentioned above

Medicare Prescription Drug Cost Sharing Has Devastating Consequences for Health

A new **research paper** demonstrates that cost-sharing in Medicare's prescription drug program causes people to avoid care, to the detriment of their health. This finding builds upon previous research showing that higher cost-sharing causes patients to cut back on both high-value and low-value care.

As policymakers seek to curtail health care spending, many turn to economic theories that suggest raising costs on patients, so they have more "skin in the game," will force patients to choose only the care they need and shop for the most cost-effective services. But the new paper indicates that instead, people respond to higher costs by simply cutting back on

needed care, sacrificing even the most valuable and important treatments.

For their research, the investigators focused on Medicare Part D data. They found that higher cost-sharing for prescriptions led to higher mortality rates for people with Medicare. The connection was startlingly clear. Each percentage point increase in cost-sharing led to a several percentage point decrease in prescription fills for the examined medications—treatments for cholesterol, blood pressure, blood sugar, and chronic obstructive pulmonary disease. Alarming, the patients at highest risk for complications from dropping these medications



were the ones most likely to do so.

Another **newly released study** further disproves the idea that putting additional burdens on consumers is an effective strategy. It shows that even when consumers tried to compare costs prior to obtaining a service, they faced significant barriers, like lack of information or options. Largely unable to price shop, their decisions about what care to receive, and where, were almost entirely based on provider recommendations.

At Medicare Rights, we have long been concerned with the accepted wisdom about "skin in the game" and consumerism. We must not rely on beneficiaries to

shop their way out of high systemic health care and prescription drug prices. Most patients are not medical experts. They rely on others to guide them to the best care for their health and well-being. Cost-sharing, far from incentivizing good behaviors, merely penalizes those who need health care.

We urge all policymakers to consider how best to help people access and afford care and to reduce reliance on theories of behavior that merely cost patients money or even their lives. People must be able to get the care they need. The skin they have in the game is their own.

ADD YOUR NAME

Get The Message Out: SIGN THE GPO/WEP PETITION!!!!

Biden Administration Begins Reversing Harmful Public Charge Rules

This week, the Biden administration began work to reverse harmful immigration rules and policies that were put in place by the previous administration. This includes the **discriminatory “public charge” rules** that sought to increase the type and number of public programs where enrollment can negatively impact a person’s immigration application or status. Such changes could make it much more difficult for older adults and people with disabilities to

pursue citizenship, reunite with their families, and access the supports they need to thrive.

Through an **executive order**, President Biden directed the heads of various federal agencies, including the State Department, the Department of Justice, and the Department of Homeland Security, to review all agency actions related to implementation of the new public charge rules. While the rules cannot be rescinded by



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executive order, the order does demonstrate a commitment to unwinding the Trump-era policies.

Importantly, the order directs departments to eliminate the **chilling effect** of the rule—fear in a population that the rule may apply, causing people to avoid necessary services. At Medicare Rights, we have seen the chilling effect of the public charge rules on communities. It has prevented people from seeking health care, food

assistance, and citizenship. Even American citizens have avoided programs for fear that their use may impact another family member’s immigration status or ability to get a green card.

We applaud this effort to eliminate both the harmful changes of the public charge rules and their perceived impact. Especially during a pandemic, we must do all we can to enable everyone within our borders to have access to needed care that protects both individual and public health.

Biden administration acts to ensure people with disabilities keep their Social Security benefits

The Trump administration worked hard to destroy Social Security every which way it could. Among other things, it made it extraordinarily difficult for people to get the Social Security benefits to which they are entitled. Now, Jake Johnson reports for **Common Dreams**, that the Biden administration has withdrawn a Trump administration not-yet-final regulation that would likely have taken disability benefits from hundreds of thousands of Americans.

The Trump administration tried to subject people receiving

Social Security long-term disability benefits to constant reviews if they wanted to retain these benefits. The additional reviews would have posed challenging administrative hurdles for people receiving benefits. As it is, qualifying for Social Security disability benefits is not easy.

Social Security Works led the advocacy effort. According to its executive director, Alex Lawson, the proposed regulation was “the Trump administration’s most brazen attack on Social Security yet.” “When Ronald Reagan



implemented a similar benefit cut, it ripped away the earned benefits of 200,000 people.

Ultimately, Reagan was forced to reverse his attack on Social Security after massive public outcry—but not before people suffered and died.”

President Joe Biden has a history of proposing Social Security cuts. And, he was criticized for his record on Social Security during the 2020 presidential campaign. He is now holding true to his word during the campaign that he would protect Social Security.

President Biden also promised during the campaign to **increase Social Security benefits**, which are not as high as they should be. For a wealthy country, Social Security benefits in the US are **stingy relative to other countries**. To increase Social Security benefits, it would be particularly helpful for President Biden to **fire the Social Security Administration Commissioner Andrew Saul and Deputy Commissioner David Black**. Donald Trump is responsible for putting these high-level anti-Social Security officials in charge of Social Security.

Medicare Rights Center Asks Biden Administration to Take Swift Action on Several Urgent Policy Matters

Last week, Medicare Rights sent a sign-on **letter** from 50 state and national organizations to the U.S. Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS), urging the agencies to reinstate important COVID-19 related Medicare enrollment flexibilities. As **previously discussed**, this is necessary to help at-risk individuals connect with their coverage during the pandemic. Re-opening these enrollment pathways aligns with the administration’s COVID-19 response strategy, including the decision to improve access to Marketplace plans. We applaud that change and implore the administration not to leave

older adults and people with disabilities behind.

This enrollment ask was also part of a more comprehensive **letter** that Medicare Rights and the Center for Medicare Advocacy sent to HHS and CMS on February 9. Together, we outlined Medicare, Medicaid, and Affordable Care Act policies that need immediate agency attention due to looming deadlines and the unmet needs of millions of Americans.

