

Message from the Alliance *for* Retired Americans Leaders



AGE MY WAY: MAY 2022

White House Issues "Older Americans Month" Proclamation



Robert Roach, Jr.
 President, ARA

The White House has officially proclaimed the month of May "Older Americans Month," outlining a number of programs and resources that will help seniors remain safe and healthy as they age.

President Biden noted that the American Rescue Plan, passed into law in 2021, invested \$1.4 billion to provide older adults with services for nutrition, health promotion, disease prevention, caregiver support, and long-term care. It also provided additional Medicaid funding to support millions of older adults with disabilities and to help states improve the quality of caregiving jobs. "Older Americans contribute their time and wisdom to make our

communities stronger, more informed, and better connected," said Biden in the proclamation. "They are our loved ones, friends, mentors, essential workers, volunteers, and neighbors."

In addition, the proclamation stated that the Administration is dedicated to improving the safety and quality of care in nursing homes — ensuring that facilities have sufficient staff, that families have the necessary information to support their loved ones, and that poorly performing nursing homes are held accountable. "This White House is truly committed to providing the resources that seniors need to have a secure and healthy retirement," said Richard Fiesta, Executive Director of the Alliance.

"President Biden is a strong ally and Alliance members are determined to work with him to expand Social Security and lower drug prices."

Alliance Facilitates Partnership with Labor Movement, SUNY to Help Students with Family, Financial Obligations



Rich Fiesta,
 Executive Director, ARA

Building on a mentorship program that the International Association of Machinists and Aerospace Workers (IAMAW) established with Aviation High School in Long Island City, New York, the Alliance has helped bring together the American Federation of Teachers (AFT), the United Federation of Teachers (UFT) and IAMAW in a partnership with the State University of New York (SUNY) that provides pre-enrollment credits toward a college degree for high school students. The credits are for extra classes taken in a high school aviation program.

The partnership will credit graduates from Aviation High School who earn their Federal Aviation Administration airframe or powerplant license with 28 to 29 college credits — roughly the equivalent of one year of college — toward a bachelor's degree in transportation management or labor studies before they enroll

in courses at SUNY Empire State College.

IAMAW officials have been working on the program with Aviation High School for two decades, and the Alliance facilitated discussions between AFT, UFT and SUNY officials to set a goal and execute a plan. The work culminated in Aviation High School and SUNY Empire State College representatives formally signing the new agreement on April 27

"The Alliance is engaging with young people as well as seniors. The program helps students who have to take care of other family members during high school, so they are not left behind due to their caregiving responsibilities. It also helps students who have financial or other family obligations and may need to work," said Robert Roach, Jr., President of the Alliance. "UFT members, who are affiliated with AFT, were key to obtaining this agreement. Their dedication and expertise led to this successful outcome. This is a program that could go nationwide if the results are what we believe we can achieve."

NATIONAL WEP/GPO REPEAL TASK FORCE DAY OF ACTION & RALLY IN WASHINGTON, DC MAY 18, 2022

If you can't make it to the Rally, call your congressional members and tell them you **SUPPORT** the complete repeal of the WEP/GPO and ask them to also **SUPPORT** the complete repeal



ADD YOUR NAME

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



**Come join the Task Force to help
support the repeal of the WEP/GPO**



**NATIONAL WEP/GPO REPEAL TASK FORCE
DAY OF ACTION & RALLY IN WASHINGTON, DC**

May 18, 2022. 8 AM - 5 PM.

Rally from noon - 1 PM

The Rhode Island Alliance *for* Retired Americans will meet with:

Senator Jack Reed at 11:30 a.m.

Senator Sheldon Whitehouse at 1:30 pm

Congressman James Langevin at 4 p.m.

Congressman David Cicilline at 11 a.m.



Tell Congress we need help, and we need it

NOW!!!!!!!



Can't Make It To Washington On May 18th, Do The Next Best Thing, Please call Washington on May 18th to back us up! CALL, CALL, CALL Your Legislators, It's That Important



Social Security Fairness

Social Security Fairness is working with the National WEP/GPO Repeal Task Force rally in Washington D.C. to demand repeal of the offsets.

We knew that asking a group of older adults with WEP/GPO depleted financial situations and health issues to make it to Washington, D.C., could be too much of a stretch for many people. We know you are out there, and you can support us from home!

Please call your legislators' offices on May 18th, or email them any day that week. (this is easier if you have their numbers on your electronic email and phone lists. Become a frequent caller...

- ◆ **Senators or Member of Congress.**
- ◆ **Contact by email and telephone.**
- ◆ **Representatives**
- ◆ **Senators**
- ◆ See if they have signed on to the repeal bills:
- ◆ Davis' bill in the House: <https://www.congress.gov/bill/117th-congress/house-bill/82/cosponsors?r=1&s=1&searchResultViewType=expanded>
- ◆ Brown's bill in the Senate:
- ◆ <https://www.congress.gov/bill/117th-congress/senate-bill/1302/cosponsors?searchResultViewType=expanded>

Ask yourself.....

- ◆ Have you decided what your best case is?
- ◆ You have calculated what you should be getting and what you have lost.
- ◆ How has this changed your retirement plans?
- ◆ Tie what has happened to you to the bigger picture. Below is a list of some of the ways the WEP/GPO has wronged public servants. Decide which one

or two issues affect you the most and point them out to your Senators or Member of Congress.

More information to back up your case:

Information for Legislators: The Windfall Elimination Provision (WEP) and the Government Pension Offset (GPO) were voted into law nearly 40 years ago with little understanding of how their provisions would affect retirees over the years. They currently affect 4% of this country's retirees.

1. Both provisions have a harsher effect on retiree benefits for those who had lower incomes than on retirees with higher incomes.

- In the calculations for Social Security benefits, most retirees have the first \$996 of their assigned benefit rate reimbursed at 90%. The WEP cuts the first 90% repayment rate for retirees to 40%. This hits those harder whose Social Security benefit isn't much larger than \$996.
- The Government Pension Offset also causes a more devastating cut for those with a lower pension. Most people (71%) affected by the GPO lose ALL their Social Security spousal or survivor benefits. Losing \$800 every month because of a \$1,200 government pension has a more drastic effect than losing \$2,000 a month because of a \$3,000 pension. The higher-income retiree still has \$3,000 a month to live on, but the lower income retiree only has \$1,200 left after the GPO.

