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Publication 2020 Issue 48
Published in house by the RI ARA

November 29, 2020 E-Newsletter

Boosting Social Security, Important Now More Than Ever

One of the most important pieces of Social Security legislation considered during this Congress is the Social Security 2100 Act. This is the bill that would strengthen Social Security benefits by:

- providing a boost to benefits of about $30 per month ($360) for all retirees,
- tying the annual cost-of-living adjustment (COLA) to the Consumer Price Index for the Elderly, CPI-E, and,
- adjusting income thresholds that subject Social Security benefits to taxation allowing retirees to keep more of their benefits.

Many of you want to know what would happen if the lame duck Congress fails to enact this bill by the end of December 2020. Rest assured, TSCL will see to it that the bill is re-introduced in the next Congress, as quickly as possible.

TSCL was encouraged that the bill has seen more action, and received more attention in this Congress than any previous version of this bill, and was co-sponsored by more than 200 Members of the House. For those of you who want more details about it's progress, here are some tools to help you keep up with the status of legislation:

The official name of the bill is the Social Security 2100 Act (H.R. 860) that was introduced in the House by Representative John Larson (CT-1). You can look up any bill on **www.Congress.gov**, a website that provides a great search tool to learn the status and details about any bill.

The bill was evaluated and analyzed by the Social Security Office of the Actuary. The **first few pages** of the analysis are an interesting breakdown of the major provisions. You will note the SSA Actuary gives the opinion that the legislation would provide "full solvency for the program over a 75-year period: **(https://www.ssa.gov/oact/solvency/LarsonBlumenthalVanHollen_20190130.pdf)**

A House Committee hearing was held July 25, 2019 on the bill and this link will take you to the posted testimony and transcript: **(https://waysandmeans.house.gov/legislation/hearings/legislative-hearing-social-security-2100-act-0).**

The bill was paused when the Congressional Joint Committee on Taxation differed from the Social Security Administration Actuary, over the solvency provided by the legislation. The difference was due to the longevity assumptions that each source used to make its projections.

A small difference in assumptions, like how long people receive benefits in retirement, can make a big difference over the 75-year period used to evaluate Social Security's solvency. This difference in estimates is not uncommon, but when it occurs, both sides need to come together to resolve the differences. In TSCL's opinion, the funding issues could be resolved by tweaking the effective dates of the various provisions of the boost bill. There needs to be enough new revenues coming in to finance the boosted benefits.

However, little new work was achieved on the bill in 2020 because, by early in the year, the coronavirus changed ...**Read More**

Voters say Biden should make coronavirus vaccine a priority: poll

Forty percent of voters say President-elect Joe Biden should make distributing a coronavirus vaccine his top priority when he is sworn into office next year, according to a new Harvard CAPS-Harris survey released exclusively to The Hill.

Thirty-three percent of voters polled said Biden should make it a priority to pass a new coronavirus stimulus package through Congress.

The findings come as coronavirus cases are on the rise across the U.S. Public health officials are urging Americans to forgo Thanksgiving holiday gatherings, warning that they will likely lead to an even greater surge in cases.

However, officials say there is a light at the end of the tunnel. A number of breakthroughs have been made on the vaccine front, and some experts say there is a possibility a vaccine could be distributed as soon as next month.

Drugmaker AstraZeneca **announced on Monday** that its vaccine candidate, developed by Oxford University, is up to 90 percent effective in preventing COVID-19.

Additionally, last week the drug companies Pfizer and Moderna announced successful tests of their proposed vaccines, both of which found success rates of about 95 percent.

On the stimulus package front, Republicans and Democrats appear to face an uphill climb. House Democrats passed a $3 trillion version of the HEROES Act in May and passed a $2.2 trillion, slimmed-down version of the package in October, but the package has gone nowhere in the GOP-controlled Senate.

Biden, who met with Speaker **Nancy Pelosi** (D-Calif.) and Senate Majority Leader **Charles Schumer** (D-N.Y.) on Friday, has supported the Democrats' legislation.

He urged Congress to pass a coronavirus relief package "like the HEROES Act."

Biden and Vice President-elect Kamala Harris are set to meet with U.S. mayors amid the coronavirus surge on Monday.

The Harvard CAPS-Harris poll of 2,205 registered voters was conducted between Nov. 17 and 19. It is a collaboration of the Center for American Political Studies at Harvard University and The Harris Poll.

Full poll results will be posted online later this week. The survey is an online sample drawn from the Harris Panel and weighted to reflect known demographics. As a representative online sample, it does not report a probability confidence interval.

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FDA authorizes first rapid Covid-19 self-testing kit for at-home diagnosis

The US Food and Drug Administration has issued **an emergency use authorization** for the first self-test for Covid-19 that can provide rapid results at home.

The Lucira COVID-19 All-In-One Test Kit is a molecular single-use test available by prescription for self-diagnosis of the coronavirus, the agency said Tuesday.

The rapid test utilizes a molecular amplification technology to detect the virus in people with known or suspected Covid-19 and can return results in 30 minutes, the FDA said.

"While COVID-19 diagnostic tests have been authorized for at-home collection, this is the first that can be fully self-administered and provide results at home," FDA Commissioner Dr. Stephen Hahn said in a statement.

The new test, which uses self-collected nasal swab samples, is authorized for people 14 and older with suspected Covid-19 and people under 13 when performed by a health care provider.

It is also authorized for use in point-of-care settings, such as doctor's offices, hospitals, urgent care centers and emergency rooms for all ages but must be collected by a health care provider, the FDA said.

"This new testing option is an important diagnostic advancement to address the pandemic and reduce the public burden of disease transmission," Hahn added.

Health and Human Services Secretary Alex Azar agreed.

"Making it possible for Americans to do their own rapid COVID-19 self-test at home by prescription is the latest addition to our constantly expanding arsenal of COVID-19 testing options," Azar said in a statement.

But some health experts urged caution.

"The data is just still emerging, Tom Bollyky, the director of the global health program and senior fellow for global health, economics, and development at the Council on Foreign Relations, told CNN. "Obviously with some past emergency use authorizations it pays to be cautious with what the FDA has put out here, but it's certainly a promising sign."

The self Covid-19 home test could be one more step that gets the country closer to a new normality.

"Expanded testing, rapid testing really could be one more tool that brings us back to a life that approaches more normalcy. If we're able to identify at least on, perhaps even a daily basis, what our current viral load is and it helps us make ourselves safer and others," he said.

The new self-testing kit includes a sterile swab, a sample vial, a test unit, batteries and a plastic disposal bag.