In addition to simplifying Medicare transitions during the COVID-19 public health emergency, other issues include further changes to ensure all Medicare-eligible individuals can access their earned benefits



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during the pandemic; improvements to Medicare outreach and enrollment strategies to promote timely, effective **BENES Act** implementation and the availability of accurate consumer tools; and an increase in regulatory review efforts to prevent harmful or rushed program modifications. With respect to actions outside of Medicare, we asked the administration to protect access to Healthcare.gov, revoke a misinterpretation of Medicaid Maintenance of Effort (MOE) requirements, and restore Medicaid safeguards.

We look forward to working

with our partners and with policymakers to advance these and other critical reforms.

- ◆ **Read the February 5 letter from 50 organizations calling on the Biden administration to ease Medicare enrollment during the pandemic.**
- ◆ **Read the February 9 Medicare Rights Center and Center for Medicare Advocacy letter urging the Biden administration to take immediate action on key issues.**

The retirement plans of many Americans have been delayed by the pandemic, survey says

Over 40% of retirement savers said the pandemic has made them less confident they will have sufficient funds to retire, according to a **recent survey** from finance magazine Kiplinger and Personal Capital, a wealth management organization.

The pandemic caused many people to borrow from their future in order to meet everyday needs throughout state shutdowns and the **highest number of job losses** since the Great Depression. One third of survey respondents said they took a distribution or loan from their retirement account.

The US government tried to implement bills that would spare Americans from the financial

consequences of the pandemic, through the CARES Act signed into law in March, which permitted loans of up to \$100,000. 58% of those who took loans borrowed between \$50,000 and \$100,000.

For many Americans, the pandemic has caused a major setback in their retirement plans. One third said as a result they plan to work longer.

The withdrawals were not small sums either. Most withdrawals from retirement accounts represented significant amounts of money, with about one-third of respondents who took withdrawals, taking out over \$75,000.

The Kiplinger survey was



conducted during the end of the year and included 744 respondents between the ages of 40 and 74, evenly split between genders with retirement savings of at least \$50,000. The online survey has a 95% confidence level.

The editor of Kiplinger Personal Finance, Mark Solheim, said the survey shows the long-term ramifications of the pandemic.

"The past year rocked the confidence of most Americans saving for retirement," Solheim said in a press release. "With many people dipping into their retirement savings or planning to work longer, 2020 will have a lasting impact for years to

come."

According to the National Bureau of Economic Research, most retirement funds in the US were already underfunded before the pandemic started. Nearly half of Americans between the ages of 32 and 61 do not have any retirement savings and most of those that do have savings under \$21,000, according to a **2019 study** from the Economic Policy Institute.

"Last year presented many challenges," said Personal Capital President Jay Shah. "The pandemic not only created a global health crisis, it impacted the financial outlooks and retirement plans of many." ...**Read More**

Dental Coverage Under Medicare

Two bills that would provide for coverage of dental services under the Medicare program were introduced in Congress last week. *H.R.502*, authored by Rep. Nanette Diaz Barragan (D-Calif.) has been introduced in the House of Representatives, while *S.97*, authored by Sen. Ben Cardin (D-Md.) has been introduced in the Senate.

As of yet, the text of the bills

has not been released but TSCL will be closely monitoring these bills to determine if we will be supporting them. Coverage of dental and hearing care are two of our priorities and we are hopeful this legislation will provide the solution for one of those goals.

Provisions in this legislation will likely be debated within



contentious discussions surrounding "Medicare for All" and healthcare system reform legislation.

A Democratic-controlled Congress means that there will be frequent hearings and proposals related to the future of healthcare coverage in the U.S.

The House passed similar legislative provisions to those in the Medicare Dental Benefit Act

in late 2019 via a Democratic-supported drug price negotiation bill *H.R.3*, the *Lower Drug Costs Now Act*. The legislation did not receive bipartisan support at that time, and slim Democratic seat-majorities in the House and Senate will be a significant hurdle to passing partisan legislation in the current Congress.

Recent Steps to Improve Access to the Federal Marketplace Should Be Expanded to Include Medicare

The Biden administration has taken a number of steps to respond to the COVID-19 public health emergency, including outlining a **national strategy** and issuing executive orders to spur the implementation of that framework.

Among the recent White House directives are several aimed at improving access to care and treatment. This is an especially critical goal for older adults and people with disabilities, as they have a **high risk** of infection, serious illness, and even death from the virus, as well as **disproportionate rates** of unemployment from the resulting economic crisis.

We are encouraged that the January 21 executive order,

"Improving and Expanding Access to Care and Treatments for COVID-19," directs the U.S. Department of Health and Human Services (HHS) to "evaluate Medicare" and other health programs and to "take any available steps to promote insurance coverage for safe and effective COVID-19 treatments and clinical care."

However, the concrete improvements to date currently exclude the Medicare program and those who rely on its coverage. For example, the January 28 executive order, **"Strengthening Medicaid and the Affordable Care Act,"** asks HHS to establish a Special Enrollment Period (SEP) for federal Marketplace coverage "in



light of the exceptional circumstances caused by the ongoing COVID-19 pandemic." We applaud

this decision. As outlined in a **fact sheet** from the Centers for Medicare & Medicaid Services, this enrollment pathway will help more people obtain affordable, comprehensive coverage during the public health emergency.

As significant as this SEP is, it leaves some people behind. It will not help those who are eligible for Medicare and unable to quickly enroll or use their earned benefits. They are no less impacted by the pandemic. Accordingly, we urge policymakers to ease enrollment across federal health care programs. Doing so would

appropriately recognize that all Americans are facing "exceptional circumstances."

As we note in our **transition memo**, "The COVID-19 pandemic and its attendant economic fallout will have a lasting impact on people with Medicare and on the program itself. While additional interventions may be necessary as the situation evolves, the administration must first focus on reforms that are urgently needed to help people with Medicare maintain their health, safety, and independence."

This includes helping people connect with their Medicare at a time when they need it most

What is Ambulance Transportation or Medical Transport?

