Rhode Island Alliance for Retired Americans ©



# RI ARA

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

## June 11, 2017 E-Newsletter

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## ANNIVERSARY SUMMER 2017

### LEGISLATIVE CALENDAR

- *In the coming weeks and months, we expect a number of attacks to our health care.*
- Senate Republicans will introduce their version of AHCA
- President will release his budget this week
- Congress must pass a 2nd Budget Resolution For FY 2018
- Congress must pass 2nd Budget Reconciliation, which will include tax reform: Summer or Fall 2017
- Congress must pass a 2nd continuing resolution by September 30th– Trump expressed interest in a shutdown
- Debt Ceiling – October or November

### Social Security and Medicare

### The Many Faces of Social Security

♦ Nearly 171 million workers contribute to Social Security through payroll taxes.
♦ Nearly 61 million people receive monthly Social Security benefits:
∗44.2 million receive retirement benefits
∗6.0 million receive survivors' benefits
∗10.6 million receive disability benefits

### Tracking Issues: Social Security

### Average 2017 Monthly Social Security Benefit

Retired Worker: **$1,360**
Retired couple: **$2,260**
Social Security Cost of Living Adjustment (COLA) for 2017: **0.3%**

### 2017 Social Security & Medicare Contribution Amounts

- Social Security: **6.2%** on earnings up to $127,200.
- Medicare: **1.45%** on all wage

### 2017 Social Security Eligibility:

- Full Retirement Age: **66**
- Early Retirement Age: **62** (Taking early retirement can reduce Social
- Security benefits up to 30%.)

### Medicare at Risk in 2017

On November 10, 2016, House Speaker Paul Ryan told Fox News that he would push legislation in early 2017 that would end Medicare's guaranteed health care benefits. This is not the first time Speaker Ryan has tried to dismantle Medicare or Medicaid and his plans are available on his website. They include:

- Raise the Medicare Eligibility Age from 65 to 67
- Vouchers or Coupon-care
- Medigap Plans Will Cover Less
- Costs Shifted to Seniors

### Know the AHCA language tricks

*Are you hearing two different descriptions of the AHCA? That's because the language being used is full of tricks. Here's a glossary:*

- 'Premium support vouchers' = **Coupons** *(you get less, pay more out-of-pocket)*
- 'Choice' = **Cutting your benefits**
- 'Means Testing' = **Middle class pays more**
- 'Medicaid Block Grant' and 'Per-capita caps' = **States get less money and People lose benefits**
- 'Flexibility' = **Benefit cuts**
- 'Access' = **Not affordable**

### How will AHCA affect 65+

*On May 4, 2017, the House passed American Health Care Act by a vote of 217 – 213.*

- Raids Medicare trust fund and reduces solvency by 3 years
- Guts Medicaid by shifting costs to states and threatening long term care services

### AHCA will affect younger than 65

- Allows entrance in Medicaid expansion states until 2018, then shuts the door to everyone – even for short term lapses in coverage.
- Tax credits based on age, not income – no matter how much you can afford to pay
- Insurers can charge 50-64 year old patients 5 times more (up from current rate of 3x)
- Allows states to waive Essential Health Benefits to exclude coverage & waive community rating allowing plans to charge more for pre-existing conditions
- Health savings accounts
- High risk pools

### Trump's skinny budget

- Cuts Funding for Medical Research
- Eliminates Funding for Low-Income Energy Assistance Program (LIHEAP)
- Cuts Senior Nutrition Assistance
- Eliminates Senior Workforce Development Program

### *Petitions*

***I pledge to support any petitions that oppose budgets that undermine Older Americans***

# U.S. Senate Picks up Pace with Efforts to Repeal the Affordable Care Act

Last month, the U.S. House of Representatives **passed**—by a very narrow margin—the American Health Care Act (AHCA) (H.R.1628) a partial repeal of the Affordable Care Act as well as a major rewrite of the Medicaid program. The House passed the bill without the usual process of public hearings and input from experts and citizens. Further, in a highly unusual move, the House voted without having a score from the Congressional Budget Office (CBO), a non-partisan independent body that provides analyses of major legislation so that both lawmakers and the public can understand what a bill would cost if it became law.