2. The GPO penalty can increase every year.

For those who get Social Security spousal or survivor benefits, whenever the retiree gets a cost-of-living raise in their



pension the GPO cuts the amount of the raise by two-thirds. If the government pension is raised

by \$90 a month, the retiree is required to report that raise to the Social Security Administration, so their Social Security benefits will be cut by \$60 more every month. Hard to keep up, much less get ahead!

3. Social Security benefits are generally based on both the years of work covered and the amount of money contributed.

The Government Pension Offset is based only on the amount of money in the earned pension. A person who is married for more than 10 years and has not earned their own pension or Social Security is entitled to an amount equal to half their spouse's Social Security benefit, even if they later divorce. A person who has been married and not had their own personally-earned income for ten years, and then, later in the marriage, earns a government pension, usually loses all rights to their ten years of earned Social Security dependency benefits.

4. Because of their generally lower incomes, the WEP offset hurts women more drastically than it does men.

The mitigation of the WEP happens gradually, as people earn qualifying amounts, called "substantial earnings," annually in FICA-contributing jobs. After a person has 30 years of substantial earnings, the WEP penalty disappears. Because women historically have had lower earnings than men in all work, they are less likely to earn this income-based reprieve from the WEP penalty. The amount of FICA-covered income that a person has to earn to begin to mitigate the WEP in 2022 is \$27,300.

5. The Government Pension Offset affects 723,970 (December 2021) women in this country, not counting those who haven't filed for Social

Security benefits because they know they will get nothing.

Adding together all retirees affected by the WEP and those affected by the GPO, more women than men have lost retirement income because of these penalties.

6. Retirees can be affected by both offsets at the same time.

Many lose all their spousal benefits because of the GPO, and then the WEP causes a reduction in their own earned Social Security retirement benefit.

7. Government pensions and Social Security benefits are earned and taxed differently in different states.

Although everyone pays the same percentage of their earnings into FICA, different government retirement systems have different contribution rates. In some states pension earnings are fully taxable, and Social Security benefits are not. Trying to penalize the people in different states with the same formula across the country is inherently unfair.

8. The argument that there needs to be additional funding in order for the Social Security Administration to pay the benefits that have been cut or eliminated by the offsets is a fallacy.

People affected by the offsets have already paid into Social Security at the same rate as other beneficiaries. They deserve no more and no less than what they paid for!

9. The annual cost to repeal both WEP and GPO would be around \$15 billion, less than 1.6% of the cost of benefits paid out.

The current annual cost of paying Social Security old age and survivors insurance (OASI) benefits is \$961 billion (2020).

**PLEASE, PLEASE,
PLEASE
HELP US TO HELP
YOU LIVE A
BETTER LIFE**

New Legislation Would Improve FDA Drug-Approval Process

The recent controversy over Medicare's decision to only cover the cost of the Alzheimer's drug Aduhelm for patients enrolled in a clinical trial approved by the Center for Medicare and Medicaid Services (CMS) or supported by the National Institutes of Health (NIH) started with a decision made by the Food and Drug Administration (FDA) last June.

In that decision, the FDA approved Aduhelm using the "accelerated approval pathway," which can be used for a drug for a serious or life-threatening illness that provides a meaningful therapeutic advantage over existing treatments.

As a result of that FDA decision, three members of its own medical advisory committee, which had overwhelmingly voted against approving the drug, resigned in protest. One of them said the decision was wrong "because of so many different factors, starting from the fact that there's no good evidence that the drug works."

The committee had found that the evidence did not convincingly show that Aduhelm could slow cognitive decline in people in the early stages of the disease — and that the drug could cause potentially serious side effects of brain swelling and brain bleeding.

The "accelerated approval pathway" the FDA used in that approval has come under scrutiny and last March the Chairman of the House Energy and Commerce Committee Frank Pallone, Jr. (D-N.J.) introduced legislation that seeks to ensure that drugs that enjoy a quick trip through the regulator offer "proven clinical benefit" to patients.

The FDA's accelerated approval pathway lets the agency base approvals on certain factors other than a demonstrated clinical benefit, like extending patients' lives. The route helps certain drugs for diseases with unmet needs, like some types of cancers and rare diseases, reach patients sooner. But companies with these drugs are required to run trials to confirm the effectiveness of the drugs after it has received the "fast-track" approval.

If those studies do not bear fruit, the FDA has procedures in place to remove the product from the market.

This past week it was revealed that a bi-partisan group of House lawmakers are moving a little closer toward cracking down on drug-makers that dishonestly use the FDA's accelerated approval pathway.

The House Energy and Commerce Committee announced Wednesday that its sweeping user fee authorization bill will include a revised policy from Chairman Pallone that



would make it easier for the Food and Drug Administration to rescind its approval for drugs cleared through the pathway when drug makers do not complete required follow-up studies.

It has been said that a disease-controlling or preventing drug does no good if you cannot afford it. It is also true that a drug that received "fast-track" approval does no good if it does not really work.

TSCSL will continue to monitor this legislation as the House of Representatives further develop it.

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Home Health Care Worker Shortage Causes Concern

The number of adults aged 60 and older in the U.S. is expected to increase 30 percent by 2050. Even now, more seniors and people with disabilities are choosing to stay in their homes rather than going into institutional care.

As a result, home health aides are predicted to be one of the fastest-growing nations in the next decade.

However, there is a shortage of home health aides now and there is concern that the need for them will outstrip the number of people who are willing to go into the field.

One of the big reasons is the low pay home health workers receive and employers say they are already struggling to attract

serious candidates. In fact, some fast-food restaurants, like McDonalds, now pay their employees more than some home health care workers get.

Experts say raising wages is an important first step, but it is not the only change that is needed. Home health aides need more training opportunities and support to develop specialized skills, and most do not have career opportunities that would allow them to move up into other related health care or social work positions.

