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RI ARA

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White House vague on surprise billing, drug pricing bills

In President Donald Trump's final State of the Union address of his first term, he told Congress he would swiftly sign bipartisan drug-pricing legislation if lawmakers sent a bill to his desk.

But Trump stopped short of a full endorsement of a major bipartisan drug-pricing deal brokered by Senate Finance Chair Chuck Grassley (R-Iowa) and ranking member Ron Wyden (D-Ore.). While he called upon Congress explicitly "to pass Senator (John) Barrasso's highway bill," by contrast Trump's comments on drug pricing left some wiggle room.

"I have been speaking to Senator Chuck Grassley of Iowa and others in the Congress in order to get something on drug pricing done, and done properly. I am calling for bipartisan legislation that achieves the goal of dramatically lowering prescription drug prices," Trump said.

The statement is emblematic of the White House's approach to healthcare policymaking in Congress so far in 2020 — to support bipartisan progress broadly, but to hold back from exclusively endorsing major bipartisan legislative packages that stalled in December. Some observers and congressional staff see the approach as leaving room for bipartisan dealmaking, while others worry that vague calls for action will not be enough to break through stubborn gridlock.

White House spokesman Judd Deere said that Trump has clearly stated he wants Congress to address drug pricing and surprise medical billing legislation, and that Democrats "ducked completing work on key healthcare priorities" last year.

"Many excellent provisions are being considered on Capitol Hill and the White House remains in close contact with Members as we work to move a solution forward that advances the President's priorities," Deere said in a statement.

"Congressional Republicans are paralyzed because they are not clear what the President's position is, and this confusion coming from the White House is holding up efforts to get these priorities done," the Democratic source said.

Congressional observers and staff agreed that the impasse on both issues has been persistent, and Trump may be the only actor with the leverage to compel Congress to act on major healthcare legislation ahead of a May 22 deadline to fund some expiring Medicare and Medicaid programs.

"President Trump's support for a specific policy on surprise billing or drug pricing could be the key to unlock months of gridlock on these challenging issues," said Shea McCarthy, a senior vice president at Thorn Run Partners. "For now, that key might as well be hidden under a mattress somewhere."

Trump promised to save Medicare and Social Security — his proposed budget targets them

The budget cuts also include Medicaid spending

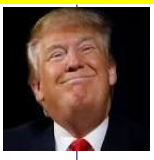
The White House unveiled its budget proposal on Monday, part of which appears to contradict the promises the president made to save safety-net programs like Social Security and Medicare.

Among the cuts, the proposal — which is for **fiscal year 2021** — would impact Medicare prescription-drug pricing and disability benefits. The proposed budget also suggests changes to Medicaid and food stamps.

See: Trump's latest plan will make a 'big dent' in deficit, White House budget office claims

This is not the first time a budget proposal has suggested cuts to entitlement programs. The **2020** fiscal year budget, released last winter, and the 2019 fiscal year budget the year **prior,** had similar suggestions.

But this budget proposal does come just a week after the president said he would protect these programs. "We will always protect your Medicare and we will always protect your Social Security. Always," he said during the State of the Union **speech** on Feb. 4.



He also said last month he would save Social Security, and that the Democrats would destroy it. "I have totally left it alone, as promised, and will save it!" he tweeted on Jan. 23, after being criticized for saying entitlement programs would "**at some point**" be on the table for cuts during the World Economic Forum in Davos, Switzerland.

"This budget foreshadows a broader attack on seniors' earned benefits that President Trump hinted at in a recent interview, when he said that cutting 'entitlements' is 'the easiest of all things,'" said Max Richtman, president and chief executive officer of the National Committee to Preserve Social Security and Medicare, referring to the comments in Davos.

Also see: Trump's election year gamble: Cutting entitlements for seniors

The claims of cuts are usually not as bad as they seem, said Marc Goldwein, senior vice president and senior policy director at the Committee for a Responsible Federal Budget. The cuts to Medicare and Social Security last year were focused on **program integrity**, which includes reducing fraud and double payments. In some cases, the reforms would reduce costs to beneficiaries, such as through lower premiums and out-of-pocket health care costs for seniors, he said.

The proposal, at least in terms of the safety-net programs, will likely not pass as is, especially considering it is an election year, said Shawn Fremstad, senior policy fellow at the Center for Economic and Policy Research. "Even if the president can successfully spin it as he is trying to do, you won't see much appetite for people up for reelection," he said. The Democrats also control the majority of the House of Representatives.

Still, targeting safety-net programs at all seems like an attack on working-class Americans, Fremstad said. "We are talking about elderly or disabled working-class people who aren't the poorest of the poor, but are in unstable work situations and rely on these programs to get them through tough times," he said.

What are the major differences between Medicare for all and a public option?

The latest **Kaiser Family Foundation health tracking poll** reveals substantial public confusion about various health reform proposals. Americans do not understand major differences between Medicare for all and a public option. Here's a cheat sheet.

Would both Medicare for All and a public option cover all Americans? Would they both require people to pay monthly premiums? No. Medicare for All is designed to guarantee all Americans health care coverage automatically. It would be paid for much like Social Security, public schools, and police departments. Medicare for All does not require people to pay monthly premiums.

Rather, with Medicare for All, premium contributions that once went to private health insurers would go to the government in the form of taxes, based largely on income. Everyone would be covered by single-payer, public health insurance. Instead of paying private premiums, you would pay an income-based tax, effectively a public premium. Yet, 44 percent of people surveyed did not understand that they would not need to pay monthly health insurance premiums with Medicare for All.

In stark contrast, a **public option**, which could be designed in a variety of ways, would likely work more like private health insurance today, requiring you to pay a monthly premium. Still, 50 percent of people surveyed did not understand that they would have to pay a monthly premium for their coverage. Moreover, 53 percent of people surveyed thought the public option would cover everyone, which is not at all clear.

