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RI ARA

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Social Security Announces 1.3 Percent Benefit Increase for 2021

Social Security and Supplemental Security Income (SSI) benefits for approximately 70 million Americans will increase 1.3 percent in 2021, the Social Security Administration announced today.

The 1.3 percent cost-of-living adjustment (COLA) will begin with benefits payable to more than 64 million Social Security beneficiaries in January 2021. Increased payments to more than 8 million SSI beneficiaries will begin on December 31, 2020. (Note: some people receive both Social Security and SSI benefits).

The Social Security Act ties the annual COLA to the increase in the Consumer Price Index as determined by the Department of Labor's Bureau of Labor Statistics.

Some other adjustments that take effect in January of each year are based on the increase in average wages. Based on that increase, the maximum amount of earnings subject to the Social Security tax (taxable maximum) will increase to $142,800 from $137,700.

Social Security and SSI beneficiaries are normally notified by mail starting in early December about their new benefit amount. Most people who receive Social Security payments will be able to view their COLA notice online through their personal my Social Security account. People may create or access their my Social Security account online at **www.socialsecurity.gov/myaccount**.

Information about Medicare changes for 2021, when announced, will be available at **www.medicare.gov**. For Social Security beneficiaries receiving Medicare, Social Security will not be able to compute their new benefit amount until after the Medicare premium amounts for 2021 are announced. Final 2021 benefit amounts will be communicated to beneficiaries in December through the mailed COLA notice and my Social Security's Message Center.

The Social Security Act provides for how the COLA is calculated. To read more, please visit **www.socialsecurity.gov/cola**.

Statement by Retiree Leader Richard Fiesta

Statement by Retiree Leader Richard Fiesta on the 1.3% COLA Increase for Social Security Beneficiaries

The following statement was issued by Richard Fiesta, Executive Director of the Alliance for Retired Americans, regarding the government's announcement that there will be a 1.3% cost-of-living (COLA) benefit increase for millions of Social Security beneficiaries, disabled veterans and federal retirees next year:

"The members of the Alliance for Retired Americans are disappointed and angry that 64 million Social Security beneficiaries will receive a paltry 1.3% benefit increase in 2021.

"While any COLA is better than nothing, 1.3% is not nearly enough to keep up with the escalating cost of prescription drugs and other expenses seniors have to spend their money on. **Twenty-nine percent of Americans** report that they are not taking a prescription their doctor prescribed due to cost and seniors are bearing the brunt of it.

"The coronavirus pandemic is also hitting many seniors hard. At least 16% of seniors who work have lost their job due to the coronavirus pandemic meaning Social security is a larger portion of their income.

"There is a better way. To help seniors and strengthen Social Security, we need to protect and expand the program. We can modestly increase benefits by making the wealthiest Americans pay their fair share by removing the artificial earnings cap. This would strengthen the Social Security Trust Fund and provide all retirees with increased benefits. Also, Congress should require future COLAs to be based on the CPI-E, the Consumer Price Index for the Elderly. The CPI-E reflects health care and housing costs, things that seniors actually spend their money on, and will result in a fairer COLA."

Rich Fiesta, Executive Director, ARA

Coronavirus: It will be challenging for many older adults to vote

It seems inconceivable in the year 2020 that everyone in this country eligible to vote should not be able to do so easily. With technology as sophisticated as it is, voting should be a simple protected click of a button. Instead, barriers to voting for large portions of the population remain huge; **Kaiser Health News** reports that many older adults living in nursing and other living facilities may not be able to vote this November.

The novel coronavirus is keeping family members from visiting with their loved ones in nursing homes and other group home settings. That will make it harder for older adults to vote. Family members are often responsible for helping their older loved ones complete voting ballots. Moreover, COVID-19 will also keep group homes from establishing on-site voting precincts.

In some group homes, volunteers are assisting residents with voting by mail. But, this is not standard. And, it is generally not required. So, it seems more than likely that a smaller portion of older adults will vote in the upcoming election.

States can step in to require facilities to help older residents with voting. California's Department of Public Health is telling facilities housing older adults that they must help their residents with voting. But, a lot of these facilities are short-staffed.

And, even when there are staff, the staff might worry about being seen as influencing residents' votes.

ADD YOUR NAME

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

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Federal District Court Orders Texas to Provide More Ballot

Siding with Retirees and Voting Advocates, Court Agrees that Governor Abbott's Proclamation Created an Undue Burden to Voting

AUSTIN – In a significant development in the fight to remove burdensome requirements for voting, Judge Robert Pitman of the United States District for the Western District of Texas today issued a preliminary injunction and temporary restraining order halting Governor Abbott's proclamation which limited Texas counties from providing more than one location for mail ballot returns.

The order came as a result of a **lawsuit** filed October 3 by the Texas Alliance for Retired Americans and Bigtent Creative, which is working to register and encourage young Texans to vote.

"Governor Abbott's intervention was a blatant act of voter suppression. We are gratified that the Court recognized that," said Richard Fiesta, executive director of the Alliance for Retired Americans. "Older Texans have borne the brunt of the coronavirus pandemic in Texas, and they should not have to stand in long lines to deliver a ballot so they will be assured it will count."

"We appreciate the swift decision from the Court that will help protect the rights of millions of young Texans to have their voices heard this election," said Ysiad Ferreiras, CEO of Bigtent Creative. "As an organization investing in, reaching, and mobilizing young voters of color, we know there is an active group of concerned Gen Z voters in Texas that are ready to stand up for change in the state. These are young people who would have otherwise been silenced by the governor's Executive Order."

Abbott's proclamation effectively closed hundreds of ballot return locations that election officials throughout the state established or planned for, and would have forced thousands of older voters to choose between protecting their health or casting a ballot they know will be counted.

The complaint notes that for many voters who will vote by mail, the nearest drop-off location will now be dozens or even hundreds of miles away, forcing those voters to travel long distances to deliver their ballots to their county's election administration or to put their ballots in the care of the Postal Service which has informed the state that Texas election mail will be delayed.

A copy of the court order is **here**.

This year the Alliance for Retired Americans, working with its state chapters, has filed lawsuits to protect vote by mail and absentee voters in Florida, Maine, Michigan, Minnesota, North Carolina, Pennsylvania, and Wisconsin in addition to Texas.

Pence Said Biden Copied Trump's Pandemic Response Plan. Pants on Fire!