The purpose of ambulance transportation is to transport injured or sick individuals to and from an emergency room, medical center, or physician's office. Ambulance transportation is classified into two categories: emergency and non-emergency transportation. Although non-emergency transport can be purchased for any reason, it is most notably used in pre-scheduled transports after a surgery or operation, especially when the patient is in a

wheelchair or confined to a bed. Emergency transportation is typically used in the event of a medical emergency, when the individual's health is in serious danger.

Average Cost of Ambulance Transportation

Non-emergency ambulance transportation is only covered if you have Medicare Part B. It will only bring you to the closest appropriate medical facility equipped to provide the care needed. Medicare will pay



to have you transported out of your area if there are no adequate services provided closer to you. If the ambulance company will not cover the charges, they are required to supply an Advance Beneficiary Notice of Noncoverage. All ambulance suppliers must accept your Medicare privileges.

Conditions and Requirements for Non-Emergency Ambulance Transportation

All ambulance transportation must be medically necessary, and you will need a physician's note to qualify. This is known as a Physician Certification Statement. They can be administered by a physician assistant, clinical nurse specialist, nurse practitioner, registered nurse, or your primary physician. Non-emergency ambulance transportation is used when other means of transit would endanger a senior's health. ...[Read More](#)

NARFE Applauds Introduction of Bill That Would End the Windfall Elimination Provision and Government Pension Offset

Alexandria, VA – *In response to Reps. Rodney Davis, R-IL, and Abigail Spanberger, D-VA, introducing the Social Security Fairness Act, H.R. 82, that would repeal the Windfall Elimination Provision (WEP) and the Government Pension Offset (GPO), NARFE National President Ken Thomas issued the following statement:*

"For decades, NARFE has supported full repeal of the Windfall Elimination Provision

and Government Pension Offset, and applauds introduction of a bill in the House, H.R. 82, to do just that. These policies have unfairly punished retired public servants through reduced Social Security benefits for far too long.

"This bill would provide much-needed relief for the millions of retirees and survivors currently affected by this inequitable practice and will



improve fairness for future retirees. Public servants already receive lower wages, on average, than those in the private sector. Government annuitants and their families are penalized yet again for their sacrifice through Social Security benefit reductions imposed by WEP and GPO, which disproportionately affect lower-earning households and widows. These individuals are unduly punished simply

because they worked in the public sector on behalf of their country.

"NARFE applauds Reps. Davis and Spanberger as they reach across the aisle, setting an example for their parties, in an effort to put an end to these shameful policies, which have harmed millions of hardworking and dedicated public servants for too many years."...[Read More](#)

Community Health Workers, Often Overlooked, Bring Trust to the Pandemic Fight

For 11 months, Cheryl Garfield, a community health worker in West Philadelphia, has been a navigator of pandemic loss and hardship. She makes calls to people who are isolated in their homes, people who are sick and afraid and people who can't afford their rent or can't get an appointment with a doctor.

The conversations always start with a basic question: "Tell me about yourself." She wants to know her clients before she figures out how she can help.

"Sometimes a patient just needs somebody to listen to them, so you just listen," said Garfield, 52.

Public health authorities are relying on Garfield and her peers to be a bridge to communities that have been

hardest hit by covid-19 and who are most skeptical about the new vaccines. African Americans and Hispanics have been hospitalized with covid at **rates more than three times higher** than for non-Hispanic white Americans, but they are **among the most hesitant** to get the vaccine. As the pandemic brings long-standing health disparities into sharper view, community health workers are coming to the forefront in the public health response.

It is an about-face after their efforts were largely curtailed early in the pandemic, when "nonessential" health services came to a halt. Community health workers "were sidelined but the needs of the community weren't sidelined," said Lisa



Hamilton Jones, co-president of the Florida Community Health Worker Coalition. "Now we're seeing more hiring of community health workers than ever. If you look at the virus and the timeline, why did it take so long?"

President Joe Biden has endorsed a bigger role for these workers as part of his \$1.9 trillion "American Rescue Plan." The proposal includes the **hiring of 100,000 people** to help with "vaccine outreach and contact tracing in the near term, and to transition into community health roles" after the covid crisis is over.

With their deep roots in the community, many of these workers were disappointed when they were not called on to help

initially in the pandemic. Community health workers often work on grant-funded projects with a specific goal, such as improving blood sugar control among people with diabetes. When the pandemic shutdown suspended those programs, many found themselves without a job.

They became marginalized workers within marginalized communities.

"We were hearing from our members across the country, 'I'm trying to get in touch with my local health department to say I want to help,'" said Denise Octavia Smith, executive director of the National Association of Community Health Workers. "They couldn't even get through to the [local covid] task force."...[Read More](#)

What is Independent Living?

Independent Living, also known as retirement living, is a senior housing option for aging adults in which the resident lives independently without aid or assistance. The philosophy behind independent living is to keep the resident sovereign, create a social community, and promote healthy living and independence. Independent Living refers to level of care rather than age. Generally speaking, most individuals who living in a retirement home are senior citizens, however it is common to find ages ranging from people in their late fifties to early nineties. Independent Living provides the lowest level of care in senior housing spectrum, followed by **assisted living** and **skilled nursing**.

Services Provided by Retirement Communities:

- ◆ Transportation to medical appointments
 - ◆ Transportation for errands
 - ◆ Laundry Services
 - ◆ Dining Services - options may vary from buffet-style, sit-down dining, open-hour dining, set-hour dining
 - ◆ In-Community Social Programs – bingo, movie nights, trivia nights, holiday celebrations, etc.
 - ◆ Outside -the-Community Social Programs – day trips to museums, movies, casinos, etc.
 - ◆ Fitness and exercise programs
 - ◆ Salon, barber and spa services
- Retirement Living does not include:
- ◆ Medical Assistance and

Health Care

- ◆ Rehabilitation Therapy
- ◆ Assistance with Daily Living (ADL's) – self performance activities such as bathing, homemaking, feeding, grooming, dressing, and going to the bathroom

What does a Retirement Community look like?