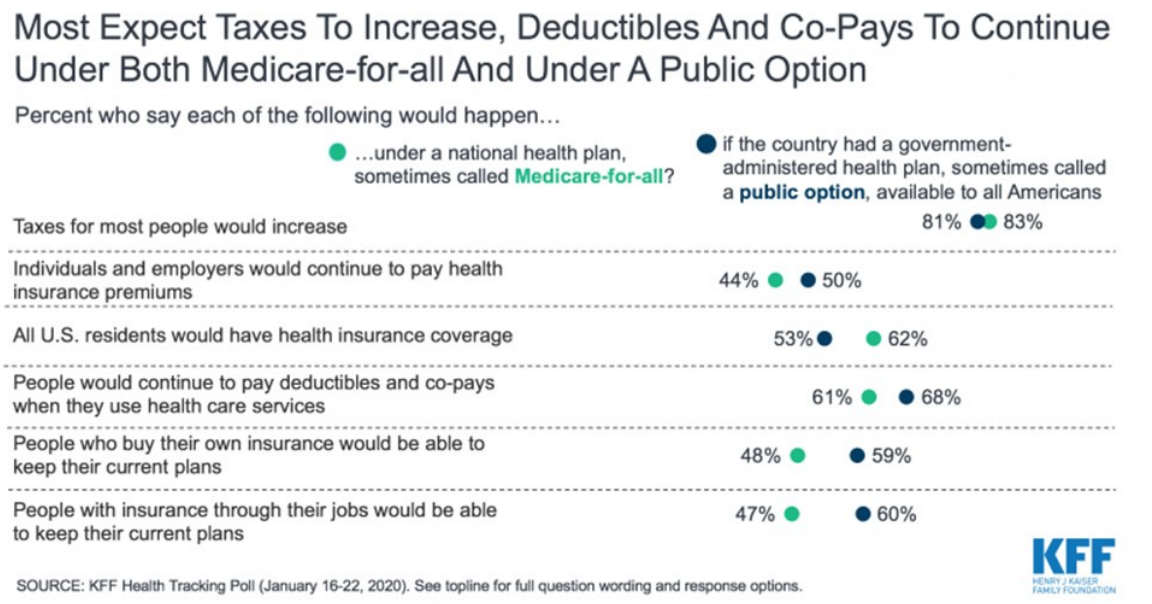
A public option would not likely guarantee coverage to all Americans, unless the federal government increased taxes enormously to pay for it. And, no one is proposing a sizable tax increase to cover the cost of the public option; rather, proponents, **like Pete Buttigieg**, are saying that a public option would not raise taxes significantly. Consequently, people could opt not to pay their premiums. And, it's more than likely many people would not be able to afford their premiums, since the public option would not rein in health care costs substantially.

Would both Medicare for All and a public option require people to pay deductibles and copays? No. Medicare for All eliminates deductibles and copays. But, more than six in ten Americans don't understand that people would not pay deductibles or copays with Medicare for All. And, more than three in ten Americans do not understand that people would continue to pay deductibles and copays with a public option, as the do today.

How about unrestricted access to doctors and hospitals? With Medicare for All, you can use whichever doctors and hospitals you would like. But, a public option builds on our current system and likely would allow provider networks, restricting access to doctors and hospitals.

What about costs? Only Medicare for All reins in health care costs substantially. It is estimated to **save middle-income households 9.6 percent of their annual income**. Medicare for All creates significant savings because it eliminates private health insurers and, with that, about **$600 billion a year in administrative costs**. It also cuts prescription drug costs in half. A public option could not save much money. It would cut prescription drug costs, but it keeps all the administrative waste in our health care system.

And, what happens to private health insurance? With Medicare for All, your primary insurance is public insurance; you could not keep your private health insurance. Still, almost half of Americans do not understand that Medicare for All would not allow them to keep their current health insurance; that's key to bringing down costs. About 40 percent believe that a public option would not allow them to keep their current health insurance either, though it would.



Our Issues: Alliance for Retired Americans

Get involved! Here's how you can take action:

Economic Security – Tell Congress to expand our earned Social Security benefits and urge them to require that the Social Security Administration base future COLAs on the Consumer Price Index for the Elderly (CPI-E), which much more accurately reflects the cost of things retirees purchase, including health care and housing.

Retirement Security – Defined benefit pension plans are under attack. Read our fact sheets, attend our local events, and join our lobbying efforts to ensure that America's retirees, their spouses and their partners are able to maintain their standard of living after a lifetime of work. Americans should not fall into poverty as they age.

Alliance for Retired Americans®

Health Care Security – Medicare celebrated its 50th Birthday in 2015. Help make sure it lasts another 50 years by **sharing your story** about what the program has meant to you and your family. Read about the experiences of other Alliance members and educate your children and grandchildren about this American success story, so that Medicare remains strong for them.

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CMS Watching Home Health Providers Closely Amid Shifting Therapy Strategies

Home health providers aggressively changing how they're delivering physical, occupational and speech therapy services need to remember one thing: The U.S. Centers for Medicare & Medicaid Services (CMS) is watching.

Since Jan. 1, several industry-leading providers that Home Health Care News has connected with in the aftermath of the Patient-Driven Groupings Model (PDGM) have reaffirmed their commitment to therapy in their service mix. Those providers include Birmingham, Alabama-based Encompass Health Corporation (NYSE: EHC) and Moorestown, New Jersey-based Bayada Home Health Care, just to name a few.

But while some providers take tempered, responsible approaches to therapy under PDGM, it's becoming increasingly clear that many others are not. Stories of widespread layoffs of PTs, OTs and SLPs persist — and now new reports of agencies incorrectly telling their patients that Medicare no longer covers therapy under the home health benefit have surfaced.

That kind of misconception is dangerous for providers and Medicare beneficiaries alike.

"It's something that we had never heard before," Sharmila Sandhu, the vice president of regulatory affairs for the

American Occupational Therapy Association (AOTA), recently told HHCN. "So, we are trying to understand where that is coming from."

If home health providers needed a reminder of CMS's oversight, they got one. On Monday, CMS released a special edition Medicare Learning Network (MLN) Matters article highlighting the role of therapy under PDGM. MLN is CMS's educational arm tasked with informing the physician, provider and supplier communities about the latest Medicare changes.

In the article, MLN's authors don't mince words when answering the question: "Has home health eligibility and coverage changed under PDGM?"

Their answer: No.

"While there has been a change to the case-mix adjustment methodology and the unit of payment beginning in CY 2020, eligibility criteria and coverage for Medicare home health services remain unchanged," the MLN team wrote. "That is, as long as the individual meets the criteria for home health services …, the individual can receive Medicare home health services, including therapy services."...**Read More**

CMS Proposes to Curtail Deceptive Medicare Advantage Plans

The Centers for Medicare & Medicaid Services (CMS), the agency that oversees the Medicare program, recently proposed a rule to help deter Medicare Advantage (MA) plans from deceptively targeting people who are dually eligible for Medicare and Medicaid. If the proposals go into effect, dual eligibles could face less confusion in plan selection and may be less likely to enroll in a plan that does not meet their needs.

Dual Eligible Special Needs Plans (D-SNPs) are a type of MA plan that is intended to meet the specific needs of people who have both Medicare and Medicaid. Historically, D-SNPs provided some coordination of benefits between the Medicare and Medicaid programs. In recent years, Congress and CMS have required D-SNPs to do more to ensure that dually eligible people can more easily get the care they need. For example, D-SNPs must create a single appeals process for both Medicare and Medicaid appeals to ensure enrollees can find answers and access their care.