Referring to plans to combat COVID-19: *"The reality is when you look at the Biden plan, it reads an awful lot like what President Trump and I and our task force have been doing every step of the way." Pence.*

During last week's vice presidential debate, moderator Susan Page, USA Today's Washington bureau chief, asked Vice President Mike Pence about the U.S. COVID-19 death toll. Pence replied by touting the Trump administration's actions to combat the pandemic, such as restrictions on travel from China, steps to expand testing and efforts to accelerate the production of a vaccine.

Pence also took a jab at Democratic presidential nominee Joe Biden, a strong critic of the Trump pandemic response. "The reality is, when you look at the Biden plan, it reads an awful lot like what President Trump and I and our task force have been doing every step of the way," said Pence. "And, quite frankly, when I look at their plan," he added, "it looks a little bit like plagiarism, which is something Joe Biden knows a little bit about."

(Pence's gibe about plagiarism is likely a reference to **Biden copying phrases** from a British politician's speeches during his first run for president in 1987, an issue that caused him to drop out of the race. In 2019, the **Biden campaign acknowledged** it had inadvertently lifted language in its climate and education plans without attributing the sources.)

Because COVID-19 continues to spread throughout the United States, with nearly 8 million cases and upward of 215,000 deaths, we decided to examine both the Trump and Biden plans to curb the pandemic and investigate whether Pence was on target in his charge that the Biden plan is rooted in Trump's ideas.

We reached out to both presidential campaigns for their candidates' COVID-19 plans. The Trump campaign did not respond to our request, but we looked at a campaign website **timeline of administration actions on COVID-19**, as well as **a coronavirus fact sheet from the White House**. The Biden campaign sent us a link to **Biden's COVID-19 plan**….**Read More**

Regeneron CEO: Trump 'is a case of one' and 'weakest evidence' for Covid-19 treatment

Regeneron chief executive Leonard Schleifer on Sunday said President Donald Trump's treatment with the company's experimental antibody cocktail is "a case of one," but stressed ongoing clinical trials still need to show its efficacy.

"The president's case is a case of one, and that's what we call a case report, and it is evidence of what's happening, but it's kind of the weakest evidence that you can get," Schleifer said in an interview on CBS' "Face the Nation."

Schleifer added that there were "some very interesting aspects" in Trump's case, such as his age. He also noted that the president "had some risk factors," and that Trump "did not have his own immune system in gear when he was sick and he got treated" with Regeneron's treatment.

He added that Trump's case is "perhaps the most analyzed case report ever" but is "just low down on the evidence scale that we really need."

He noted that clinical trials are the standard for whether it's effective. "The real evidence has to come about how good a drug is and what it will do on average has to come from these large clinical trials, these randomized clinical trials, which are the gold standard. And those are ongoing," Schleifer said. "We've got some preliminary evidence that we've talked with the FDA, and we're going for an emergency use authorization, because we think it's appropriate at this time."

Trump, who was hospitalized at Walter Reed National Military Medical Center after being diagnosed with coronavirus, was treated with the experimental antibody drug and touted it as a "cure."

In an interview Sunday with Fox News host Maria Bartiromo, Trump said he's beaten Covid-19 and **claimed immunity from the vir**us.

Asked on CBS by host Margaret Brennan whether Regeneron's drug creates immunity, Schleifer said, "It does."

"If you get it in our vial, if you will, that's probably going to last you for months," Schleifer said.

Covid drug given to Trump developed using cells derived from an abortion

Trump touts Regeneron antibody cocktail as a potential 'cure' while he has consistently sought to restrict abortion access

One of the drugs taken by Donald Trump that he has touted as a potential "cure" for coronavirus was developed using human cells originally obtained from an elective abortion, a practice repeatedly denounced by the president and many of his supporters.

The drug is a monoclonal antibody cocktail developed by Regeneron. The president received an 8-gram infusion under a "compassionate use" exemption when he was hospitalized over the weekend after testing positive for Covid-19. There is no cure for Covid-19, and the drug is not approved.

The cells used to develop the drug are known as HEK-293T cells, a line of cells used in laboratories. The cells were originally derived from an embryonic kidney after an elective abortion performed in the Netherlands in the 1970s. HEK-293 cells are one of the most commonly used cell lines in laboratories across a wide array of research.

Trump has consistently sought to restrict abortion access, including most recently, when he nominated the conservative Catholic Judge Amy Coney Barrett to the supreme court last month. The anti-abortion movement is one of Trump's most enthusiastic bases of support.

The 2020 Republican party platform explicitly opposes embryonic stem cell research, and calls for a ban on federal funding for embryonic stem cell research, because like HEK cells they are derived from an embryo.

Trump has already limited research using embryonic stem cells for ideological reasons. In 2019, his administration paused funding for government scientists to work on studies involving embryonic stem cells, affecting about $31m in research, according to **Science magazine**.

"We stopped the federal funding of fetal tissue research, which everybody felt was so important …" the president told supporters in **January 2020**. "We're standing up to the pro-abortion lobby like never before."

The HEK-293T line of cells has been "immortalized", meaning they divide freely in the lab. Regeneron said the company does not consider the cells "tissue".

"It's how you want to parse it," a Regeneron spokeswoman, Alexandra Bowie, told the **MIT Technology Review**. "But the 293T cell lines available today are not considered fetal tissue, and we did not otherwise use fetal tissue."

Development of the Regeneron antibody cocktail is supported by a $450m grant from the Biomedical Advanced Research and Development Authority (Barda).

….**Read More**

A Reconfigured U.S. Supreme Court: Implications for Health Policy

U.S. Supreme Court decisions shape health policy in important ways. The nomination of Judge Amy Coney Barrett, if confirmed, is expected to establish a solid 6:3 conservative majority that could affect case outcomes in several areas. This issue brief considers the potential implications of a reconfigured Court for health policy issues, including those already on the Court's docket for the coming term and those that the Court may choose to consider in this term or in the future:

- **The future of the ACA:** The Court will decide California v. Texas, a case that could determine whether the entire Affordable Care Act can continue, with significant implications for the U.S. health care system and virtually every American. Oral argument is scheduled for November 10, 2020.
- **Cases requesting Supreme Court review:**
- **Abortion:** The Court may decide to consider one or more cases that could overturn the precedent of Roe v. Wade, alter the standard to evaluate whether abortion regulations are constitutional, or decide that abortion providers cannot sue to challenge abortion regulations.
- **Title X:** The Court is likely to want to resolve conflicting appeals court decisions about whether the Trump Administration Title X Federal Family Planning regulations that prohibit federal funding to clinics that offer or refer for abortion are permissible under federal law.
- **Medicaid enrollees' free choice of provider:** The Court will decide whether to hear a case about whether Medicaid enrollees can sue to challenge a state's refusal to allow Planned Parenthood to offer Medicaid services if that provider also separately offers abortion services (which are not covered by Medicaid). Federal appeals courts are split on this issue. The case has implications for enrollees' ability to bring lawsuits challenging state violations of federal Medicaid law as well as enrollees' free access to providers.
- **Medicaid work requirements:** The Court will decide whether to hear cases about whether the HHS Secretary can approve Section 1115 waivers that condition Medicaid eligibility on meeting work and reporting requirements, which have led to over 18,000 people losing coverage in Arkansas.

