Rhode Island Alliance for Retired Americans

RI ARA

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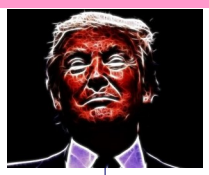
Trump Executive Order will drive up people's Medicare costs

Watch out, older Americans and people with disabilities! President Trump just announced a plan to give corporate health insurers even more control over your health care. His **new executive order** also calls for "market-based" pricing, which would drive up costs for everyone with Medicare, eviscerate traditional Medicare, and steer more people into for-profit "Medicare Advantage" plans.

Seema Verma, the Trump appointee who heads the Centers for Medicare and Medicaid Services (CMS) may not have warned Trump about the slew of government audits revealing that many Medicare Advantage plans pose **"an imminent and serious risk to the health of… enrollees."** They also overcharge taxpayers to the tune of $10 billion a year.

In the last few years alone, **CMS' limited audits** have highlighted major issues with Medicare Advantage plans. Reports from the Department of Health and Human Services **Office of the Inspector General** (OIG) and **Government Accountability Office** (GAO) have underscored these issues. They have recommended that CMS increase its oversight of Medicare Advantage plans and its enforcement efforts.

A **Medicare Payment Advisory Commission report** indicates that the problems with Medicare Advantage may be even more far-reaching than the government audits indicate. The Medicare Advantage plans have **failed to turn over reliable and complete claims data**, as required by law. Without this data, it's not possible to know whether they are covering the health care services they are paid to provide or to oversee them to the extent necessary.



Last month, Senators Brown, Klobuchar, Murphy, Blumenthal, Sanders and Stabenow laid out several serious malfeasances by these corporate Medicare insurers—including UnitedHealth Group, Aetna, Cigna and Humana—in a **detailed letter** they sent to Verma.

The insurers' wrongdoings are systematic. They are ongoing. They endanger the health and financial well-being of millions of people. They undermine the financial integrity of the Medicare program and harm the US Treasury. Yet, to date, CMS has failed to develop, let alone execute, a plan to hold these insurers accountable for violating their legal obligations and to ensure their members get the health care to which they are entitled.

Tens of billions in overcharges are one big problem. Medicare Advantage plans have been **upcharging the government** for their services for many years now, by claiming that their members are **in worse health** than they actually are in order to increase payments. To make matters worse, they have refused to pay back the tens of billions in overpayments that the federal government has made to them. UnitedHealth successfully **fought to keep the government from collecting this money.**

Another major concern is that Medicare Advantage plans are failing to cover care their members need and are entitled to. Government audits show that Medicare Advantage plans are **inappropriately delaying and denying care and coverage to hundreds of thousands (if not millions)** of their members. This puts patients' health and safety at risk. Thousands of people end up paying for care that should have been covered — or foregoing care altogether.

CMS has not named or flagged these corporate health plans on its Medicare website or notified people in any other way of plans with serious violations, as it had **agreed to do** on the recommendation of the Office of the Inspector General. So, people with Medicare are unaware when they enroll in a Medicare Advantage plan that the government has found to be jeopardizing the health and safety of its members. Instead, **CMS continues to give four- and five-star ratings** to some of these health plans. In the process, it misleads older adults and people with disabilities about their performance.

What's more, CMS has found that a sizable number of Medicare Advantage plans have for years issued highly inaccurate provider directories; and, the **GAO** has noted "concerns about ensuring enrollee access to care." Many of these health plans have narrowed their provider networks. GAO suggests that it is not at all clear which of these Medicare Advantage plans have an adequate number and mix of health care providers in their networks.

To date, the Trump Administration has been **steering people into Medicare Advantage plans,** without regard to their deficiencies. And, it has failed to provide people with Medicare with meaningful information about their health plan choices as required by law. It is on a reckless path, promoting the business interests of Medicare Advantage plans that violate the law over the health care needs of vulnerable Americans.

The Administration and its Congressional allies are playing a game of bait and switch with older adults and people with disabilities. They allow Medicare Advantage plans to lure people with benefits that traditional Medicare does not offer, such as dental care and transportation services to the doctor, without exposing their failings. The Trump Administration's goal is to fully privatize Medicare and shift more costs onto older and disabled Americans.

To be clear, Trump's executive order does nothing to hold the Medicare Advantage plans accountable for their fraudulent overcharges or their inappropriate denials of care and coverage. Rather, it rewards them. It gives them even more discretion regarding the services they cover and the freedom to create new bells and whistles to lure in members. The health and financial well-being of older and disabled Americans hangs in the balance

As Medicare Enrollment Nears, Popular Price Comparison Tool Is Missing

Millions of older adults can start signing up next week for private policies offering Medicare drug and medical coverage for 2020. But many risk wasting money and even jeopardizing their health care due to changes in Medicare's **plan finder,** its most popular website.

For more than a decade, beneficiaries used the plan finder to compare dozens of Medicare policies offered by competing insurance companies and get a list of their options. Yet after a website redesign six weeks ago, the search results are missing crucial details: How much will you pay out-of-pocket? And which plan offers the best value?

That's because the plan finder can no longer add up and sort through the prescription costs plus monthly premiums and any deductibles for all those plans. A mere human can try, but it is a cumbersome process fraught with pitfalls. One plan might have the lowest premium but not the lowest drug prices. Another could exclude a plan's preferred pharmacy that offers lower prescription prices.

"We can't guarantee you that you're going to be in the best plan or the cheapest plan anymore," said Howard Houghton, the former Fairfax County coordinator for the Virginia Insurance Counseling and Assistance Program who still helps with enrollment as a volunteer.

Using the old plan finder produced big savings. Counselors at Passages, the Senior Health Insurance Information Program (SHIP) serving five counties in Northern California, said in August they used it to save one woman $8,400 for this year and more than $5,000 when helping another client.

Medicare officials say the total cost calculator will be fixed in time for the annual enrollment season, which starts nationwide Oct. 15 and runs through Dec. 7. But they have yet to address multiple other issues raised by the **Medicare Rights Center** and **industry** groups.

