Rhode Island Alliance for Retired Americans®

RI ARA

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"Fighting for the future of our members."
"NOW, more than ever!!!"

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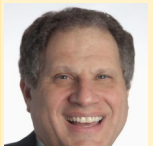
Message from the Alliance *for* Retired Americans Leaders

Senate Confirms Frank Bisignano as SSA Commissioner

Despite Controversy Over His DOGE Connections, Lack of Relevant Experience The Senate confirmed Frank Bisignano to head the Social Security Administration (SSA) along party lines on Tuesday, with a 53-47 vote. His term – set to expire in January 2031 – coincides with a tumultuous period for the agency, as Elon Musk and operatives from the Department of Government Efficiency (DOGE) work to gain access to Americans' most personal information and possibly dismantle the agency.


Robert Roach, Jr
President, ARA

"Mr. Bisignano's testimony before the Senate, along with his long career in the finance and tech sectors, provides no reassurance that he understands — let alone prioritizes — the needs of older and disabled Americans," said **Richard Fiesta, Executive Director of the Alliance,** in a statement. "We remain alarmed by the risk that he will support privatization schemes or replace essential SSA workers with AI systems, which could undermine the quality and accessibility of services."


Rich Fiesta,
Executive
Director, ARA

The evening before the vote, the Alliance joined Senate Minority Leader Chuck Schumer (NY), Sen. Chris Van Hollen (MD), Sen. Elizabeth Warren (MA), Sen. Ron Wyden (OR), Rep. John Larson (CT), former Social Security Commissioner Martin O'Malley, AFT President Randi Weingarten, Social Security Works President Nancy Altman, and retirees and members of AFSCME and AFT for a "Hands Off Social Security" rally.

Maryland Alliance member Pam Parker spoke at the event, criticizing DOGE's efforts to dismantle the SSA: "Let me be clear: This isn't about efficiency, this isn't about preventing fraud, this is about making it harder for seniors and people with disabilities to access the benefits they've earned," said Parker. "This is nothing less than a cruel, calculated plan to weaken Social Security."

Alliance members sent nearly 15,000 letters to their Senators urging them to vote no on Bisignano's confirmation.

"We will continue watching to see what Mr. Bisignano does next," said **Robert Roach, Jr., President of the Alliance**. "Our members won't stop speaking out and demanding that the Social Security Administration put the needs of retirees first."

Alliance Protects Voting Rights With Key Victory in North Carolina

North Carolina state Supreme Court candidate Jefferson Griffin conceded his loss to Justice Alison Riggs on Wednesday, ending a lengthy fight in which he attempted to void 60,000 ballots with allegedly incomplete registration information as well as thousands of ballots cast by military and overseas voters. The North Carolina Alliance intervened in a lawsuit over the last several months to defend votes that were legally counted in the election. North Carolina Alliance President Bill Dworkin was also an intervenor in the case. Griffin's concession effectively ended the lawsuit, ensuring that the ballots Griffin contested will be counted and Riggs will be sworn in.

"This victory is a major win for voters in North Carolina. Rules are set before elections – not after – for a reason," said **Joseph Peters, Jr., Secretary-Treasurer of the Alliance**. "We will continue to fight attempts to suppress older Americans' votes across the nation whenever and wherever we see it."


Joseph Peters, Jr.
Secretary
Treasurer ARA

Retirees Congratulate Jan Schakowsky on Exceptional Career in Congress

Rep. Jan Schakowsky (IL) announced on Monday that she will not seek another term in Congress. She has represented Illinois' 9th congressional district since 1999. Following the announcement, the Alliance thanked her for always fighting for seniors.

"Rep. Schakowsky has been a friend to Illinois seniors and the Alliance throughout her career. She has earned a lifetime pro-retiree score of 100 percent," said President Roach. "We're grateful for her work to strengthen and protect Social Security, spearheading various legislative efforts to bolster our guaranteed earned Social Security and Medicare benefits and fighting for lower drug prices."

"Rep. Schakowsky is a legend with a lifelong commitment to older Americans. Her decades of leadership have made life better for seniors and all Americans," added Executive Director Fiesta. "We are grateful for the unending passion she brought to Congress and wish her all the best."

KFF Health News:

At Social Security, These Are the Days of the Living Dead
By Darius Tahir

Rennie Glasgow, who has served 15 years at the Social Security Administration, is seeing something new on the job: dead people.

They're not really dead, of course. In four instances over the past few weeks, he told KFF Health News, his Schenectady, New York, office has seen people come in for whom "there is no information on the record, just that they are dead." So employees have to "resurrect" them — affirm that they're living, so they can receive their benefits.

Revivals were "sporadic" before, and there's been an uptick in such cases across upstate New York, said Glasgow. He is also an official with the American Federation of Government Employees, the union that represented 42,000 Social Security employees just before the start of President Donald Trump's second term.

Martin O'Malley, who led the Social Security Administration toward the end of the Joe Biden administration, said in an interview that he had heard similar stories during a recent town hall in Racine, Wisconsin. "In that room of 200 people, two people raised their hands and said they each had a friend who was wrongly marked as deceased when they're very much alive," he said.

It's more than just an inconvenience, because other institutions rely on Social Security numbers to do business, Glasgow said. Being declared dead "impacts their bank account. This impacts their insurance. This impacts their ability to work. This impacts their ability to get anything done in society." **Read more here.**

Senator Whitehouse, Congressman Boyle Reintroduce Legislation to Extend Social Security and Medicare Solvency Indefinitely

Medicare and Social Security Fair Share Act would make wealthiest Americans pay fairer share to protect solvency of bedrock health care and retirement programs

Washington, DC – U.S. Senator Sheldon Whitehouse (D-RI) and Congressman Brendan Boyle (D-PA) today reintroduced the Medicare and Social Security Fair Share Act to protect the future solvency of Medicare and Social Security by reversing inequities in the tax system so the nation's highest earners contribute their fair share. The bicameral legislation would extend Social Security and Medicare solvency by at least 75 years – the furthest allowable projection period – according to analyses from the actuaries of the Centers for Medicare and Medicaid Services and Social Security Administration.