Independent living communities can vary in size from small to large, from approximately 30 units to 300 units, and can look and feel very different depending on the setting and ambiance of the community. When choosing a retirement community it is important to find an option that best suits your needs, income and lifestyle:

- ◆ Condo Setting - apartment style living with community amenities located in the building
- ◆ Cottage Setting – small houses or townhomes with community amenities located in a detached building on-site
- ◆ Mobile Homes – caravan style living with community amenities located in a detached building on-site
- ◆ Active 55+ Communities – geared towards individuals with higher incomes, these communities are well known for having updated amenities, well-maintained facilities, and a fantastic curriculum of programs and classes
- ◆ Low-Income Housing/ HUD Housing/ Subsidized Housing/ Section 8 Housing – geared



towards individuals with low annual household incomes, typically a portion of rent is subsidized by the government

- ◆ Veteran Housing – reserved only for Veterans and their spouses, typically a portion, if not all, of rent is subsidized by the government

What if the resident needs help with Assistance in Daily Living (ADL's) and/or Medical Care?

Retirement Homes do not provide Assistance with Daily Living and Medical Care; therefore when a situation requires one of these services there are multiple routes the resident can take. The first step should always be to assess the extent of care required. If the resident needs assistance with grooming, bathing, dressing, medication reminders, dressing, etc. then hiring a third party homecare provider may be the easiest and most affordable option. If the situation deteriorates to the point that it is unsafe for the resident to live without 24 hour readily available assistance, then moving the resident to an assisted living facility is the best option.

If medical care is required then the extent of medical attention should be assessed immediately. If it is determined that care can be provided inside the home then outsourcing a third party Home Health Agencies is a great option. Home Health Agencies provide nursing care, physical therapy, occupational therapy, and speech therapy, among other

services. In some cases the needs of the resident calls for a doctor's attention rather than the aid of a **home health agency**. Conveniently, there are visiting physicians and house-call doctors who are experts at providing care in the retirement facility.

In more extreme cases, the resident may need to be transferred temporarily or moved permanently from the retirement home in order to receive the proper level of care. **Short-term rehab facilities** are designed with the intent to quickly rehabilitate the patient and get them back in their home as fast as possible. If long-term rehab is needed the senior should be transferred to a nursing home. Many retirement homes also provide assisted nursing, and some even provide all three (**CCRC - Continuum Care Retirement Community**). The virtue of a CCRC is the resident rarely has to leave the facility to receive the appropriate care needed. In the event that hospitalization is required immediately call 911.

, or are simply looking to find out more information, we have FREE Care Counselors who can help by calling 1-800-955-8510, or sending an email to info@seniordirectory.com.

5 of the best meal delivery services for seniors

Seniors, or older adults, may wish to use a meal delivery service for convenience and ease. Some brands cater to older adults by specifically considering their health requirements.

Older adults may only need meals for one or two people and may be unable to shop for ingredients or cook meals easily.

Using a meal delivery service can help save time and effort. There are many brands available online, but some may be more suitable for an older person's health and lifestyle requirements.

This article looks at five meal delivery services that are suitable for older adults. It discusses how they work and looks at their menus. It also looks at potential health benefits and drawbacks of meal delivery and some alternatives that people can consider.

How does meal delivery work?.

Meal delivery services offer either ready-made meals or meal kits.

Meal kits include ingredients and a recipe, which a person can



use to prepare meals at home.

Some older adults may prefer the convenience of heating up a ready-made meal. Others may enjoy cooking but like not having to source recipes or shop for ingredients, in which case they may prefer a meal kit.

Brands that deliver meals for one or in smaller portions may suit older adults. Additionally, some older adults may have health conditions or need to eat special diets, so they may prefer services that provide meals to

suit them. Depending on their health, some older adults may need to eat pureed food, and some brands offer this.

Older adults may prefer to use a service that is easy to order from and has the flexibility to skip weeks or vary the number of meals they choose.

With these points in mind, the following meal delivery services may be suitable for older adults.... **Read More**

Well-kept secrets of Medicare Advantage plans (MA)

Written by **Diane Archer**

In the last few weeks, I've given a couple of talks focused on Medicare Advantage. I always highlight the biggest well-kept secrets of Medicare Advantage plans, summarized below. They should give anyone thinking of joining a Medicare Advantage plan pause.

Believe me, I realize that traditional Medicare is unaffordable for many people because **it lacks an out-of-pocket cap**. That's an issue Congress needs to fix because traditional Medicare gives people the **freedom to choose** the care they want from the doctors and hospitals they want to use. Anyone who joins a Medicare Advantage plan loses that freedom and takes a big gamble.

Insurance is about tomorrow at least as much as today. Not needing much health care now is not a reason to choose a Medicare Advantage plan. When you do, accessing care in an MA plan can be stressful. Inappropriate delays and denials of care are routine, as are restricted and ever-changing networks.

Medicare Advantage can take a huge financial and emotional toll on you and your family. As long as you're healthy, you're fine. If you get sick, it's impossible to know whether your Medicare Advantage plan will meet your needs. If you're able to get the care you need when you develop a costly or complex condition, Medicare

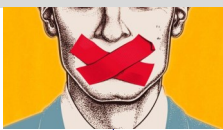
Advantage can be far more expensive than traditional Medicare. Out-of-pocket costs are now more than **\$7,550 for in-network care alone**.

It's inhumane and unconscionable for Congress to force vulnerable Americans to take such a large risk with their healthcare in Medicare Advantage. It's equally wrong to keep people from switching out of Medicare Advantage to traditional Medicare because it lacks an out-of-pocket cap and getting affordable supplemental coverage is not guaranteed.