"The new tool will provide more enhanced price and quality information" to assure informed health care decisions, Seema Verma, administrator at the Centers for Medicare & Medicaid Services, said when she unveiled the redesign in August.

During open enrollment, beneficiaries can sign up for Medicare Advantage plans, the alternative to traditional Medicare that offer drug coverage and often more benefits than the government program does. About a third of the 64 million people in Medicare choose this option. Next year, the average Medicare Advantage monthly premium **is expected to drop 14%** compared with 2019 to an estimated $23, according to CMS.

This is also the only time most people in traditional Medicare can sign up for a drug plan, also known as Part D, to help cover their prescription costs. It's a good idea to review plans every year since costs and covered drugs can change from year to year. Estimated average monthly premiums for these policies will be $30 next year, about 8% less than in 2019, CMS has reported..**....Read More**

Don't be seduced by Medicare Advantage bells and whistles

As you're thinking about your Medicare options this Fall, don't be seduced by new bells and whistles available from some **Medicare Advantage** plans. Congress is allowing these corporate health plans, which contract with the federal government to provide Medicare benefits, to spend money on health-related services that otherwise would be spent on medical services. The question is to what extent these health plans are stinting on the delivery of medical care in order to provide the bells and whistles.

A story in **Forbes** by Howard Gleckman indicates that some corporate Medicare plans will offer modest new benefits, including additional home care services, adult day programs, transportation services and home-modification services. These services will be attractive to some people with Medicare. They could help people with chronic conditions who have difficulty living independently in their homes. If you need these supports, the **PACE program**, which works with traditional Medicare, is another option to explore.

Traditional Medicare does not cover these non-medical services. Rather, it covers all medically reasonable and necessary medical care you need. You can see virtually any doctor or use virtually any hospital anywhere in the United States. If you have **supplemental insurance**, which fills virtually all coverage gaps, such as Medigap, retiree coverage or Medicaid, your out-of-pocket costs are minimal. With Medicare Advantage, your out-of-pocket costs can be as high as $6,700 a year for in-network services alone and unlimited for out-of-network care if you're in an HMO.

The corporate Medicare plans do not explain how they can afford to pay for the additional non-medical services they offer. They are not receiving extra money to do so. However, for the last several years, federal audits suggest that they have **overcharged the government tens of billions** a year for their services. Those overpayments may be one way they fund the non-medical services, though the government is trying to get that money back. They also may be charging higher copays for people who need care. There is no data on copay amounts these plans charge their members for different services.

Federal reports also show that these corporate health plans are **not reporting accurately or completely the Medicare-covered services they are delivering their members**, as they are required to do by law. That should give people who consider joining these plans pause. It's reasonable to believe that they are stinting on the delivery of the medically necessary services they are supposed to be covering.

Given the data, it's particularly fair to be concerned that if you join a Medicare Advantage plan, you might be denied the care or coverage your treating physicians believe you need. A **report from the Office of the Inspector General** reveals that these corporate health plans engage in widespread inappropriate delays and denials of care. Since the government has yet to advise people of which corporate plans to beware of, you take a gamble when you join one of them.

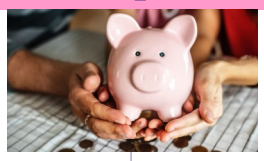
Medicare Extra Rx HELP Act Companion Bill Introduced in the House

This week, Rep. Brad Schneider (D-IL) introduced a House companion to the Medicare Extra Rx HELP Act (**S. 691**/**H.R. 4583**). Championed in the Senate by Bob Casey (D-PA), this bill would make improvements to the Medicare Part D Low-Income Subsidy (LIS), commonly known as Extra Help, to better reflect current needs.

Created almost 15 years ago, Extra Help is a federal program that helps people with Medicare who have low incomes and limited assets afford their Medicare prescription drug coverage (Part D). In 2018, more than **12 million** older adults and people with disabilities were enrolled in the program, saving an **average** of $4,900 a year.

Currently, far too many people who need this critical assistance are unable to access it. They may be unable to overcome the complex, bureaucratic application processes or meet the program's outdated eligibility thresholds. Those left behind may be forced to choose between prescription drugs and other basic needs.

Based on our work with people with Medicare and their families, we know that prescription drug affordability is an ongoing challenge. Many people with Medicare live on fixed or limited incomes and cannot keep paying ever-rising health and prescription drug costs.



Currently, half of all Medicare beneficiaries—nearly 30 million older adults and people with disabilities—live on $26,200 or less per year, while one quarter have incomes below $15,250 and less than $14,550 in savings. At the same time, health care costs are taking up a larger and more disproportionate share of beneficiaries' limited budgets. **In 2016**, nearly 30% of Medicare households spent 20% or more of their income on health care, while only 6% of non-Medicare households did so. Out-of-pocket costs for prescription drugs represent a significant share of this spending, accounting for nearly **one out of every five** beneficiary health care dollars.

The consequences of rising unaffordability are **significant,** both for the Medicare program and those who rely on it. Beneficiaries who cannot afford their medications or pay for coverage may be forced to go without care—leading to worse health outcomes and quality of life, hospitalizations, or even death. And the cost to the Medicare program is also extreme, as beneficiaries who forgo needed care and experience declining health as a result may need more costly interventions later, like emergency department or inpatient care.

The Medicare Extra Rx HELP Act would help alleviate these challenges by easing access to Extra Help and ensuring more older adults and people with disabilities can obtain needed care. The bill would:

Eliminate the asset test and streamline program administration.

Only Part D enrollees who meet an exceptionally low asset threshold ($7,730 for an individual for full benefits) are currently eligible for assistance with their Part D premiums and cost sharing. The verification of asset information is burdensome to administer and presents a significant barrier to program enrollment. The Medicare Extra Rx HELP Act would do away with the asset test under Extra Help.

Provide full Extra Help benefits to those living on the edge of poverty.