Medicaid pays for many home health care workers and in order to help improve the situation the Biden administration has proposed investing \$150 billion towards home health care as part of its Build Back Better Act.

But the legislation, which also contains a provision to lower drug prices by allowing Medicare to negotiate prices with drug companies, is stalled because of disagreements within Biden's own party.

TSCSL supports the legislation precisely because of the two provisions regarding drug prices and health care and we urge you to contact your senators, especially if you live in West Virginia, and urge them to find a way to pass the bill this year.

Drug Prices Remain High and Unpredictable as Beneficiaries Look to Lawmakers for a Fix

Medicare drug prices keep rising **faster than inflation**, and 8 in 10 adults say the **cost of prescription drugs is unreasonable**. A recent *Health Affairs* article examines how and why Medicare Part D net prices are "significantly higher and growing much more rapidly than those paid by other payers, such as Medicaid. . . ."

The article references two Congressional Budget Office publications that found that Part D brand name costs are high relative to other federal payers and have grown much faster than inflation. The reports find that "market-wide assessments of net price growth hide

significant variation" across payers. When considering both the net price growth and the change over time in the mix of drugs taken by people with Medicare, brand name drug costs grew more than five times the rate of inflation from 2009 to 2018. They argue that this increase "is largely driven by use of high-price specialty drugs, which are a **growing share of the drug pipeline**," and that comprehensive reform is needed to avoid increasing burdens on Medicare, taxpayers, and beneficiaries because most of the expected gains from lower-cost generics have been realized.



Blog

Earlier this year, **Medicare Rights flagged** an

AARP Public Policy Institute **analysis** that found drug companies increased list prices for 75 of the 100 brand name drugs with the highest Medicare Part D spending within the first two months of 2022. These increases mean that copayments or coinsurances that people expected when choosing their Part D plan during open enrollment may have also increased. Plans may change coinsurance and copay amounts when manufacturers change prices because copay amounts are set based on the full cost of

the medication. These adjustments and increases can result in **surprise increases** in costs at the pharmacy counter.

These reports make it even more apparent that we must take immediate action to reform drug pricing. We support comprehensive efforts to lower prescription drug prices through capping beneficiary out-of-pocket (OOP) drug costs; realigning Part D financial obligations; penalizing drug manufacturers for price hikes that outpace inflation; and allowing Medicare to negotiate drug prices.

[Read the Health Affairs article.](#)

OIG finds widespread inappropriate care denials in Medicare Advantage

A new HHS **Office of the Inspector General report** (OIG) finds widespread and persistent inappropriate denials of care and coverage in Medicare Advantage. As the **OIG found in 2018**, tens of thousands of Medicare Advantage plans are not receiving the care they need, to the detriment of their health and well-being. The OIG again urges the Centers for Medicare and Medicaid Services (CMS) to conduct better oversight of these health plans and alert people to serious Medicare Advantage violations. Will CMS act this time round?

Better oversight and warnings about Medicare Advantage are critical, but they are not nearly enough. Most people are **locked into Medicare Advantage** after they initially enroll. People need **supplemental insurance** to fill coverage caps in traditional Medicare, but it's hard to come by for people in Medicare Advantage because insurers are only required to offer this insurance when people are first eligible for Medicare, when they have been in a Medicare Advantage plan for no more than 12 months, and in other very limited circumstances.

One key concern with

Medicare Advantage highlighted by the OIG is that the government pays Medicare Advantage plans a flat fee each month regardless of the amount these plans spend on care, creating a powerful incentive for them to deny care in order to maximize profits. Unsurprisingly, every year CMS finds "widespread and persistent problems related to inappropriate denials of services and payment."

The OIG found that nearly one in seven (13 percent) Medicare Advantage prior authorization denials were inappropriate. Medicare Advantage plans frequently denied requests for care that met Medicare coverage rules. Consequently, enrollees often could not get the medically necessary care their doctors prescribed, or their access to care was delayed.

Prior authorization requirements create administrative barriers to care for people enrolled in Medicare Advantage. Inappropriate denials can result in enrollees having to pay for care that Medicare should be covering. Worse still, inappropriate denials can jeopardize the health and well-being of enrollees.

People with costly and



complex conditions are at particular risk in Medicare Advantage. And, people with limited incomes are often at the mercy of their Medicare Advantage plans to cover their care. Delays and denials of needed care and coverage put them in especial danger.

Prior authorization denials are numerous, totaling 1.5 million in 2018 alone, according to the OIG. And, it appears that at least some, if not many, of the prior authorization requirements Medicare Advantage plans impose are not medically justified and out of line with Medicare coverage rules. To date, CMS has not prevented them.

It's often the most expensive services that Medicare Advantage plans inappropriately deny. That's where they can increase their profits most. Consequently, people in Medicare Advantage are less likely to benefit from inpatient rehabilitation services and skilled nursing services after a hospitalization. They are also less likely to have coverage for MRIs.

The OIG found that the lower cost alternatives to nursing and rehab care that Medicare

Advantage plans were willing to cover for their enrollees were not adequate to meet enrollees' needs. Similarly, delays of testing hurt patients. Here's just one case example the OIG highlighted of an MA (MAO) inappropriate denial:

"Case D421: MAO delayed a CT scan by 5 weeks for a beneficiary with cancer. An MAO denied a request for a CT scan of the chest and pelvis for a beneficiary with endometrial cancer. The provider was able to get the denial reversed 5 weeks after the initial request by submitting additional information and filing an appeal. However, our physician panel determined that the original request had sufficient documentation to demonstrate that the CT was needed to assess the stage of the cancer and to determine the appropriate course of treatment. Delayed care can negatively affect beneficiary health, particularly for urgent conditions. Our physician reviewer noted the importance of timely monitoring the growth and extent of cancer to assess severity of the disease and determine the course of treatment."

Interactive Tool Illustrates Medicare Spending Data and Trends

The Kaiser Family Foundation (KFF) developed a useful **interactive display** that shows the current state of Medicare spending nationally and trends for the future. This tool provides valuable data and insights into where money is being spent and what the future might hold for the program.