As the requirements for D-SNPs have increased, however, MA plans have arisen that look a lot like D-SNPs but do not offer the same services. Often called "look-alikes," these plans are marketed aggressively to

dual eligibles. Because the look-alikes do not provide the health delivery system coordination of D-SNPs, they can exacerbate the challenges dually eligible individuals face in accessing and managing their care.

In a proposed rule, CMS announced its intention to curtail such look-alikes by ending the contracts of non-D-SNP MA plans that over-target dually eligible individuals. People who are enrolled in such plans will be able to choose another plan, including a real D-SNP, or select Original Medicare instead.

Medicare Rights is encouraged to see CMS taking this issue seriously. MA plans must be held to a high standard to serve the Medicare population and true D-SNPs can play a valuable role in helping dual eligibles access the care they need. The look-alike plans are interfering with efforts to better serve people who are dually eligible for both Medicare and Medicaid.

In our comments on the proposed rule, we will urge CMS to do more to strengthen protections and weed out deceptive plans. This proposal would be an important step toward eliminating a risk to dually eligible individuals.

Read the proposed rule.

Medicare Advantage "Surprise medical billing"

Health care for seniors is also one of the top issues on our agenda at TSCL and we have been talking to Congressional offices about our concerns. That's why we were happy to see progress this week regarding the issue of surprise medical billing. Surprise billing has been a real problem for some seniors who have Medicare Advantage. It's an issue that TSCL has been discussing with Congress and that we've written about for the last few weeks.

If you've received a medical bill for services that you thought were covered by your health insurance you already know what surprise medical billing is. But as a reminder, "Surprise medical billing" is a term commonly used to describe charges received by someone who has health insurance but they received care from a health care provider who is not included in their insurance coverage. This situation could arise in an emergency when the patient has no ability to select the emergency room, treating physicians, or ambulance providers. Surprise medical bills might also happen when a patient receives planned care from an in-network provider (often, a hospital or ambulatory care facility), but other treating providers brought in to participate in the patient's care are not in the same network. This can end up costing patients thousands of dollars they thought their insurance would pay.

As we've found out in our meetings with Congressional staff members, Congress is hearing thousands of complaints from voters who want surprise billing stopped. But, they are also hearing from the health care providers who are making a lot of money from surprise billings and they are fighting back to try and stop or modify legislation. ...**Read More**

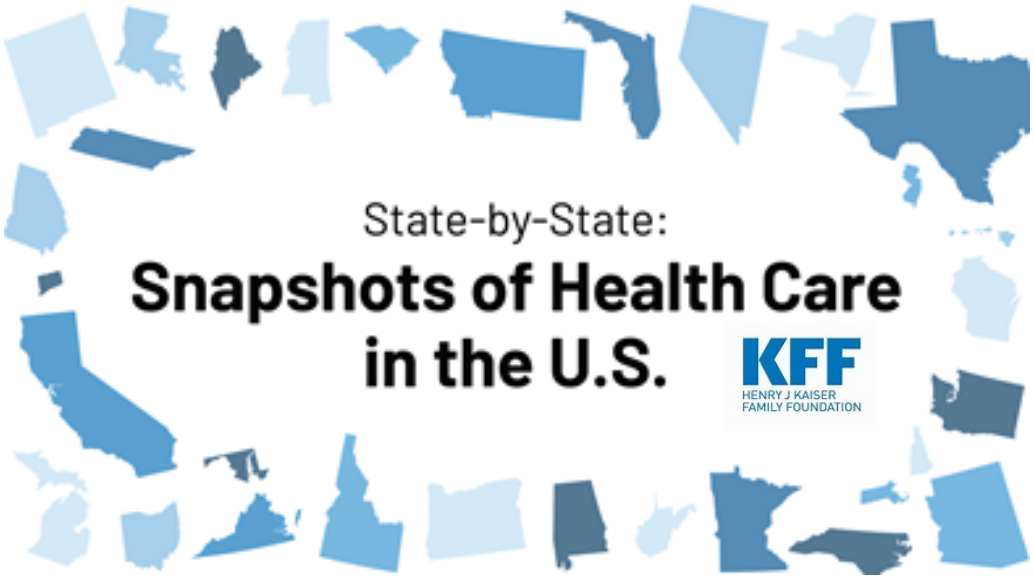
Election 2020: State Health Care Snapshots

Health care is a top issue for voters in the 2020 election. Polling indicates voter concerns range from the high cost of health coverage and prescription drugs, to protections for people with pre-existing conditions, to women's health issues.

To understand the health care landscape in which the 2020 election policy debates will unfold, these state health care snapshots provide data across a variety of health policy subjects, including health care costs, health coverage—Medicaid, Medicare, private insurance—and the uninsured, women's health, health status, and access to care. They also describe each state's political environment.

***Please note**, the data included in these snapshots come from a variety of different sources and time periods, and therefore, may not be comparable. **Sources** are available at the bottom of this page.*

Click on the map for individual state information



President's Budget Again Takes Aim at Key Health Care Programs

The President's FY21 budget includes harmful policy and payment changes that could create barriers to care for people with Medicare. Among other things, the administration's proposal could jeopardize beneficiary access to critical services by significantly cutting provider payments. Though intended to control costs by reducing spending growth rather than by cutting services directly, we are skeptical that reductions of the magnitude proposed could be implemented without negatively affecting beneficiaries. Additionally, the budget includes a concerning site-neutral post-acute payment model. This payment policy could improperly divert patients from clinically appropriate settings to less costly settings that are not able to provide the full array of services they need.

The budget also calls for $1 trillion in cuts to Medicaid and the ACA's premium tax credits, which could cause millions of people to lose health coverage and access to care. Gutting Medicaid could lead to the rationing of care and force many low-income older adults and people with disabilities out of their homes and communities. In addition, the proposed policies could endanger Medicaid coverage for struggling families by imposing punitive eligibility restrictions and administrative barriers.

While the budget includes an allowance for prescription drug pricing reform, it does not provide a roadmap for improving the current system. We urge the administration to support the *Lower Drug Costs Now Act* (H.R. 3), which passed the House of Representatives last year. That bill would restructure the Part D benefit, limit beneficiary out of pocket drug costs to $2,000 per year, and empower Medicare to negotiate directly with drug companies to lower the price of certain prescription drugs. H.R. 3 would reinvest much of these savings back into the Medicare program, achieving monumental coverage and affordability gains for consumers.

Similarly, the budget fails to identify a replacement plan for the ACA that would maintain the health law's coverage pathways and consumer protections, even as the administration is actively supporting its full repeal.

As in previous years, President Trump's FY21 budget is full of damaging policies that would make it harder for older adults, people with disabilities, and working families to meet their basic needs. We urge Congress and the administration to reject this flawed budget, and to instead pursue solutions that prioritize the health and well-being of all Americans.