The sample collected on the nasal swab is inserted into the vial which then enters the test unit where it is analyzed. The results are displayed on the test unit by a color change in the LED indicators, according to the FDA. Instructions on how to use the test are included with the prescription.

States Are Getting Ready to Distribute COVID-19 Vaccines

With the U.S. still in the midst of an escalating COVID-19 pandemic, attention to the race for a safe and effective COVID-19 vaccine has intensified. What is clear is that when vaccines do become available, ensuring equitable and rapid distribution to the U.S. population **will present an unprecedented challenge.** The Trump Administration, under **Operation Warp Speed**, has already purchased in advance hundreds of million doses of several vaccine candidates, two of which have already demonstrated **significant efficacy** in Phase 3 clinical trials, and has begun planning for what will be the largest scale vaccination distribution effort ever undertaken in the U.S. This task will soon be inherited by the incoming Biden Administration, which has established a **COVID-19 Task Force** and is already **planning** its response.

A limited number of COVID-19 vaccine doses may start to become available **as early as December**, with more doses available over time. State, territorial, and local governments, who already have primary authority over routine vaccination, will play an increasingly important role in the distribution of these vaccines as more doses become available. In preparation, the federal government has asked the 64 jurisdictional immunization programs (all 50 states and DC, 8 U.S. territories and freely associated Pacific states and five cities) that the Centers for Disease Control and Prevention (CDC) **funds and works with** to develop COVID-19 vaccine distribution plans based on an **Interim Playbook**. The Playbook includes planning assumptions for jurisdictions to follow and requested information in 15 key areas (see Box). First drafts of these plans were due by October 16.

CDC Interim Playbook Planning Assumptions and Key Areas of Information Requested from States for Vaccine Distribution Planning

In its **Interim Playbook** CDC provided states with a set of planning assumptions as they developed their vaccine distribution plans. For example, CDC outlined how vaccine distribution will likely proceed in phases:

- Phase 1 – there is an initial limited supply of vaccine doses that will be prioritized for certain groups and distribution more tightly controlled and limited number of providers administering the vaccine;
- Phase 2 – supply would increase and access expand to include a broader set of the population, with more providers involved, and;
- Phase 3 – there would likely be sufficient supply to meet demand and distribution would be integrated into routine vaccination programs.

CDC requested each state outline its capacities for distributing COVID-19 vaccines across a broad set of 15 critical areas: public health preparedness planning; organizational structure; plans for a phased approach; identifying and reaching critical populations to be prioritized for vaccine access; identifying and recruiting providers to administer the vaccine; vaccine administration capacity; allocating, distributing, and managing its inventory of vaccines; storage and handling; collecting, tracking, and reporting key measures of progress; second dose reminders; immunization information system requirements; developing a comprehensive communications plan around vaccination; regulatory considerations; safety monitoring; and program monitoring.

CDC guidance and federal oversight could evolve over the next several months as vaccines become available and distribution begins. The Biden campaign and transition team have planned for a more prominent role for the federal government in the U.S. COVID-19 response, which would likely include more detailed federal guidance and a stronger federal hand in vaccine distribution, planning and implementation, even as state and local jurisdictions will remain responsible for much of this effort. A critical challenge facing vaccine distribution efforts will be **funding**. To date, only **$200 million** has been distributed to state, territorial, and local jurisdictions for vaccine preparedness, though it is estimated that at least $6-8 billion is needed. President-elect Biden has said his administration would seek to **invest $25 billion** in manufacturing and distribution, which would require Congressional action….**Read More**

Take It From an Expert: Fauci's Hierarchy of Safety During COVID

As a health journalist, a physician and a former foreign correspondent who lived through SARS in Beijing, I often get questions from friends, colleagues and people I don't even know about how to live during the pandemic. Do I think it's safe to plan a real wedding next June? Would I send my kids to school, with appropriate precautions? When will I trust a vaccine?

To the last question, I always answer: When I see Anthony Fauci take one.

Like many Americans, I take my signals from Dr. Fauci, the country's top infectious disease expert and a member of the White House task force on the coronavirus. When he told The Washington Post that he was **not wiping down packages** but just letting them sit for a couple of days, I started doing the same. In October, he remarked that **he was bringing shopping bags into the house.** He merely washes his hands after unpacking them. (Me too!)

Now we are in a dangerous political transition, with cases spiking in much of the country and Fauci and the original task force largely sidelined. President-elect Joe Biden has appointed his own, but it can't do much until the **General Services Administration** signals that it accepts the results of the election. And Fauci told me he has not yet spoken with the Biden task force.

President Donald Trump has resisted the norms on government transition, in which the old and new teams brief each other and coordinate.

The past tumultuous months have been filled with information gaps (we're still learning about the novel coronavirus), misinformation (often from the president) and a host of "experts" — public health folks, mathematical modelers, cardiologists and emergency room doctors like me — offering opinions on TV. But all this time, the person I've most wanted to hear from is Fauci. He's a straight shooter, with no apparent conflicts of interest — political or financial — or, at 79, career ambition. He seemingly has no interests other than yours and mine.

So I asked him how Americans might expect to live in the next six to nine months. How should we behave? And what should the next administration do? Some answers have been edited for clarity and brevity….**Read More**

Trump seeks final stamp on drug prices with sweeping rule

President Donald Trump has resurrected a long-delayed plan to slash drug prices, with advisers pitching him on an added benefit: It would hit an industry that Trump believes slow-walked coronavirus vaccine development until after the election.

The about-face came after Oval Office meetings last week where Trump railed against vaccine maker Pfizer for not revealing that its vaccine was more than 90 percent effective until after Election Day, according to three people familiar with the discussion.

Senior officials worked through the weekend to craft a version of the policy that Trump plans to announce as soon as Wednesday — positioning it as an interim final rule to leapfrog the monthslong process of releasing a draft and gathering public feedback.

The plan, known as the most-favored nations rule, would link government payments for medicines to lower prices paid abroad. It could cut Medicare drug payments by as much as 30 percent, lopping off a chunk of pharmaceutical companies' profits in one of their largest customer pools.

It's also part of a broader White House effort to deliver on Trump's signature 2016 campaign pledges — in this case, lowering drug prices — before he leaves office in January.

Trump first floated the plan in May 2018, denouncing "foreign freeloaders" for jacking up prices paid by Americans. But momentum for the idea quickly died down amid swift opposition from drugmakers and criticism from several Republicans who likened the idea to importing price controls from other countries that, unlike the United States, take an active role in setting drug prices.