Only the lowest income people with Medicare receive full benefits through Extra Help, including $0 premiums and deductibles as well as fixed copayments. Individuals with incomes between 135% and 150% of poverty (about $16,860 to $18,735 in 2019) who also meet the program's asset test are nevertheless exposed to Part D premiums, deductibles and high coinsurance rates. The Medicare Extra Rx HELP Act would extend full Extra Help benefits to Medicare-eligible seniors and people with disabilities living below $24,980 per year (200% FPL for an individual).

Medicare Rights strongly supports this legislation. We recently urged lawmakers in the **House** and **Senate** to include the Medicare Extra Rx HELP Act in any forthcoming drug pricing legislation. We will continue to support the adoption of these reforms and urge all Members of Congress to do the same.

Learn more about Extra Help on Medicare Interactive.

The FAMILY Act would ensure paid leave to workers caring for older family members

Across the country, millions of working people must give up their jobs or take unpaid leave to be caregivers for older relatives, putting their financial well-being at risk. Advocates are now engaged in a campaign to urge Congress to create a comprehensive, national paid leave program through the Family And Medical Insurance Leave (FAMILY) Act. The Act would ensure that workers are not financially penalized for leaving work to care for themselves or family members with serious health conditions.

Around **40.4 million Americans** serve as unpaid caregivers for older adults. More than six in ten of them are working people and nearly half of them work full-time. But, not even one in five working people (just 19 percent of workers) has paid family leave through their employers. As a result, when people need to stop working or to reduce their workload to care for an aging relative, they often face a significant loss of income.

The FAMILY Act would enable working people to take up to a total of 12 weeks each year (60 working days) to care for themselves or a family member with a serious health condition. And, they would still receive a portion of their wages. Workers could take the paid time away from work however they please, all at once or intermittently.

Workers could earn as much as two-thirds of their monthly wages up to a capped amount. And, the FAMILY Act would cover all workers, no matter the size of their employer. The Act covers full-time, part-time and self-employed workers.

The FAMILY Act would not require government funding. The Act would create an affordable and self-sustaining national family and medical leave insurance fund to cover all workers. Workers and their employers would pay .02 cents on every $10.00 earned, less than $2.00 a week (less than $100 a year) for most workers. All workers would be required to participate in the program.

Representative Rosa DeLAuro (D-CT) introduced the FAMILY Act, **H.R. 1185** in the House and Senator Kirsten Gillibrand (D-NY) introduced the FAMILY Act, **S. 463** in the Senate.

We need a groundswell of support for this Act. If you support the FAMILY Act, **please sign this petition**.

Office of Inspector General finds that Part D plans inappropriately deny drug coverage

.A new **report** from the HHS Office of the Inspector General (OIG) finds that Medicare Part D drug plans are inappropriately denying drug coverage to their members. Consequently, thousands of people with Medicare are forced to pay for drugs that should be covered or to forego filling their prescriptions.

The OIG report explains that, much like **Medicare Advantage plans**, Part D plans are coming between patients and their doctors, second-guessing whether their members need the drugs their doctors have prescribed. It also shows that Part D insurers are putting their profits ahead of the health care needs of their members. The question is whether the federal government has a way to hold these private insurers accountable for their misdeeds and ensure that they cover the prescription drugs their members need.

According to the OIG, in 2017, Medicare Part D insurers denied millions of claims for prescription drugs presented at people's pharmacies. However, on appeal, they overturned many of the claims they had previously denied. The reversals indicate that the original denials were inappropriate.

In some cases, the drugs people had been prescribed were not on the Part D insurer's approved drug list or they required a preapproval. Whatever the case, older adults and people with disabilities were forced to pay out of pocket for their drugs, to forego filling their prescriptions, or to take further steps to get their drugs approved. And, in many cases, they could not navigate the process to get their drugs approved.

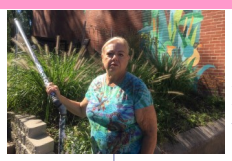
The small fraction of people who appealed their coverage denials, won a partial or total reversal nearly three out of four times (73 percent). But, the overwhelming majority of people whose claims were denied did not appeal. The goal should be for the Medicare Part D plans to have systems in place that eliminate the wrongful denials in the first place.

In short, Medicare Part D plans sometimes engage in inappropriate denials or delays of medications for people with Medicare. The OIG recommends that CMS take action: 1) so that communication improves between Part D plans and prescribers to minimize avoidable rejections at the pharmacy and denials of coverage; and, 2) to reduce inappropriate pharmacy rejections and inappropriate coverage denials. It further recommends that CMS notify people with Medicare about inappropriate denials and other performance problems by Part D plans.

CMS agreed with all four recommendations. But, CMS has been **misleading people with Medicare about Medicare Advantage** over the last few years. Time will tell if CMS acts on these recommendations.

If you believe Congress should rein in drug prices, **please sign this petition**..

The Deep Divide: State Borders Create Medicaid Haves And Have-Nots



Patricia Powers went a few years without health insurance and couldn't afford regular doctor visits. So she had no idea cancerous tumors were silently growing in both of her breasts.

If Powers lived just across the Mississippi River in Illinois, she would have qualified for Medicaid, the federal-state health insurance program for low-income residents that 36 states and the District of Columbia decided to expand under the Affordable Care Act. But Missouri politicians chose not to expand it — a decision some groups are trying to reverse by getting signatures to put the option on the 2020 ballot.

Powers' predicament reflects an odd twist in the way the health care law has played out: State borders have become arbitrary dividing lines between Medicaid's haves and have-nots, with Americans in similar financial straits facing vastly different health care fortunes. This affects everything from whether diseases are caught early to whether people can stay well enough to work.

It wasn't supposed to be this way. The ACA, passed in 2010, called for extending Medicaid to all Americans earning up to 138% of the federal poverty level, around $17,000 annually for an individual. But the U.S. Supreme Court in 2012 let states choose whether to expand Medicaid. Illinois did, bringing an additional 650,000-plus people onto its rolls. Missouri did not, and today about 200,000 of its residents are like Powers, stuck in this geographic gap.