The CBO **released** its analysis of the AHCA bill in late May, finding that the bill would result in 23 million Americans losing health care coverage, many of them over age 50, and would cut over $800 billion from the Medicaid program. At the same time, the bill would provide $600 billion in tax cuts for wealthy Americans and corporations.

Now the focus turns to the U.S. Senate. Though many Senators initially expressed deep concerns with the AHCA's provisions, there are strong indications that the chamber is moving forward through a similarly rushed, secretive process and making only minor changes to the bill. Recently, Senate leaders have promised their plan will be essentially the same as the House's bill, despite the AHCA's deep unpopularity.

Like the House, the Senate is forgoing public hearings or expert testimony and has not released the text they are working on. This leaves the public in the dark about what the bill will contain and what it will mean for American families.

Process aside, Medicare Rights believes passage of the AHCA bill or any similar policies will result in higher health care costs or coverage losses for older adults, people with disabilities, and their families. The AHCA ends the Medicaid expansion, allows insurers to charge older enrollees even higher premiums, and provides less generous assistance to help people in the Marketplaces afford premiums and cost sharing. The AHCA also effectively dismantles Medicaid—cutting federal payments to the program through what's known as a per-capita cap—that could significantly harm older adults and people with disabilities who rely on both Medicare and Medicaid.

Eleven million people with Medicare need help from Medicaid to cover vital long-term home health care and nursing home services, to afford their Medicare costs, and more. Federal cuts to Medicaid brought about by per-capita caps would drive states to make hard choices, likely leading states to scale back benefits, impose waiting lists, implement unaffordable financial obligations, or otherwise restrict access to needed care for older adults and people with disabilities...**Read More**

# IMPORTANT: Tell Your Senators to Abandon the American Health Care Act


Senate leaders are reportedly rushing forward to vote on a secret health plan, and they're starting with the policies in the American Health Care Act, a destructive bill passed by the House of Representatives last month.

The American Health Care Act would yank coverage out from under 23 million Americans, impose an unaffordable "age tax" on older Americans, end Medicaid as we know it, and undermine the Medicare guarantee. Not only that, the bill leaves people with pre-existing conditions out in the cold.

**Stand with the American people, who overwhelmingly reject the policies in the American Health Care Act. Tell your Senator to abandon the bill once and for all.**

Even if you have already contacted your Senator, follow our two steps today and urge your Senator to reject this secret health plan. Urge your Senator to commit to an open, bipartisan policymaking process that will enhance access to affordable coverage.

**Step One: Write to your Senators.**

Take action and send your Senators a letter. You can use our letter template or adapt the letter with your own message.

After you send your letter, be sure to share your action so we can get as many people involved as possible. The more your Senators hear from their constituents, the more likely they are to listen!

**Take Action Here**

**Step Two: Call 866-426-2631 to contact your Senator.**

After you write to your Senators, give them a call. Phone calls are a very effective way to reach your elected officials. **Call 866-426-2631 to contact your Senator.** You will be asked to enter your five-digit zip code before being transferred to your Senator. Urge your Senator to:

- **X Vote "no"** on taking health care away from 23 million people. The American Health Care Act increases health care costs—most of all for Americans in their 50s and 60s—and puts coverage out of reach for millions.
- **X Vote "no"** on capping Medicaid dollars. The American Health Care Act cuts more than $800 billion in funding from Medicaid. These caps will force states to ration care, threatening access to long-term home care that allows older adults and people with disabilities to stay in their communities and to receive nursing home care when it is needed.
- **X Vote "no"** on cutting Medicare. The American Health Care Act creates a tax windfall for the wealthiest Americans and pharmaceutical corporations at Medicare's expense. These tax breaks undermine the Medicare trust fund, which helps pay for hospital care that older adults and people with disabilities need, and will hike Medicare Part B premiums.

## Supreme Court Ruling Could Let Catholic Hospitals 'Pocket' Millions in Retirement Funds

The impact of the decision means Catholic hospitals, which employ tens of thousands of low-to middle-income workers, can now generally avoid the pension and health insurance protections required by federal law.