Free & Cheap College Classes for Senior Citizens (By State & University)

Many people look forward to retirement as a time to travel, garden, play golf, or visit their grandchildren. Others have no definite plans beyond a vague idea about "relaxing." When they leave work, they sometimes find themselves feeling a bit lost, not sure what to do with themselves without a job to go to every day.

If you're still not sure how you want to spend your retirement, here's one option you may not have considered: Take advantage of your golden years to go back to school.

Many colleges across the country offer cheap or even free classes for senior citizens. In most cases, older students only get to "audit" these classes – that is, attend the lectures without earning credit toward a degree. However, even without the credit, it's still a great opportunity to learn about a subject that interests you at no cost to yourself. And at some schools, it's even possible to earn a college degree for free, one class at a time.

Here is a look at some of the many opportunities you can find across the country.

View the list of state wide programs for seniors...**Read more**

2019's Social Security Raise Was Downright Pathetic, Data Shows

What was supposed to be a fairly generous boost in seniors' monthly income wound up falling short in practice.

Each year, seniors on **Social Security** eagerly await their cost-of-living adjustment, or COLA, which dictates how much of a boost their monthly benefits will get. In 2019, seniors saw a fairly decent 2.8% COLA, which left many a bit more optimistic about their financial prospects, at least at first. But new data from the Senior Citizens League reveals that despite a respectable COLA, most seniors did not receive a substantial boost to their monthly income last year. And that's troubling on so many levels.

How much did benefits climb last year?

Last year's 2.8% COLA should have, in theory, raised the average benefit of $1,422 all the way up to $1,461, resulting in an extra $39 a month for the typical senior. But according to the Senior Citizens League, 45% of Social Security beneficiaries got a monthly income boost of $10 or less in 2019 after accounting for Medicare Part B premium deductions (those premiums are paid directly from Social Security benefits for seniors enrolled in both programs). Meanwhile, 25% of seniors saw a monthly raise that fell between $10.01 and $25, and only 30% of beneficiaries saw their monthly Social Security income rise by more than $25.

s year's COLA could be even less effective

The above-mentioned numbers don't bode well for seniors who are heavily reliant on Social Security to stay afloat this year. The COLA going into 2020 was a **mere 1.6%** -- barely more than half of the 2.8% COLA seniors saw going into 2019. But what's more disturbing is the fact that Medicare premiums rose a lot more in 2020 than they did in 2019.

Going into 2019, seniors saw a modest $1.50 increase in their Part B premiums, paying $135.50 a month instead of the $134 they paid in 2018. This year, the standard Part B premium is $144.60, representing a $9.10 jump.

Now, if 45% of seniors last year saw their Social Security benefits go up $10 or less per month with a 2.8% COLA and $1.50-a-month Medicare premium hike, it stands to reason that things aren't looking too good for the current year, what with a much larger Medicare increase and a much lower COLA. As such, we're likely to see even more depressing numbers once this year's data is crunched.

Making up for a meager raise

Seniors who are heavily dependent on Social Security may need to employ some serious lifestyle changes this year to avoid falling behind on bills. These could include downsizing, moving to a less expensive part of the country, or working part-time to generate income on top of Social Security.

Current workers, meanwhile, would be wise to look closely at the numbers above and understand why they underscore the importance of **saving for retirement** independently. Clearly, Social Security raises aren't all that effective, even during years when COLAs are relatively generous. Those who don't wish to struggle financially during retirement can boost their savings as much as they can, and keep their savings invested in a **reasonably aggressive fashion** to generate additional retirement income.

The purpose of Social Security COLAs is to help seniors retain their buying power in the face of inflation. But clearly, a monthly boost of $10 or less isn't going to do much for the typical retiree. On the other hand, a robust IRA or 401(k) that continuously generates growth in retirement could not only be the ticket to compensating for those measly COLAs, but to long-term financial security.

Greenstein: President Trump's 2021 Budget Would Widen Country's Divisions

CBPP today released a statement from Robert Greenstein, president, on President Trump's new budget:

In the face of a bitterly divided country that needs healing, President Trump today threw gasoline on the fire by releasing a stunningly harsh budget that would tear us further apart.

It would push tens of millions of less fortunate Americans into or deeper into poverty and cause widespread hardship even as it doubles down on tax cuts for the most well-off. It would take health coverage away from millions of people and cut aid to millions of families and individuals struggling to make ends meet. At the same time, the budget would make permanent the 2017 tax law's tax cuts for individuals, which are heavily weighted toward the top. As a result, the budget would further widen inequality and racial disparities.

The budget proposes $1 trillion in cuts to Medicaid and Affordable Care Act premium tax credits over ten years, causing millions of people to lose coverage. It calls for cuts of more than $180 billion over ten years in basic food assistance for hard-pressed families by slashing SNAP (formerly known as food stamps). It also shrinks assistance for people with disabilities; eliminates a raft of low-income housing programs; steeply cuts a range of programs that support long-term economic growth, like investments in college affordability; and even calls for large cuts in the National Institutes of Health.

The budget walks away from last year's bipartisan agreement for funding non-defense appropriated programs, which took months to hammer out. It calls for cutting 2021 funding for these programs $46 billion below the 2020 level and $51 billion below the level established for 2021 in the bipartisan agreement. These cuts would come from the part of the budget that funds priorities like education, environmental protection, housing assistance, national parks, and scientific research. Furthermore, the cuts in these programs would spiral after 2021, reaching a stunning 38 percent (in inflation-adjusted dollars) by the tenth year. Indeed, by the tenth year, expenditures for non-defense discretionary programs, measured as a share of the economy (GDP), *would reach their lowest level since Calvin Coolidge was President in the 1920s.*

A few examples of these cuts: legal services for the poor — gone; low-income energy assistance — gone; funding to make capital repairs in public housing — gone. These are but a small fraction of the draconian cuts in non-defense appropriated programs the budget calls for.

Infrastructure is another broken promise. Despite trying to create an impression of major action on this front, the budget's infrastructure investment is very modest relative to the need. And part of the modest new investment would be cancelled out by cuts in other infrastructure programs.

The President's budget shows us his priorities for this year and, if he's re-elected, years after that.

The Center on Budget and Policy Priorities is a nonprofit, nonpartisan research organization and policy institute that conducts research and analysis on a range of government policies and programs. It is supported primarily by foundation grants.

Democrats press Trump official for answers on ObamaCare replacement plan

Democrats are seething at President Trump's top health official Thursday for not having a backup plan in case the Affordable Care Act (ACA) is overturned in a pending lawsuit supported by the Department of Justice (DOJ).