MA plans offer insurance that can disappear when you need it

- ◆ They can tempt you with inexpensive things like gym club memberships and low premiums
- ◆ They can tease you by not interfering with routine inexpensive items of healthcare
- ◆ They can arbitrarily deny you access to expensive healthcare your doctors recommend
- ◆ They can arbitrarily **restrict and change their provider networks at any time**
- ◆ They can arbitrarily change their coverage rules at any time
- ◆ They can change ownership, leadership and behaviors at any time

MA plans take away your choices



◆ They often **do not cover care from many of the providers** in your community

- ◆ They often do not cover any care at **Centers of Excellence**
- ◆ They impose out-of-pocket costs for most care
- ◆ They don't reliably cover the care your doctors think you need
- ◆ They can endanger your health with **widespread and inappropriate delays and denials of care**
- ◆ They often do not offer high-value care for people with complex conditions; if they do, they don't make it easy to get, and may not even let you know about its availability
- ◆ They do not disclose their mortality rates, denial rates, and average out-of-pocket costs

MA plans are paid a fixed rate upfront; the less they spend on your healthcare, the more of your money they keep and the more profits they make

- ◆ Their business model prioritizes covering low-cost care over high-value care
- ◆ Their business priorities are to **pay for less care** and pay less for care
- ◆ To compete effectively and keep their premiums low, they design their plans to avoid enrolling people with complex conditions
- ◆ They lack an incentive to focus on people's long-term

needs or the needs of the community, as they must answer to Wall Street on a quarterly basis.

- ◆ They see money spent on your health as an avoidable expense, not as an investment in our mutual futures
- ◆ They are difficult and **costly to oversee**
- ◆ They are largely unaccountable for violating their **contractual obligations** or engaging in fraud
- ◆ They can leave your community at any time

Here's more links on Medicare Advantage plans:

- ◆ **What if the government paid Medicare Advantage plans differently?**
- ◆ **Medicare Advantage gold mine puts traditional Medicare at grave risk**
- ◆ **Ten ways Medicare Advantage plans differ from traditional Medicare**
- ◆ **Senators ask Medicare agency why it is not holding Medicare Advantage plans accountable for violating their contractual obligations**
- ◆ **Will Congress allow Medicare drug price negotiation in 2021?**

Important Documents Checklist

What financial and legal documents do you and your elderly loved ones need? One way to make doctor or hospital visits just a tad easier on yourself is by having all the necessary documents with you when you go. Your best bet is to get a notebook with some pockets so that you can keep all this important paperwork in one place. Plus it makes it easy to grab as you head out the door.

What to Keep in Your Notebook

1. Insurance and Medicare card
2. List of Current and Past Medications
3. Names and phone numbers of relatives, friends or geriatric care managers
4. Discharge papers, if applicable
5. Care Plan document, if applicable

Face sheet, if applicable
Other Important Documents
Additionally there are a few



documents that you should create so that your wishes in regard to care are known and that someone can act on your behalf. A copy of the following records should be kept in a safe place. You will not need these documents on a typical doctor's visit, but you should have them if you are hospitalized with any prolonged ailment. If you put these documents into your notebook have them towards the back so they aren't exposed. Make sure

trusted loved ones know where copies of the following documents are kept:

1. Advanced Health Directive or a Living Will
2. Durable Power of Attorney **Health Care Proxy or Medical Power of Attorney (MPOA)**
Finding an Elderlaw Attorney
If you need help drafting these documents, contact a
Assisted Living Costs Near You
Compare pictures, pricing, options.

When Heart Attack Strikes, Cancer Patients Often Miss Out on Lifesaving Treatment

Too few cancer patients who have a heart attack are receiving emergency angioplasties that could save their lives, a new study finds.

"This is an important study, which underscores the broader issue in cardio-oncology of cancer patients too often being passed over for potentially beneficial procedures," said Dr. Robert Copeland-Halperin, a cardiologist unconnected to the new research.

While cancer patients may be at higher risk for some complications, there's "the potential [of angioplasty] to not only open the artery or valve, but open the future for these patients, by enabling them to receive more effective treatment for their cancer," said Copeland-Halperin.

He's a specialist in cardio-oncology at Northwell Health Cancer Institute in Lake Success, N.Y.

Because cancer and heart disease often occur in the same person, "what we want is to help the patient, and hence a cardiologist and an oncologist must work together to produce the best results for the patient," Copeland-Halperin said.

In the new study, published Feb. 4 in *European Heart Journal – Acute Cardiovascular Care*, British researchers compared rates of what's formally known as "primary percutaneous coronary intervention" (PCI) -- also called coronary angioplasty -- in heart attack patients with and without



cancer. They also assessed the effectiveness and safety of the treatment in the two groups of patients.

PCI involves a stent being placed in a blocked artery to help restore blood flow to the heart. Ideally, the procedure should be performed within two hours to minimize heart muscle damage.

Primary PCI is the standard of care for heart attack patients. But there's been anecdotal evidence that patients with cancer are less likely to receive it, and the benefits of PCI in heart attack patients was unclear, explained study lead author Dr. Mohamed Mohamed, of Keele University in England.

As Copeland-Halperin explained, cancer and its

treatments can raise risks during heart procedures. "Cancer patients are undoubtedly a high-risk cohort, with increased incidence of bleeding," as well as an increased odds for heart attacks and strokes, re-hospitalization, and death. But he said that's true "in essentially any [medical] context."

To find out if discrepancies in heart attack care exist, Mohamed's team analyzed 2004-2015 data from more than 1.8 million adults treated for heart attacks in the United States. All had what's known as an "ST-elevation myocardial infarction" (STEMI) heart attack, which is caused by a blockage of an artery that supplies blood to the heart....[Read More](#)

How to improve poor circulation in the feet

Poor circulation in the feet can cause the feet to become cold, discolored, or numb. Sometimes, it is a symptom of an underlying condition.

The body transports blood, oxygen, and nutrients to cells around the body through the circulatory system. If blood vessels in an area close, harden, or narrow, a person may develop reduced circulation.

In this article, we will look at the symptoms of poor circulation in the feet, potential causes, treatments, and self-care techniques.