"Working-class seniors pay into Social Security and Medicare their whole careers so they can enjoy a dignified retirement, but they end up paying a much larger share of their income in taxes than billionaires because the tax code is rigged in favor of the rich," said Senator Whitehouse. "As the Trump administration and Congressional Republicans gear up to deliver budget-busting giveaways for their billionaire donors, I will continue pushing to make our tax code fair and protect these twin pillars of retirement security as far as the eye can see."

"From my first day in Congress, I've pledged to protect the long-term stability of Social Security and Medicare—two bedrock promises our country made to seniors, workers, and people with disabilities," said Congressman Boyle, Ranking Member of the House Budget Committee. "Now, with Donald Trump, Elon Musk, and DOGE-fueled billionaires openly attacking these programs, that fight is more urgent than ever. This bill would protect Social Security and Medicare for generations by making the wealthiest Americans pay what they owe. While Republicans are pushing a $7 trillion tax giveaway to the ultra-rich, we're working to protect the benefits that millions of Americans have earned—and we won't let them be stolen to fund another billionaire windfall."

Medicare and Social Security are twin pillars of economic fairness and retirement security, providing lifelines to elderly Americans and their children, and disabled workers. In 2022, Social Security alone lifted 28.9 million Americans out of poverty, and nearly half of seniors live in households that receive at least 50 percent of their family income from Social Security benefits that they have earned after a lifetime of work. Medicare protects its over 65 million beneficiaries from potentially catastrophic health care costs. Despite the bedrock importance of these programs, both are at risk of being unable to fully pay out benefits within the next 15 years. Without new revenue, the Hospital Insurance trust fund and the Old Age and Survivors Insurance trust fund are expected to become insolvent in 2036 and 2033, respectively.

The bicameral legislation would:

Preserve Medicare and Social Security while safeguarding benefits.

Significantly extend Social Security and Medicare solvency by at least 75 years, according to analyses from the Centers for Medicare and Medicaid Services Office of the Actuary and the Social Security Administration's Office of the Chief Actuary.

Require taxpayers with over $400,000 in income to contribute a fairer share to Social Security.

Lift the Social Security tax cap to ensure that no matter the source of their income, high-income taxpayers would pay the same tax rate on their income exceeding that threshold.

Require taxpayers with incomes above $400,000 to contribute more to Medicare.

Increase the rate for income above $400,000 by 1.2 percent, and ensure that wealthy owners of pass-through businesses like hedge funds and private equity firms with more than $400,000 in annual income cannot avoid Medicare taxes.

Joining Whitehouse and Boyle on the bill as original cosponsors are Senators Amy Klobuchar (D-MN) and Chris Van Hollen (D-MD).

The bill has been endorsed by Alliance for Retired Americans, American Federation of Government Employees, American Federation of Labor and Congress of Industrial Organizations, American Federation of State, County and Municipal Employees (AFSCME), American Federation of Teachers, Americans for Tax Fairness, Center for Medicare Advocacy, Committee for a Responsible Federal Budget, Communications Workers of America, Doctors for America, Families USA, Groundwork Collaborative, International Federation of Professional and Technical Engineers, Main Street Alliance, Mary's Center, MomsRising, National Committee to Preserve Social Security and Medicare, National Council on Aging, National Education Association, National Women's Law Center Action Fund, NETWORK Lobby for Catholic Social Justice, People's Action, Public Citizen, Revolving Door Project, Social Security Works, and Teamsters.

The Walls Might Be Closing in on Social Security

Older Americans are increasingly worried about the future of Social Security, with a new AP-NORC poll showing rising doubt even among those nearing retirement.

-Three in ten adults over 60 are skeptical about benefits being there when needed, notably driven by declining confidence among Democrats

While President Trump insists he won't cut Social Security, recent DOGE-led staff cuts and disruptions at the Social Security Administration (SSA)—including attempts to slash customer services—have sparked bipartisan alarm.

-The confirmation of Wall Street veteran Frank Bisignano as the new commissioner brings fresh uncertainty, as GOP lawmakers urge him to avoid further SSA cuts impacting retirees and disabled beneficiaries.

Social Security In Trouble?

The main trust fund that funds Social Security is scheduled to run out of the ability to pay full benefits at some point in the mid-2030s, which has led many younger Americans to worry that Social Security won't be there for them when it's time for them to retire.

A new poll shows that many older Americans are also beginning to have that fear.

According to the most recent numbers from **the AP-NORC Center Poll**, respondents were asked the question, "How confident are you that each of the following benefits will be available to you when you need them?"

"About 3 in 10 U.S. adults age 60 or older are "not very" or "not at all" confident that Social Security benefits will be there for them when they need it, up from about 2 in 10 in **an AP-NORC poll conducted in 2023**,"

according to **an AP story about the poll results.**

The summary added that there has been a "substantial decrease in confidence" among Democrats that Social Security will be there for them. Half of Democrats 60 or older are "not very" or "not at all confident" that Social Security will be there for them, a number that was only 1 in 10, just two years ago.

Older Republicans, however, have become more confident about the availability of Social Security to them. Six in 10 Republicans 60 or older are confident that it will be there for them….**Read More**

"Skinny" Budget Shows President's Worrying Health Policy Priorities

Late last week, the Trump administration released a **budget outline** for fiscal year 2026, which starts on October 1. While this document does not include many details—a fuller explanation of the budget numbers is expected later in May or early June—the included information shows a willingness to cut funding and eliminate whole programs that serve many older adults and people with disabilities.

Proposed Cuts to Programs that Bolster Healthy Aging

Overall, the proposed budget would cut projected spending by $163 billion, over 20%, by slashing many programs that support public health and individuals with few resources. For example, the Low-Income Home Energy Assistance Program (LIHEAP) helps 6 million families with young children, older adults, and people with disabilities pay their heating and cooling bills. The budget proposes to eliminate LIHEAP. Other proposals include massive cuts to the **Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Disease Control and Prevention (CDC)**, the Ryan White HIV/AIDS Program, and the medical research agency the **National Institutes of Health (NIH)**. Still other programs that help fund hazardous waste cleanup, clean air and water, job training for older adults, rental assistance for low-income individuals, support for the homeless, and renewable energy initiatives would also be on the chopping block.