Health and Human Services (HHS) Secretary Alex Azar told senators during a hearing Thursday a plan is not needed until the "final judgment" is made in the lawsuit.

"I don't know what you're waiting for. If you have a better idea show us, but I have yet to see one plan that the administration has put forward," Sen. Bob Menendez (D-N.J.) told Azar during a Senate Finance Committee hearing on the HHS budget request.

"We would wait until there's a final judgment in the final court of authority — in this case, it would obviously be the Supreme Court," Azar responded.

The DOJ has refused to defend the ACA against a lawsuit, brought by attorneys general in Texas and other Republican-led states, that seeks to overturn the law that expanded health care to 20 million Americans.

A district court judge sided with the plaintiffs in 2018, ruling ObamaCare cannot stand without the individual mandate penalty, which was repealed by a tax-reform law passed by Congress in 2017.

Democratic-led states had won the right to defend the ACA in the litigation and appealed that ruling to the 5th Circuit Court of Appeals, which agreed the individual mandate was now unconstitutional but sent the case back to the lower court to determine which parts of the law could stand.

Azar's comments Thursday drew the ire of Democrats who argue the administration should be prepared in the event that the Supreme Court overturns the entirety of the ACA.

Azar has maintained that the law would not be overturned immediately following a decision and there would be time to develop a replacement that would protect people with pre-existing conditions.

"These are hypotheticals at this point. We are faithfully administering the ACA now," he said Thursday.

Menendez shot back: "These are hypotheticals we don't play with."

Sen. Catherine Cortez Masto (D-Nev.), who also asked Azar about the lawsuit, rejected the idea that a replacement isn't needed now.

"Don't try to walk around it somehow by saying 'this is going to be prolonged so we don't care, it doesn't really matter right now.' It does matter. That's what this administration values, and it sets it out and the American public needs to know that so please don't start with that," she said.

The Supreme Court is still weighing whether to take up the case and on what schedule. Republican-led states and the administration say they should let the case play out in the lower courts first. But Democratic-led states have asked the Supreme Court to take up the case quickly.

NOTE:

This proves that the President is not protecting preexisting conditions.

How can I appeal an IRMAA?

Dear Marci

Dear Marci:

I received a notice that I need to pay an Income-Related Monthly Adjustment Amount (IRMAA) in addition to my Part B premium, but I don't believe I should have to pay it. What can I do?

-Woodie (Topeka, KS)

Dear Woodie,

The Medicare Income-Related Monthly Adjustment Amount is an amount you may pay in addition to your **Part B premium** and/or **Part D premium** if your income is above a certain level. The Social Security Administration (SSA) sets income brackets that determine your (or you and your spouse's) IRMAA. SSA determines if you owe an IRMAA based on the income you reported on your IRS tax returns two years prior, meaning two years before the year that you started paying IRMAA. The income that counts is the adjusted gross income you reported plus other forms of tax-exempt income.

If Social Security determines that you should pay an IRMAA, they will mail you a notice called an initial determination. This notice should include information on **how to request a new initial determination**. A new initial determination is a revised decision that Social Security makes regarding your IRMAA. You can request that Social Security revisit its decision if you have experienced a life-changing event that caused an income decrease, or it you think the income information Social Security used to determine your IRMAA was incorrect or outdated.

Social Security considers any of the following situations to be life-changing events:

- The death of a spouse
- Marriage
- Divorce or annulment
- You or your spouse stopping working or reducing the number of hours you work
- Involuntary loss of income-producing property due to a disaster, disease, fraud, or other circumstances
- Loss of pension
- Receipt of settlement payment from a current or former employer due to the employer's closure or bankruptcy
- You can make the case that Social Security used outdated or incorrect information when calculating your IRMAA if, for example, you:
- Filed an amended tax return with the IRS

Have a more recent tax return that shows you are receiving a lower income than previously reported

To request a new initial determination, submit a Medicare IRMAA Life-Changing Event form or schedule an appointment with Social Security. You will need to provide documentation of either your correct income or of the life-changing event that caused your income to decrease. If you do not qualify to request a new initial determination, but you still disagree with Social Security's IRMAA decision, you have the right to appeal. Appealing an IRMAA decision is also referred to as requesting a reconsideration. Keep in mind that there are no strict timeframes in which Social Security must respond to a reconsideration request. Contact the Social Security Administration to learn how to file this request

-Marci

Dear Marci Health Tip

When the weather is cold, it is important to stay warm both outside and inside. The **National Institute on Aging** has tips for saying warm inside during cold-weather months:

- Set your heat to at least 68-70° F. Close off rooms you are not using to save on heating bills.
- Make sure your house isn't losing heat through the windows. Keep your blinds and curtains closed.
- Dress warmly on cold days, even if you are staying in the house.
- Wear long underwear under your pajamas and use extra covers when going to sleep.
- Make sure you eat enough food to keep up your weight.
- Drink alcohol moderately, if at all. Alcoholic drinks can make you lose body heat.
- Ask family or friends to check on you during cold weather.

If you are having a hard time paying your heating bills, there are some resources that might help. You can contact the National Energy Assistance Referral Service at 866-674-6327 (TTY: 866-367-6228) to learn more.

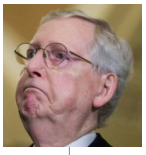
'GRIM REAPER' MITCH MCCONNELL ADMITS THERE ARE 395 HOUSE BILLS SITTING IN THE SENATE: 'WE'RE NOT GOING TO PASS THOSE'

During a television interview, Senate Majority Leader Mitch McConnell said that 395 bills sitting in the Senate are not going to be passed.

On Fox News Friday, anchor Bret Baier asked McConnell if Democrats' statements about those bills were true and whether they could move forward. McConnell confirmed that it was the case, but also said that proposed legislation would be rejected.

"It is true," the senator said. "They've been on full left-wing parade over there, trotting out all of their left-wing solutions that are going to be issues in the fall campaign. They're right. We're not going to pass those."

McConnell explained that the bills would not get passed, because the government is divided. He said that instead they "have to work on things we can agree," listing government spending, the U.S.-Mexico-Canada free trade agreement, an infrastructure bill, a parks bill and some environmental issues as examples of bills that they may be able to agree on.



When asked about a bipartisan infrastructure bill, McConnell said that it may not be a "big" bill, because it would "require dealing with the revenue sources that both sides are nervous about raising the gas tax, which is a regressive tax on low-income people."

When asked about legislature regarding prescription drugs, McConnell said that while there are "differences on both sides," there is a chance that the Senate will be able to legislate on the issue.

"It's not that we're not doing anything. It's that we're not doing what the House Democrats and these candidates for president on the Democratic ticket want to do," he said.