Powers briefly thought about moving to another state, just to be able to get Medicaid. "You ask yourself: Where do you go? What do you do?" said Powers, who was in her early 60s when diagnosed. "Do I look at what's happening in Illinois, right across the river?"

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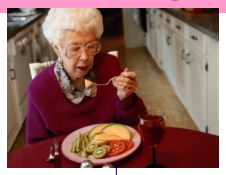
A recent University of Michigan study found Medicaid expansion substantially reduced mortality rates from 2014 to 2017. The researchers said Illinois averted 345 deaths annually while Missouri had 194 additional deaths each year.

….**Read More**

Many U.S. Seniors Are Going Hungry, Study Finds



Madden said the problem of what researchers call "food insecurity" isn't a new one. It's officially defined as an inability to get enough food due to financial reasons.

She said things are being done within the health care system to try to address this, such as screening patients for the problem and giving patients access to social workers that can help them find services available to them, such as the Supplemental Nutrition Assistance Program (SNAP) from the U.S. federal government.

"But it's a systemic problem and people really struggle. Addressing it solely in the health care system is just staunching the bleeding," Madden added.

For the study, she and her team looked at data from nearly 10,000 people who took part in a 2016 Medicare survey. Just over 8,000 were over 65 and on Medicare, and almost 1,600 were under 65 and on Medicare.

Thirty-eight percent of those under 65 reported they were going hungry. Slightly more than 9% of those over 65 were in the same boat. Risk factors that increased the odds of going hungry included having an income of less than $15,000 a year, four or more chronic illnesses, depression and anxiety.

Dawn Apgar is director of the Department of Sociology, Anthropology and Social Work at Seton Hall University in South Orange, N.J. "This study highlights an important social problem -- food insecurity among older adults," she said.

"The issue of hunger is often not discussed in the United States, so this study is important to reminding us that there are disparities which still exist between who has access to adequate and nutritious food and who does not," said Apgar, who wasn't involved with the research.

She said there's often still a stigma attached to the problem, especially for older adults. That may keep people from accessing government programs when they need them. Plus, with America's obesity problem, people often don't realize that not having enough food or not having access to nutritious food is a big problem, too, Apgar noted.

Both Madden and Apgar also said it's possible that food insecurity might set up a vicious circle. If someone isn't getting enough food, that might lead to worsening health, which in turn might then lead to even more trouble getting enough food.

For people checking in on older parents or grandparents, Apgar said that not having enough food to eat is often a problem that emerges slowly. Decreased mobility, lower income and chronic illnesses are factors that may play a part.

"Weight loss or other physiological changes may be indicators of poor nutrition," she said. "Often, older adults may not even realize that they are food-insecure. Children and grandchildren should never assume that food insecurity is not a problem for the older adults in their lives, as it is often hidden and hard to detect."

Apgar pointed out that even if finances aren't a concern, older people or those with chronic illnesses may have trouble making meals or getting nutritious foods.

She said Meals on Wheels, which delivers food to needy or homebound people, can be very helpful for addressing the nutritional needs of older adults. Apgar said it has the added benefit of helping lessen social isolation.

The researchers suggested automatic enrollment or an easier recertification process for low-income people receiving food assistance might help lessen the problem in these vulnerable groups.

The findings were published Sept. 30 in the journal *JAMA Internal Medicine*.

More information

Get information on getting help if you can't afford food from **Feeding America**.

Almost 1 in 10 U.S. seniors doesn't have enough food to eat, a new study shows.

And for those under 65 who qualify for Medicare because they're disabled, 4 of 10 may be going hungry, the researchers added.

"People are always talking about Medicare and how to tweak it and improve access to care, but these kinds of social problems [hunger] can be just as much of an issue," said study author Jeanne Madden, from Northeastern University in Boston.

Medicare Fraudsters Now Tap Telemedicine In Medical Equipment Scams

Dean Ernest had been living in a nursing home about a year when his son, John, got a call last winter asking if his father was experiencing back pain and would like a free orthotic brace.

The caller said he was with Medicare. John Ernest didn't believe him, said "no" to the brace and hung up. He didn't give out his father's Medicare number.

And yet, not just one, but 13 braces arrived soon afterward at Ernest's house in central Pennsylvania.

Medicare, the federal taxpayer-supported health care insurance program for older Americans, had paid over $4,000 for 10 of the braces: a back brace, two knee braces, two arm braces, two suspension sleeves, an ankle brace, a wrist brace and a heel stabilizer.

The orders came from four medical equipment companies and were prescribed by four separate health care professionals — a prescription being required to receive an orthotic brace. But Ernest said he didn't talk to any doctors during the phone call.

That's how the latest Medicare frauds work, said Ariel Rabinovic, who works with Pennsylvania's Center for Advocacy for the Rights & Interests of the Elderly. He helped report Ernest's fraud case to authorities at Medicare. Rabinovic said the fraudsters enlist health professionals — doctors, physician assistants, nurse practitioners — to contact people they've never met by telephone or video chat under the guise of a telemedicine consultation.

"Sometimes the teledoctors will come on the line and ask real Mickey Mouse questions, stuff like, "Do you have any pain?" explained Rabinovic. "But oftentimes, there is no contact between the doctor and the patient before they get the braces. And in almost all of the cases, the person prescribing the braces is somebody the Medicare beneficiaries don't know."

While prescriptions for durable medical equipment, such as orthotic braces or wheelchairs, have long been a staple of Medicare fraud schemes, the manipulation of telemedicine is relatively new. The practice appears to be increasing as the **telemedicine industry grows**. **...Read More**

The Visitors' Guide to Nursing Homes

IF YOU WANT TO BRIGHTEN a loved one's day, visit him or her in a **nursing home**. "It's one of the most wonderful things you can really do, to continue to be there," says Anne Weisbrod, director of social services at the Hebrew Home at Riverdale in New York. "It may not be the home you grew up in or the home you remember, but this is their home now."