The U.S. Supreme Court on Monday issued a decision that could have devastating effects for the tens of thousands of people employed by Catholic hospitals.

The decision came in the case of Advocate Health Care Network v. Stapleton and its two related cases that address the scope of the "church plan" exemption under the Employee Retirement Income Security Act of 1974 (ERISA), the federal law governing employee benefit programs like pensions and health insurance. Among the provisions set by ERISA are requirements that pension plans meet certain minimum funding requirements, and that plans do not discriminate in their benefits by doing such things as providing comprehensive health insurance coverage for men but not women.

However, ERISA contains an exemption from its regulatory requirements for "church plans." The law defines church plans as those "established and maintained … by a church or by a convention or association of churches which is exempt from tax under section 501 of the Internal Revenue Code." Church plans also include those plans maintained by an organization "controlled by or associated with a church or by a convention or association of churches." ...**Read More**

## Senate panel to hold hearing on drug prices

The Senate's health panel will hold a hearing next week on drug pricing, questioning experts about the prescription delivery system.

The Health, Education, Labor and Pensions (HELP) committee will hold the hearing June 13 at 10 a.m., according to a media advisory.

The long-awaited hearing will focus on "the process of moving prescription drugs from the manufacturer to patients and how the drug deli system affects what patients pay when picking up their prescriptions," it says.

Last month, HELP unanimously passed an amendment aimed at increasing generic drug competition and driving prices down.

During that same markup, an amendment from Sen. **Bernie Sanders** (D-Vt.) that would allow the importation of prescription drugs was tabled.

The Trump administration is also **working** on actions to bring down drug prices, in an attempt to follow through on one of the president's main campaign promises. That could include speeding up the Food and Drug Administration's approval of new drugs.

However, Trump's budget proposal did not include any major proposals that would attempt to bring down prices…**Read More**

## If Insurance Market Crashes, Can Lawmakers Put The Pieces Back Together?


In his high-stakes strategy to overhaul the federal health law, President Donald Trump is threatening to upend the individual health insurance market with several key policies. But if the market actually breaks, could anyone put it back together again?

The question is more than theoretical. The Trump administration has already acted to **depress enrollment** in Affordable Care Act plans, has instructed the IRS to **back off enforcement** of the requirement that most people have health insurance or pay a penalty and **threatened to withhold** billions of dollars owed to insurance companies. All of those actions make it more difficult for insurers to enroll the healthy people needed to offset the costs of the sick who make it a priority to have coverage.

The president himself has made his strategy clear in **interviews** and tweets. "The Democrats will make a deal with me on healthcare as soon as ObamaCare folds — not long," Trump tweeted March 28. "Do not worry, we are in very good shape!"

But the individual insurance market is not in such good shape. A growing number of insurers are asking for double-digit premium increases or deciding to leave the market altogether. In the latest announcement, **Anthem said Tuesday** that it was pulling out of the Ohio marketplace next year. And while most analysts say the market probably would eventually rebound, in the short term things could get messy.

"Is the administration doing what it needs to do to stabilize the market? No, they're doing the opposite," said Kevin Counihan, CEO of the insurance exchange program during the Obama administration.

Trump's biggest weapon, by far, is refusing to reimburse insurance companies for billions of dollars in payments the law requires them to make to help policyholders with incomes up to 250 percent of the federal poverty level (about $30,015 for an individual and $61,500 for a family of four) afford their deductibles and other out-of-pocket payments. These "**cost-sharing subsidies**" are the subject of an ongoing lawsuit, and Trump can effectively end them at any time by dropping the suit...**Read More**

# RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"


## Many COPD Patients Struggle To Pay For Each Medicinal Breath

After a lifetime of smoking, Juanita Milton needs help breathing She's tethered to an oxygen tank 24/7 and uses two drug inhalers a day, including Spiriva, which she called "the really expensive one."

"If I can't afford it, I won't take it," Milton said.

The 67-year-old's chest was heaving one recent morning from the effort of walking down the hallway into the kitchen. Her voice was constricted as she loaded medication into a device about the size of her palm.