The White House then used the international-pricing plan in subsequent efforts to pressure the drug industry, including an attempt this summer to extract price cuts from the industry before the election. Officials revived the model again last week, initially intending to issue it as a proposed rule as part of Trump's broader drug-cut agenda, as The Hill **first reported.**

It's all but certain that the pharmaceutical industry will challenge the White House's latest decision to issue the policy as an interim final rule — without soliciting and sifting through thousands of industry and public comments over several months.

Spokespeople for the White House, HHS and the Centers for Medicare and Medicaid Services did not respond to requests for comments.

With roughly two months left in the Trump presidency, lawsuits could easily stall the measure until President-elect Joe Biden assumes office.

Administration officials involved in the drug-pricing effort also have questioned the legal justification for speeding up the process.

"Leaving office and not having time to go through the right process, like a proposed rule, does not an emergency make," said one HHS official who's been briefed on the plan.

The president revived the 2018 plan with an executive order this summer that dubbed it the "most-favored nations" rule. While the original approach focused only on physician-administered drugs in Medicare Part B, Trump in August ordered officials to eventually extend the move to medicines bought at the pharmacy counter in Part D — encompassing virtually every major drug sold to consumers.

The latest version would be structured as a seven-year Medicare demonstration and as a mandatory model, three officials said, tying U.S. prices for affected drugs to those paid in a group of developed countries. But according to two of those sources, it would only affect Medicare Part B. That means it would have a minimal impact on Pfizer, where pharmacy-counter medicines covered under Part D drive significant revenue.

It's not clear how the Biden administration would deal with such massive, last-minute Medicare overhauls. Biden has discussed establishing an independent review board to assess medicines' values, another approach borrowed from European countries.

The most-favored nations rule and another proposal to eliminate rebates that drugmakers pay to pharmacy benefit managers could be Trump's final legacy in his bid controlling drug costs, once a key campaign promise and fixture of State of the Union addresses. While price hikes for prescription medicine slowed in recent years, costs did not drop and other key proposals — such as a requirement to list prices in direct-to-consumer ads or a pathway for states to import cheaper medicines from Canada — never took flight.

"I'm cutting drug prices. I'm going with favored nations, which no president has the courage to do, because you're going against Big Pharma," Trump said during the first presidential debate against Biden.

The president-elect fired back: "He has no plan for health care. He hasn't lowered drug costs for anybody."

Pfizer files COVID-19 vaccine application to U.S. FDA

Pfizer Inc **PFE.N** applied to U.S. health regulators on Friday for emergency use authorization (EUA) of its COVID-19 vaccine, the first such application in a major step toward providing protection against the new coronavirus.

The application to the U.S. Food and Drug Administration (FDA) comes just days after Pfizer and German partner BioNTech SE **22UAy.DEBNTX.O** reported final trial results that showed the vaccine was 95% effective in preventing COVID-19 with no major safety concerns.

Pfizer Chief Executive Officer Albert Bourla confirmed the application had been made in a video posted on the company's website on Friday afternoon.

The FDA said on Friday it would hold a meeting of the advisory committee on Dec. 10 at which members would discuss the vaccine. The agency declined to predict how long its review would take, although both Pfizer and U.S. Health Secretary Alex Azar have said the FDA could authorize the vaccine in mid-December.

Pfizer's shares closed up 1.4% and BioNTech shares ended 9.6% higher in New York, as the possibility of a vaccine soon raised hopes for the end of a pandemic that has claimed more than a quarter of a million lives in the United States and over 1.3 million worldwide.

For an interactive graphic tracking the global spread of COVID-19, open **here** in an external browser.

The application also includes safety data on about 100 children 12-15 years of age. The company said 45% of U.S. trial participants are 56-85 years old.

If the data is solid, "we literally could be weeks away from the authorization of a 95% effective vaccine," Azar said on CBS's "This Morning."

The companies expect the FDA to grant the EUA by mid-December and said they will begin shipping doses almost immediately. Pfizer has said it expects to have 50 million vaccine doses ready this year, enough to protect 25 million people.

The final trial data showed the vaccine provided a similar level of protection across different ages and ethnicities - an encouraging result as the disease disproportionately hurts the elderly and minorities.

Of the 170 volunteers who contracted COVID-19 in Pfizer's trial involving over 43,000 people, 162 had received only a placebo, meaning the vaccine was 95% effective, far higher than originally expected. The U.S. FDA had set minimum bar for efficacy of 50%.

Pfizer said nearly 42% of global participants and 30% of U.S. participants in the Phase 3 study have racially and ethnically diverse backgrounds.

"Filing in the U.S. represents a critical milestone in our journey to deliver a COVID-19 vaccine to the world and we now have a more complete picture of both the efficacy and safety profile of our vaccine," Bourla said in a statement.

Moderna Inc **MRNA.O** is expected to be the next company to seek a U.S. emergency use nod for a COVID-19 vaccine. An initial analysis of data from its late-stage trial showed the vaccine was 94.5% effective. Final results and safety data are expected in the coming days or weeks.

Both the Pfizer/BioNTech and Moderna vaccines work using a new technology to trigger an immune response known as synthetic messenger RNA that can be produced at scale much more quickly than traditional vaccines.

Of dozens of drugmakers and research institutions racing to develop COVID-19 vaccines, the next late-stage data is expected to come from AstraZeneca Plc **AZN.L**, which is working with the University of Oxford, in November or December.

Johnson & Johnson **JNJ.N** said it expects to have data needed to seek U.S. authorization for its experimental vaccine by February.

Trump's Lame-Duck Status Leaves Governors to Wing It on COVID

Not long after the world learned that President Donald Trump had lost his reelection bid, states began issuing a new round of crackdowns and emergency declarations against the surging coronavirus.

Taking action this time were Republican governors who had resisted doing so during the spring and summer. Now they face an increasingly out-of-control virus and fading hope that help will come from a lame-duck president who seems consumed with challenging the election results.

President-elect Joe Biden has promised a more unified national effort once he takes office on Jan. 20, and pressure is building on Congress to pass a new financial relief package. But with record hospitalizations and new cases, many governors have decided they can't afford to wait.

"I don't know any governor who's sitting there waiting for the knight to come in on the horse," said Lanhee Chen, a fellow at the Hoover Institution and a former senior health official in President George W. Bush's administration. "There's no way for these guys to just sit and wait. The virus and the crisis is getting worse hour by hour, day by day."

As new measures trickle out across states, public health policy experts worry many don't go far enough. For those states attempting to impose meaningful restrictions, their success depends on cooperation from a population with pandemic fatigue. And people may be reluctant to curtail their holiday gatherings.

Residents of many conservative states don't acknowledge the depth of the health problem, especially given Trump and some of his allies have stressed the crisis is being overplayed and will end quickly.