Signs and symptoms

People with poor circulation may notice their feet feel cold or numb. They may also notice discoloration. The feet may turn red, blue, purple, or white.



These symptoms may worsen in certain situations, such as when a person sits still for long periods of time or goes outside in cold weather. However, for some people, these symptoms may be constant or flare up due to an underlying condition.

Additional symptoms of poor circulation can include:

- ◆ dry or cracked skin
- ◆ hair loss on the legs or feet
- ◆ weak toenails
- ◆ slow wound healing

Underlying causes

Below are some of the underlying conditions that may cause reduced circulation....[Read More](#)

Are Your Allergies Worse? Blame Climate Change

In a grim development for allergy sufferers in North America, a new investigation warns that pollen seasons are getting longer and worse.

Over the last three decades, the annual pollen season has expanded by nearly three weeks, accompanied by a 21% jump in pollen concentrations.

A big underlying cause: climate change.

"It is clear that global warming is the major culprit in the lengthening of pollen seasons, and it seems to be playing a more moderate role in exacerbating annual pollen

levels," explained study lead author William Anderegg, an assistant professor of biology at the University of Utah, in Salt Lake City.

For the study, Anderegg and his team analyzed pollen concentration data gathered between 1990 and 2018 from 60 pollen count stations across the United States and Canada. The stations are run by the U.S. National Allergy Bureau.

After stacking pollen data up against two dozen climate models, the investigating team concluded that climate change



accounted for roughly half of the expanding pollen season trend. Rising temperatures were pegged

responsible for about 8% of the rise in pollen concentrations.

"This is because pollen seasons are incredibly sensitive to temperature, and global warming is far and away the main driver of temperature increases in the U.S. over this period," Anderegg said. "There are likely other drivers influencing pollen patterns, too, things like changing vegetation and wind patterns. But the

impact of global warming particularly on pollen season start and length is quite clear."

The study findings were published online Feb. 8 in the *Proceedings of the National Academy of Sciences*.

Anderegg explained that pollen season "is the window of time when pollen concentrations rise above a certain minimum threshold." This is often when allergy sufferers start to experience issues, such as sneezing and wheezing....[Read More](#)

What is the Black Box Warning?

The U.S. Food and Drug Administration (FDA) monitors, tests and certifies all medications which become available to us on the market. A black box warning, sometimes referred to as boxed warnings, is the most stern warning that the FDA issues. They are issued when there are certain serious safety risks related to taking the prescribed medicines. Though the risk of injury may be relatively small, when compared to the number of people who take the medicine, the injuries can be severe enough to warrant the attention of our doctors, pharmacists and us, the patients.

These warnings communicate to us the potential, albeit rare, but dangerous side effects. They also inform us of safe usage and a variety of potential factors which might increase an unwanted episode injurious to our health. The black box warnings are on the outside of the prescription bottle, in bold print, with a black border. They may also be printed on information sheets inside the packaging.

Warnings Communicate Possible Risk

When we pick up a prescription which has a black box warning, it does not necessarily mean that we should

not take the drug. The warnings are primarily to alert health care professionals, so that they can either discuss the medicine with the patient or at least know what to be aware of if they are already familiar with the patient's medical history. Some medicines should not be taken by someone who is pregnant or nursing.

What prompts a black box warning?

All medicines go through clinical trials, wherein the proposed medicine is tested on people who have the malady, or symptoms, which the drug has been designed to treat. When the trial data is such that the FDA identifies a concern with possible serious outcomes, the manufacturer can be required to state the concern/warning on the labeling of its product. Again, this does not mean that all people who take the prescribed drug will have a high risk of what is termed an "adverse event." It does mean, however, that health care providers and patients alike should be aware of those risks.

Information Available From the FDA

The [Guide to Drug Safety Terms at the FDA](#) is an excellent source of information



provided to us by our government. As patients of, presumably, some doctor(s) or another, we have a responsibility to

be at least somewhat educated about the medicines we take. Government agencies use terms which are often stark, direct and sometimes a bit frightening or intimidating. Such is the nature of the language of government. We do not have to learn how we can assist our medical professionals in our own health care.

We also have a responsibility to be aware that our doctors are not omniscient and infallible. It is not possible for them to remember every risk factor for every patient that they attend to. If we are taking aspirin for headaches, and our doctor prescribes a blood thinner for us, the onus is on us to make certain that the doctor knows that we take something for headaches. Aspirin is a blood-thinning agent. It does not go well with taking a prescription blood thinner. Similarly, if we eat a lot of leafy greens and other green vegetables which are high in vitamin K, which is a blood coagulator, we need to let our doctors know. Vitamin K

works against blood thinners. But if we do not tell our doctors all that we are taking, then she or he might prescribe something that could harm us.

In short, Dear Reader, black box warnings are there to protect us from unwanted side effects from medicines we ingest. Most of the time, those medicines alleviate whatever is ailing us. It is important that we remain vigilant and mindful about what we put into our bodies, particularly when we have some years under our belts and/or suspenders. None of us can live a 100% risk-free, pain-free or malady-free life. It just does not work that way, not even in Utopiaville. Read the labels and black box warnings on any medications you are taking. If you have questions, ask your doctor, PA or pharmacist before taking the first dose. Then go outside and play! Don't worry. Be happy. Back in the days depicted in the old Flintstone cartoons, prescription medicines were not even an option. We would all do well to be grateful that we have such options today.

Feeling SAD? Here Are Ways to Ease Winter Blues

The COVID-19 pandemic can make mental health struggles even worse for some people with seasonal affective disorder (SAD).

SAD is a type of depression triggered by the shorter daylight hours and gray skies of winter. It causes symptoms such as overeating, social withdrawal and decreased energy.

Pandemic-related effects such as stress, anxiety and social isolation could make SAD even worse for some people, according to Dr. Drew Pate, chief of psychiatry at LifeBridge Health, a health care corporation in Baltimore.

He offered some advice for people with SAD. No. 1 on his list: Get as much exposure to

sunlight as you can.