Presidential Budgets are Messaging Tools

Presidential budgets are used to kick off discussion around funding the federal government for the year, but they are not binding. Instead, they serve as messaging tools and guideposts to the administration's goals. In most years, Congress takes little or no action on a budget's specific provisions. It appears some of this year's budget proposals **will not be welcomed by either party,** and working out a federal funding plan generally requires bipartisan Congressional action. But some of the destructive changes have already been made, such as the **dismantling of important agencies like the Administration for Community Living (ACL),** which has put **access to federal services for older adults and people with disabilities at risk**.

At Medicare Rights, we urge the administration to abandon attempts to severely cut or eliminate these programs and instead work to bolster public health and well-being.

Will insurers dump Medicare enrollees with high health costs to please Wall Street?

Wall Street is speaking loudly to Medicare Advantage insurers: If you want us to stick with you, keep dumping seniors who are pinching your profit margins.

Investors continue to punish UnitedHealth Group since the company downgraded its 2025 profit expectations on April 17. On Friday, UnitedHealth's stock price hit not only a 52-week low—$393.11—but its lowest point in years. The last time UnitedHealth's stock price went below $400 a share was on October 14, 2021.

The company's shares lost nearly 4.5% of their value during the past week, contributing to a decline that started soon after the company set an all-time high of $630.73 last November. UnitedHealth's shares have lost more than 33% of their value since then.

Wall Street Sends a Message

Meanwhile, investors have once again embraced UnitedHealth's top two rivals in the Medicare Advantage business –Humana and CVS/Aetna. Those companies told investors last year, when both were in the Wall Street dog house for spending more than investors expected on patients' medical care, that they would dump hundreds of thousands of their costliest Medicare Advantage enrollees to improve their profits. They made good on that promise, shedding almost 650,000 seniors and people with disabilities by the end of the year.

Many of those people enrolled in a UnitedHealth Medicare Advantage plan. The company reported 400,000 more Medicare Advantage enrollees in the first quarter of 2025 than in the fourth quarter of 2024. That used to be a good thing, but UnitedHealth's executives told investors on April 17 that it wouldn't make as much money for them as the company had assured them just three months earlier because it likely will have to spend more than they expected on those new MA enrollees' medical care. Investors responded by immediately dispatching the company's shares to the cellar. Those shares lost about 23% of their value in a single day.

The Street had also punished Humana and CVS last year when they said they were paying more for seniors' medical care than they'd expected. Shares of both companies cratered, losing around half their value. So, executives at both Humana and CVS started identifying Medicare markets to get out of entirely. The culling was ruthless. CVS shed 227,000 MA enrollees. Humana got rid of 419,000.

Locked Out of Traditional Medicare

Those seniors and disabled people had to scramble to find a new Medicare Advantage insurer because it is difficult for most people to go back to traditional Medicare and find an affordable Medicare supplement policy. Medicare supplement insurers must waive underwriting during the first six months of applicants' eligibility for Medicare, but people who enroll in a Medicare Advantage plan and want or need to make a change months later find out that insurers will charge them more unless their health is nearly perfect.

Of the seven big for-profit health insurers, four (Cigna, CVS/Aetna, Humana and Centene) collectively cut 1.3 million of their Medicare Advantage enrollees adrift at the end of 2024 in an effort to stay in Wall Street's good graces. Cigna dumped all 600,000 of its MA enrollees, selling them to the Blue Cross corporation HCSC. For-profit Blue Cross insurer Elevance picked up 227,000; Molina added 18,000, and, as noted, UnitedHealth signed up 400,000 new MA enrollees.

While UnitedHealth's shares have lost a third of their value, CVS's shares have increased more than 50% since the first of this year. They even set a 52-week high of $72.51 on Thursday. Humana's shares closed Friday at $258.48, up 1.88% since January 1. They are out of the Wall Street dog house – for now, anyway.

Profits, Lobbying Soar

I trust you are not feeling sorry for UnitedHealth because of its misfortune on Wall Street. It is still a hugely profitable company –just not profitable enough lately to please investors. This huge corporation, the fourth largest in America, reported **$9.1 billion in profits in just the first quarter of this year**. If the company makes it more difficult for its health plan enrollees to get the care they need this year, it could make even more than the **$34.4 billion in profits it made last year**.

And as a group, the seven big for-profits, including those that spent more than Wall Street felt was necessary on patients' medical care, made **$70 billion** in profits last year. (UnitedHealth made nearly as much as the other six combined.)

And collectively, those giant corporations took in a record $1.5 trillion in revenue from us as customers and taxpayers last year. They are doing quite well. But that won't stop them from trying to keep lawmakers and Trump administration officials from cracking down this year on the widespread waste, fraud and abuse in the Medicare Advantage program. You can expect them to spend a record amount of our money on lobbying expenses in Washington this year to keep their Medicare Advantage cash cow well fed.

Medicare Advantage doesn't work for rural Americans

Rural Americans with Medicare are in a bind. Too often, they cannot afford the high cost of supplemental coverage that limits out-of-pocket costs in traditional Medicare. And Medicare Advantage HMOs don't meet their needs, reports Kelly Hooper for **Politico Pro**. Rural hospitals won't agree to be in the Medicare HMO network because the insurers don't pay them adequately and endanger patient safety. What will Republicans in Congress do?

Some rural Americans in Medicare HMOs must drive as much as four hours to get the medical care they need. It's hard enough to get care in rural America. People in Medicare HMOs struggle all the more. The insurers don't pay the rural hospitals as much as traditional Medicare and impose all kinds of costly administrative hoops.

Traditional Medicare pays rural hospitals extra to ensure they are there for rural communities. But, even though the government pays that money to insurers serving rural communities supposedly to pass on to the rural hospitals, the insurers tend to pocket that extra money. The harder it is for their enrollees to get care, the more they profit.

Congress needs to change the payment system to rural hospitals. It could take the extra money that goes to the insurers and give it to the hospitals directly. It could also constrain insurers' ability to impose administrative obstacles to care. But, will it?