Tips for a Good Nursing Home Visit

To help you get the most enjoyment from your time together, long-term care experts and a family caregiver offer guidelines for successful **nursing home** visits. Here are some of their top take-home messages:

- **Shared activities help break the ice.** Working on a puzzle or adding photos to an album together can stimulate conversation.
- **A change of scenery brightens the mood.** Going outdoors or simply leaving a resident's room to spend time in a comfortable facility lounge area can help lift their spirits.
- **Kids can make visits more fun.** Grandchildren or other young visitors add their own cheerful energy.
- **Gifts are nice but not necessary.** Bringing a thoughtful gift is a nice gesture – just keep space limitations in mind.
- **Pets may be welcome but check with staff first.** Animals can bring extra happiness to visits – ask the facility about their rules.
- **Other residents might like to chat.** Say hello and be friendly to roommates and dining room table-mates who are eager to talk with you.
- **Memory challenges may call for another approach.** When visiting someone with cognitive issues or **dementia**, you can guide the discussion.
- **Sometimes just sitting is enough.** Sitting beside a loved one and holding his or her hand shows that you care without words.

Every Resident Is Unique

What's considered a successful visit may not have the same meaning from one resident to the next. Mary Ann, 89, a resident of Concordia at Villa St. Joseph in western Pennsylvania, is always happy to chat with visitors – whether they came to see her or someone else. "I'm a talker," she admits, and says it's nice to have a listening ear.

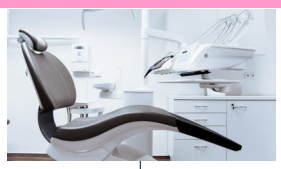
Mary Ann, who asked that only her first name be used, has family members who must drive in from a distance. When they can get together, she enjoys family meals, perhaps with a beer, at local restaurants.

There's no need for visitors to bring a gift, Mary Ann says, pointing out that there isn't much space for clutter. If you happen to bring something, give perfume a pass – she doesn't care for the smell. Although others might be thrilled to receive jewelry, she's not a big fan: "I don't want to bother with it."...**Read More**

Ways to Expand Access to Dental Coverage for People with Medicare

Currently, Medicare does not cover most dental services. The Kaiser Family Foundation (KFF), a non-partisan, non-profit focused on national health issues, recently released an issue brief discussing various options to increase access to dental coverage for people with Medicare. According to the brief, nearly two out of every three Medicare beneficiaries have no dental coverage, leading many to go without necessary care.

While some people with Medicare have dental benefits through other sources, access and coverage tends to be limited. Some may be eligible for Medicaid or may have coverage through a private plan. A minority of beneficiaries get access to coverage through Medicare Advantage (MA). For example, in 2016, about 10.2 million people with Medicare had access to some MA dental coverage, though these MA benefits are often quite narrow in scope and may not cover needed services like fillings, crowns, implants and dentures. To access that care, beneficiaries would be forced to pay out of pocket.



The KFF issue brief highlights five policy options that could extend Medicare coverage of oral health care by:

1. adding a dental benefit to Medicare Part B,
2. creating a voluntary dental benefit under a new part of Medicare,
3. permitting greater access to medically necessary dental services under Medicare,
4. testing models for dental coverage, and
5. offering dental discount cards.

The brief also discusses the policy considerations and implications for each approach.

Medicare Rights considers **oral health a priority** and continues to advocate for increased coverage of this important care. Our advocacy primarily focuses on two of the options the KFF brief highlights: permitting greater access to medically necessary dental services and ultimately adding a dental benefit to Medicare Part B.

Currently, Medicare covers only a handful of medically necessary dental services, **despite the Medicare statute permitting more extensive coverage.** "Medically necessary dental care" means care that a person may need for oral health issues that might complicate or stand in the way of receiving other care. For example, someone with an untreated oral infection may not be able to have a life-saving organ transplant or heart surgery. Lack of medically necessary dental care harms patients and can also increase Medicare's costs for treating their illnesses. Medicare has the option to cover more oral health care in these situations, but has not chosen to do so. We urge the Centers for Medicare & Medicaid Services, the agency that oversees the Medicare program, to increase this coverage.

Ultimately, our focus is a comprehensive dental benefit within Medicare Part B. Such a benefit would do more to ensure that all Medicare beneficiaries have access to oral health care when they need it, including preventive care, appropriate treatment, and denture coverage. The distinction between oral health and other bodily systems should be eliminated to improve the overall health of older adults and people with disabilities.

Read the KFF issue brief.
Read more about medically necessary dental care.
Read more about the need for a comprehensive dental health benefit.

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

Stroke Rate Continues to Fall Among Older Americans

Starting in the late 1980s, stroke rates among older Americans began to fall -- and the decline shows no signs of stopping, a new study finds.

The researchers found that between 1987 and 2017, the rate of stroke incidence among Americans aged 65 and older dropped by one-third per decade. The pattern has been steady, with no leveling off in recent years.

It's not completely clear why, according to researcher Dr. Josef Coresh, a professor at Johns Hopkins School of Public Health, in Baltimore.

Over time, fewer older adults in the study were smokers, which is a major risk factor for stroke. On the other hand, some other risk factors -- such as high blood pressure and type 2 diabetes -- became more common.

Of course, those conditions can be treated. And it's known that for any one person, getting high blood pressure, high cholesterol and diabetes under control can cut the risk of stroke, Coresh said.

"However," he added, "at the population level, we found that the decline [in strokes] was larger than what would be predicted from risk factor control alone."

That suggests something else is going on, Coresh said.

The findings are based on data from a long-running heart health study that began in 1987. At the outset, it recruited almost 15,800 adults aged 45 to 64 from communities in four U.S. states.

A previous study found that the stroke rate among the participants fell between 1987 and 2011 -- a decline seen only among people aged 65 and older.

The new analysis, published online Sept. 30 in *JAMA Neurology*, shows that the trend continued between 2011 and 2017.

Over 30 years, Coresh's team found, there were 1,028 strokes among participants aged 65 and older. The incidence dropped by 32% over time.