"Open your curtains and blinds in the morning and position yourself near windows at work if you can," Pate suggested in a LifeBridge news release.

"Exposing yourself to natural light early in the day, even light on a cloudy day, can help improve your mood and energy level."

If possible, sit outside during work breaks, Pate recommended. And, he added, consider using a light therapy box.

"Using a light therapy box in the morning soon after waking up can have dramatic effects on your mood and energy level throughout the day," Pate said.



Here are some other coping strategies:

◆ **Be active.** "Regular exercise and activity can be especially powerful in combating low moods and low energy," but be sure to follow social distancing rules, Pate said.

◆ **Maintain consistent schedules.** Go to bed and wake up at the same times daily, and stick to a mealtime schedule, Pate advised. "Consistent routines will help keep your mood on track and ensure your mind and body's need for appropriate rest and nutrition is met so that you can address other potential causes of worsening mood or

low energy," he said.

◆ **Stay connected.** Isolation "can be a major contributor to worsening mood and energy level," and increased social isolation and disconnection during the pandemic "are harmful to our overall well-being," Pate said. In-person interaction may not be possible, but you can phone, text or have video chats.

◆ **Relax and do things you enjoy.** Set aside time for self-care and activities.

If your mood or energy still aren't improving, consider seeking professional help, Pate advised.

Whole Wheat Better for You Than White Bread, Study Confirms

New research reinforces advice to include more whole grains in your diet.

A diet heavy in "refined" grains (such as white bread, cookies and muffins) may increase your risk for heart disease and early death, while whole grains may lower it, according to the study.

"We encourage people to have moderate consumption of carbohydrates and to have different types of grain, especially whole grain," said lead researcher Mahshid Dehghan, of the Population Health Research Institute at McMaster University in Hamilton, Ontario, Canada.

"Reduction in quantity and improving the quality of carbohydrates is the message of our study," Dehghan said.

Grains like oats, rice, barley and wheat make up about half of diets around the world and as much as 70% in low- and middle-income countries, particularly in Africa and South Asia, the researchers noted.

The findings don't prove that a diet heavy in refined grains causes stroke, heart attacks or other forms of heart disease, only that there seems to be a link.

For the study, the research team collected data on more than



137,000 people in 21 countries who were aged 35 to 70, had no history of heart disease and were tracked for more than nine years.

People who reported eating 12 ounces of refined grains a day were found to have 27% higher odds of early death and a 33% higher risk of heart disease than those who limited their intake to less than 2 ounces a day.

A diet heavy in refined grains was also linked to higher blood pressure, the findings showed.

The participants self-reported the quantity and type of grains in their diet, so the researchers

noted that they can't vouch for accuracy of that data.

The study looked at white rice apart from other refined grains because more than 60% of participants lived in Asia, where rice is a staple.

Dehghan said no significant link was found between eating whole grains or white rice and adverse health outcomes.

"Getting about 50% to 60% of energy from carbohydrates is OK, but we encourage people to lower their carbohydrate consumption," she said....[**Read More**](#)

Daily Green Tea, Coffee Tied to Lower Risk for 2nd Heart Attack, Stroke

If you have had a heart attack and a stroke, you might want to stock up on green tea.

New research from Japan finds survivors who drink plenty of green tea may live longer lives.

Stroke survivors who drank at least seven cups per day were 62% less likely to die during the study period, versus non-drinkers. Similarly, the risk was cut by 53% among heart attack survivors who downed that much tea.

Green tea was not the only beverage tied to longer life. For heart attack survivors -- as well as people with no cardiovascular problems -- moderate coffee

intake was also linked to better survival.

The coffee benefit did not extend, however, to stroke survivors.

What does it all mean?

The findings do not prove that either beverage is a life-prolonging elixir. But they do add to evidence that plant compounds called flavonoids are good for cardiovascular health, according to Dr. Andrew Freeman.

Freeman, who was not involved in the study, is director of cardiovascular prevention and wellness at National Jewish Health in Denver.

There are no magic bullet foods, and a few cups of green



tea won't "cancel out the effects of a bacon cheeseburger," Freeman said.

He stressed the importance of an overall diet low in processed foods and rich in plant-based ones -- including fruits, vegetables, beans, whole grains and vegetable oils.

That said, people would benefit from replacing sugary drinks with tea and coffee -- provided they don't load those beverages down with cream and sugar, Freeman noted.

He said brewed teas and coffee are also better options than "diet" drinks, with their artificial sweeteners.

A caveat, Freeman said, is that people sensitive to caffeine would want to be judicious, especially with coffee.

The study was led by Dr. Hiroyasu Iso, a professor of public health at Osaka University, and published Feb. 4 in the journal *Stroke*. It involved more than 46,000 Japanese adults aged 40 to 79 who were followed for about 20 years. The group included 478 stroke survivors and 1,214 heart attack survivors.

At the outset, the participants completed questionnaires on their diets and other lifestyle habits. By the end of the study, 9,253 people had died....[**Read More**](#)

Why Adding on a Few Pounds as You Age Might Be Good for You

Putting on a few extra pounds in your 50s may add years to your life -- *if* you start off at a normal weight and your weight gain doesn't tip into obesity, a new study suggests.

But two outside experts cautioned that the findings are not a license to pack on the pounds, as study participants who started off obese and continued to gain weight over the years were actually least likely to survive into old age.

"If you are already heavy, getting heavier isn't going help, it will harm you," said Dr. Ann Rogers, who reviewed the

findings. She's director of the surgical weight loss program at Penn State Health Milton S. Hershey Medical Center.

For the new study, researchers looked at data from two generations of participants in the Framingham Heart Study, which began in 1948. They were grouped into categories based on their weight gain over the years. The study focused on body mass index (BMI), a measure of body fat based on height and weight, between ages 31 and 80.



Folks who started out at normal weight (BMI: 18.5 to 24.9) but gradually gained with advancing age lived

longer than their counterparts who maintained their younger normal weight throughout their life span, the study found.