- **Cases that could reach the Supreme Court:**
- **Payment of ACA cost-sharing reductions to insurers:** The Court could be asked to hear cases brought by Marketplace insurers seeking unpaid cost-sharing reductions (CSRs) from the Trump Administration. Restoring CSR payments could lower Marketplace premiums and federal costs and improve affordability for individuals who do not qualify for Marketplace premium tax credits.
- **Nondiscrimination in health coverage and care:** The Court could be asked to review cases challenging the Trump Administration's rollback of regulations implementing ACA Section 1557, which bans discrimination in health programs and activities that receive federal funding. Issues include whether discrimination based on gender identity is prohibited and the extent to which individuals and entities are exempt from discrimination claims based on religious freedom.
- **Public charge rule:** The Court could be asked to review cases challenging the Trump Administration's regulations that prevent individuals from obtaining a green card or entering the U.S. if they are determined likely to use certain public programs, including Medicaid. The regulations are likely to lead to decreased participation in Medicaid by immigrant families and their primarily U.S. born children.
- **Hospital price transparency rule:** The Court could be asked to hear a challenge to the Trump Administration's regulations requiring hospitals to disclose their negotiated rates with insurers. The Administration argues that the regulations could lead to lower costs for consumers. However, if the Supreme Court accepts the argument, supported by the Trump Administration, that the entire ACA is invalid, Congress would need to pass new legislation before any price transparency regulations could be adopted….**More**

Looking for Old Friends: How to Find Your Long-Lost Buddies or Gal Pals

Want to locate important people from your past that you've lost touch with? You definitely can. Looking for old friends may seem like a challenge, but finding them is probably easier than you think. From old classmates to former coworkers to cherished confidantes, it's possible to find people online—often for free. By using modern search methods, you can turn a lost friendship into a renewed connection that adds extra joy and meaning to your life.

That's why it's often worth the effort to try to locate old friends. Besides, the resources that are available today make it very likely that your search will be successful. You just need to learn how to find a lost friend with the tool that is most widely used for that purpose—the Internet.

At the most basic level, you find an old friend on the Internet by using search engines like Google, social networking platforms like Facebook, personal information aggregators like TruthFinder, alumni websites, and other online resources. If the Internet doesn't turn anything up, you can find a long-lost friend by hiring a private investigator (or using traditional investigative methods yourself).

Keep in mind that it's perfectly normal for people to lose touch with each other as the years go by. In fact, the number of friends in a person's life tends to peak at about the age of 25, according to research in **Royal Society Open Science**. After that, friendships often drop off as people move away, get married, have children, and focus on their careers. So a lot of adults maintain fewer friendships than they did when they were younger because they simply have less time and energy to nurture them. But as an older adult, you may have more time to restore important friendships and even cultivate new ones, especially if you're retired.

When you find long-lost friends, the good feeling is often hard to describe. And if you're able to catch up and renew those friendships, it feels even better. Of course, not everyone wants to be found. An old friend may not be interested in reconnecting. But you'll never know unless you try.

In this article, you'll discover plenty of practical tips about how to track someone down by name or by other types of information. You'll also learn how to make completely new friends. Here's the best process to follow:

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What questions should I ask of a Part D prescription drug plan?

Dear Marci

Dear Marci,

My job-based drug coverage is ending soon, so I want to sign up for a Medicare Part D prescription drug plan. Before choosing one, what questions should I ask of a Part D prescription drug plan?
- Bonnie (Madison, WI)

Dear Bonnie,

Medicare Part D, the prescription drug benefit, is the part of Medicare that covers most outpatient prescription drugs. Part D is offered through private companies either as a stand-alone prescription drug plan (PDP), for those enrolled in **Original Medicare**, or a set of benefits included with your **Medicare Advantage Plan**.

You should make sure to find a Part D plan that meets your specific health care needs. Before you start looking at plans, gather a list of the prescriptions you take, including their dosages and usual costs, and the pharmacies you regularly use.

MEDICARE RIGHTS CENTER
Getting Medicare right

Here are some questions you should ask before choosing a Part D plan:

Drug coverage

- Are my prescriptions on the plan's formulary?
- The **formulary** is the list of prescription drugs for which a Part D plan will help pay.
- Does the plan impose any coverage restrictions, such as prior authorization, step therapy, or quantity limits?
- **Prior authorization** means that you must get approval from your Part D plan before the plan will pay for the drug.
- **Step therapy** means that your plan requires you to try a cheaper version of your drug before it will cover the more expensive one.
- **Quantity limits** restrict the quantity of a drug you can get per prescription fill, such as 30 pills of Drug X per month.
- If the plan does not cover a medication I take, does it cover one that will work for me? (Ask your doctor.)

Costs

- How much will I pay at the pharmacy (copayments or coinsurance) for each drug I need?
- How much will I pay for monthly premiums and the annual deductible?
- How much will I have to pay for brand-name drugs? How much for generic drugs?
- What will I pay for my drugs during the coverage gap?
- If a drug I take has a high coinsurance, is there a drug I can take that will cost less? (Ask your doctor.)
- Am I eligible for **Extra Help** or a **State Pharmaceutical Assistance Program (SPAP)**?

Pharmacy network

- What is the service area for the plan?
- Can I fill my prescriptions at the pharmacies I use regularly?
- Can I fill my prescriptions when I travel?
- What will my coverage options and costs be if I visit out-of-network pharmacies?
- Can I get prescriptions by mail order?

Coordination with other insurance

- Will Part D work with other coverage I have to lower my costs?