"Capsule in. You close it and you push this blue button," Milton said, demonstrating how the device punctures the pill. She then takes two labored breaths to inhale the powder inside the capsule. "And that's it."

Milton, like many Medicare enrollees, is on a fixed income. She has $2,000 a month to pay for a mortgage, car payment, Medicare premiums and other expenses.

"I got to stretch out that, plus I have the less costly medicines that I have to pay for and also my oxygen," Milton said. "You can only stretch it so far."

An estimated 1 in 9 Medicare beneficiaries are diagnosed with chronic obstructive pulmonary disease, or COPD. And, in 2014, COPD was the **third-leading cause of death** in the country, according to the U.S. Centers for Disease Control and Prevention. Inhalers like Spiriva and Advair account for billions in Medicare spending each year.

Yet, even if responsible only for monthly copays, many enrollees like Milton can't afford their inhalers. Milton depends on free samples provided by her doctor for her prescription of Breo Ellipta — the supply is limited, so she regularly skips one of the two daily doses. And she received one year's worth of free samples for Spiriva after applying for drugmaker Boehringer Ingelheim's financial assistance program.

Milton was down to two doses of Spiriva one recent morning. Holding up a silver sleeve of medication, Milton said: "This is all I have left. So, if [the drugmaker doesn't] approve me for this year, I'm going to have to ask Dr. Stigall if there's something else I can take." ...**Read More**

## How a simple tech tool can help cancer patients live longer

Doctors often don't hear about the serious side effects of chemotherapy because patients are reluctant to complain or don't have enough time to talk about such problems during jam-packed office visits, experts say.

But a new **study** points to a potential solution: using simple technology to encourage "real time" reporting of symptoms. Its findings show that patients with advanced cancer who reported side effects frequently via an online tool lived a median of five months longer than those who waited to mention problems during office visits.

Lead study author Ethan Basch, an oncologist at Lineberger Comprehensive Cancer Center at the University of North Carolina at Chapel Hill, acknowledges that a five-month improvement might sound modest. But, he notes, it is a greater benefit than what's provided by many targeted drugs for metastatic cancer.

Results of Basch's randomized, controlled trial were published Sunday morning in JAMA and will be presented at the plenary session of the American Society of Clinical Oncology annual meeting in Chicago. Only four studies, thought to have the greatest potential to affect patient care, are being highlighted at that session.

The trial involved 766 patients who were receiving outpatient chemotherapy at Memorial Sloan Kettering Cancer Center in New York, where Basch practiced before moving to Lineberger. The patients had a variety of cancer types, including prostate, breast and lung. ..**Read More**

## Daylight On Diabetes Drugs: Nevada Bill Would Track Insulin Makers' Profits

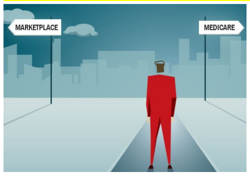
Patients notched a rare win over the pharmaceutical industry Monday when the Nevada Legislature revived a bill requiring insulin makers to disclose the profits they make on the life-sustaining drug. In a **handful of other states**, bills addressing drug prices have stalled.

Many of the 1.25 million Americans who live with Type 1 diabetes cheered the legislative effort in Nevada as an important first step in their fight against skyrocketing costs of a drug on which their lives depend. The cost of insulin medications has steadily risen over the past decade **by nearly 300 percent**.

Prominent patient advocacy groups, like the American Diabetes Association, have maintained stony silence while diabetes patients championed the bill and lobbied the legislature during this debate — a silence that patients and experts say stems from financial ties.

"Normally all of the patient advocacy groups rally around causes and piggyback on each other in a productive way — that's what advocacy groups are good at — but that hasn't been the case here," said Thom Scher, chief operating officer of Beyond Type 1, which does not accept donations from the pharmaceutical industry. Beyond Type 1 has not issued a formal opinion on the Nevada bill.…**Read More**

# Feds To Waive Penalties For Some Who Signed Up Late For Medicare




Each year, thousands of Americans miss their deadline to enroll in Medicare, and federal officials and consumer advocates worry that many of them mistakenly think they don't need to sign up because they have purchased insurance on the health law's marketplaces. That decision can leave them facing a lifetime of enrollment penalties.