McConnell's failure to pass many of the bills that are currently in the Senate has been a frequent target for Democrats, earning him the nickname the "Grim Reaper," from House Speaker Nancy Pelosi last December. She **has said that bills** are sitting in a "legislative graveyard," during this cycle.

"I have news for him," Pelosi said. "He may think they're dead on arrival, but they are alive and well in the general public."

Earlier in the interview, Fox showed clips of Democratic presidential candidates criticizing McConnell for not passing bills.

Discussing issues such as gun control and raising wages, former South Bend, Indiana, Mayor Pete Buttigieg said the "trouble is, none of it can get past Mitch McConnell's Senate."

"We have a second thing we better be working hard on and thinking about, and that is: take back the Senate and put Mitch McConnell out of a job," Massachusetts Senator Elizabeth Warren said on the campaign trail Sunday.

Feds probing how personal Medicare info gets to marketers

A government watchdog is launching a nationwide probe into how marketers may be getting seniors' personal Medicare information aided by apparent misuse of a government system, officials said Friday.

The audit will be formally announced next week said Tesia Williams, a spokeswoman for the Health and Human Services inspector general's office. It follows a narrower probe which found that an electronic system for pharmacies to verify Medicare coverage was being used for potentially inappropriate searchers seemingly tied to marketing. It raised red flags about possible fraud.

The watchdog agency's decision comes amid a **wave of relentlessly efficient telemarketing scams** targeting Medicare recipients and involving everything from back braces to **DNA cheek swab**s.

For years, seniors have been admonished not to give out their Medicare information to people they don't know. But **a report on the inspector general's initial probe**,also released Friday, details how sensitive details can still get to marketers. It can happen even when a Medicare beneficiary thinks he or she is dealing with a trustworthy entity such as a pharmacy or doctor's office.

Key personal details gleaned from Medicare's files can then be cross-referenced with databases of individual phone numbers, allowing marketers to home in with their calls.

The initial audit focused on 30 pharmacies and other service providers that were frequently pinging a Medicare system created for drugstores.

The electronic system is intended to be used for verifying a senior's eligibility at the sales counter. It can validate coverage and personal details on millions of individuals. Analyzing records that covered 2013-15, investigators discovered that most of the audited pharmacies, along with a software company and a drug compounding service also scrutinized, weren't necessarily filling prescriptions.

Instead, they appeared to have been tapping into the system for potentially inappropriate marketing.

Medicare stipulates that the electronic queries — termed "E1 transactions"— are supposed to be used to bill for prescriptions. But investigators found that some pharmacies submitted tens of thousands of queries that could not be matched to prescriptions. In one case, a pharmacy submitted 181,963 such queries but only 41 could be linked to prescriptions.

The report found that on average 98% of the electronic queries from 25 service providers in the initial audit "were not associated with a prescription." The inspector general's office did not identify the pharmacies and service providers.

Pharmacies are able to access coverage data on Medicare recipients by using a special provider number from the government.

But investigators found that four of the pharmacies they audited allowed marketing companies to use their provider numbers to ping Medicare. "This practice of granting telemarketers access to E1 transactions, or using E1 transactions for marketing purposes puts the privacy of the beneficiaries' (personal information) at risk," the report said.

Some pharmacies also used seniors' information to contact doctors treating those beneficiaries to see if they would write prescriptions. Citing an example, the report said, "The doctor often informed (one) provider that the beneficiary did not need the medication."

The inspector general's office said it is investigating several health care providers for alleged fraud involving E1 transactions. Inappropriate use of Medicare's eligibility system is probably just one of many paths through which telemarketers and other sales outfits can get sensitive personal information about beneficiaries, investigators said. drugs.

The watchdog agency began looking into the matter after the Centers for Medicare and Medicaid Services, or CMS, asked for an audit of a mail order pharmacy's use of Medicare's eligibility verification system….. **More**

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Shingles Vaccine Bonus: Reduced Risk of Stroke?

Seniors who get the shingles vaccine may gain stroke protection as well, a new study suggests.

Shingles is a viral infection tied to heightened risk of stroke. But overall stroke risk dropped 20% among patients under age 80 who got the shingles vaccine. In patients 80 and older, risk was cut by about 10%, said researchers led by Quanhe Yang, a senior scientist at the U.S. Centers for Disease Control and Prevention.

"This is a win-win for vaccination," said Dr. Gregg Fonarow, director of the Ahmanson-University of California, Los Angeles Cardiomyopathy Center.

"Less shingles, less stroke," said Fonarow, who was not involved in the study.

The findings follow a review of Medicare records for more than 1 million patients over age 66. All received the shingles vaccine between 2008 and 2014. Stroke incidence was tracked for four years afterward.

Shingles is a painful bout of rashes and blisters caused by the chickenpox virus, according to the U.S. National Institute of Neurological Disorders and Stroke. If you've had chickenpox, you face a significant risk for eventually developing shingles.

Nearly all Americans 40 and up carry the dormant chickenpox virus, or varicella-zoster virus. That, said Fonarow, means that "almost one in three adults in the U.S. will develop shingles at some point in their lifetime."

However, Yang and his colleagues noted that overall shingles risk drops by about half with vaccination.

Given that most shingles patients are at least 50, the CDC recommends all adults 50 and older get the shingles vaccine.

Yang's team concluded that vaccination also reduced the risk for clot-induced (ischemic) stroke by about 18%, while cutting the risk for a bleeding (hemorrhagic) stroke by roughly 12%. Stroke protection was found to be particularly strong among patients between 66 and 79.

But why would a vaccine focused on reducing shingles risk also protect against stroke?

According to Fonarow, the answer may have to do with inflammation.

"Prior studies have shown that adults developing shingles have a greater risk of heart attack and greater risk of stroke," Fonarow said. "This increased risk is greatest within the first 12 months of developing shingles, and decreases over time. The inflammatory response to shingles has been thought to account for this increase in heart attack and stroke."

So it stands to reason that a vaccine that can prevent shingles from taking hold might also prevent a shingles-provoked stroke.

There are some caveats, however. For one, the vaccine used was Zoster Vaccine Live. Introduced in 2006 with the brand name Zostavax, it is no longer the vaccine of choice. A newer vaccine -- the Adjuvanted, Non-Live Recombinant Shingles Vaccine (brand name Shingrix) -- is more effective and is the CDC's preferred choice.

But Yang's study was completed before the 2017 introduction of Shingrix. So follow-up research will need to look into whether the new vaccine also appears to lower stroke risk.

The findings are scheduled for presentation Feb. 20 in Los Angeles at the American Stroke Association International Stroke Conference. Research presented at meetings is usually considered preliminary until published in a peer-reviewed medical journal.

More information

Learn more about shingles from the **U.S. National Institute of Neurological Disorders and Stroke**.