The bottom line is that many people just aren't sufficiently scared of the virus to do what must be done to stop the spread, said Rodney Whitlock, a health policy consultant and former adviser to Sen. Chuck Grassley (R-Iowa).

"You're dealing with folks there who definitely put liberty over everything else because they're not afraid enough," Whitlock said. "Even in the face of cases, even in the face of people around them getting it. They're just not afraid."

Among the first governors to act was outgoing Utah Gov. Gary Herbert. The day after The Associated Press called the presidential election for Biden on Nov. 7, the Republican announced Utah's first-ever statewide mask mandate and clamped down on social gatherings and other activities until Nov. 23.

"All of us need to work together and see if there's a better way," Herbert said **in a news conference.**

Republican and Democratic governors alike followed with measures of their own in Colorado, Iowa, Michigan, Nebraska, New York, Ohio, Oregon, Pennsylvania, Washington and other states. Strategies included partial lockdowns, limits on crowds, canceling in-person classes for schools and reducing hours and capacity for bars and restaurants. **..Read More**

These Front-Line Workers Could Have Retired. They Risked Their Lives Instead.

Sonia Brown's husband died on June 10. Two weeks later, the 65-year-old registered nurse was back at work. Her husband's medical bills and a car payment loomed over her head.

"She wanted to make sure all those things were taken care of before she retired," her son David said.

David and his sister begged her not to go back to work during the coronavirus pandemic — explaining their concerns about her age and diabetes — but she didn't listen.

"She was like the Little Engine That Could. She just powered through everything," David said. But her invincibility couldn't withstand COVID-19, and on 29 July she died after contracting the deadly virus.

Sonia's death is far from unusual. Despite **evidence** from the Centers for Disease Control and Prevention that adults 65 and older are at a higher risk from COVID-19, **KHN and The Guardian** have found that 338 front-line workers in that age group continued….**Read More**

Medicare Part D drug coverage in 2021

Whether you are enrolled in traditional Medicare or a Medicare Advantage plan, you can get prescription drug coverage that will cover your costs at the pharmacy through a **Medicare Part D** drug plan. Medicare Part D doesn't cover your full costs, but it provides important partial coverage. About 75 percent of people with Medicare–46 million–are enrolled in Part D.

Commercial insurance companies contract with the federal government to provide Part D drug coverage to people with Medicare. In **Medicare Advantage** plans, the Medicare private option through which private health insurers contract with the federal government to deliver Medicare benefits, Part D coverage is usually administered by the insurer offering the Medicare Advantage plan.

Here's how Medicare Part D coverage works in 2021 and what to consider before choosing a Part D drug plan, along with how to enroll in Part D and Part D premiums. In choosing among Medicare Advantage plans, in addition to considering your deductibles and copays for medical and hospital services, you should factor in your prescription drug costs. Your costs could differ considerably in different **Medicare Advantage plans.**

- Part D drug plans usually have a **deductible,** which can require you to pay up to several hundred dollars out of pocket before your coverage kicks in. In 2021, the defined standard benefit deductible is $445. Enhanced drug plans generally have low or no deductibles and cover a wider array of drugs, but they charge higher monthly premiums.
- After you pay your deductible, your drug plan covers 75 percent of your drug costs. During this "initial coverage period," you pay 25 percent coinsurance until your total drug costs reach $4,130.

- If your drug costs are higher than $4,130, you will spend 25 percent of the drug plan's cost for covered brand-name drugs and 37 percent of the drug plan's cost for covered generic drugs until your total out-of-pocket costs reach $6,550 ($10,048 in total drug spending.)
- If your income is low, you may be eligible for the **"Extra Help"** program, which helps cover your coinsurance costs.
- No matter which Part D plan you choose, after you have paid $6,550 of your own money for covered drugs, Medicare will pick up 95% of the cost of your drugs. You will pay the greater of 5 percent of the cost or $3.70 for generic drugs and $9.20 for brand-name drugs.

Keep your costs down: Unfortunately, if you take a lot of high-cost drugs, unless your income is low and you qualify for **Extra Help** or another low-income program, there is no limit on your out-of-pocket drug costs. No matter what your drugs cost, you can save a lot of money if you do your homework when picking a Part D plan. Each drug plan has different premiums, deductibles and copays and covers different drugs under different conditions.

- **Does the Part D plan cover the drugs you take?** You want to make sure the drugs you take are on the Part D drug plan's formulary and about any restrictions on coverage. If you choose a plan that does not cover some of your drugs, you should ask your doctor if you could take the drug on the formulary instead. Or, you should figure out which plan covers the most of your drug costs.
- **Where can you get your drugs?** Find out whether you can continue to use the pharmacy you currently use to get your drugs as well as whether you can get drugs by mail order and when you travel.
- **What will your costs be?** Ask what your out-of-pocket costs will be for the monthly premium, the deductible, copays for your drugs at in-network pharmacies and the copays at out-of-network pharmacies. If your income is below 150 percent of the federal poverty level ($19,140 for individuals/ $25,860 for married couples in 2020) and you have modest assets (less than $14,610 for individuals/$29,160 for couples in 2020), you qualify for help paying your Part D costs under the **Extra Help** (Low-Income Subsidy (LIS) program.)
- **Is the drug plan in your service area?** If you are enrolled in traditional Medicare, you must choose a drug plan in your service area, so you should understand what that area is.

You should also check to see whether you are eligible for a **state pharmaceutical plan.**

Enrollment: If you have traditional Medicare, you can call Medicare at 1-800-633-4227 to sign up for Part D at the same time you sign up for traditional Medicare, so that you have full coverage. Most Medicare Advantage plans fold Medicare Part D coverage into their benefit package. Again, if your income is low, **you may be eligible for help paying the cost of this coverage**. And, if you'd like, you can ask to have your Part D premium deducted from your Social Security check.

Click here for **Medicare's plan finder tool** that can help you choose a drug plan. It will tell you which drugs a particular plan covers at any given time.

Keep in mind that each Fall you will need to study your options if you want to keep your costs down, since most drug plans, as well as Medicare Advantage plans that offer drug coverage, change their premium, deductibles, copays and the drugs they cover from one year to the next. The average drug plan **monthly premium** is around $33, but the premium can be a lot higher. Premiums, copays and coinsurance vary tremendously depending upon the plan you choose.

If you use insulin, look into plans that **offer low-cost insulin** under a new Trump administration initiative.

Medicare charges you a **higher premium if your income is above $88,000.** That additional premium for your Part D drug coverage will be as low as $12.30 if your income in 2019 was above $88,000 and no more than $111,000, and as high as $77.10 a month if your annual income in 2019 was above $500,000.