One major takeaway from the data is that Medicare spending mirrors growth in the aging population. In 2010, just as the Baby Boomer generation began reaching retirement age, around **13%** of the population was 65 or older. As of 2020, that number was 17%. KFF projects that 23% of the population will be 65+ by 2060. An aging population means more people are eligible for and enrolled in

the Medicare program, from around 65 million today to an estimated 93 million in 2060.

Importantly, as people 65+ get older, their spending tends to increase. Average Medicare spending for 70-year-olds is just over \$10,000 per year, while spending for 95-year-olds is just over \$19,000. KFF estimates that the population age 80 or above will rise sharply as the Baby Boomers age. In 2020, 24% of older adults were 80+, and 5% were 90+. In 2060, those numbers will be 35% and 10%, respectively.

Despite the aging population, Medicare's spending growth per person was lower from 2010 to 2020 than growth in private health insurance. This reflects



Medicare's **lower payment rates** for all services except

prescription drugs.

Hospital inpatient services as a share of spending have shrunk from 47% in 2010 to 40% in 2021. KFF projects this trend to continue.

KFF also shows the growth in Medicare Advantage spending, from 26% of Medicare spending in 2011 to 46% in 2021, and a projected 54% in 2030. This number includes **overpayments to Medicare Advantage plans**: "In 2022, payments to Medicare Advantage plans are estimated to be **104%** of what traditional Medicare would have spent on the same beneficiary, on average. This is lower than in 2010 when Congress changed

how Medicare Advantage plans are paid—but this amount has been trending higher since 2017."

The KFF data also show increases in the amount people with Medicare are paying out-of-pocket for their benefits. In 2002, premiums and deductibles took up 15% of the average Social Security benefit. In 2022, that number is 19%, and it is expected to rise.

Health care and coverage are vital to ensure the well-being and financial security of the entire population. At Medicare Rights, we value these data insights that show the stakes for the millions of people who rely on Medicare for their care.

KFF: Up to 14M enrollees could lose Medicaid coverage as states restart eligibility checks

Between 5.3 million and 14.2 million enrollees could lose Medicaid coverage next year as the Biden administration is expected to roll back the program's continuous coverage provision, a new analysis finds.

The analysis, released Tuesday by the Kaiser Family Foundation, explores how much enrollment in Medicaid changed during the pandemic, including the impact of a requirement that could go away that prevented states from disenrolling recipients. It also found that a boost in federal funding helped to cover the costs of new enrollment for states.

"As states resume redeterminations, it is likely that there could be a lot of enrollment churn as individuals who may be eligible lose coverage and then re-enroll in a short period of time," the analysis said.

At the onset of the pandemic in 2020, the federal government increased the matching rate for Medicaid by 6.2% to states that met certain requirements. Chief among those stipulations is states

cannot disenroll anybody on Medicaid until the end of the COVID-19 public health emergency, which was recently extended through July.

If the PHE is not extended again, states will have to begin the massive task this summer of redetermining who is eligible or not for Medicaid coverage. The analysis lays out the stakes for states on in terms of how many people could drop off.

Kaiser estimated that Medicaid enrollment will grow by 25% from 2019 through the end of the 2022 federal fiscal year, which ends in September, representing a spike of 22.2 million people. The foundation looked at simulation models that relied on Kaiser estimates of Medicaid enrollment.

Of that 22.2 million, 3.5 million will be from baseline growth and another 18.7 million from the continuous coverage requirement.

It is difficult to pin down an exact figure on how many Medicaid beneficiaries could lose



coverage after redeterminations begin. "The effects by eligibility group will depend on how states prioritize renewals once the continuous coverage requirement ends," Kaiser said.

"Additionally, individuals could be at risk of losing coverage even if many continue to be eligible due to barriers navigating the redetermination process."

Some groups that saw major boosts in enrollment—such as children and adults from Medicaid expansion states—could see the largest losses though.

"Efforts to conduct outreach, education and provide enrollment assistance can help ensure that those who remain eligible for Medicaid are able to retain coverage and those who are no longer eligible can transition to other sources of coverage," Kaiser added.

The foundation also looked at the amount of funding states got via the enhanced match. Kaiser estimated states got

approximately \$100 billion in relief from the boosted funding, more than double the total estimated costs states have faced from the additional enrollment from 2020 through 2022.

The higher matching rate provided "relief to states using an existing federal funding mechanism, which has allowed money to be distributed quickly and freed up state funds for other purposes, including the ability to support Medicaid and fill gaps in overall state budget shortfalls," the analysis said.

The Centers for Medicare & Medicaid Services **has given states guidance** on how to handle redeterminations and states have up to 14 months to perform such redeterminations. The Department of Health and Human Services has promised to give a 60-day notice on when the PHE will end, and that notice could come as early as next week.

Could the US lower drug costs through "value-based" pricing?

President Biden said in his State of the Union address that he supported Medicare drug price negotiation. Since the Democrats in Congress appear unable to pass legislation that would allow Medicare to negotiate drug prices, would he support a different fix? Some experts believe that "value-based" pricing of drugs is the way to go.

Before we get to value-based pricing as a way to lower drug prices, let's not forget far simpler solutions. For example, there's exercising the "march-in rights" authority that the administration has under the **Bayh-Dole Act**. The administration could use march-in rights to buy the patent of any critical drug that is unreasonably priced and allow other drugmakers to manufacture generic substitutes at lower cost. The administration could also make it legal for people to import drugs for personal use. President Biden does not appear interested in either of these fixes though.

In a **blog post** for the

Commonwealth Fund, Patricia G. Synnott, Daniel A. Ollendorf, and Peter J. Neumann suggest that if Biden wants to lower drug prices, perhaps "value-based pricing is a solution. It would reward drug manufacturers for innovations that delivered valuable drugs and therefore could not be said to stifle innovation. And, it could keep the price of drugs that offered little or no value way down.

Of course, Medicare drug price negotiation could easily promote innovation of high-value drugs. The government could deploy the savings from lower drug prices towards innovations that are of most benefit to the public. This policy was embedded in **HR3**, Speaker Pelosi's drug price negotiation bill that passed the House a few years ago.