Predicting Alzheimer's disease progression

—by Sharon Reynolds for NIH Research Matters

Studies estimate that more than 5 million people in the U.S. are living with Alzheimer's disease. That number is expected to rise as the population ages.

The brains of people with Alzheimer's disease have two distinct hallmarks. These are abnormal clumps called amyloid plaques and tangled bundles of fibers called neurofibrillary, or tau, tangles. These changes disrupt nerve cells and eventually cause them to die. The loss of brain tissue destroys memory and thinking skills and, eventually, the ability to carry out tasks of daily living.

In order to better understand whether tau tangles and amyloid plaques may predict the development of Alzheimer's, researchers need to be able to track tau and amyloid in the brain as disease develops.

Recently, scientists have developed molecules that allow them to use PET imaging to measure the levels of amyloid plaques and tau tangles in living brain tissue. In a new study, a team led by Drs. Renaud La Joie and Gil Rabinovici from the University of California, San Francisco, used these molecules, called tracers, to see if amyloid or tau levels in the brain could predict the loss of brain matter over time.

The study included 32 people with early-stage Alzheimer's disease. All participants underwent PET imaging to assess the levels and locations of amyloid and tau at the beginning of the study. They also had MRI scans of the brain to calculate brain volume. About 15 months later, they underwent a second MRI scan to measure loss of brain tissue.

The research was funded in part by NIH's National Institute on Aging (NIA). Results were published on January 1, 2020, in *Science Translational Medicine*.

People with higher levels of tau seen by PET at the start of the study had a greater loss of brain matter by the second MRI scan. In contrast, levels of amyloid measured at the start of the study were not strongly associated with subsequent brain changes. The researchers estimated that the tau patterns measured by PET could explain about 40% of the difference in future brain degeneration, compared to only 3% for amyloid PET.

The participants in the study were relatively young for people with Alzheimer's disease: 63% were under the age of 65 when they enrolled. The younger patients had higher levels of tau in the brain overall and experienced more rapid loss of brain tissue.

"The match between the spread of tau and what happened to the brain in the following year was really striking," says Rabinovici. "Tau PET imaging predicted not only how much atrophy we would see, but also where it would happen. These predictions were much more powerful than anything we've been able to do with other imaging tools and add to evidence that tau is a major driver of the disease."

PET imaging of tau may be helpful for future clinical trials of drugs targeting the tangles. Such imaging could potentially help detect early response — or lack of response — to new treatments. More work is needed to understand other factors that can help predict loss of brain tissue in Alzheimer's disease.

What Are the Warning Signs of a Stroke?

Using the acronym FAST is the best way to recognize stroke and get immediate medical care.

IN THE TIME IT TAKES TO read this article, at least one person in the U.S. will die from a stroke. Depending on how fast you read, 10 or more **will suffer a stroke** before you reach the last sentence. Stroke, obviously, is nothing to take lightly.

The Centers for Disease Control and Prevention estimate that stroke kills about 140,000 Americans each year. That is about 1 of every 20 deaths that occur annually in the country. Someone in the U.S. has a stroke every 40 seconds, and someone dies from it every four minutes. Although **stroke risk** increases with age, about one-third of people hospitalized for stroke are under 65 years old.

The CDC estimates that stroke costs the U.S. $34 billion each year in health care services, medicines to **treat stroke** and missed days of work. Stroke is a leading cause of serious long-term disability.

Yet, despite these dire statistics, the American Stroke Association says that stroke "is preventable, treatable and beatable." The treatment part, however, depends the most on one important factor: speed. The faster you recognize the signs and symptoms of a stroke and begin treatment, the more likely you are to prevent long-term disability and death.

Types of Stroke

First, it's important to understand what a stroke is. The most common type is called ischemic stroke. This is when a blood vessel supplying blood to the brain is obstructed by fatty deposits in the vessel lining, which is known as atherosclerosis. The ASA says about 87% of all strokes are ischemic in nature.

Hemorrhagic strokes, which comprise about 13% of stroke cases, result when a weakened blood vessel ruptures – most often the result of untreated or poorly treated high blood pressure – causing bleeding into the brain. The blood builds up and compresses the surrounding brain tissue, causing tissue damage and cell death.

In each case, the longer the condition lasts, the more damage occurs. Stroke specialists use the phrase "time is brain" – every second the stroke lasts, more brain cells are damaged and die.

Another important type of stroke to know about is called a transient ischemic attack, or TIA. Also called a ministroke, a TIA is a temporary blockage of blood flow to the brain. It doesn't cause permanent damage, may not cause noticeable or long-lasting symptoms and is often ignored. But the ASA warns that TIAs may signal that a full-blown stroke is soon to come, so symptom awareness is critical.

Symptoms

There is an easy way to remember the symptoms of stroke: Just use the acronym **FAST, for face, arm, speech and time**. And because time is of the essence, it's the perfect term to use.

"FAST is a very simple tool that even a nonmedical person can employ for timely recognition and treatment of stroke, and can save brain tissue during the critical time period when you have the opportunity to do so," says Dr. Dhanunjaya Lakkireddy, a cardiologist specializing in electrophysiology and the medical director for the Kansas City Heart Rhythm Institute at HCA Midwest Health.

The ASA describes FAST like this:

- **Face drooping.** Does one side of the face droop or is it numb? Ask the person to smile. Is the person's smile uneven or lopsided?
- **Arm weakness.** Is one arm weak or numb? Ask the person to raise both arms. Does one arm drift downward?
- **Speech.** Is speech slurred? Is the person unable to speak or hard to understand? Ask the person to repeat a simple sentence.
- **Time to call 911.** If the person shows any of these symptoms, even if the symptoms go away, call 911 or get them to the hospital immediately.
- Again, if any of these symptoms present themselves, **get to a hospital** or call 911 immediately. ….**Read More**

Time Spent on the Links May Lengthen Life

Grab your golf clubs. Spending a day on the green at least once a month may lower the risk of early death among older adults, a new study finds.

About 25 million Americans play golf, which is a sport that can reduce stress and yield exercise benefits. Social in nature and played at a controlled pace, people often continue enjoying the sport into old age.

"Our study is perhaps the first of its kind to evaluate the long-term health benefits of golf, one of the most popular sports among older people in many countries," said lead study author Dr. Adnan Qureshi. He is a professor of neurology at the University of Missouri, in Columbia.

The U.S. Department of Health and Human Services Physical Activity Guidelines for Americans does not yet include golf in the list of recommended physical activities," Qureshi said in an American Heart Association news release. "Therefore, we are hopeful our research findings could help to expand the options for adults to include golf."