NB: Because out-of-pocket costs for drugs can be very high, Kaiser Health News reports that millions of people who use a lot of costly drugs buy them **from abroad** at far lower cost.

As COVID-19 Vaccines Approach, Governments Gear Up for Distribution

This week, the Kaiser Family Foundation (KFF) released an **analysis of different state government plans** for COVID-19 vaccine distribution. Current projections show that a limited number of COVID-19 vaccine doses may start to become available **as early as December**, with more doses available over time.

While the Centers for Medicare & Medicaid Services (CMS) has already announced that available COVID-19 vaccines will be covered for Medicare beneficiaries with no cost-sharing, who has first access is yet to be decided. State, territorial, and local governments, who already have primary authority over routine vaccination, will play an increasingly important role in distribution. In preparation, the federal government has asked jurisdictional immunization programs to develop COVID-19 vaccine distribution plans.

While the Centers for Disease Control and Prevention (CDC) has made **executive summaries** of these plans available, there is no central repository for the full plans. KFF collected available plans and reviewed each plan to "gauge how states described their vaccine distribution planning progress to date." They focused their analysis on the following key areas:

- identifying **priority populations** for vaccination in their state;
- identifying the **network of providers** in their state that will be responsible for administering vaccines;
- developing the **data collection and reporting** systems needed to track vaccine distribution progress; and
- laying out a **communications strategy** for the period before and during vaccination.

The report finds that states are in varying stages of preparation for distributing a COVID-19 vaccine. While all have established a task force or planning committee to steer these efforts, which include representatives from different sectors, "some have been planning for several months while other states' planning efforts have started more recently." KFF notes that some states have already begun the process of signing up providers to administer COVID-19 vaccines, while others are still just developing plans to do the same. All states reported, however, that these initial plans are to be considered drafts only, to be updated as more information from the federal government and about a vaccine itself was available. Specifically, nearly every state cited the need to know which vaccine(s) would be authorized or approved and highlighted the need for clear guidance and direction from the federal government.

Fear of Flying Is a COVID-Era Conundrum

The holidays are approaching just as COVID-19 case rates nationwide are increasing at a record-breaking pace, leading to dire warnings from public health experts.

The Centers for Disease Control and Prevention has **issued cautions** and updated guidelines related to family gatherings. Dr. Anthony Fauci, a White House coronavirus adviser and director of the National Institute of Allergy and Infectious Diseases, said in interviews that his kids won't be coming home for Thanksgiving because of coronavirus risks. "Relatives getting on a plane, being exposed in an airport," he told **CBS News**. "And then walking in the door and saying 'Happy Thanksgiving' — that you have to be concerned about."

Are Americans listening? Maybe not. Especially as airlines, reeling from major revenue blows since the pandemic took hold in March, tell passengers they can travel with peace of mind and sweeten the deal with special holiday fares.

The airlines argue more is now known about the virus and recent industry-sponsored studies show flying is just as safe as regular daily activities. They also tout policies such as mask mandates and enhanced cleaning to protect travelers from the coronavirus….**Read More**

New Paper Suggests Needed Changes to Medicare Appeals Processes

The American Cancer Society Cancer Action Network **released a paper this week** that outlines problems and potential solutions for various issues within Medicare appeals processes. The hurdles in various appeals processes can pose insurmountable burdens for people with Medicare who need access to care, services, medication, and items.

Two key findings from the paper are that the processes are overly complex and can take too long. At Medicare Rights, our national helpline experience contributed to the paper and aligns with its conclusions. We agree that appeals processes should be streamlined and the burdens on beneficiaries must be reduced to ensure more people have access to the benefits they need.

In addition, the paper flags that some Medicare plans may be inappropriately denying care. This warning is consistent with findings from the Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services—a watchdog agency that oversees the Medicare and Medicaid programs. **The OIG found that Medicare Advantage organizations appeared to regularly and inappropriately deny coverage** and would only reverse course when the decisions were appealed. This is very concerning, as we know that many people do not appeal denials—either paying out of pocket or going without care entirely because they do not know about their appeal right or because the process is daunting and confusing.

Because many of the data on Medicare plan denials are not publicly available, it is difficult to know precisely how widespread problems may be. But we regularly hear from callers on our national helpline who are struggling with denials, frustrated with appeals, and unable to afford health care costs out of pocket.

More must be done to streamline, simplify, and improve appeals in all aspects of the Medicare program. In our most recent **helpline trends report**, we highlighted issues our callers face as they try to appeal Medicare Advantage decisions. We urge the Medicare program to increase its oversight of and penalties for Medicare Advantage Plans that inappropriately deny care.

We also support improvements to the Medicare Part D appeals process, such as more information being provided at the pharmacy counter. Bipartisan legislation such as the **Streamlining Part D Appeals Process A**ct (116th Congress, S 1861, HR 3924) would allow a refusal at the pharmacy counter to serve as the plan's initial coverage determination. This would give people with Medicare more timely information and eliminate unnecessary steps within the appeals process.

Identifying the Right Time for Senior Care

Signs your aging loved one needs help, and where you can turn to get it.

AT LEAST 17.7 MILLION individuals in the U.S. are **helping to take care of an older adult** with health needs, according to the 2016 report from Families Caring for an Aging America. As we age, the odds of declining physical or cognitive health that affects our ability to function independently steadily increase. The report notes that between ages 85 and 89, more than half of older adults (58.5%) require a family member's help because of health or functional issues, and about three-fourths of adults age 90 and up (74%) need some help from others.

Of course, some of us need help sooner because illness or an accident can befall us at any age. How do family members know when a loved one has reached the stage where help is needed? And how do they decide where to turn to get the appropriate level of care their loved one requires?

Sometimes the need is obvious. A debilitating health event like a **stroke** or **fall**, or a traumatic accident like a car crash can render someone incapable of self-care. But perhaps more common is the case where the signs are subtle and accumulate gradually. Here are some things to look for.

Warning Signs

The Mayo Clinic breaks the warning signs of decline into eight basic categories.

Is Your Loved One Able to Manage Self-Care?

Common signs of decline include poor hygiene, sloppy dressing and unkempt appearance, says Maria Hood, director of admissions at United Hebrew in New Rochelle, a senior care facility in New York. "With my dad, we began to notice he wasn't shaving, and his clothes were rumpled. This was a man who always took very good care of himself," Hood says.

Also notice if the home is being kept up. Are the **bills getting paid**? Are the lightbulbs working? Are the appliances clean and the dishes put away? Are they able to go to the grocery or drugstore? Any changes in household upkeep or personal care offers clues to their health, the Mayo Clinic says.