Value-based pricing works to ensure that costly drugs for which there are no alternatives are evaluated. Is their cost appropriate relative to the health



they promote? So, instead of Medicare drug-price negotiation focusing on the prices other countries pay for the same drug, value-based pricing would focus on a drug's value.

The blog post authors appear to think it would make sense for Americans and Medicare to pay a lot more than people in other countries for highly effective drugs developed in the US and/or with US taxpayer money. Really? It's not clear if they are offering up this proposal because they think it is more likely to be enacted into law than international reference pricing—setting prices in this country at the same average level as other wealthy nations—or because they think it is preferable.

The authors say that international reference pricing is imperfect because it could lead drug manufacturers to delay release of drugs in countries where prices would be lower. And, it could also increase prices

in other wealthy countries. While true, these points are trivial relative to the huge price reductions people would see for drugs with a high value—and that's what's needed.

Moreover, value-based pricing is beyond imperfect. Just imagine the money and lobbying that drug manufacturers would put into ensuring that a mediocre drug was credited with being highly effective. How do you define a drug's value anyway? Remember, it didn't seem to take that much effort for the Sacklers, aka Purdue Pharma, to get the FDA to allow broad use of OxyContin. And, it seems to take virtually no effort for Medicare Advantage plans to get CMS to give them **four and five-star ratings**, even when the government has sanctioned them for endangering the health of their enrollees....**Read More**

Dear Marci: What is the Medicare Savings Program?

Dear Marci,

It has been challenging to live on a fixed income recently. A friend told me she has the Medicare Savings Program and that it really helps her financially. What should I know about this program?
-Sabrina (Randleman, SC)

Dear Sabrina,

Medicare Savings Programs help pay your Medicare costs if you have limited income and savings. Medicare Savings Programs are also called MSPs, Medicare Buy-In programs, or Medicare Premium Payment Programs. There are three main programs, with different benefits and eligibility requirements. *

- ◆ **Qualifying Individual (QI) Program:** Pays for Medicare Part B premium. Also reimburses for premiums paid up to three months before your MSP effective date, and within the

same year of that effective date.



- ◆ **Specified Low-income Medicare Beneficiary (SLMB):** Pays for Medicare Part B premium. Also reimburses for premiums paid up to three months before your MSP effective day, but unlike QI, you may be reimbursed for premiums from the previous calendar year.
- ◆ **Qualified Medicare Beneficiary (QMB):** Pays for Medicare Parts A and B premiums. If you have QMB, typically **you should not be billed** for Medicare-covered services when seeing Medicare providers or providers in your Medicare Advantage Plan's network. This means you should not owe Medicare deductibles, copayments, and

coinsurances, as long as you see the right

providers.
*There is a fourth MSP called the Qualified Disabled Working Individual (QDWI), which pays for the Medicare Part A premium for certain people who are eligible for Medicare due to disability. Contact your local Medicaid office to learn more.
There are even more benefits to enrolling in an MSP. MSP enrollment:

- Allows you to enroll in Part B outside of the regular enrollment periods
- Eliminates your Part B late enrollment penalty if you have one
- Automatically enrolls you in **Extra Help**, the federal program that helps pay your Medicare prescription drug (Part D) plan costs
To qualify for an MSP, you

must have Medicare Part A and meet **income and asset guidelines**.

If you do not have Part A but meet QMB eligibility guidelines, your state may have a process to allow you to enroll in Part A and QMB outside of the General Enrollment Period.

It also may be helpful to note that income and asset guidelines vary by state. Certain income and assets may not count and some states do not count assets at all when assessing MSP eligibility. You can contact your **State Health Insurance Assistance Program (SHIP)** to learn more about MSPs in your state and to receive assistance with **the application process**.

This really is a great program that helps so many beneficiaries with their Medicare costs! Again, contact your local SHIP to see if you're eligible for an MSP in your state. Best of luck!
Marci

Medicare: 2020 facts and figures

Today, Medicare covers 65 million older and disabled Americans. What does that mean for the US budget, national health care spending and the future of Medicare? A new **Kaiser Family Foundation** interactive, the facts about Medicare spending, takes a deep dive into the 2020 data.

One in five Americans now have Medicare. And, although people with Medicare use three times more health care services than younger people, Medicare represents 20 percent of national health care spending. Traditional Medicare, which covers slightly more than half of the Medicare population is extremely cost-effective, with less than two percent of its budget going towards administrative costs. In sharp contrast, Medicare Advantage plans take 15 percent of their budget for administration and profit.

About one-eighth of the federal budget—\$769 billion—covers Medicare costs. In 20 years, those costs have almost quadrupled. And, projections are that Medicare costs will double in the next ten years because the Medicare population is growing, as are health care costs. By 2060,

there will be 93 million people with Medicare.

What does Medicare cost per enrollee? Each person with Medicare cost an average of \$14,400 in 2020, up from \$5,800 in 2000.

Why is Medicare growing so much? People are living longer. There are more people 80 and older, and, by 2060, they will represent one-third of the population over 65. Today, they represent about one-fourth the population over 65. Of note, the percentage of people over 90 will double, from 5 percent of those over 65 today to 10 percent in 2060. (The Kaiser paper does not speak to the high cost of Medicare Advantage, which has already cost Medicare over \$100 billion more than traditional Medicare and is projected to cost an additional \$600 billion over the next nine years.)

Where is Medicare spending highest? Today, nearly half of all Medicare spending (48 percent) happens under Medicare Part B for outpatient services. Inpatient services under Medicare Part A represent 40 percent of Medicare spending. Prescription drugs represent the remaining 12



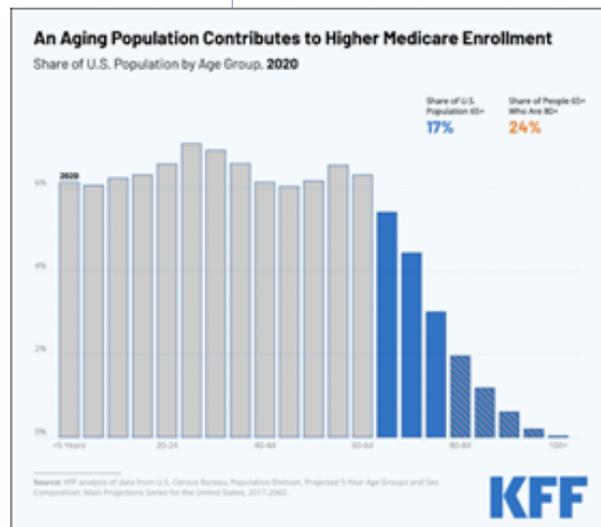
percent. Medicare Advantage spending is growing faster than traditional Medicare, eating into the Medicare Trust Fund. Today, the government spends about four percent more per person in Medicare Advantage than in traditional Medicare.