In more recent years, many more older adults were on medication for high blood pressure or high cholesterol, versus the late 1980s. But risk factor control did not fully explain why the stroke rate dropped so much, according to Coresh.

He said that other factors not measured in the study -- including exercise, salt intake and overall diet -- might be involved.

Dr. Larry Goldstein, a spokesperson for the American Heart Association/American Stroke Association, made another point: The study could not account for exactly how well -controlled people's blood pressure and other risk factors were.

That could go a long way toward explaining the decline in stroke incidence, according to Goldstein, who is also a professor of neurology at the University of Kentucky.

But while the latest findings are good news, there are also more sobering stroke statistics, Goldstein said. Although strokes are most common among people aged 65 and older, they strike younger adults, too, and the incidence of stroke among younger people has been inching up in recent years.

Plus, Goldstein said, the death rate from stroke -- which had been declining -- has recently "stalled" and is starting to reverse course.

"It might be because folks are now having more severe strokes," Goldstein noted.

It's critical, he added, that people be aware of the signs of stroke and get help quickly if they think they, or a family member, is having one.

Some of the warning signs include a drooping or numbness on one side of the face; arm weakness or numbness; slurred speech; sudden confusion or difficulty seeing or walking; or, as Goldstein described it, "the worst headache of your life."

His advice: "Don't delay getting help. Time saved is brain

What to do if someone you love struggles to use a computer

Modern technology can be a godsend for handling affairs speedily. But, there often comes a time when older adults struggle to use their smart phones, computers and tablets, and caregivers need to step in. What should you do if someone you love starts having difficulty using a computer?

Judy Graham reports for Kaiser Health News that **millions of older adults** (nearly three in four) depend on computers to pay their bills, access their bank statements, and connect with their families and friends. Blocking their use of a computer may disconnect them from things they care deeply about. More than four in ten (42 percent) of them own smartphones.

We all know how easy it is to forget a password and not be able to access online accounts. It can be particularly difficult for older adults. Problems could be related to people's vision, coordination or cognition. When struggling to use a computer stems from loss of mental function or **dementia**, it's likely time for caregivers to act.

Learn what's confusing: Ask about what's confusing on the computer and smart phone. And, if possible, sit down at the computer with the people you love to see what they can and cannot do.

Share passwords: It's wise to create shared passwords so that you too have access to the programs your loved ones use. If you want to check their accounts online, make sure you have power of attorney or, at the very least, their written agreement to do so. Otherwise, it's a federal crime!

Reduce confusion: One easy fix is to delete any apps that are confusing older adults. In fact, the fewer the apps, likely the better. Why should they struggle?

Minimize scamming: Make sure that the older adults whom you care for know not to give anyone their Social Security, Medicare or credit card information. Scams abound. **Scammers** are pros at pretending to be a relative or a government agency staffer in order to obtain this information.

Manage purchases: Get permission to unsubscribe your loved ones from marketing emails. If appropriate, ask to install a parental control app that can block use of online devices at certain times.

Replace a credit card with a stored value care: A stored value card limits the amount of money that can be spent. Or, reduce the credit amount on the credit card.

Notify credit bureaus not to open new accounts in the name of your loved ones.

CDC says it's flu vaccine time — here's what you need to know

Get your tissues ready — **flu season** is coming.

The influenza (flu) virus typically makes its rounds starting in the late fall through early spring, which is why the Centers for Disease Control and Prevention (CDC) is beginning to get the word out that it's time to start thinking about getting vaccinated.

Everyone six months of age and older, who does not have contraindications, needs to get a flu vaccine, according to **the CDC**'s 2019-2020 flu season recommendations.

While no vaccine can offer 100 percent immunity, when the viruses in the flu vaccine match the strains circulating in the population, "the flu vaccine has been shown to reduce the risk of having to go to the doctor with flu by **40 percent to 60 percent,"** according to the CDC.

Here's what you need to know about flu vaccination:

When to get the flu vaccine

The CDC recommends getting the vaccine by late October. However, infants and children ages 6 months through 8 years, who require two doses of the flu vaccine, should get their first shot as soon as possible so they can receive the second dose (which needs to be administered around four weeks later) by the end of October.

Sophia Tolliver, MD, family medicine physician at The Ohio State University Wexner Medical Center, tells Yahoo Lifestyle: "Per the CDC, flu activity can start as early as October/November and continue as late as May; peak flu activity is between December and February. The earlier the vaccination, the earlier the coverage and benefit against contracting the flu virus."

That said, "You don't want to get the flu shot too early, such as July or August," Tolliver adds, "as protection could wane closer to the end of the flu season."

But even if you do get the flu vaccine after October, it can still be beneficial. The CDC recommends getting vaccinated "as long as influenza viruses are circulating, even into January or later."

How the flu vaccine works

It takes about two weeks after being vaccinated for the body's immune response to kick in and offer protection from the flu virus. About two weeks after you've been vaccinated, **antibodies** — a protective protein made by your immune system — start to develop in your body. These antibodies are able to recognize the virus (known as an antigen) from the vaccine and can latch onto it and neutralize it.

Yes, you do need to get one every year.

Protection from the flu vaccine lasts about six months, according to the **Immunization Action Coalition**. That's because the antibodies decline over time, making the vaccine less effective, and the specific flu virus that's circulating in the population can change year-to-year. So you need an annual vaccination "to promote the body's best immune response" against the flu, says Tolliver.

No, the vaccine doesn't give you the flu.

For some reason, this myth continues to persist. That may be because some people experience mild reactions to the vaccine. While the most common ones are "soreness, redness, tenderness or swelling where the shot was given," according to the **CDC**, some may experience a "low-grade fever, headache and muscle aches" soon after the shot, which can last for one or two days.

"What vaccinations essentially do is trigger the body into protecting itself in case the real thing — a virus/bug — comes around, so you may expect some level of a natural body response after receiving the flu shot," explains Tolliver. "However, it is more likely that you were already brewing an infection even before the vaccination was given."

She adds: "Also, the vaccination takes about two weeks to reach its full potential so in the interim if you are exposed to the flu virus, one might mistakenly blame a recent vaccination."