Jerry Moran, a Republican Congressman from Kansas knows how dire the financial situation is for rural hospitals as a result of the Medicare HMOs. But, he is not proposing a fix. Nonetheless, hospitals are hopeful Congress and the administration will address insurer misuse of prior authorization to delay and deny care inappropriately.

The truth is that CMS lacks real power to prevent the insurers from inappropriate delays and denials of care. The laws and regulations have no teeth. CMS cannot punish violators in meaningful ways. And, now, with massive staffing cuts, CMS has even less ability to undertake oversight and enforcement.

A spokeswoman at CMS stated that staff would continue to do use its statutory authority to oversee Medicare HMO insurers. But, CMS lacks the resources and the tools to protect Americans in Medicare HMOs, and CMS continues to allow the insurers to overcharge Medicare for their services.

Over the last ten years, more than 100 rural hospitals have closed their doors. More than 400 more are at "high financial risk," says a report of the American Hospital Association. Yes, more rural Americans might be enrolling in Medicare HMOs, but HMO enrollment does not mean satisfaction, nor does it help the bottom lines of the rural hospitals.

Today, almost **half of all health systems across the country** are either dropping or thinking about dropping their Medicare HMO contracts because of inappropriate denials of care and underpayments, reports the Healthcare Financial Management Association and Eliciting Insights.

Does Medicaid Cover Nursing Homes?

Medicaid can cover nursing home care if you meet certain income and health requirements. Here's what you need to know.

Health care at any level is expensive, but at the top of the list is **nursing home care**. The national annual median cost of care for a resident in a private room in a nursing home is now $127,750, according to Genworth and CareScout. A semi-private room clocks in at a similarly staggering $111,325 per year.

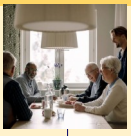
Footing the bill for **nursing home costs** is a financial challenge for most people.

"Nursing homes are one of most expensive levels of care, and most people don't have that money," says Amie Clark, a senior care expert and creator of AgingToday.com, a company specializing in geriatric care management and senior housing advisory.

There is, however, one option for older adults who **don't have the funds to pay for a nursing home**: Medicaid.

Does Medicaid Cover Nursing Home Costs?

The short answer is yes. **Medicaid**, not to be confused with Medicare, is a federal health insurance program for low-income individuals, and it's administered at the state level. Medicaid kicks in when there are no other options available to a senior who needs nursing home care.



"Medicaid was built to be the payer of last resort for people in poverty," says Chris Orestis, a Maine-based senior care advocate and expert in retirement, long-term care and specialty senior living funding solutions.

Data from KFF, an independent source of health policy research, shows that Medicaid is the primary payer for nursing home care, covering 63% of nursing home residents.

How to Get Medicaid to Pay for Nursing Home Care

Securing Medicaid coverage for nursing home care takes some effort, and requirements for eligibility can be complex. However, you may qualify for Medicaid nursing home care even if you previously have not been eligible for other Medicaid services.

Income requirements

Eligibility is usually based on modified adjusted gross income, or MAGI, which is your taxable income plus certain deductions, including nontaxable Social Security benefits, individual retirement contributions and tax-exempt interest. It's usually the same or quite close to your adjusted taxable income that's listed on your tax return.

Most states also have multiple Medicaid programs, each with different eligibility criteria. However, generally speaking, if you make less than 100% to 200% of the federal poverty level and are elderly, disabled or a parent/caretaker, for instance, you probably qualify for a Medicaid program.

If you make less than 133% of the federal poverty level, you'll most likely qualify for a Medicaid program in your state. In 2025, the federal poverty level is $15,650 annually for a single person and $21,150 for a couple in all 48 contiguous states and the District of Columbia. In Alaska, the rates are $19,550 for a single person and $26,430 for a couple. In Hawaii, the rate is $17,990 for a single person and $24,320 for a couple.

Asset requirements

For a single person, your assets can't be greater than one house, one car and $2,000 or less in all accounts combined. For a married couple, assets can't exceed one house, one car and approximately $3,000 in all accounts.

If you have more than that, you likely won't qualify for Medicaid benefits, unless you go through an involved **spend-down process** to reduce your assets, says Kelsey Simasko, an attorney with Simasko Law in Mount Clemens, Michigan.

It can be a challenging process, though, especially because the state will review your assets and income over the prior five years to evaluate your eligibility. This is called the "look back" period. If Medicaid determines that you moved some assets in violation of its rules, you may lose some or all of your nursing home coverage. So, it's a good idea to work with an elder law attorney to make sure you're doing it right.

Care requirements

Each state sets its own criteria for how much care you may need, a measure called Nursing Home Level of Care, or NHLOC. Assessment tools vary but typically focus on determining the individual's physical functioning, cognitive ability and medical and behavioral health needs. People who don't meet these criteria won't qualify for nursing home coverage under Medicaid….**Read More**

KFF Health News

KFF Health News: 'If They Cut Too Much, People Will Die': Health Coalition Pushes GOP on Medicaid Funding

By Christine Mai-Duc

Tina Ewing-Wilson remembers the last time major Medicaid cuts slashed her budget.

In the late 2000s, during the Great Recession, the pot of money she and other Medi-Cal recipients depend on to keep them out of costly residential care homes shrank.

The only way she could afford help was to offer room and board to a series of live-in caregivers who she said abused alcohol and drugs and eventually subjected her to financial abuse. She vowed to never rely on live-in care again.

Now the 58-year-old Republican from the Inland Empire is worried Medicaid cuts being mulled by her party in Washington could force her into another vulnerable spot.

"f they reduce my budget, that doesn't change the fact that I need 24-hour care," said Ewing-Wilson, who has struggled with seizures and developmental disabilities her entire life. "If they cut it too much, people will die or they'll lose their freedoms."

Similar stories have already surfaced in GOP-held swing districts nationwide where activists have been applying political pressure to sway vulnerable House members from supporting $880 billion in cuts that health experts say would almost certainly hit safety net programs. But in California, which sends more Republicans to Congress than any state west of Texas, consumer groups and health industry giants are joining forces in a quieter campaign to lobby lawmakers in solidly red districts, some of which they say would be **disproportionately affected** if those cuts materialize. ***Read more here***. .