How much are people with Medicare spending out of pocket? People with Medicare are spending a lot more out of pocket than they used to. Over the last 20 years, out-of-pocket costs have gone from about 15 percent of the average Social Security benefit to 19 percent. Medicare premiums represented 6 percent of people's average Social Security benefit in 2002; they now represent 10

percent.

Consequently, people with Medicare—most of whom rely heavily on Social Security to make ends meet in retirement—have increasingly less to spend on other necessities.

The Part A Trust Fund, which pays for inpatient care, is projected to stop being able to pay full benefits as of 2026. At that point, it will only be able to cover 91 percent of those benefits, unless Congress steps in, which it has always done.



RI ARA HealthLink Wellness News

FDA Limits Use of J&J COVID Vaccine Due to Blood Clot Risk

Citing the accumulated data on a raised risk for a type of dangerous blood clot, the U.S. Food and Drug Administration on Thursday greatly restricted the recommended use of the Johnson & Johnson COVID-19 vaccine.

With safer two-dose vaccines such as Pfizer and Moderna widely available, the one-dose J&J shot should be limited "to individuals 18 years of age and older for whom other authorized or approved COVID-19 vaccines are not accessible or clinically appropriate," the agency said in a **statement**.

It may also be used by "individuals 18 years of age and older who elect to receive the Janssen COVID-19 Vaccine because they would otherwise not receive a COVID-19 vaccine [at all]," the FDA advised.

While the J&J vaccine has appealed to some because it only requires one-dose, data soon

emerged suggesting a higher risk in users of a rare form of blood clot known as **thrombocytopenia syndrome** (TTS).

According to the FDA, TTS is "a syndrome of rare and potentially life-threatening blood clots in combination with low levels of blood platelets."

Some people -- often young males -- typically developed symptoms about a week or two after getting the J&J shot. The data accumulated on this risk now "warrants limiting the authorized use of the vaccine," the agency said.

Getting the J&J vaccine can still help prevent serious illness with COVID-19, so the shot "still has a role in the current pandemic response in the United States and across the global community," Dr. Peter Marks, director of the FDA's Center for Biologics Evaluation and Research, said in the statement.



But "our action reflects our updated analysis of the risk of TTS following administration of this vaccine," he said, "and limits the use of the vaccine to certain individuals."

Marks added that "the agency will continue to monitor the safety of the Janssen [J&J] COVID-19 Vaccine and all other vaccines, and as has been the case throughout the pandemic, will thoroughly evaluate new safety information."

The vaccine first received an emergency use authorization in late February of 2021. But after six cases of TTS were reported, the FDA placed a temporary "pause" on use of the J&J shot as it gathered more data.

That pause was lifted on April 23, 2021, when a total of 15 cases of TTS were reported from the more than 8 million vaccine doses doled out across across the United States.

At the time, "the known and potential benefits of Janssen [J&J] COVID-19 Vaccine outweighed its known and potential risks in individuals 18 years of age and older," the FDA said.

However, by December, the agency advised that mRNA COVID vaccines (those made by Pfizer or Moderna) were now preferred over the J&J shot.

In the latest assessment, the FDA noted that by March 18, 2022, "the FDA and CDC have identified 60 confirmed cases, including nine fatal cases," of TTS in people who'd received the J&J vaccine.

The risk still remains extremely rare: About three cases for every 1 million doses of vaccine administered. It's remains unclear if any specific factors place an individual at heightened risk for the **blood clots** after receiving the vaccine...[Read More](#)

Hope for 1st Vaccine Against Virus Driving 'Mono,' Cancers and Maybe MS

Two experimental vaccines show promise in protecting against infection with the "mono" virus, which also causes cancer and has been implicated as a potential trigger of multiple sclerosis, a new paper reports.

Tested only in animals so far, the vaccines block two pathways by which the **Epstein-Barr virus** (EBV) takes root inside the body, said senior researcher Dr. Gary Nabel, president and CEO of ModeX Therapeutics, a small biotech startup in Natick, Mass.

Epstein-Barr is tricky to prevent because it takes up residence in two types of cells, Nabel said — B immune cells that produce antibodies, and epithelial cells that line the internal and external surfaces of the body.

These new vaccines are genetically engineered to induce an immune response that would block infection of both cell types, Nabel said.

"That gives us an opportunity

to really damp down any foothold the virus may be able to take in establishing itself in the body," Nabel said. "That's why we think that this is a worthwhile approach, because we've essentially isolated two critical entry proteins for the virus, and can block its ability to enter cells and cause infection."

Currently, there's no approved vaccine that protects against Epstein-Barr virus, which has infected more than 95% of adults worldwide, researchers said in background notes.

Epstein-Barr is primarily known as the cause of **mononucleosis**.

"It infects B cells in the body, your antibody-producing cells, and it causes those cells to proliferate abnormally," Nabel said. "You get a lot of inflammation, and you get a lot of immune dysregulation. And that's why people feel lousy. That's why it takes several months to get over. That's why



you get super infection with these sore throats and upper respiratory symptoms, and these systemic symptoms that give rise to infectious mono."

But EBV also was the first human virus associated with cancers, primarily lymphomas and gastric cancers, Nabel said. The virus causes more than 200,000 cases of cancer every year.

More recently, researchers also have learned that a person's risk of **multiple sclerosis** (MS) skyrockets 32-fold if they've been infected with Epstein-Barr, according to a study published in *Science* in January.