For the study, researchers analyzed data from the Cardiovascular Health Study, which had examined risk factors for heart disease and stroke in adults aged 65 and older. Nearly 5,900 participants with an average age of 72 were studied. Out of all of these patients, 384 were identified as golfers.

During follow-up, 8 percent of golfers suffered strokes and nearly 10 percent had heart attacks. When comparing the death rates, golfers had a significantly lower rate of death -- 15 percent compared to just under 25 percent of non-golfers. However, the study did not prove that golfing itself boosts longevity.

"While walking and low-intensity jogging may be comparable exercise, they lack the competitive excitement of golf," Qureshi explained.

"Regular exercise, exposure to a less polluted environment and social interactions provided by golf are all positive for health," he added. "Another positive is that older adults can continue to play golf, unlike other more strenuous sports such as football, boxing and tennis."

The findings are to be presented next week at the American Stroke Association's International Stroke Conference, in Los Angeles. Such research is considered preliminary until published in a peer-reviewed medical journal.

The researchers are performing more analyses to determine whether playing golf might counter other health conditions.

Changing Clocks Is Bad For Your Health, But Which Time To Choose?

Researchers on human biological rhythms come down squarely on the side of the standard, wintertime hours referred to as "God's time" by angry farmers who objected to daylight saving time when it was first widely adopted during World War I.

What's not in question is that the clock switching is unpopular. Some **71% of people want to stop springing forward** and falling back, according to a 2019 Associated Press-NORC Center for Public Affairs Research poll.

Politicians have reacted accordingly. More than 200 state bills have been filed since 2015 to either keep summer hours or go to permanent standard time, according to the National Conference of State Legislatures.

The measures getting the most traction right now are for permanent daylight saving time, which makes more sun available for after-work activities. In 2018, Florida passed a bill and California voters backed a ballot measure to do so. Maine, Delaware, Tennessee, Oregon and Washington joined in 2019, passing permanent daylight saving bills. President **Donald Trump even joined the conversation** last March, tweeting: "Making Daylight Saving Time permanent is O.K. with me!"

But none of those efforts can become reality without the blessing of Congress. States have always been able to opt out of summer hours and adopt standard time permanently, as Arizona and Hawaii have done. But making daylight saving time year-round is another story.

Still, Scott Yates, whose **#Lock the Clock** website has become a resource for lawmakers pushing for change, believes this year will be another big year. Yates is particularly encouraged by the attitude he saw from state legislators in August when he presented on the issue at the legislators' annual national summit in Nashville, Tennessee.

"I wasn't the court jester and it wasn't entertainment," he said. "It was like, 'What are the practical ways we can get this thing passed?'"

Seeking To End 'Spring Ahead, Fall Back' Cycle

Yates, 54, a tech startup CEO based in Denver, has been promoting an end to clock switching for six years. He doesn't pick a side. It's the switching itself that he wants to end. At first, it was just about the grogginess and annoyance of being off schedule, he said. But then he began to see scientific studies that showed the changes were doing actual harm.

A German study of autopsies from 2006 to 2015, for instance, showed a significant uptick just after the spring switch in deaths caused by cardiac disease, traffic accidents and suicides. Researchers have also noted a significant increased risk for heart attacks and strokes.

Three measures pending in Congress would allow states to make daylight saving time permanent. But, in the meantime, state lawmakers who want the extra evening sunlight are preparing resolutions and bills, some of which would be triggered by congressional approval and the adoption of daylight time in surrounding states.

The Illinois Senate passed such a bill, and Kansas is considering one after a bill to end daylight saving time died there last year. Utah passed a resolution in support of the congressional bill last year, and state Rep. **Ray Ward,** a Republican family physician from Bountiful, is steering a recently passed state Senate permanent daylight bill through the House.

"The human clock was not built to jump back and forth. That's why we get jet lag," said Ward, who was a co-presenter with Yates at the NCSL summit. "It is very easy to show that if you knock people off an hour of sleep there's a bump temporarily in bad things that will happen."

Efforts have been particularly strong in California, where 60% of voters passed a ballot issue for permanent daylight time in 2018. A bill is pending in the state Assembly.

Science Backs Sticking With Standard Time

All of this alarms scientists who study human biological rhythms.

Researchers in the U.S. and the European Union have taken strong positions about permanent summer hours. **The Society for Research on Biological Rhythms** posts its opposition prominently at the top of its website.

Messing with the body's relationship to the sun can negatively affect not only sleep but also cardiac function, weight and cancer risk, the society's members wrote. According to one often-quoted study on different health outcomes within the same time zones, each 20 minutes of later sunrise corresponded to an increase in certain cancers by 4% to 12%.

"Believe it or not, having light in the morning actually not only makes you feel more alert but helps you go to bed at the right time at night," said Dr. Beth Malow, director of the sleep division of Vanderbilt University School of Medicine. Malow has seen a lot of anecdotal evidence to back that up at the sleep clinic. Parents report their children with autism have a particularly hard time adjusting to the time change, she said.

Jay Pea, a freelance software engineer in San Francisco, was unhappy enough about California's proposed permanent daylight time that he started the **Save Standard Time** website to promote the health arguments for keeping it permanent. He said he doesn't think the scientific community is being heard.

"Essentially it's like science denial," he said. "It's bizarre to me that politicians are not hearing the experts on this."

Pea, 41 and an amateur astronomer, understands the human need to have the sun directly overhead at noon. "It's a wonderful connection to natural reality that unfortunately is lost on many people," he said. Daylight saving time "distances us from the natural world."

At the very least, lawmakers ought to consider history, he said. Daylight saving time was originally a plan to save energy during the two world wars but wasn't popular enough to be uniformly embraced after the conflicts were over. In 1974, the federal government decided to make it temporarily year-round as a way to deal with the energy crisis (although energy savings were later found to be underwhelming).

Its popularity fell off a cliff after the first winter, when people discovered the sun didn't rise until 8 a.m. or later and parents worried for the safety of kids waiting in the dark for school buses.

Pea finds it frustrating that the momentum now is for permanent summer hours — a fact he attributes to the emotional attachment with summer. "It's a shame that every generation we have to revisit this issue," he said.

The AP-NORC poll found 40% of its respondents support permanent standard time, with 31% opting for permanent daylight saving time.

Ward said people have gotten comfortable with daylight saving time since its duration has been lengthened to eight months by extensions in 1986 and 2007. (Before 1986, daylight saving time lasted six months.)

"So now really most of the year we are on the summer schedule, and people are used to that and they like it," he said. "That makes them more aggrieved when we change back to the winter schedule."

In any case, changing the clocks is a rare issue in that it isn't partisan, Ward said. "If the government can't respond to people when they want something and it's not even a partisan issue, that's just a sad commentary," he said. "Can't we please fix something that doesn't make sense anymore?"