It's also worth noting that when you get a flu vaccine, you are either receiving flu viruses that are inactive (dead) and not infectious or else a single gene from a flu virus (rather than the full virus) to trigger an immune response, according to the CDC.

Why you don't want to get the flu

The flu isn't just a bad cold. It's a serious disease — **especially** for infants, young children, adults ages 65 and older, and people with certain chronic health conditions, including asthma, heart disease, or diabetes — that can lead to hospitalization and even death, according to the CDC. Between October 2018 and May 2019, the CDC **estimates** that 36,000 to 61,000 people died from the flu.

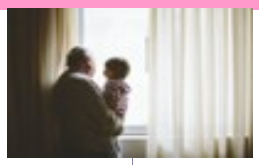
"Vaccinations have been proven to save lives and additionally, decrease the severity and length of a potential infection," says Tolliver.

5 Signs It's Time for Memory Care

Changes in behavior, confusion and declining physical health could signal someone needs memory care.

YOUR AGING MOM WHO'S living with dementia has always been conscientious about opening her mail and paying her bills. You and other family members check on her regularly to see she's OK. Yet over time, relatives notice she's letting her mail accumulate unopened and forgetting to pay her bills.

These are potential signs that someone who's **living with dementia** may need memory care, says Dr. Elaine Healy, a geriatrician and vice president of medical affairs and medical director of United Hebrew of New Rochelle in New York.



About 5.8 million people in the U.S. have **Alzheimer's**, the most common form of dementia, according to the Alzheimer's Association. Family members care for some people with dementia, and others live in nursing homes or **assisted living facilities.**

Memory Care Units

People with dementia who exhibit certain kinds of behavior that affect their day-to-day living are better off in the **memory care unit** of such facilities, Healy says. These are units where staff members are trained in working with people with dementia who require specialized care.

Here are five behaviors or circumstances that can indicate someone needs memory care:

- Changes in behavior.
- Confusion and disorientation that **imperils physical safety**.
- A decline in physical health.
- A **caregiver's deterioration.**
- Incontinence.

……**Read More**

What You Must Know About Vaccines for Seniors

As we age, the **immune system** slows down, chronic conditions become more common, and the body may be less able to fight off infection and more vulnerable to its complications.

That's where vaccines come in. These immunity boosters help prevent serious diseases at any age.

"Vaccines are not only for kids or teens," says David Kim, M.D., director of the National Vaccine Program of the U.S. Department of Health and Human Services. "If you're older, you're at a higher risk for certain vaccine-preventable diseases."

Here are the shots you may need, when to get them, and why they're critical for keeping you and your loved ones healthy.

Flu Shot

Who needs it, and when: All adults need a flu shot every year, ideally sometime in October, before flu season. But if you don't get it then, just do it as soon as you can. The protection offered by the shot takes two weeks to fully kick in.

Why: Most people recover from the flu. But **older adults are at the greatest risk for severe complications,** such as pneumonia. The flu shot isn't perfect—last season's vaccine was just 29 percent effective overall, and only 12 percent effective for people 65 and older—but research shows that if you do get the flu, being vaccinated reduces your risk of serious illness.

Remember: Two versions of the vaccine are available specifically to people 65 and older: Fluzone High-Dose and Fluad. They're designed to produce a more robust immune response in older adults. Still, the Centers for Disease Control and Preven-tion says the most important thing for older adults is that they get the flu shot by the end of October, before flu season begins. So don't delay getting vaccinated with the shot that is available if Fluzone High-Dose or Fluad isn't in stock at your pharmacy.

Pneumonia Vaccine

Who needs it, and when: All adults should get the vaccine known as PPSV23 (Pneumovax 23) once they turn 65. Talk to your doctor about whether you should also get PVC13 (Prevnar 13) for added protection (more on this below).

Why: These vaccines protect against pneumococcal bacteria, which can cause **pneumonia and other illnesses**, such as meningitis. In older adults, these illnesses can lead to serious disease and even death. (Pneumonia, for example, kills 1 in 20 older adults who get it.) Pneumovax 23 is 50 to 85 percent effective at preventing serious disease from these bacteria, according to the CDC.

Remember: Prevnar 13, one of the pneumococcal vaccines, used to be recommended for all older adults in addition to Pneumovax 23. But recently, the CDC's expert vaccine panel voted to take it off the list of shots that all older adults should routinely get. Data shows that routinely giving children Prevnar 13 indirectly protects seniors too, so vaccinating older adults isn't always necessary. Talk to your doctor to see whether you might benefit from Prevnar 13.

Shingles Vaccine

Who needs it, and when: Everyone 50 and older should get the **shingles vaccine Shingrix,** which is given in two doses separated by two to six months. (If you've had Zostavax, the older shingles vaccine, you should still get Shingrix.)

Why: Shingrix is 97 percent effective at preventing shingles in people ages 50 to 69 and 91 percent effective in people 70 and older. It's also highly effective at preventing postherpetic neuralgia (PHN), a complication of shingles that can cause excruciating pain that can last for months or years.

Remember: The U.S. continues to **experience a shortage** of Shingrix because demand for the shot is so high. You may need to hunt around to find a dose. Try the CDC's vaccine finder tool. And be sure to call the doctor or pharmacist before you visit to make sure the shot is really in stock. If it isn't, check to see whether you can be put on a wait list for when more doses are available. (In the interim, it's an option to receive Zostavax—although it may also be unavailable, and Shingrix is preferred.)

Tdap Vaccine

Who needs it, and when: Older adults need a single dose of Tdap **for protection against pertussis** (whooping cough) if they've never had one before. A dose of Tdap has been recommended for all adults since 2005, but only about 20 percent of older adults have ever received it, according to the CDC. So check with your doctor to make sure you get this booster.

Why: Children receive vaccinations against whooping cough. But research has shown that immunity to pertussis, which can cause fits of violent coughing, wanes as you age. A dose of Tdap can increase your immunity. It's about 70 percent effective against pertussis for the first year, then about 30 to 40 percent effective after four years.