"For people with normal weight in early adulthood, moderate weight gain into overweight in later adulthood is associated with lower [death] risks compared to those who remain in the range of normal weight over the course of adulthood," said study lead

author Hui Zheng, an associate professor of sociology at Ohio State University.

People who are overweight or obese in early adulthood and gain weight have the highest risk of dying early, he said.

But "modest extra body weight in old age, including lean tissue mass and fat mass, might provide protection against nutritional and energy deficiencies, metabolic stresses, the development of wasting and frailty, and loss of muscle and bone density caused by chronic diseases such as heart failure," Zheng said....[**Read More**](#)

What are Post Acute Rehabilitation Hospitals?

Most hospitals deal mainly with short-term acute care. This means that the goal for most visits to the hospital is to immediately make someone better, usually with surgery or some other medical procedure. Post-acute care rehabilitation hospitals deal with the aftermath. Many seniors need time after short-term post acute care to become stable

enough to reach the point where discharge back to their normal living residency is possible.



Post-acute rehabilitation can take place in any of the following settings:

- ◆ Long-term care hospitals
- ◆ Inpatient rehabilitation facilities
- ◆ Skilled nursing facilities

◆ Home Health Agencies
Post-acute rehabilitation helps seniors with one or more of physical, occupational, and speech therapy:

- ◆ Coordination and balance
- ◆ Strength and flexibility
- ◆ Swallowing and speech
- ◆ Cognition

Some of the common reasons seniors undergo post-acute rehabilitation are for:

- ◆ Pelvis breaks
- ◆ Degenerative or spinal cord injuries
- ◆ Surgery and amputations
- ◆ Strokes and heart attacks
- ◆ Neurological disorders such as Parkinson's or Multiple Sclerosis

Patients With Diabetes Need More Counseling on Low Blood Sugar

Doctors need to do a better job of discussing low blood sugar with patients who take high-risk diabetes medications such as insulin, researchers say.

Low blood sugar (hypoglycemia) is the most common serious side effect of diabetes treatment. Severe cases can lead to falls, emergency department visits, and may increase the risk of stroke and death.

"For patients to have safe diabetes treatment, there needs to be open communication between them and their health care provider about medication side effects, especially hypoglycemia," said study leader

Dr. Scott Pilla. He is assistant professor of medicine at Johns Hopkins University School of Medicine, in Baltimore.

The study was published recently in the *Journal of General Internal Medicine*.

According to the researchers, 12% of diabetes patients who participated in a 2018 survey said they had had severe hypoglycemia within the previous year.

In the new study, Pilla's team looked at 83 primary care visits by 33 patients with diabetes who took insulin or sulfonylureas, such as glipizide (Glucotrol) and



glyburide (Glynase). Low blood sugar and how to prevent it came up in less than one-quarter of those visits, the researchers found.

Even though patients were concerned about hypoglycemia, doctors rarely checked how often it occurred, its severity or how it affected patients' quality of life, according to the study authors.

"For example, we found in our study that clinicians almost never counseled against driving a car if a patient thinks his or her blood sugar is low or may become low," Pilla said in a Hopkins news release. "This is

an important discussion to have because low blood sugar could cause a person to think unclearly and have an accident."

Primary care clinicians must make hypoglycemia counseling a priority for patients taking high-risk diabetes medications, he said. But it's also important for patients to raise the topic, he added.

"Primary care clinicians should work together with patients to figure out how to best prevent low blood sugar episodes and choose the safest diabetes treatment," Pilla said.

Specialist Care for Alzheimer's Is Tough to Find for Poorer, Rural Americans

Although Alzheimer's disease is a devastating diagnosis that is better delivered earlier rather than later, new research suggests poor patients living in rural areas may not have access to the specialists who could spot the first signs of memory declines.

The team from Vanderbilt University in Nashville, Tenn., led by Sayeh Nikpay, now an assistant professor at the University of Minnesota's School of Public Health, sought to determine whether Medicare beneficiaries with Alzheimer's and related dementias were receiving care from specialized geriatric providers, as well as whether there were socioeconomic differences in access to care.

"Folks with Alzheimer's disease and related dementias are in fact seeing these providers, and that's good," Nikpay said. "However, what's

troubling is that there are longstanding, socioeconomic disparities and also geographic disparities in access to specialized care. And what we're seeing is those disparities still apply here in this population."

The research team used the Southern Community Cohort Study, which enrolled about 85,000 people, aged 40 to 79, in 12 southeastern states between 2002 and 2009. That data came from a predominantly low-income population.

The investigators followed 10,380 participants who had turned age 65 by 2016. Of these, 1,295 participants had at least one Medicare claim that indicated Alzheimer's disease and related disorders between 1999 and 2016.

For those who have these diseases, people with incomes



above \$24,999 were more likely to have seen a geriatric specialist than those with incomes below \$15,000. And the odds of having at least one visit were lower for those in non-metropolitan areas, according to the study.

More than 5 million Americans aged 65 and older have Alzheimer's disease and related dementias. That could grow to 13.8 million by the middle of the century, according to the study authors.

Specialists in geriatrics are trained in how to identify people with cognitive ("thinking") decline and may be able to identify Alzheimer's and related dementias earlier in the disease process, Nikpay said.

"When we're thinking about how to improve care for these populations, we really need to think about how we increase

access for these lower socioeconomic groups. How do you design a payment policy that maybe makes it easier for them to access care," Nikpay said.

Though the researchers don't address this in the study, it opens up a broader set of questions, she said. Is it transportation that's difficult? Is it the lack of a caregiver? Is it not having the money for cost-sharing? Nikpay said she plans to do further research to determine the specific barriers.

The study was funded by the U.S. National Institutes of Health and the National Cancer Institute. The findings were published recently in the *Journal of General Internal Medicine*.

Nikpay thinks it would help to have qualitative interviews with families experiencing these issues to identify the barriers to access.... **[Read More](#)**