Do I need to enroll in Part D if I have other **creditable coverage?**

Do I need to enroll in Part D if I have **job-based drug coverage**?

There is no one best Part D plan for everyone. Instead, you should ask questions and make sure to find a Part D plan that meets your specific health care needs.

-Marci

Caregiver Duties: Understanding the Differences

Are you looking for a list of caregiver duties because you're about to begin caring for a loved one? Or are you or a family member preparing to move into a senior living facility, prompting you to ask questions like "What is a caregiver?" and "What do caregivers do?" Well, in both professional and family-care settings, caregivers make a positive difference for seniors, frequently improving their quality of life. They provide loving, compassionate care and, in return, they often report that the work is gratifying, rewarding, and fulfilling.

Professional and family caregivers are essential to the fabric of society. According to the **U.S. Department of Health and Human Services**, in 2014, there were more than 46 million seniors aged 65 and older in America. By 2060, the number of seniors could reach almost 100 million. That means caregivers are more important than ever. And it may surprise you to learn that unpaid family caregivers actually play a larger role in senior care than professional caregivers.

Check out the following sections to uncover essential information about caregivers and their roles and responsibilities:

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5 Steps for Picking a Medicare Plan

FOR MOST OF US, MAKING the move from private, employer-provided health insurance to Medicare is a daunting task. First, there's the new lexicon: Medicare Advantage, Part B, **Part D**, Medigap – what do they mean? Then there's the fear: "The Medicare decisions you're about to make will affect your health care and out-of-pocket costs for the rest of your life," says the Medicare information organization 65 Incorporated.

Yikes – that's a lot of pressure! Take a deep breath, because with some research and careful consideration, you can **find a Medicare plan that works for you**. Here are the steps you should take to make the right choice.

1. Check your timing. "Timing is one of most important decisions a person can make," says Diane Omdahl, co-founder and president of 65 Incorporated. Many people need to enroll during the Initial Enrollment Period, which is the seven months surrounding one's 65th birthday – including the three months before your birthday month and the three months after. Patients may be responsible for late penalties and lapses in coverage if they don't qualify for a Special Enrollment Period, which allows you to enroll outside your 65th birthday window or during annual open enrollment, for unplanned events like losing a job and associated health insurance coverage.

But for those still working, there's often no need to enroll. "There is a perception that you must enroll when you turn 65. That is true except with people still covered by an employer plan," Omdahl says. Federal law says that an employer group health plan (sponsored by a company with 20 or more employees) can be the primary carrier over Medicare. "People working at 65 or past 65, that population makes the most of the mistakes with enrollment," she says.

For those already enrolled, the annual **open enrollment period**, which runs from Oct. 15 until Dec. 7 each year, is the best time to consider switching plans or adding coverage.

2. Learn about your options. There are two types of Medicare plans: **Original Medicare and Medicare Advantage**. According to Medicare.gov, Original Medicare is a government-provided, fee-for-service plan that is made up of two parts: Part A is hospital insurance and Part B is medical insurance. After you pay a deductible, Medicare pays its share of the approved amount, and you pay your share through coinsurance and/or deductibles. Prescription drug coverage requires signing up for Medicare Part D, with an additional premium. There are also supplemental policies, known as Medigap policies, which can cover certain benefits not covered by parts A and B, such as vision and dental care.

Medicare Advantage is a plan offered by a private insurance company that contracts with Medicare. These plans include Part A and Part B coverage, and may be set up as an **HMO, PPO, fee-for-service** or other type of plan. They typically include prescription drug coverage and may offer vision, dental and other services.

3. Look closely at prescription drug coverage. Studies find that too many Medicare eligibles fail to choose the least expensive drug plan and overpay by hundreds of dollars a year. When researching plans, keep all your current medications handy. "I find that when people call us, they often don't have their medication names, dosages or frequencies," says Tatiana Fassieux, a consultant with California Health Advocates, a Medicare advocacy organization. And every year, plans change what drugs fall into which payment tiers and which pharmacies they work with to offer the best prices. **Check your plan's formulary carefully each year** to see what may have changed. Medicare.gov also has excellent price comparison tools.

"Don't be complacent," Fassieux says. "If a person doesn't proactively review prescription drug coverage, in the end it can cost them hundreds if not thousands of dollars."

4. Pick your plan. "If you are new to Medicare, your first decision is a simple fork in the road," says Andrew Shea, vice president of Medicare products at eHealth.com. "Do you want Original Medicare or an Advantage plan? They are very different plans. Each has pros and cons."

Of course, monthly premium is one important factor when choosing a plan. But there is much more to it than that, according to 65 Incorporated:

- **Other costs:** What are the **out-of-pocket costs**, like copays and deductibles?
- **Coverage:** Is there coverage for all your physicians, medications and required services?
- **Quality:** How does Medicare rate the plan, in terms of customer service, fairness of appeals and other important factors?

The best way to wade through these differences is to work with a **Medicare** expert. "Our strong belief is you need to work with someone who understands senior insurance really well and can help you weigh the pros and cons," Shea says. "You don't want a jack of all trades who sells you home and auto insurance and, oh by the way, also has medical insurance if you want it."

5. Enroll. If you are new to Medicare, you first need to enroll by:

- Going to **https://www.ssa.gov/benefits/medicare/**
- Calling Social Security at 1 (800) 772-1213 (TTY 1-800-325-0778) 24/7
- Visiting a local Social Security office

Next, decide who you want to work with to choose your plan – an insurance agent or broker, or the insurance company directly. The premiums are set by Medicare or the insurance company if you select a Medicare Advantage or Medigap plan. Medicare premiums do not change regardless of who you work with, but the other plans vary among companies based on the state they are licensed to do business in.

COVID-19 Harming Older Adult Employment, Increasing Strain on Medicare

It is clear that older adults have been disproportionately impacted by the COVID-19 pandemic, with far too many experiencing **significant complications, hospitalization, and even death**. But the harm of the pandemic goes beyond devastating health consequences to also include negative changes to employment, income, and financial security. This week, the Commonwealth Fund released an **issue brief** discussing the widespread economic damage the pandemic has caused older adults, and what these impacts may mean going forward for people with Medicare and the program.

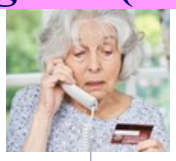
People who continue to work past age 65 may do so because they like working, or they may need the income from a job in order to make ends meet. According to the brief, around 7.5 million people with Medicare were employed in 2012, and that number increased to over 10 million people in 2018. Almost half of these workers had employer health insurance coverage in addition to Medicare.