Federal cuts to Medicaid will have devastating consequences for older adults and people with

About 12 million older adults and people with disabilities are enrolled in both Medicare and Medicaid. For most services, Medicare is the primary payer and Medicaid secondary. For services that Medicare does not cover, such as long-term care in a nursing home or at home, Medicaid is the exclusive payer. Republican plans to slash Medicaid spending will inevitably have devastating consequences for hundreds of thousands of older and disabled people with Medicare who rely on Medicaid for their long-term care needs.

N.B. If Republicans want to cut $1 trillion from the budget, they should stop giving billions in handouts to corporate health insurers and end the $1.2 trillion in Medicare Advantage HMO waste and abuse.

How many people with Medicare and Medicaid receive long-term care through Medicaid? Of the **12.8 million people with Medicare and Medicaid**, more than one million older adults and people with disabilities rely exclusively on Medicaid for their long-term care needs.

What is the income of people with Medicaid and Medicare receiving long-term care through Medicaid? In 44 states, people with incomes no greater than 300 percent of the SSI level or 226 percent of the federal poverty level, $2,829 a month (2024), are eligible for Medicaid long-term care. **MACPAC** reports that more than 60 percent have annual incomes below the poverty level; 94 percent have annual incomes below 200 percent of poverty. A high proportion do not have a high school diploma and are African American or Hispanic.

What is the health status of people with Medicare and Medicaid? More than one-third of dual eligibles are enrolled in Medicare because of a disability, and 14 percent are over 85 years old. According to **MACPAC**, they are more likely to have cognitive impairments and mental disorders than others. They also have higher rates of diabetes, pulmonary disease, stroke, and Alzheimer's disease than non-dual-eligibles.

What services does Medicaid provide in nursing homes? Medical services, nursing care, and rehabilitation services. Medicaid also provides help with activities of daily living such as bathing, dressing and toileting.

How much does the federal government spend on Medicaid relative to the states? The federal government spent **about 69% of Medicaid's total costs**, including nursing home care– around $606 billion–out of a total of $880 billion in FY 2023. About **34 percent of Medicaid spending is for long-term services and supports**, including institutional and home-based care. The federal government provides support for Medicaid long-term care to different degrees in each state.

What happens to nursing home residents if Medicaid money is cut? Medicaid covers **63 percent of nursing home residents**. The **vast majority** of dual eligibles receiving institutional or home-based care are covered through an "optional eligibility group." The states could end their eligibility. Most nursing home residents may be forced to go without long-term care. Medicaid coverage is available only to people with low incomes, who could not otherwise afford to pay for their nursing home or home care. In 2024, the average cost of a nursing home stay in a semi-private room was **over $111,000**.

What will states do if Congress cuts federal Medicaid significantly? States would likely end optional Medicaid home and community-based long-term programs and would stop providing Medicaid long-term care for millions of Americans. They might reduce long-term care services considerably. They might pay less for nursing home care, which could lead to nursing home staff shortages, as well as poor quality of care and poor health outcomes for patients.

Dear Marci: Can SPAPs really help me save money?

Dear Marci,

What are State Pharmaceutical Assistance Programs, and can one help me save money?

Juan (Pheonix, AZ)

Dear Juan,

State Pharmaceutical Assistance Programs (SPAPs) are state-created and administered programs to help residents pay for prescription drugs. An SPAP may help pay for your Part D plan's premium, deductible, or copayments.

Each SPAP works differently. States may design their SPAP to target different populations and different pharmaceutical costs. Some states coordinate their drug assistance programs with Medicare's prescription drug benefit (Part D) and require that you sign up for Part D to receive assistance. In these cases, if a drug is covered by both your SPAP and your Part D plan, the SPAP can lower your costs at the pharmacy for each prescription and your overall annual costs. Both the amount you pay and the amount the SPAP pays toward your covered drugs will count toward the **Part D out-of-pocket cap.** Certain states have qualified SPAPs. Being enrolled in a qualified SPAP gives you a **Special Enrollment Period (SEP)** to enroll in or make changes to your Part D coverage. You can visit Medicare.gov to find out if your state has an SPAP. For help with learning about and applying for SPAPs, call your State Health Insurance Assistance Program (SHIP). You can find your local SHIP by calling **877-839-2675** or visiting **www.shiphelp.org**.

Hope this answers your question!

-Marci

Trump could easily end high drug costs

In an op-ed for **MarketWatch**, Brett Arends explains that President Trump names the wrong culprit when it comes to prescription drug prices in America. The problem is not that pharmaceutical companies are manufacturing their drugs abroad. The problem is that we let pharmaceutical companies set prices sky high, unlike every other wealthy country; Trump could end that.

Trump's **tariffs will only to drive prescription drug prices higher**. Pharma claims that a 25 percent tariff will increase prescription drug costs by 13 percent on average. The tariff is not going to bring drug manufacturing back to the US. Already, many drugs are manufactured in the US. But, we import a lot of the ingredients.

Older Americans will pay the lion's share of these higher drug costs as older Americans take more drugs than other Americans. (N.B. If you travel abroad, you can save a lot of money by buying your medicines abroad. Usually, you don't need a prescription.)

People in other wealthy countries pay far less than we do for the same drugs. And, it's not because the drugs are being manufactured in their countries. According to RAND, a major research institution, we spend 72 percent more than Mexicans for the same prescription drugs and 129 percent more than the Canadians. We are spending around three times more for our prescriptions than the British, French, Germans and Italians and about 350% more than the Japanese.

Think about it. If you live in Western Europe or Japan, you are likely to pay a third as much as we pay for the same exact drugs. That's insane.

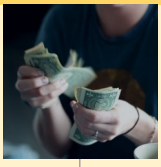
The biggest reason we pay more is that other countries negotiate the price of drugs for their citizens. Our federal government does not. Our high costs are a direct result of the fact that Congress won't require negotiated drug prices for Americans; and, President Trump has issued an **executive order** benefiting the pharmaceutical industry, which will reduce the number of Medicare-negotiated drug prices significantly.

Trump needs to sign an executive order requiring pharmaceutical companies to sell their drugs in the US for the same prices as they sell their drugs in Europe. Or, he could require that we import our drugs at the same prices as Europeans pay.