It's believed that EBV triggers MS in some people by tricking the immune system into attacking the body's own nerve cells, according to another January study published in *Nature*.

The experimental vaccines work by genetically fusing two different attachment proteins —

the keys that allow EBV to enter B cells and epithelial cells — onto a common particle called ferritin, Nabel said.

Ferritin's regular job is to carry iron in the bloodstream, but the genetic engineering gives it an extra purpose, Nabel said.

"It serves as a carrier, where we can essentially decorate the outside of the particle with the viral proteins," Nabel said. The immune system sees the viral infection proteins and mounts a response that theoretically would protect against future infection by the real virus.

The vaccines prompted strong antibody responses in mice, ferrets and monkeys, according to a new report published May 4 in *Science Translational Medicine*.

The vaccines also appeared to block development of lymphomas in "humanized" mice — rodents grafted with human stem cells...[Read More](#)

Obesity Raises a Man's Odds for Fatal Prostate Cancer

Men with widening waistlines may be more likely to die from prostate cancer.

Specifically, a man's risk of dying from prostate cancer increases 7% for every 4-inch increase in belly fat, [new research](#) suggests.

"Our findings should encourage men to maintain a healthy weight," said study co-author Dr. Aurora Perez-Cornago, a nutritional epidemiologist at the University of Oxford in England. Exactly why carrying around extra weight makes men more likely to die from prostate cancer isn't fully understood yet.

"It is possible that some molecular disturbances in men with obesity may be causing this

increased risk, but it is also possible that men with obesity have a delayed diagnosis compared with men with normal weight, and hence the tumors may be diagnosed at a more advanced stage," Perez-Cornago said.

More research is needed to determine if weight loss in obese men decreases the risk of dying from the cancer, she said.

For the study, the researchers reviewed data on 2.5 million men from 19 published studies plus a new analysis of more than 200,000 men who were part of the [UK Biobank](#).

None of the men had [prostate cancer](#) at the start of the studies. Weight was assessed via body



mass index ([BMI](#), an estimate of fat based on weight and height), waist circumference, waist-to-hip ratio, and/or body fat percentage.

The risk of dying from prostate cancer rose along with increases in all of these measures, and every five-point increase in BMI resulted in a 10% increase in the risk of dying from prostate cancer, the study showed.

What's more, a 5% rise in total body fat percentage raised the risk of dying from prostate cancer by 3%, and each 0.05 increase in waist-to-hip ratio upped the risk of dying from prostate cancer by 6%, the investigators found.

The findings were presented this week at the European Congress on Obesity in Maastricht, the Netherlands, and published online May 5 in [BMC Medicine](#).

These results are another reason for men who are overweight or obese to slim down, according to experts not affiliated with the new study.

"The meta-analysis presented in this publication is consistent with several other prospective analyses supporting obesity and central adiposity as a risk factor for prostate cancer incidence and death," said Dr. Andrew Laccetti, a medical oncologist at Memorial Sloan Kettering Cancer Center in Montvale, N.J.... [Read More](#)

COVID Transmission 1,000 Times More Likely from Air vs. Surfaces: Study

If you're still wiping down groceries, doorknobs and light switches in an attempt to thwart COVID-19, maybe you can relax a little: You're 1,000 times more likely to get COVID from the air you breathe than from surfaces you touch, a new study suggests.

University of Michigan researchers tested air and surface samples around their campus and found odds are greater for inhaling virus particles than picking them up on your fingers.

"In this study, we set out to better understand potential exposures to the [SARS-CoV-2](#)

[coronavirus](#) -- the virus which causes COVID-19 -- in several college campus settings," explained study author Richard Neitzel, a professor of environmental health sciences and global public health.

The settings included offices, classrooms, performance spaces, cafeterias, buses and a gym. However, the samples were taken during the pandemic



lockdown, so these were relatively empty spaces. "We also used information on campus

COVID-19 infections to estimate the probability of infection associated with our environmental measurements," added Neitzel.

"The overall risk of exposure to the virus was low at all of the locations we measured," he said.

However, "our results suggest that there was a much higher risk of infection from inhalation than from contact with surfaces

like door handles, drinking fountains, keyboards, desks, sinks and light switches," he noted.

To get a handle on relative risk, between August 2020 and April 2021 Neitzel and his colleagues used air pumps and swabs in various locales across the locked-down campus.

In all, more than 250 air samples were gathered, of which 1.6% tested positive for the virus that causes COVID. Of over 500 surface samples, 1.4% were positive. [Read More](#)

Americans Now Living Longer After Heart Attack

Long-term survival after a [heart attack](#) has improved significantly overall among Medicare beneficiaries, although poorer people and Black Americans have been left behind, a new study claims.

"Our results demonstrate some accomplishments and some work ahead; we are making progress on improving long-term outcomes overall, but we are failing to reduce the inequalities in long-term health outcomes that may cause death or another heart attack," said senior study author Dr. Harlan Krumholz. He is director of the Center for Outcomes Research and Evaluation at Yale School of Medicine, in New Haven, Conn.

For the study, Krumholz and his team analyzed the medical records of 3.9 million Medicare beneficiaries, average age 78, who survived for at least 30 days after a heart attack between 1995 and 2019. Nearly half of the patients were women.

During the study period, the death rate was nearly 73% and the rate of hospitalization for another heart attack was 27% in the 10 years after a heart attack. But 10-year death rates fell 1.5% a year and 10-year hospitalizations for another heart attack fell almost 3% a year during the study period.

Compared to patients hospitalized from 1995 to 1997, those hospitalized in 2007 to



2009 (the last three years for which full 10-year follow-up data were available) had a nearly 14% lower 10-year death risk and a 22.5% lower risk of another heart attack.

The 10-year death risk was higher (about 81%) for patients who had another heart attack than for those who did not (72%), the investigators found.

The study also found that hazard ratios for death and heart attack recurrence were: 1.13 and 1.07, respectively, for men versus women; 1.05 and 1.08, respectively, for Black patients versus white patients; 0.96 and 1.00, respectively, for other races (including American Indian and Alaska Native,

Asian, Hispanic, other race or ethnicity) versus white Americans.