Now Medicare has temporarily changed its rules to offer a reprieve from penalties for people who kept Affordable Care Act policies after becoming eligible for Medicare.

"Many of these individuals did not receive the information necessary [when they became eligible for Medicare or when they initially enrolled] in coverage through the marketplace to make an informed decision regarding" Medicare enrollment, said a Medicare spokesman, explaining the policy change.

Those **who qualify** include people 65 and older who have a marketplace plan or had one they lost or canceled, as well as people who have qualified for Medicare due to a disability but chose to use marketplace plans.

They have until Sept. 30 to request a waiver of the usual penalty Medicare assesses when people delay signing up for **Medicare's Part B**, which covers visits to the doctor and other outpatient care. Medicare beneficiaries who already pay the penalty because they had a marketplace plan can request that it be eliminated or reduced.

Medicare also imposes a waiting period for coverage on people who do not sign up when first eligible. If they meet the waiver requirements, they now can request that be lifted.

"This has been a problem from the beginning of the Affordable Care Act, because the government didn't understand that people would not know when they needed to sign up for Medicare," said Bonnie Burns, a consultant for **California Health Advocates**, a consumer group. "Once they had insurance, that relieved all the stress of not having coverage and then when they became eligible for Medicare, nobody told them to make that change."...**Read More**

# Improving Medicare Advantage: ACPA Has Suggestions

The American College of Physician Advisors (ACPA) has responded to a Centers for Medicare & Medicaid Services (CMS) request for recommendations for improvements to the Medicare Advantage program with a detailed position paper outlining a wide variety of proposed changes.

In an April 24 letter to U.S. Secretary of Health and Human Services Tom Price and CMS Administrator Seema Verma, more than a dozen ACPA officials praised the concept of Medicare Advantage under Part C – but strongly suggested that far more oversight and controls are desperately needed.

"Medicare Part C offers several potential advantages to Medicare beneficiaries and to (CMS). MAOs (Medicare Advantage Organizations) are already required to provide all of the benefits of traditional Medicare," the letter read. "Among the potential advantages to beneficiaries are receiving benefits which would not otherwise be covered by traditional Medicare, such as vision and dental benefits, prescription drug coverage, and wellness programs. The principle benefit to CMS is fixed program cost, as the third party assumes both financial risk and administrative claims responsibilities."

Yet, the letter continued, "our members have repetitively insisted that stronger oversight of MAOs is needed as the current process has led to increasingly wasteful amounts of plan-related administrative burden imposed on hospitals in order for them to be fairly reimbursed for the care they provide. This has resulted in many clinical support personnel spending the majority of their productive time meeting these individual MA Plan-specific rules, rather than focusing on the many complex issues surrounding beneficiary care."...**Read More**

# Persistent Pain May Lead to Memory Troubles

Pain that continues, day in and day out, may trigger an unexpected and unwanted side effect -- a bigger risk of mental decline and dementia, a new study suggests.

The findings suggest that chronic pain may be related to changes in the brain that contribute to memory problems. The findings may also point to new ways to protect age-related mental decline, the University of California, San Francisco (UCSF) researchers said.

However, it's important to note that the study wasn't designed to prove a cause-and-effect relationship. It can only show an association between pain and memory issues.

The study included information on more than 10,000 people. All of the study participants were 60 and older.

Those who had moderate or severe chronic pain in both 1998 and 2000 had more than a 9 percent faster decline on memory tests over the next 10 years than those who didn't have pain.

The decrease in memory would likely be enough to affect people's ability to do things such as manage their finances or keep track of their medications, the researchers said.

Patients with chronic pain also had a small but significantly increased risk of developing dementia, the study found.

"Elderly people need to maintain their cognition to stay independent. Up to one in three older people suffer from chronic pain, so understanding the relationship between pain and cognitive decline is an important first step toward finding ways to help this population," study first author Dr. Elizabeth Whitlock, a postdoctoral fellow in the department of anesthesia and perioperative care, said in a UCSF news release