Case study: Costco saves one couple hundreds of dollars over Medicare Part D

If you ask me, often the smartest way to save money on prescription drugs is to **import them from abroad**. But, though no one has ever reported a safety issue from importing drugs from **verified pharmacies abroad**, importation is still not legal, even for personal use. One Just Care reader, D Busa, wrote in to explain how he saves money on prescription drugs without relying on importation and, with his permission, I am sharing Busa's story.

Busa takes a good bit of time to check out all his options under **Medicare Part D**, which provides prescription drug coverage, each year. Most people with Medicare don't take that time, even though it's super important. Whether you're in Traditional Medicare or in a Medicare Advantage plan, the Part D plan or Medicare Advantage plan offering Part D coverage that met your needs one year, can cost you a lot more than expected the following year.



Unfortunately, with Part D, your prescription drug costs can change at any time. And, if you need new drugs, the plan you chose because of its lower cost for the drugs you had been taking could end up costing you more than other Part D plans because of new drugs your doctor prescribes. Curiously, even when you are a careful shopper of Part D plans, you can sometimes save a lot of money getting your drugs without relying on Part D coverage.The system is INSANE. It works very well for the insurers at the expense of people with Medicare.

Busa saw his prescription drug costs rising in Medicare Part D even though he shopped around for the best possible Part D plan. So, he looked to see whether he could get the single prescription drug he takes for less without using his Part D coverage. He found that by using Costco mail order, he could reduce his annual out-of-pocket costs by $459, $275 through Part D premium savings and $244 for drugs through Costco minus the $60 for annual Costco membership.

Again, the only word to describe Busa's discovery that his Medicare Part D plan was effectively ripping him and Medicare off is INSANITY. How in god's name does Medicare agree to pay its share of the cost of a Part D drug or say it is providing Medicare coverage for a drug that costs so much less at Costco without prescription drug coverage?

Busa found that his wife was also better off getting two of her drugs through Costco. On Part D, she paid $280 for the drugs. At Costco, she paid $57, saving $223 over three months.

Busa explains that sometimes Part D is less expensive than Costco. Two other drugs his wife takes cost her $6 through her Part D plan and $14 at Costco.

Busa's strategy is to pick the Part D plan with the lowest premium. By doing so, he says, "overall I save $550 on Part D premiums and $1,684 on drugs or $2,234 annually." INSANITY.

A new health literacy study finds that just 20 percent of people with health insurance through their employer feel they understand their coverage, reports Alan Goforth for **BenefitsPro**. While the researchers did not look at older Americans' understanding of their Medicare coverage, it seems fair to assume that only a tiny proportion of older Americans feel they understand their coverage. People who don't understand their coverage are not likely to get the care they need; going without good care could cost them a bundle financially, emotionally and physically.

The direct costs to people's health from lack of understanding their insurance is tremendous. Not only can they be deprived of needed care, but they can suffer undue stress and worse health conditions. In Medicare Advantage, most people don't appreciate the obstacles to their getting the care they need when they need it. Insurers take a narrow view of what care is covered, often second-guessing treating physicians, because that is how they maximize their profits. Many people do not know they easily can **appeal an insurer denial** and go without needed care.

Cigna Healthcare produced the health literacy report, with the apparent goal of getting employers to do a better job of educating their employees about their health insurance coverage. Lack of understanding costs employers billions of dollars in lost productivity, according to Cigna Healthcare. But, people have lots of things they need to learn, and it is not likely that they are going to spend any time trying to understand their health insurance until they need it.

The solution to low health literacy when it comes to health insurance is to create a simple system that is easy to understand, such as traditional Medicare, the government-administered health care coverage for older adults and people with disabilities. With traditional Medicare, access to care is far less burdensome a process–even for people with

RI ARA HealthLink Wellness News

Please Note: All Articles In This Section Are For Information Only And Not Medical Advice

HealthLink Wellness "Taking Control"

John Oliver: RFK Jr., a danger to our public health

In a piece for **Last Week Tonight**, focused on public health, John Oliver skewers RFK Jr. for the damage he has wrought on the nation's health. RFK Jr. has led a dramatic downsizing of the Department of Health and Human Services, a critical government agency, which is responsible for our collective health–child welfare, Medicare annd Medicaid, drugs, food safety and a lot more. The chilling consequence, according to one fired HHS employee: "We're going to have a lot of people die needlessly."

Oliver explains that President Trump has let RFK Jr. "go wild on health." Thousands of jobs have been cut and thousands of HHS employees have retired. Some staff were told to file complaints with an HHS staffperson who died last year.

The wholesale gutting of HHS will endanger the health and well-being of Americans. "People will die because of the mistakes we are making right now." "Secretary Kennedy is a danger to the public health and should resign or be fired." He can't manage this devastation. He is "spreading dangerous nonsense and gutting life-saving research," says Oliver.

Shouldn't RFK Jr. figure out what needs cutting, before he cuts whole divisions of HHS? RFK Jr. doesn't think so. Instead, there has been a radical restructuring of HHS and huge spending cuts. It's alarming. HHS is critical to the well-being of Americans. It funds and oversees a wide array of invaluable work at the National Institutes of Health, the world's largest funder of biomedical and cancer research; the Food and Drug Administration; the Centers for Medicare and Medicaid Services, which supports Medicare and Medicaid, and much more. It accounts for 28 percent of federal spending. But, RFK Jr. has made dangerous cuts to all these vital agencies. Here is a sampling of HHS's "shitshow," which Oliver calls an understatement.

- Wholesale cuts to NIH, which has stopped funding important medical research across the country, even though every dollar of research by NIH returns $2.56 in economic activity. Some studies can't be restarted.
- FDA cuts to staff that are responsible for urgent safety recalls and specialists investigating bird flu transmission. For example, we won't know if there's bird flu in milk.
- Cuts to the CDC, which among other things can no longer study Alzheimer's disease awareness and prevention, tracking STIs or respond to lead poisoning.
- $12 billion in cuts to states for health research.
- Cuts to nearly half of the Meals on Wheels staff.
- Cuts have led to the first pediatric measles death in 22 years because vaccinations have been cancelled; whooping cough cases are also spreading; the bird flu virus is spreading. If there's an ebola outbreak, we will not have the staff or expertise to end it.