The findings show that measures to prevent a second heart attack could have important long-term consequences, according to the report published online May 4 in [JAMA Cardiology](#).

"Another notable finding is that about a quarter of the patients had another heart attack over the next decade, perhaps indicating that we need to be bolder in efforts to prevent repeat events and ensure that patients have access to the information and medications that can reduce their risk," Krumholz said in a Yale news release.

Vegan Diet Brings Weight Loss to Overweight and Diabetic Folks

Are you overweight or struggling with type 2 diabetes? Try going vegan, researchers suggest in a new data review.

Vegan diets are high in fruits, vegetables, nuts, legumes and seeds and have no animal-derived foods.

The meta-analysis of 11 studies published through March 2022 that included a total of nearly 800 people found that following a vegan diet for at least 12 weeks helped people lose weight and lower their blood sugar, more so than a **Mediterranean diet**, different diabetes diets or portion-

controlled diets did.

Compared with the other diets, vegan diets significantly reduced weight (an average of 9 pounds) and body mass index or **BMI** (a person's weight in kilograms divided by the square of height in meters, or kg/m²) by -1.38 kg/m².

The researchers found even greater reductions in body weight and BMI when they compared vegan diets to a normal diet (16.3 pounds and -2.78 kg/m², respectively) than when comparing other diets to a normal diet (6 pounds and -0.87



kg/m²).

Vegan diets also led to slight improvements in **blood sugar levels**, total cholesterol and "bad" LDL cholesterol, but had little effect on blood pressure or triglycerides compared to other diets, according to the study presented at the European Congress on Obesity, May 4-7, in the Netherlands.

"This rigorous assessment of the best available evidence to date indicates with reasonable certainty that adhering to a vegan diet for at least 12 weeks may result in clinically

meaningful weight loss and improve blood sugar levels, and therefore can be used in the management of overweight and type 2 diabetes," said study author Anne-Ditte Termansen, from the Steno Diabetes Center in Copenhagen, Denmark.

"Vegan diets likely lead to weight loss because they are associated with a reduced calorie intake due to a lower content of fat and higher content of dietary fiber," she added in a meeting news release. "However, more evidence is needed regarding other **cardiometabolic** outcomes."

Having a Hip, Knee Replacement? Some Tips to an Optimal Recovery

(HealthDay News) -- If you're one of the estimated one million Americans having total hip or knee replacement surgery this year, some lifestyle changes might improve your chances of a good outcome, an expert says.

Lose weight safely through diet and exercise before surgery, said orthopedic surgeon Dr. Matthew Abdel. The target body mass index (**BMI**) — an estimate of body fat based on weight and height — is less than 40, but the closer you can get to a BMI of 25 to 30, the better, added Abdel, who specializes in hip and knee replacement at the Mayo Clinic in Rochester, Minn.

Even losing 20 pounds before hip or knee replacement surgery

improves outcomes, he said. Here are some of his other suggestions:

Stop using cigarettes, chewing tobacco, cigars and all other nicotine products at least six weeks before having surgery. After surgery, do not use nicotine products.

Stop taking narcotic pain medications at least two weeks before surgery.

If you have **diabetes**, make sure you have it under adequate control before surgery. That's defined as **hemoglobin A1C** less than 7.5. You also want excellent blood sugar control in the time around surgery.



Some lifestyle changes do not improve outcomes after hip and knee replacement surgeries, Abdel noted. Those include herbal supplements and vitamins, wound creams and electrical stimulation devices.

The jury is still out on whether other measures before surgery help improve outcomes. Among them: physical therapy before hip and knee replacements and post-op physical therapy for knee replacements.

Some patients have **weight-loss (bariatric) surgery** before hip or knee replacement surgery, but recent research by Abdel and colleagues raises questions

about that.

The investigators found these patients had more complications than those who just had **joint replacement surgery**, regardless of their BMI. The complications included infection and instability and affected the success of the joint replacement surgeries.

"We think it may have something to do with the bariatric patients' underlying system, such as their **gut microbiome** and underlying genetic host variation," Abdel said in a Mayo Clinic news release. "Even though they lost the weight, the soft tissues and underlying collagen status were still of their original nature."

Unvaccinated and Having Heart Trouble? That Can Be Deadly When COVID Strikes

(HealthDay News) -- Your chances of dying or having severe complications from COVID-19 are much higher if you're unvaccinated and have heart problems or heart disease risk factors, researchers warn.

In a new study, British investigators analyzed 110 previous COVID-19 studies that included a total of nearly 49,000 unvaccinated patients.

The researchers found that unvaccinated people with evidence of heart muscle damage when they were hospitalized for COVID-19 had a ninefold higher risk of death. This group was also more likely to have major complications such as severe lung failure

(**acute respiratory distress syndrome**) and acute kidney injury. They also had higher rates of intensive care admission and mechanical ventilation. In addition, unvaccinated people with pre-existing **high blood pressure**, diabetes or heart artery disease had a two- to threefold increased risk of death, and up to a 2.5-fold increased risk of COVID-19 complications, according to the report published online recently in the journal **Frontiers in Cardiovascular Medicine**.

Those with diabetes had the highest risk of severe lung failure, the study authors noted.

"These findings present a



strong case for these at-risk groups to be prioritized for vaccinations and other preventative measures. This is especially true in low- and middle-income countries, where the impact of cardiovascular disease is particularly high," said study co-author Dr. Ajay Gupta, senior clinical lecturer at Queen Mary University of London.

"In more developed countries, groups with cardiovascular risk factors in addition to other vulnerable groups could be selected for booster and annual vaccination programs, similar to the influenza vaccination program," Gupta said in a

university news release.

Before the COVID-19 pandemic, high blood pressure, diabetes and heart artery disease were already common risk factors for heart attack and stroke, the study authors explained.

"These findings can help us identify unvaccinated individuals who are at a higher risk of worse outcomes, even without special tests," said study co-author Sher May Ng, of Barts Health NHS Trust. "This is particularly relevant where health care resources are limited but the proportion of unvaccinated individuals remains high."