Is There Significant Memory Loss?

We all lose some memory as we age, and the occasional misplaced keys or disappearing remote are nothing to worry about. What is worrying, though, is **memory loss** that affects bigger issues, like where you are, how to drive and what you just said minutes ago.

The Mayo Clinic's signs of this type of memory loss include:

- Asking the same questions over and over.
- Getting lost in familiar places.
- Being unable to follow instructions.
- Being confused about location, time and well-known people.

Is Your Elderly Loved One Safe in the Home?

Check the home for clutter, loose rugs, exposed electrical cords and other dangers that could cause a fall. If your loved one seems in danger when climbing stairs or moving normally about the house, that is a red flag.

In addition, are they able to reach dishware, tools and other daily objects easily? Can they read and follow instructions on medication and other labels? Have you seen worrisome incidents, like falls, dropped glasses or missed medication doses? A safe home is paramount to keeping your loved one well.

Is He or She Safe Driving a Car?

We all make jokes about the old man driving too slow in the left lane, but it's not funny. Hood noticed her father driving "white-knuckled" at 45 mph in a 65 mph zone, and took it, appropriately, as a sign that he was not up to the task. Slowed reflexes, diminished vision and hearing and increasing confusion all make **driving a challenge as we age.**

In addition, if you notice more dents and dings in the car, or if your loved one has gotten a ticket or a warning for a driving mishap, those are signs of the need for an intervention…

Has Your Loved One Lost Weight?

Unexpected and unexplained weight loss could be a sign of either physical or **mental health** problems – or potentially both.

The Mayo Clinic says weight loss could be a result of:

- **Difficulty cooking.** It may be hard to summon the energy or desire to cook, difficult to hold and manipulate cooking tools or challenging to read labels or follow directions and recipes.
- **Loss of taste or smell.** Aging naturally causes diminishment in these senses, and when food doesn't taste or smell good, eating becomes less enjoyable.
- **Socioeconomic issues.** Your loved one might find **grocery shopping** physically difficult or too expensive if they have financial pressures.
- **Other health conditions.** Weight loss can be a symptom of a serious underlying medical problem, such as malnutrition, **dementia, depression** or **cancer**.

Has Your Elder's Mood or Spirits Changed?

Everyone gets sad, and the elderly often have a lot to be sad about, with the loss of friends and family and the everyday challenges of growing older.

.**Read More**

Long-Term Care Insurance for the Elderly: What You Need to Know

It feels good to imagine living all of your senior years without any worry. That's why the topic of long-term care insurance for the elderly is worth learning more about. After all, some people eventually need help with basic activities of daily living—things like eating, bathing, getting dressed, using the bathroom, taking care of personal hygiene, or moving from place to place. You may never need that sort of help, but wouldn't it be nice to know that you could access care if it ever became necessary?

For those who need it, long-term care (LTC) is a saving grace. Of course, the longer you live, the greater your chances of eventually needing LTC—as well as a reliable way to pay for it. (If you're wealthy, paying for care is probably not an issue. If you're financially disadvantaged, you can use Medicaid for certain types of care. But if your financial situation falls somewhere between those two extremes, your options may be a little less clear.)

That's where long-term care insurance (LTCI) comes in. Under the right circumstances, it can provide peace of mind and the ability to pay for extended help if you ever need it. But this care-funding option isn't right for everybody. So it's essential to understand the potential advantages as well as the risks. This article will give you a good introduction to the topic.

The following information is not a substitute for professional, personalized advice. Everyone's circumstances are different.

Contents

- **What is LTC insurance?**
- **How much does long-term care insurance cost?**
- **Do I really need long-term care insurance?**
  - **Pros**
  - **Cons**
- **What are the alternatives to LTC insurance?**
- **When should you buy long-term care insurance (if you decide to get it)?**
- **Who should I buy from, and what should I look for?**
- **How do you file an LTC insurance claim?**

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

Hormone Therapy for Prostate Cancer May Raise Heart Risks

Hormone therapy can be a lifesaver for men with prostate cancer, but it also appears to put some at increased risk of heart problems, a new study reports.

Long-term androgen deprivation therapy (ADT) increased the risk of heart-related death nearly fourfold in a group of prostate cancer patients, and also caused their heart fitness to decrease, researchers found.

There is one important caveat: These patients were not in great shape to begin with. At the start of the study, 4 out of 5 men had two or more risk factors for heart disease, the study says.

"Our data are not suggesting that androgen deprivation therapy definitely causes worse heart health," said lead researcher Dr. Jingyi Gong, a clinical fellow with the Brigham and Women's Hospital Heart and Vascular Center in Boston. "Rather, it suggests that for folks who are sicker on baseline with multiple cardiac comorbidities, they are more likely to deteriorate with androgen deprivation therapy from a cardiopulmonary perspective."

Doctors treating prostate cancer patients with poor heart health need to be vigilant regarding heart-related side effects of ADT, said Dr. Bonnie Ky, editor-in-chief of *JACC: CardioOncology*, the journal in which the study appears.

"We need to do everything we can to ensure the patients can receive lifesaving cancer therapy in a safe manner," Ky said.

About 1 in every 9 men will be diagnosed with prostate cancer during their lifetime, researchers said in background notes. It is the second-leading cause of cancer death in American men.

ADT combined with radiation therapy is a standard treatment for prostate cancer, researchers note.

Prostate cancer is fueled by male hormones, which are called androgens. Drugs that block production of testosterone are used to lower androgen levels in the body, with the aim of stalling out the cancer.

Prolonged use of ADT in some patients has become more popular lately, in the wake of studies that showed keeping men on hormone therapy improves their cancer outcomes. But questions have arisen about the effects of long-term hormone therapy on heart health.

This study tracked the heart health of 616 prostate cancer patients as they received hormone therapy for nearly five years after their cancer diagnosis.

All had an exercise treadmill test at the beginning of the study to determine their initial heart fitness, as well as a thorough analysis of their heart risk factors.

From the start, nearly 82% of the men had two or more heart risk factors -- smoking, high cholesterol, diabetes, high blood pressure, excess weight, family history of heart problems, symptoms of heart disease, and the like.

About one-quarter of the men (150) received ADT before their first treadmill test, and 51 had been exposed to long-term hormone therapy. Most patients with prolonged exposure to hormone therapy (92%) had two or more risk factors for heart disease.

Researchers found that men on long-term ADT were 3.8 times more likely to die from heart-related illness during the five-year follow-up, and they were 2.7 times more likely to perform worse on subsequent treadmill tests.

Blocking male hormone production causes a number of changes to men's bodies that could promote bad heart health, Gong said.