RFK says that HHS will remedy any "mistakes" it makes. But, HHS has not done so as of yet. RFK also fabricates his data.

"We need to stop [RFK Jr.] before he makes us all f#$%king sick," concludes Oliver. He "needs to go, and by impeachment, if necessary."

View video.

Vast majority of Americans don't understand their health insurance

A new health literacy study finds that just 20 percent of people with health insurance through their employer feel they understand their coverage, reports Alan Goforth for **BenefitsPro**. While the researchers did not look at older Americans' understanding of their Medicare coverage, it seems fair to assume that only a tiny proportion of older Americans feel they understand their coverage. People who don't understand their coverage are not likely to get the care they need; going without good care could cost them a bundle financially, emotionally and physically.

The direct costs to people's health from lack of understanding their insurance is tremendous. Not only can they be deprived of needed care, but they can suffer undue stress and worse health conditions. In Medicare Advantage, most people don't appreciate the obstacles to their getting the care they need when they need it. Insurers take a narrow view of what care is covered, often second-guessing treating physicians, because that is how they maximize their profits. Many people do not know they easily can **appeal an insurer denial** and go without needed care.

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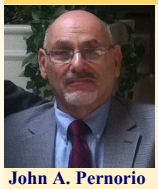
The solution to low health literacy when it comes to health insurance is to create a simple system that is easy to understand, such as traditional Medicare, the government-administered health care coverage for older adults and people with disabilities. With traditional Medicare, access to care is far less burdensome a process–even for people with mental and physical impairments and low health literacy–than in a Medicare HMO.

Traditional Medicare has no prior authorization requirements for medical or hospital care, no provider networks and no need for patients to know anything about the administrative elements of their care. Physicians and hospitals submit the bills, you pay nothing upfront, and if you have **supplemental coverage**, you often have no out-of-pocket costs to think about. Moreover, if Medicare denies a service, it is the provider who eats the cost unless the provider has given you written notice and you have agreed to pay privately.

Why a Acute Rehabilitation Hospital is a better alternative over a nursing home for rehab



John A. Pernorio
RI ARA
President

In 2023, I was sent to a nursing home after a bad blood infection for physical therapy for two weeks. While I was there, I stayed in bed 21-22 hours a day missing multiple therapy sections because I was never dressed and ready on time. The few times I did make it to therapy, the therapies had multiple patients at the same time, and I only had 40 minutes of therapy.

Fast forward to 2024, I again needed physical and occupational therapy and inquired about a new rehabilitation hospital, Encompass Health, that opened in Johnston, Rhode Island. This is an inpatient acute rehabilitation hospital, not a nursing home. I received three (3) hours of therapy a day. 90 minutes of physical and 90 minutes of occupational therapy one on one with the therapist and never missed a session.

Encompass Rehabilitation Hospital is a very good alternative to a nursing home for therapy. Each room is private, nurses and CNA's were very attentive to my needs. Unlike nursing homes.

Below is the reason why Encompass Health, located in many U. S. cities, find a location, is a clear, better alternative than a nursing home for rehabilitation of your loved ones.

Why Encompass Health Is the Trusted Choice in Rehabilitation

We know that choosing where to receive care after a life-changing illness or injury is an important decision. At Encompass Health, we are committed to helping patients get back to what matters most. As a leading provider of inpatient rehabilitation for stroke, brain injury, hip fracture and other complex neurological and orthopedic conditions, we meet patients where they are in their recovery.

When choosing Encompass Health for rehabilitation, our patients receive compassionate care from an expert team of physical, occupational and speech therapists; physicians; nurses; dietitians; pharmacists; and case managers who work together to create a plan to help meet their unique goals.

About inpatient rehabilitation

We firmly believe that every success starts with our dedicated team of professionals, so we make sure they are empowered with all the tools they need to help our patients be successful. Innovative technologies, advanced therapies, customized treatment plans, coordinated care teams - these are all part of our promise to deliver the highest level of rehabilitative care. At our inpatient rehabilitation hospitals, you'll receive at least three hours of therapy five days a week. Your team of speech, occupational and physical therapists will work with you on achieving your unique goals.

Direct From Home Admissions

General Information:

- **Admit directly from home or assisted living communities**
- **No required qualifying stay in an acute care hospital**
- **Our intensive rehabilitation program can help to avoid hospital admissions and lengthy nursing home stays, returning the individual home sooner at a higher functional level so they can resume home services**
- **NO rehospitalization penalty**

General Process:

1. **Family discussion**: Discuss with Rehab Liaison to ensure good fit and verify insurances. Medicare admissions will always be the most straightforward. Managed care insurances can still be explored and accepted.
2. **Required Documents**: Family will need to coordinate with PCP and specialist doctors to fax required documents into our system. Needed documents include Face sheet/ demographics, last visit note, medical history, and medication list.
3. **Approval**: With approval, your Rehab Liaison will work with you to coordinate admission date and answer any questions the patient and family may have.

Admitting from home is a unique capability of Inpatient Rehabilitation Hospitals. We will always do our best to be an advocate for your patient to get them admitted

Our Advanced Therapies Physical Therapy, Occupational Therapy & Speech Therapy

Some of the many Programs and Conditions

- **Amputation**
- **Brain injury**
- **Cardiac care**
- **Diabetes**
- **Hip fracture**
- **Joint replacement**
- **Multiple trauma**
- **Neurological disorders**
- **Oncology**
- **Outpatient care**
- **Pain management**
- **Parkinson's disease**
- **Pulmonary**
- **Spinal cord injury**
- **Stroke**
- **Wound care**

What to expect during inpatient rehabilitation

At an inpatient rehabilitation hospital, you'll receive at least three hours of therapy five days a week to help you regain your independence after a life changing injury or illness.

When you arrive at our hospital, your team of therapists will work with you to create an individualized care plan. We combine speech, occupational therapy and physical therapy based on your unique needs to help you achieve your goals.

Our approach to therapy goes beyond the basics and includes activities of daily living such as grooming, dressing, cooking, leisure activities and more, helping you get back to what matters most.