As of July 2020, over 1 million people over age 65 have lost their jobs, with particularly high rates among Asian and Latino older adults. This means lower incomes for these individuals and may mean an influx of people using Medicare as their primary health coverage who previously were enrolled in employer-based coverage. The issue brief's calculations show that this could mean an increase in Medicare spending by more than $4 billion per year. At the same time, as workers of all ages lose jobs, less money flows into Medicare's trust fund.

The brief assumes that Medicare-eligible older adults who lose their jobs, and their employment-based health coverage, will seamlessly transition to Medicare. However, in our experience, this is often not the case. Medicare's complex enrollment rules and timelines can lead to well-intended but incorrect guidance and enrollment mistakes. The consequences of such missteps can be significant and may include lifetime financial penalties and gaps in health care coverage.

These findings and challenges demonstrate how important gaining control of the pandemic is to the health and financial well-being of people with Medicare and the Medicare program itself. More must be done to combat the virus, shore up individual incomes and essential programs like Medicare and Medicaid, and simplify enrollment. While negotiations over the next stimulus package remain in flux, Medicare Rights hopes federal policymakers will finalize a relief package soon that prioritizes older adults, people with disabilities, and their families. Read more about **recent legislation** we support **and why.**

Elder Fraud: How to Recognize (and Avoid) Scams at Any Age



Do you know anyone who has been affected by elder fraud? Seniors are certainly not the only people who fall prey to scams and schemes, but they are attractive targets for fraudsters—for a number of reasons: They often own their homes, have a nest egg of savings, and are more trusting of strangers than younger generations. Plus, elderly fraud victims are frequently reluctant to admit they've been scammed because they are ashamed or fearful of being seen as incapable of managing their own affairs.

Every year, hundreds of thousands of people of all ages get duped by cunningly deceitful con artists. And according to a study in the ***Journal of General Internal Medicine***, nearly one in 20 adults over age 60 have been financially exploited at some point in their senior years. However, by arming yourself with information and being aware of common scams, you can take steps to avoid becoming an unfortunate statistic.

This article provides details on some of the most common scams that North Americans need to watch out for, including a few deals that fall within the law but require extra scrutiny. It also gives practical tips on how you can protect yourself from various scams and what you can do if you end up becoming the victim of a fraud.

Contents

How to Get Power of Attorney for a Parent (Without Overstepping)

As we age, some of us eventually lose the ability to handle our own affairs. That's why you're smart to find out how to get power of attorney (POA) for a parent who is sick, disabled, or experiencing mental decline. But even if your parent is in good health right now, it's wise to plan ahead for potential challenges. You simply never know when an injury or illness may take away your mom or dad's capacity to manage finances or make important decisions about medical care. In fact, the best time to start considering power of attorney is before a parent requires any caregiving.

Broadly speaking, you get power of attorney for a parent by having him or her name you as the agent in a POA document that he or she has signed while sound of mind. However, the process is rarely as simple as it seems, especially when it comes to ensuring that your power of attorney will be recognized by third parties. Things can also become more complicated if you're trying to get power of attorney for a sick parent who is already suffering from **dementia** or another **terminal illness** or incurable condition that affects his or her ability to communicate or make reasoned decisions.

So if you think your parent may need someone trustworthy to act on his or her behalf, this is the article you should read. Here are 12 essential steps for getting the authority to handle your parent's financial and/or healthcare affairs:

Contents

Nothing in this article constitutes legal advice. Please consult a lawyer who specializes in estate or elder law for up-to-date information and advice about your particular situation.

Medicare vs. Medicaid: What Is the Difference?

ALTHOUGH THEY WERE BORN ON THE SAME DAY, Medicare and Medicaid are not identical twins. And even though they have been around for 55 years, many people still confuse these government-backed two healthcare programs.

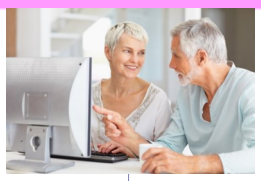
On July 30, 1965, President Lyndon Johnson signed the laws that created Medicare and Medicaid as part of his Great Society programs to address poverty, inequality, hunger and education issues. Both Medicare and Medicaid offer health care support, but they do so in very different ways and mostly to different constituencies.

According to the Medicare Rights Center:

- Medicare is a federal program that provides health coverage to those age 65 and older, or to those under 65 who have a disability, with no regard to personal income.
- Medicaid is a combined state and federal program that provides health coverage to those who have a very low income, regardless of age.

Some people may be eligible for both Medicare and Medicaid, known as dually eligible, and can qualify for both programs. The two programs work together to provide health coverage and lower costs, the MRC says. And although Medicare and Medicaid are both health insurance programs administered by the government, there are differences in the services they cover and in the ways costs are shared.

Medicare Defined



Medicare is a federal health insurance program. According to the Department of Health and Human Services, the program pays medical bills from trust funds that working people have paid into during their employment. It offers essentially the same coverage and costs everywhere in the United States and is overseen by the Centers for Medicare & Medicaid Services (CMS), an agency of the federal government.

Medicare is designed primarily to serve people over 65, whatever their income, and younger disabled people and dialysis patients who are diagnosed with end-stage renal disease (permanent kidney failure requiring dialysis or transplant). Patients pay a portion of their medical costs through deductibles for hospital and other services. They also pay small monthly premiums for non-hospital coverage.

Medicare has two parts. Part A covers hospital care, and Part B covers other services like doctor's appointments, outpatient treatment and other medical expenses. HHS says you are eligible for premium-free Part A if you are age 65 or older and you or your spouse worked and paid Medicare taxes for at least 10 years. You can get Part A at age 65 without having to pay premiums if:

- You receive retirement benefits or are eligible to receive benefits from Social Security or the Railroad Retirement Board.
- You or your spouse had Medicare-covered government employment.

If you are under age 65, you can get Part A without having to pay premiums if:

- You have been entitled to Social Security or Railroad Retirement Board disability benefits for 24 months.
- You are a kidney dialysis or kidney transplant patient.

HHS says that most people do not have to pay a premium for Part A, but everyone must pay a premium for Part B. This is deducted monthly from your Social Security, railroad retirement or Civil Service retirement check; those who do not get any of these payments are billed for their Part B premium every three months.