Men tend to lose lean muscle mass and pack on excess weight in the form of fat when their testosterone levels drop, Gong said.

Their insulin resistance and cholesterol levels also can go haywire, Ky added.

"We postulate it's all these things" increasing heart risk among prostate cancer patients, Ky said. "These factors are each modifying the cardiovascular risk."

Prostate cancer patients can fight these effects by sticking to a heart-healthy lifestyle, Gong said. That includes regular exercise, eating right, quitting smoking, managing blood pressure and cholesterol, and losing weight.

"If the treatment is indicated from a cancer survival perspective, then at the very least these patients should be encouraged to stay physically active and manage their comorbidities such as hypertension and diabetes," Gong said.

Anxiety Might Speed Alzheimer's: Study

Older adults with memory problems may progress to Alzheimer's more quickly if they are also suffering from anxiety symptoms, a preliminary study suggests.

It's common for people with Alzheimer's disease to have mood symptoms, including anxiety and depression. And some research has suggested those symptoms can, in older people, act as early indicators of the dementia process.

The new study focused on 339 patients diagnosed with mild cognitive impairment -- persistent problems with memory and thinking skills that can progress to full-blown dementia.

But progression is not guaranteed, and people vary in how quickly their mental functioning declines.

There's no way to predict how things will go for any one person, said Dr. Maria Vittoria Spampinato, senior author on the study.

But researchers are trying to figure out whether certain factors are linked to the speed of progression. The new findings suggest anxiety might be one, according to Spampinato, a professor of radiology at the Medical University of South Carolina.

Her team found that patients with more anxiety symptoms at the outset were more likely to be diagnosed with Alzheimer's disease over the next several years, compared to those with few symptoms.

Does that mean anxiety speeds up the dementia process? Not necessarily, according to Mary Sano, director of the Alzheimer's Disease Research Center at Mount Sinai in New York City.

Instead, anxiety is likely another symptom of the underlying brain disease, said Sano, who was not involved in the study.

She doubted that treating anxiety in someone with mild cognitive impairment would "change the underlying biology" of the dementia process.

Still, Sano said, recognizing anxiety in those patients is still important. For one, it might serve as a red flag that someone is at risk of more rapid decline.

That's key, Sano said, partly because anxiety symptoms are easy to measure. In this study, some other factors were linked to faster progression -- including shrinkage in certain brain areas. But that can only be gauged with a brain MRI.

Plus, Sano said, helping people cope with anxiety should be a goal in its own right. "It's an important symptom to consider," she said.

The findings are based on a study of North American patients with mild cognitive impairment that involved memory problems. At the outset, all underwent anxiety and depression screening, MRI brain scans and blood tests….**Read More**

How Hospitals Can Cut Patients' Falls

A new toolkit to help reduce falls and fall-related injuries among hospital patients is highly effective, a new study shows.

Falls are the leading cause of preventable injury, so researchers set out to create a fall prevention toolkit for patients and their families.

It includes measures such as a laminated poster to display by patients' beds, and personalized prevention plans that can be included in patients' electronic health records and printed out or displayed on a computer screensaver.

The researchers tested the toolkit among more than 37,000 patients at three hospitals -- Brigham and Women's in Boston, and New York-Presbyterian Hospital and Montefiore Medical Center Hospital in New York City -- between September 2015 and November 2016.

The toolkit led to a 15% reduction in patient falls and a 34% reduction in fall-related injuries, according to the study published recently in the journal *JAMA Network Open*.

"Our study highlights just how important it is to engage with patients for prevention," said Patricia Dykes, a senior nurse scientist at Brigham and Women's.

"If you partner with your patient to identify the risks and talk about how we can prevent them as a team, then patients and families respond to this and rise to the occasion," Dykes added in a hospital news release.

The toolkit -- which is available for free online -- is being used at Brigham and Women's and Mass General Brigham, and has been adopted by 150 hospitals in the United States and other countries.

Dykes and colleagues continue to seek feedback from nurses to get ideas on how to make the toolkit even better.

"This work represents a collaboration across disciplines and the input of nurses, patients and their families," Dykes said. "Falls take a staggering toll on patients and families, and we remain focused on continuing to decrease the rates of falls, especially injurious falls, at our hospital and globally."

People With Depression Fare Worse in Heart Health Study

Heart disease and depression are interwoven, and a new study is helping unravel that connection by linking depression with poorer scores on seven important measures of heart health.

The research included more than 4,000 people taking part in a national survey who had been screened for depression using a basic questionnaire. Participants were evaluated for weight, smoking, diet, physical activity, blood sugar, cholesterol and high blood pressure – measures known as the American Heart Association's Life Simple 7.

After adjusting for factors such as age, race and income, the researchers found people with symptoms of severe depression were 3.1 times more likely to have worse cardiovascular health than people without depression. People with mild-to-moderate depression were 1.4 times more likely.

Lead researcher Dr. Brent Medoff said the study shows a clear link between depression and poor heart health, although it can't explain what's behind the connection.

"Whether it's because they're depressed and they don't want to move around, or they're not taking care of themselves, or they're unable to get medication, (these) are things that we have to look for in other research," said Medoff, a resident physician at the University of Pittsburgh Medical Center.

The research, presented this month at the AHA's virtual Scientific Sessions conference, is considered preliminary until published in a peer-reviewed journal.

Dr. Christopher Celano, associate director of the Cardiac Psychiatry Research Program at Massachusetts General Hospital, said zeroing in on the root causes of the relationship between depression and heart disease offers fresh details on a complicated interaction. He was not involved in the new research.

It's a two-way street, studies suggest. People with depression are more likely to develop heart disease. And people with heart disease can experience depression. In fact, research suggests 15% to 30% of people with cardiovascular disease have depression – a rate two to three times higher than the general population.

Celano said some of the connection is probably behavioral. People who are depressed are more likely to smoke, less likely to be active and tend to have a less healthy diet

But depression also has a physical side. It affects the nervous system in ways that can raise blood pressure and heart rate. It affects blood platelets, which can increase the risk of clotting. It's also been associated with inflammation, which is linked to many diseases.

"Depression and depressive symptoms are not just in the brain," Celano said. "Your brain is connected to every other part of your body. We know more and more that these connections between the brain and the rest of the body go both ways. So things that happen in your body can affect how you think and feel. And changes in your brain can affect many different parts of your body, including your heart.".**Read More**

Air Pollution May Up Alzheimer Disease Risk in Elderly

Late-life exposure to particulate matter with aerodynamic diameter <2.5 µm ($PM_{2.5}$) is associated with Alzheimer disease (AD) pattern similarity (AD-PS) scores among women, corresponding to an increase in AD risk, according to a study published online Nov. 18 in *Neurology*.