Remember: Although pertussis can cause serious illness in adults, the infection is most worrisome for babies. That means it's important to get your dose of Tdap at least two **weeks before coming into any contact with newborn babies**. Getting yourself vaccinated can help keep you from spreading pertussis to an infant.

Measles Booster

Who needs it, and when: Anyone born in or after 1957 who doesn't have documented evidence of immunity to measles should **get a dose of MMR**, the vaccine that protects against measles, mumps, and rubella. Evidence of immunity can take the form of vaccination records or the results of blood tests for measles immunity.

Why: The CDC considers anyone born before 1957 to be immune to measles. Most adults who aren't immune need only one dose of MMR to be protected—but certain groups at high risk for the disease are the exception. If you're a healthcare worker or are planning any international travel, talk with your doctor about whether you might benefit from an extra dose of MMR.

Remember: A small number of people who were vaccinated for measles between 1963 and 1967 received a type of vaccine that is no longer used. Anyone vaccinated in those years should get revaccinated with today's shot. If you don't have a vaccination record and aren't sure when you had your shots, it's usually easier to get an extra dose.

Aging and cancer: A surprising two way relationship

.A new study has shown that the relationship between aging and cancer may be more intimate and complex than previously thought. In fact, some aspects of cellular aging may hinder the development of cancer.

With a vast analysis of genetic data, a group of scientists has shown that the genetic signature of aging tissue is very different from that of cancerous tissue.

This is important because the activity levels of certain genes can influence how the cells within tissues behave, and ultimately, whether diseases such as **cancer** develop.

As we age, more and more of our cells become dormant, meaning that they no longer grow, divide, and renew.

This is a process called cellular senescence, and the proportion of senescent cells in our bodies increases with age.

In the irreversible state of cell senescence, cell division ceases. Conversely, cancer is a disease defined by uncontrolled cell division that leads to the formation of tumors.

Previously, experts assumed that aging tissues are more likely to become cancerous because of an accumulation of multiple mutations in cancer causing-genes.

However, the recent study shows that, despite this accumulation, senescent cells are also likely to hinder cancer development; this is because the processes that cause cells to grow, divide, and renew are switched off during senescence.

The team behind this research has published their findings in the journal *Aging Cell*.

What did the study find?

The research group — led by Prof. João Pedro de Magalhães, from the University of Liverpool, in the United Kingdom — analyzed and compared the genetic signatures of genes involved in aging. In all, they looked at the genes involved in cancer progression in nine human tissues.

Specifically, they investigated how active these genes were in each tissue to identify any patterns of activity that may link aging to the development of cancer.

Interestingly, the researchers found that the levels of active genes contributing to cell senescence were vastly different from those of active genes involved in cancer progression.

In most tissues, aging and cancer gene activity patterns changed in opposite directions. In other words, while some aging genes were more active, some cancer genes were less active. This was true in all the tissues except the thyroid and uterine tissues, where both aging genes and cancer genes changed in the same direction.

In addition, gene signatures of cellular senescence changed in the same direction as the aging genes — in the opposite direction of the cancer genes…..**Read More**

Opioid epidemic: Study to look at how genetics might affect addiction

An Ohio doctor faces an impossible choice every time she must decide whether **to give an emergency room patient a painkiller**.

"I'm faced with this battle. How do I decide how much pain medication to give someone?" asked Dr. Caroline Freiermuth of University of Cincinnati Medical Center.

Freiermuth wants to treat their pain. She doesn't want them to suffer or purchase illicit opioids or heroin on the street. But at the same time, she doesn't want to contribute to their future opioid addiction.

She's largely left on her own to make that decision. There are few tools or guidelines she can use to guide her path.

But what if there was a genetic test that could determine whether certain people were more likely to develop opioid use disorder?

That's the goal of a year-plus study that the University of Cincinnati and Ohio State University are launching in January 2020 – the most comprehensive look to date into how our genetic makeup might affect our future addiction.

Prescriptions: Doctor gets 40 years in opioid prescription case. He gave drugs to every patient, feds say

Sackler family donations: Prestigious universities around the world accepted more than $60M from OxyContin family

The $1.6 million study will recruit up to 1,500 emergency department patients – some diagnosed with opioid use disorder and others with little experience with opioids – swab their cheeks and send the genetic information to Michigan-based Genemarkers for testing.

Patients' DNA won't be linked to their names and won't be used by local police – a potential concern if patients are being treated for overdoses.

Ohio Attorney General Dave Yost's office is overseeing the project, hoping to use science to inform opioid addiction prevention. That could ease the burden on police and addiction counselors who have become the front lines of Ohio's opioid crisis.

Fatal overdoses declined in 2018 for the first year since the opioid epidemic started, according to early data from the **U.S. Centers for Disease Control and Prevention.** But nearly 68,000 people in the United States still died of drug overdoses that year.

Yost said he wants to know why he was able to take painkillers after a back surgery without becoming addicted to the drugs, but his friend, a U.S. Marine, had his life upended by opioids.

Opioid production: DEA allowed companies to increase production of opioids as overdose deaths spiked, agency watchdog says

Ohio's opioid epidemic: 10 dead in 26 hours: Ohio coroner again raises alarm about drug overdose surge

"This is not a guy that lacks willpower," Yost said. "Why am I standing here today drug-free and he is struggling to maintain, years later, his sobriety?"

Research into the links between addiction and genetics isn't new, but Dr. Jon Sprague, who leads the Attorney General's Future of Forensic Sciences at Bowling Green State University, said Ohio's study will be the most comprehensive. A similar effort in Michigan included about 200 patients.

If researchers could predict who might be predisposed to opioid addiction, that could be an invaluable tool for doctors, Freiermuth said.

Someone facing a back surgery with a genetic predisposition toward opioid use disorder might get more counseling or more regular follow-up visits. Someone in the emergency room might receive a different dose.

"I hope the day comes when you don't have to make that decision anymore without guidance," Yost said.