Prescription drugs are covered under Medicare Part D. Everyone with Medicare, regardless of income, health status or prescription drug usage, can obtain prescription drug coverage for a monthly premium.

While the federal government administers what's known as Original Medicare, it is also possible to purchase Medicare plans from some private insurance companies. These plans are known as Medicare Advantage. These include Part A and Part B coverage, but may or may not include prescription drug coverage.

Medicaid Defined

Medicaid is a government assistance program administered by both the federal government and state governments. As such, its rules of coverage and cost vary from one state to another.

It serves low-income people, families and children, pregnant women, the elderly and people with disabilities of every age. Income levels are generally based on the federal poverty level, but each state can determine who qualifies and who doesn't.

According to HHS, patients usually pay none of the costs for covered medical expenses or a small co-payment. Some states cover all low-income adults below a certain income level, HHS says. Since the enactment of the Affordable Care Act, states have been allowed to expand their Medicaid programs to cover all people with household incomes below a certain level. Some states have done so, while others have not.

Whether you qualify for Medicaid coverage depends partly on whether your state has expanded its program. HHS says that, in states that have expanded Medicaid coverage, you can qualify for Medicaid if your household income is below 133% of the federal poverty level. Some states use a different income limit, however.

Fauci criticizes inclusion in Trump campaign ad

Dr. Anthony Fauci said on Sunday he wasn't happy about being part of a campaign ad for President Donald Trump.

"In my nearly five decades of public service, I have never publicly endorsed nor do I now endorse any political candidates," he said in a statement, according to **CNN** and **NBC News**. "The comments attributed to me without my permission in the GOP campaign ad were taken out of context from a broad statement I made months ago about the efforts of federal public health officials."

The new ad, titled "Carefully," was released after Trump's discharge from Walter Reed National Military Medical Center in Bethesda, Md., where he was being treated for coronavirus last weekend. The ad touts the strength of Trump's leadership in response to the pandemic.

An edited clip of Fauci shows him saying, "I can't imagine that … anybody could be doing more."

That footage came from an **interview** on Fox News'

"Life, Liberty & Levin" in March. The full answer to Mark Levin's question about the nation's response makes it clear that Fauci was talking about the collective response of people working in the federal government and the field of public health. "I mean, we're talking about all hands on deck," Fauci said, and went on to talk about health officials working long days as part of a team.

"I'm down at the White House virtually every day with the task force," Fauci told Levin. "I'm connected by phone throughout the day and into the night, and when I say night, I'm talking 12, 1, 2 in the morning. I'm not the only one. There's a whole group of us that are doing that. It's every single day. So I can't imagine that that under any circumstances that anybody could be doing more. I mean, obviously, we're fighting a formidable enemy — this virus."

Fauci mentioned "the president" only once in his four-minute answer to Levin's question, commending him for curtailing travel from China…**Read More**

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Dr. Fauci says U.S. faces 'a whole lot of trouble' as coronavirus cases rise heading into winter

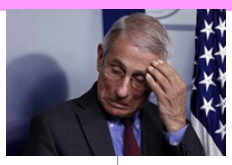
The United States is "facing a whole lot of trouble" as coronavirus cases continue to surge across the country heading into the cold winter months, Dr. Anthony Fauci, the nation's top infectious disease expert, told CNBC on Monday.

The U.S. reported more than 44,600 new cases on Sunday and the seven-day average rose to over 49,200 new cases per day, up more than 14% compared with a week ago, according to a CNBC analysis of data compiled by Johns Hopkins University. Average daily cases were up by more than 5% in 36 states and the District of Columbia, CNBC's analysis shows.

Similarly, the number of people currently hospitalized with Covid-19 rose by at least 5% in 36 states, according to CNBC's analysis of data from the Covid Tracking Project, a volunteer project founded by journalists at The Atlantic magazine.

"That's a bad place to be when you're going into the cooler weather of the fall and the colder weather of the winter," Fauci, director of the National Institute of Allergy and Infectious Diseases, said in an interview on **The News with Shepard Smith**. "We're in a bad place now. We've got to turn this around."

Fauci, who also serves on the White House Coronavirus Task Force, added that the percent of tests coming back positive, or the test-positivity rate, is on the rise across states in the Midwest and Northwest. That figure is seen as an early indicator of a growing outbreak that will lead to "more cases, and ultimately more hospitalizations, and ultimately more death," Fauci said.



Adjusted for population, many of the states with the most new infections are in the Midwest and Northwest. The Dakotas, Montana and Wisconsin reported the most new cases per capita in the country, according to CNBC's analysis of Hopkins data.

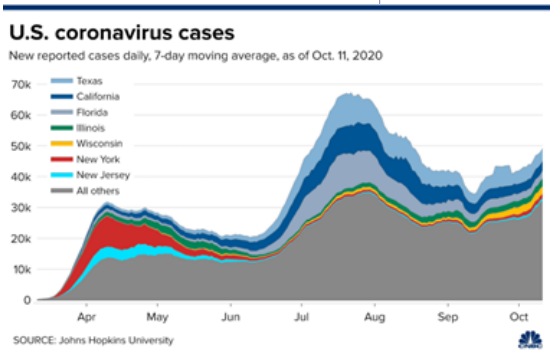
The rising cases and the indications of growing outbreaks across much of the country are particularly troubling as the weather turns colder in the northern parts of the U.S. During the colder months, people are expected to spend more time indoors and it could be the "perfect setup for an acceleration of respiratory borne diseases," Fauci added.

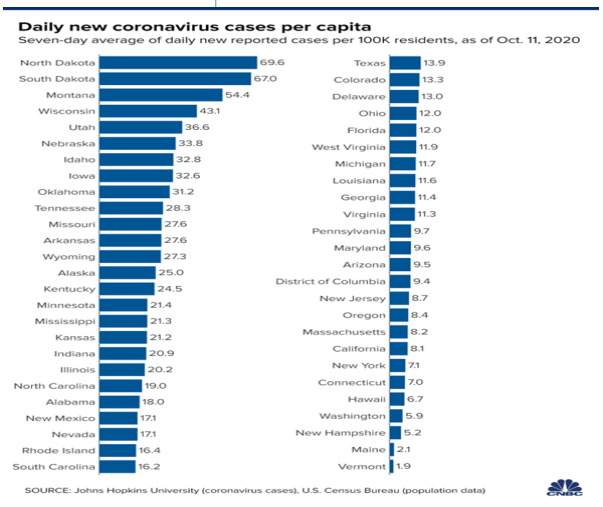
Fauci said there are five basic public health protocols that "could certainly turn around the spikes that we see and can prevent new spikes from occurring." He said universal mask use, maintaining of physical distance, avoiding crowds, doing more things outdoors and frequently washing hands would help stop the spread of the virus.