Diana Younan, Ph.D., from the University of Southern California in Los Angeles, and colleagues examined whether late-life exposure to $PM_{2.5}$ contributes to progressive brain atrophy predictive of AD. Participants were older women with up to two brain magnetic resonance imaging (MRI) scans performed in 2005 to 2006 and in 2010 to 2011. AD-PS scores were used to capture high-dimensional gray matter atrophy in brain areas vulnerable to AD. A spatiotemporal model was implemented to estimate three-year average exposure to $PM_{2.5}$ preceding MRI-1.

The researchers found that in cross-sectional analyses, for 1,365 women aged 77.9 ± 3.7 years in 2005 to 2006, no association was seen between $PM_{2.5}$ and baseline AD-PS score. Longitudinally, there was an association noted for each interquartile range increase of $PM_{2.5}$ with elevated AD-PS scores during follow-up, equivalent to a significant increase in AD risk over five years (hazard ratio, 1.24). The association persisted after adjustment for multiple confounding variables and was observed with $PM_{2.5}$ levels below U.S. regulatory standards.

"Not only did we find brain shrinkage in women exposed to higher levels of air pollution, we also found it in women exposed to air pollution levels lower than those the EPA [U.S. Environmental Protection Agency] considers safe," the authors write.

How can I troubleshoot common issues with skilled therapists?

Dear Marci,
I have been receiving outpatient physical therapy for a while now, and my condition is not improving. I am worried about reaching a therapy cap or losing coverage for not meeting an improvement standard. How can I troubleshoot potential coverage issues with my physical therapist?
-Venita (Mobile, AL)

Dear Venita,

Medicare Part B covers **outpatient therapy**, including physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT). Previously, there was a limit, known as the therapy cap, on how much outpatient therapy Original Medicare covered annually. However, in 2018, the therapy cap was removed.

If your total therapy costs reach a certain amount, Medicare requires your provider to confirm that your therapy is medically necessary. This is not a therapy cap, but it does require your provider to take action before Medicare will cover continued care.

In 2020, Original Medicare covers up to:

- $2,080 for PT and SPL before requiring your provider to indicate that your care is medically necessary.
- And, $2,080 for OT before requiring your provider to indicate that your care is medically necessary.

If your provider has questions about how to bill Medicare for more therapy, let them know they should contact the Medicare Administrative Contractor (MAC) for their state.

Medicare pays for up to 80% of the Medicare-approved amount. This means Original Medicare covers up to $1,664 (80% of $2,080) before your provider is required to confirm that your outpatient therapy services are medically necessary. If Medicare denies coverage because it finds your care is not medically necessary, you can **appeal**.

It is also important to know that Medicare will cover your physical therapy even if your condition is not improving. Medicare covers skilled nursing facility, home health, and outpatient **therapy care regardless** of whether your condition is temporary or chronic, or whether your condition is improving or not, as long as the care is medically necessary for another reason.

This was clarified in the settlement of a class action lawsuit, *Jimmo v. Sebelius*. The settlement agreement explained that an improvement standard cannot be the only test applied when Medicare is determining coverage of claims that require skilled care, such as skilled therapy. Medicare covers services that are needed to:

- Help **maintain** ability to function
- Help **regain or improve** your function
- **Prevent or slow the worsening** of your condition

In other words, your coverage of skilled therapy cannot end solely because your condition is not improving. If your therapy is being denied or ending just because you are not improving, you should file an **appeal**.
-Marci

AHA: Long-Term Survival After Heart Attack Could Hinge on Where You Live

Having a heart attack before your 50th birthday is bad enough. But new research shows if you also live in a poor neighborhood, your chances of dying within a decade of that heart attack are higher.

"This tells us that we need to focus not just on a patient's medical problems, but on the whole person, on where they live and the resources they have that will allow them to thrive," said the study's lead investigator, Dr. Adam Berman, a cardiology fellow at Brigham and Women's Hospital in Boston, a teaching affiliate of Harvard Medical School.

Berman and his team divided 2,097 people who had heart attacks before age 50 into three groups based on where they lived. They ranked home addresses using the area deprivation index, a measure of socioeconomic status that includes income, education, employment and housing quality. The study found the more disadvantaged a person's neighborhood, the higher the chances they would die within 11 years of a first heart attack.

The research was presented recently at the American Heart Association's virtual Scientific Sessions. It is considered preliminary until published in a peer-reviewed journal.

American Heart Association

Prior research shows people in disadvantaged neighborhoods are less able to afford medications, are exposed to greater amounts of pollution, and have less access to healthy foods and other resources that could improve their health, Berman said. These social determinants of health have been shown to increase the risk of heart disease and stroke.

"It is likely that a variety of neighborhood and personal socioeconomic factors contribute to the underlying mechanisms that drive this association between where someone lives and their chances of dying," he said. "We have to focus on all of those aspects in the care of our patients, particularly after they have a heart attack, and particularly in those who are young."

Overall, the number of people in the United States having heart attacks has been declining, but for younger adults, heart attacks appear to have been increasing over the past decade. And for Black adults in their 30s and 40s, heart attacks are more common and more deadly than among young white adults, prior research shows.

The new study found those who lived in the most disadvantaged neighborhoods were more likely to be Black or Hispanic, have public or no health insurance, and experience higher rates of heart-related risk factors.

But the study included a relatively small number of women – nearly 80% of participants were men. That's a problem, given the high rate of heart disease among Black women, said Dr. Tiffany Powell-Wiley, chief of the Social Determinants of Obesity and Cardiovascular Risk Laboratory at the National Heart, Lung, and Blood Institute. Nearly half of all adult Black women have some type of heart disease. They are more likely to die of heart disease – and at a younger age – than their white peers.

"We need to know what this looks like across genders," said Powell-Wiley, who was not involved in the study. "I think it's particularly important because we know that African American women have a higher risk of premature cardiovascular mortality, and so we would want to see that they are included in data that looks at this relationship."

Overall, though, the health challenges aren't only tied to limited resources, she said.

"There is some data showing mortality is related to the physiological stress of living in these environments. I think that's where the science really needs to go. We need to really dig into the mechanisms by which social and environmental stressors get under the skin and lead to cardiovascular events."

For example, Powell-Wiley said, "if you live in these neighborhoods, you're more likely to be someone who experiences racism and discrimination, and these are layers of things that are affecting you."

Figuring out how to alleviate those stressors is the hard part, Berman and Powell-Wiley agreed.…**Read More**