Leading with innovation for better patient care

As technology evolves so do we. At Encompass Health we leverage our nationwide network of more than 150 hospitals to identify and implement cutting-edge technology designed to support nearly every aspect of patients' recovery following a stroke, brain injury or other major illness or injury.

Our expert clinicians integrate these technologies into each patient's care, restoring confidence and building strength to help patients achieve their highest level of function.

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Note: ***This is not a commercial for Encompass Health. It is my personal experience between a nursing home and a rehabilitation hospital. It is to inform you that you have a better choice.***

Visit Encompass Health website.

New Research Confirms Importance of Drug Affordability and Low Out-of-Pocket Costs

As we have **highlighted in past articles**, many people with Medicare—and **many callers to our national consumer helpline**—struggle to afford their care, especially medications. **New research from Wakely** emphasizes the importance of increasing affordability and access to medications, showing that when Medicare Advantage (MA) plans for people with low incomes eliminate copays for prescription medications, more of their enrollees take their drugs as prescribed.

Eliminating Copays Led to Greater Medication Adherence

Wakely studied enrollees of some MA **Dual Eligible Special Needs Plans (D-SNPs)**—a type of Medicare Advantage plan for people with both Medicare and Medicaid. **Under a temporary experimental model,** these plans chose to waive copayments for some or all prescription medications. The researchers found that enrollees with no copays had better medication adherence for diabetes, hypertension (high blood pressure), and high cholesterol medication, with diabetes medication showing the greatest improvement.

Findings Build on Previous Research

Historically, many policymakers **wanted increased costs to dissuade people from using more care than they need**. But some of this thinking **is changing as more data come in**, and Wakely's findings corroborate **earlier research** showing that people facing higher out-of-pocket costs for health care cut back on the care they receive, even if it is necessary for their health and safety.

Studies show that "the greater the cost-sharing, the worse the medication adherence," leading to worse health, higher care needs, and more hospitalization. **Studies show** that "the greater the cost-sharing, the worse the medication adherence," leading to worse health, higher care needs, and more hospitalization. It also **costs more**. By contrast, eliminating copays does not increase costs and may save money in the long run by preventing the need for more acute care.

Increasing Threats to Affordability and Financial Stability

These findings come **amidst news** of **rising medical debt**, the Trump administration **"deprioritizing" consumer protections** for such debt, a burgeoning market for **medical credit cards**, and Congressional proposals to **slash Medicaid and other programs for people with limited resources. Drug price negotiation** from the Inflation Reduction Act (IRA) is also at risk of legislative and administrative changes, despite **new polling** that shows most voters continue to support and want Congress to expand on the IRA's drug reforms rather than limit them.

At Medicare Rights, we know that out-of-pocket costs can derail access to care and harm people's health. We urge Congress and other policymakers to reduce the financial burden of health care and coverage through Medicare and other insurance.

Take Action Now!

Members of Congress are currently home for a two-week recess through Sunday, April 27. Now is the time to remind them that their votes have consequences, and that a reconciliation bill would harm their constituents, district, and state. **Learn more and act today.**

Trump Taps Wellness Influencer Casey Means for Surgeon General

President Donald Trump has chosen **Dr. Casey Means**, a wellness influencer and health tech entrepreneur, to be his nominee for U.S. surgeon general.

The decision comes after Trump withdrew his previous nominee, Dr. Janette Nesheiwat, the *Associated Press* reported.

Trump announced the pick on social media, saying Means has "impeccable 'MAHA' credentials" and will work to improve the nation's health by fighting chronic disease. MAHA stands for "Make America Healthy Again."

"Her academic achievements, together with her life's work, are absolutely outstanding," Trump said. "Dr. Casey Means has the potential to be one of the finest surgeon generals in United States history."

Means is a former surgical resident who left her training and founded a company called Levels, which helps users track their blood sugar.

She has built a large following by promoting natural foods, lifestyle changes and supplements — earning money through sponsored products featured on her social media. She and her brother, **Calley Means**, advised U.S. Health and Human Services Secretary **Robert F. Kennedy Jr**. during his 2024 presidential bid. Calley Means now works as a White House adviser and often speaks about limiting federal food aid and removing additives from food and water, the *AP* reported. The nominee and her brother have criticized processed foods and the pharmaceutical industry, linking poor diets to health issues like obesity, **depression** and **Alzheimer's.** In a 2024 book, they wrote: "Almost every chronic health symptom that Western medicine addresses is the result of our cells being beleaguered by how we've come to live."

Some experts agree that a poor diet is linked to chronic disease, but say the solution is more complex than just avoiding processed foods….**Read More**

Daily GLP-1 pill could work as well as Ozempic

Rebecca Robbins and Gina Kolata report for the **New York Times** that a new pill to be taken each day could do as much to lower blood sugar and help with weight loss as Ozempic and Mounjaro, injectable weight-loss medicines. The FDA has not yet approved the pill for sale and is not likely to do so before next year.

What's the value of Eli Lilly's orforglipron pill? The pill conceivably could be cheaper than the current GLP-1 drugs because it costs less to manufacture a pill than an injectable drug. And, unlike an injectable, the pill does not need to be refrigerated or injected. The market for a GLP-1 pill is significant because many people do not want to inject themselves.

Lilly reports that, in a clinical trial, two-thirds of the 559 people who took the pill saw their blood sugar levels fall to the normal range. Lilly further reports that people who took the highest pill dose lost an average of 16 pounds.

But, it's not yet clear whether the clinical trial data supports Lilly's claims about the efficacy of its new pill. Side effects, such as diarrhea and nausea could be worse than claimed, and benefits could be smaller than claimed. Independent experts are not expected to analyze Lily's data until June.

Axios reports that Lilly's Zepbound, an injectable GLP-1 drug, delivered a greater amount of weight loss over 18 weeks for people without diabetes than people who took the pill. People had between 15.3 percent and 36.2 percent weight loss,, according to the data.

Today, one in eight Americans have taken a GLP-1. But, about four in ten Americans are obese. So, there's a huge market for GLP-1 drugs.

N.B.: Medicare currently only covers **weight-loss medicines** for people with diabetes and heart disease. It does not cover these medicines for people who simply want to lose weight.