"I have a great deal of faith in the American people and their ability to realize what we're facing is a significant problem," Fauci said. "We're talking about using public health measures as a vehicle or a gateway to keeping the country open, to keeping the economy going. It is not an obstacle."

Fauci, who recently said he did **not agree to be featured** in an advertisement for the Trump campaign in which he appears to be touting the president's handling of the pandemic, added that he intends to remain in his position to see the pandemic through, regardless of who wins the Nov. 3 U.S. presidential election.

"This is too important a problem. I've devoted my entire professional life to fighting infectious diseases. This is an outbreak of historic proportions, the likes of which we have not seen in 102 years," Fauci said. **"I'm not going to walk away from this outbreak no matter who's the president."**...**Read More**





Dehydration in Elderly People: Risks, Warning Signs, and Prevention Tips

Did you know that the consequences of dehydration in elderly adults are often serious—more so than in younger people? Seniors also have more risk factors for becoming dehydrated. But here's the good news: Dehydration can be easily prevented. Awareness is the first step in avoiding the health problems that can be caused by a lack of fluids.

But many people don't realize just how problematic dehydration can be for older adults—and how common it really is. Take a look at these facts:

According to a review article in ***e-SPEN, the European e-Journal of Clinical Nutrition and Metabolism***, one study showed that about 31 percent of long-term care patients were found to be dehydrated.

Treating elderly people who are hospitalized for dehydration costs the medical system about $1.36 billion annually, according to an article in ***Nutrition and Healthy Aging***. Dehydrated patients are six times more likely to die in the hospital than patients who are not dehydrated, according to a study in ***Age and Ageing***.

This article explains why older people are at greater risk for becoming dehydrated. It also lists the consequences of dehydration in the elderly. As well, you'll learn how to spot the warning signs of dehydration and discover what to do if you or a loved one experiences symptoms.

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New understanding of how immune systems differ by sex and change with age

It's no secret that our immune system function declines as we age, which can make older adults more susceptible to a variety of viral and bacterial pathogens including COVID-19. But the role of sex in immune system aging is not well understood. An NIA-supported study took a closer look at how the timing and degree of aging-related changes in the immune system varies among men and women and identified how particular immunity characteristics diverge as we grow older.

Building upon their previous studies of how aging affects immunity, a team led by scientists at The Jackson Laboratory, Farmington, Connecticut, looked deeper into the underlying molecular and genetic mechanisms behind sex differences in immunity at different stages of life. Their findings were published in the journal *Nature Communications*.

The team surveyed the blood-based immune cells of 172 healthy adult volunteers (81 men and 91 women) between the ages of 22 and 93, with an eye toward balancing gender, body mass index, frailty scores, and other health attributes to form three age-based groups: young (less than 41 years old), middle-aged (between 41 and 64), and older (over 65.) They also performed genetic analyses to track how the expression of different genes affected immune function over time.

Both sexes experienced alterations in the frequency and activity of different immune cell types with age such as declines in various types of white blood cells, including T cells (named because they mature in the thymus gland), monocytes (formed in the bone marrow), and cytotoxic cells (which kill damaged, infected, or cancerous cells). T-cell loss is particularly important as they are the cells responsible for identifying a foreign pathogen and directing the body's adaptive immune response to mount a protective immune response. Recent studies have shown that T-cell decline is associated with increased severity of COVID19 infections, especially in older patients.

Another important finding related to the frequency of B cells; a type of white blood cell vital to producing antibodies in response to pathogens. Women showed little age-related changes in B cells, but older men's B cells showed a major loss in chromatin accessibility, which relates to how DNA strands are wound and organized, indicating a decline in the B-cell function. These changes were persistently more pronounced in men than women in otherwise well-matched study groups.

The team studied shifts in immune system patterns over different life stages and found two distinct periods of rapid genomic change: one occurring in the late 30s to early 40s was found in both sexes, and another that occurred later in life that was found to be different between the sexes. Men usually experienced this phase in their early 60s whereas women underwent these changes later in life in their late 60s to early 70s. Moreover, the degree of change was less in women. This five-year gap corresponds closely to the average lifespan difference between women (81.6 years) and men (76.9 years) in the United States, the researchers noted, and occurred roughly 12 to 15 years before the end of the average lifespan.

Differences in immune system cells between men and women were most apparent after age 65. Older females had more active B and T cells, which are part of the body's adaptive immune system that acts slower than the immediate response to injury or disease, but then results in the generation of long-term resistance to particular pathogens. Conversely, older men had more activity in the innate immune system — the body's nonspecific but more rapid-reaction defense force.

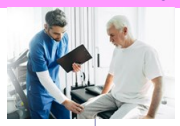
These findings regarding how and when immune system changes differ by men and women could be potentially useful to help better customize clinical care based on sex and life stage, the researchers reported. Results could also help inform future research on developing potential treatments to boost immune system function in older individuals. Data from the study are available online at **https://immune-aging.jax.org**.

Machine learning detects early signs of osteoarthritis

Osteoarthritis is the most common type of arthritis. It's a joint disease that results when cartilage, the tissue that cushions the ends of the bones, breaks down. Cartilage can sometimes wear down so much that the bones start to rub together. People with osteoarthritis can have joint pain, stiffness, or swelling. Some develop serious pain and disability from the disease.

There's no single test for osteoarthritis. Doctors use a combination of medical history and lab or imaging tests to diagnose the condition. X-rays can reveal cartilage deterioration and bone damage. Osteoarthritis is usually only found after pain has developed and bone damage has already occurred. Earlier diagnosis could allow for early interventions to prevent cartilage deterioration and bone damage.

MRI imaging can peer into the fibers that make up cartilage and reveal details about its structure. A research team led by Dr. Shinjini Kundu of Carnegie Mellon University and the University of Pittsburgh and Dr. Gustavo Rohde of the University of Virginia investigated whether artificial intelligence could be used to analyze MRI images for early signs of osteoarthritis and predict who will develop the disease. They used MRI scans from 86 people who had no initial symptoms or visual signs of disease. About half the participants developed osteoarthritis after three years.



The study team included researchers from NIH's National Institute on Aging (NIA). It was also supported in part by NIH's National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS), National Institute of General Medical Sciences (NIGMS), and National Center for Advancing Translational Science (NCATS). Results were published on September 21, 2020, in the *Proceedings of the National Academy of Sciences.*

The team used a technique they developed called three-dimensional transport-based morphometry (3D TBM) to identify biochemical changes, such as how much water is present, in cartilage using MRI scans. Using 3D TBM, they analyzed baseline "cartilage maps" of the participants' knees. After three years, they compared the cartilage maps for the participants who were eventually diagnosed with osteoarthritis with those who were not.

Using machine-learning algorithms, the team trained the system to automatically differentiate between people who would progress to osteoarthritis and those who wouldn't. The technique detected specific biochemical changes in the center of the knee's cartilage of those who were presymptomatic at the time of the baseline imaging, including decreases in water concentration. The system accurately detected 78% of future osteoarthritis cases.

"The gold standard for diagnosing arthritis is X-ray. As the cartilage deteriorates, the space between the bones decreases," says study co-author Dr. Kenneth Urish of the University of Pittsburgh. "The problem is, when you see arthritis on X-rays, the damage has already been done."

More studies are needed to determine whether 3D TBM could be useful as a clinical tool to predict who may develop osteoarthritis and benefit from early interventions.

Sundowners Syndrome: Facts, Misconceptions, & Tips for Care

"Sundowners syndrome," "sundowning," and other similar terms are commonly used in hospitals and long-term care environments when older patients become confused or agitated in the late afternoon, evening, or nighttime. But did you know that the whole concept of sundowning is somewhat **controversial**? This topic makes some caregivers and medical professionals uncomfortable for exactly that reason. They believe that opportunities for better care and treatment of patients with **dementia** may get missed as a result of this concept being too casually used to explain problematic behavior.

That's why it's essential to understand what sundowning really is—and what it's not. Once you know how and why terminology like "sundown syndrome" gets applied (or misapplied) to various behaviors, you can take actions that may lead to a better quality of life for both you and the person you care about. This article will help clarify some of the popular misconceptions you may have encountered.

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Chronic Loneliness in the Elderly: How to Help Yourself or Someone Else

Chronic loneliness can affect every part of your life. If you've ever felt lonely—which most of us have—you know that it can impact your happiness. Loneliness can also increase your risk for many health problems. But there is reason for hope. Understanding the causes of loneliness and the best approaches for dealing with it can help you overcome the issue and start thriving.

Sadly, many elderly people today are lonely. But loneliness is not an inevitable part of aging. That's why physicians are starting to pay more attention to their older patients' social networks and learning how to help improve this aspect of their lives. Plus, the UK recently appointed the world's first Minister of Loneliness, someone who leads a multidisciplinary team united in figuring out how to combat loneliness. The UK also launched the **Campaign to End Loneliness** in 2011 in order to educate people specifically about the problem of loneliness in seniors.

In the U.S., the stakes are high. Not only does loneliness take a tragic toll on the personal lives of millions of older Americans, but it also has a financial cost. An **AARP study on loneliness** calculated that Medicare spends about $134 more each month for every lonely senior than for every socially connected older adult. That adds up to an extra $6.7 billion of spending each year. And with the number of adults over the age of 65 expected to **more than double** between 2016 and 2060, the costs will continue to rise. So America has a lot of incentive to address the problems of loneliness by supporting more research and creating additional resources to help seniors.

In this article, you'll learn about the causes of loneliness, why it's becoming more common, and how it can impact your health. You'll also discover tips for overcoming loneliness and increasing your positive social connections. And you'll learn how to support people you may be worried about.

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Pain rising among younger Americans with less education

Pain serves as an important warning that something is not right in the body. It can help keep people safe by causing them to take certain actions and avoid others. But long-lasting pain can damage both physical and emotional health and lower quality of life.

More than 50 million adults in the U.S. live with chronic pain, which is pain that lasts for more than three months. Current treatments are largely ineffective for many people. And opioids, when overprescribed for pain, can actually make chronic pain worse.

Recent surveys taken across age groups in the U.S. have shown an unusual pattern of pain nationwide, in which older adults report less pain than the middle aged. In other countries, reports of pain tend to rise steadily with increasing age.

To better understand patterns of pain, Drs. Anne Case and Angus Deaton from Princeton University and Dr. Arthur Stone from the University of Southern California examined data from six large surveys that covered the U.S. and 20 other wealthy countries. Two American and two international surveys took repeated "snapshots" of pain, asking people in different age groups about their current pain levels. In these studies, it was possible to track birth cohorts (groups) in successive snapshots. The two other studies were longitudinal, following specific cohorts over time.

To model trends in pain over time, the researchers examined data from adults aged 25 to 79 years. The study was funded by NIH's National Institute on Aging (NIA). Results were published on September 21, 2020, in the *Proceedings of the National Academy of Sciences*.

Results from the four snapshot surveys found that the prevalence of pain in the U.S. increased with age until people in their late 50s. It then decreased, leveling off around age 70. In contrast, data from other rich countries did not show a midlife peak in pain. Instead, pain rose slowly but steadily with the age of the survey participants.

Results from tracking birth cohorts over time showed that, within a birth cohort, pain rose with age into old age. However, since the group born in 1940, each successive group born over 5 -year periods in the U.S. reported more pain at any given age than previous groups. This difference between birth groups was largely confined to those without a four-year college degree.

For example, among those without a bachelor's degree in the U.S., 32% of people born from 1955-1959 reported pain at age 52, compared with 40% of people born from 1965-1969. A similar trend wasn't seen in other rich countries.

Across age groups in the U.S., people with less education were more likely to report pain than those with more education. On closer examination, the researchers found that the peak in pain during midlife found in the U.S. snapshot data was largely confined to people with less than a bachelor's degree.

Rising obesity can explain some, but not most, of the rise in pain in U.S. adults. Younger Americans today may be more comfortable reporting minor pain than previous generations. However, this doesn't explain the differences in pain seen by education level.

"Pain undermines quality of life, and pain is getting worse for less-educated Americans," Deaton says.

"The connection between less-educated Americans and pain is shaped by a number of factors, and matches patterns we observe in rising deaths of despair," Case adds. "It's of great concern to us, as researchers, that it seems to be worsening."