Rhode Island Alliance for Retired Americans

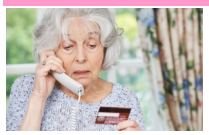
RI ARA

Affiliated with the Rhode Island AFL-CIO
"Fighting for the future of our members."
"NOW, more than ever!!!"

October 20, 2019 E-Newsletter

Publication 2019 Issue 42
Published in house by the RI ARA

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 one study, nearly one in 20 adults over age 60 have been financially exploited at some point in their senior years.[1] 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.

11 Common Scams and How to Avoid Them

The key to avoiding scams is being able to identify them. After all, the more you know, the better prepared you will be. Here are the details on 11 common scams, along with tips on how you can keep from becoming a victim of them:

1. **IRS imposter scams**
2. **Medicare phone scams**
3. **Silent calls and robocall scams**
4. **Charity scams**
5. **Counterfeit prescription medication**
6. **Funeral scams**
7. **Grandparent scams**
8. **Sweepstakes scams**
9. **Tech support scams**
10. **Sweetheart scams**
11. **Fake check scams**

What to Do If You Are the Victim of a Scam

Did you know that financial exploitation is a common form of **elder abuse**? Many people avoid coming forward because they are embarrassed about being duped, but reporting a scammer is essential in order to crack down on such cons and keep other people from being similarly victimized.

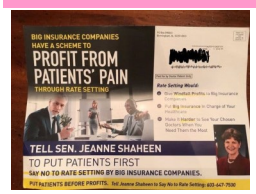
If you've been swindled out of money or are the victim of fraud, start by filing a police report. Next, contact your bank or other financial institution so that it can advise you about what actions need to be taken in your situation. For instance, it could mean stopping payment on a check or issuing you a new debit or credit card.

If a scammer has gained access to your Social Security number or other identifying information, you would be wise to put a fraud alert on your credit report. Having such an alert tells creditors that you may have been the victim of identity theft, which means they will contact you if anyone tries to apply for a credit line or open a new account in your name. You can place an alert by getting in touch with one of the following credit reporting companies:

Experian at 1-888-397-3742 (U.S. only)
TransUnion at 1-800-680-7289 (U.S. and Canada)
Equifax at 1-800-525-6285 (U.S. and Canada)

You only need to contact **one** company because whichever one you call must inform the other two about the alert. Initial alerts are free, last for 90 days, and can be renewed….**Read More**

Mystery Solved: Private-Equity-Backed Firms Are Behind Ad Blitz on 'Surprise Billing'



Two doctor-staffing companies are pushing back against legislation that could hit their bottom lines.

Early this summer, Congress appeared on its way to eradicating the large medical bills that have shocked many patients after emergency care. The legislation to end out-of-network charges was popular and had support from both sides of the aisle. President Trump **promised his support**.

Then, in late July, a mysterious group called **Doctor Patient Unity** showed up. It poured vast sums of money — now more than $28 million — into ads opposing the legislation, without disclosing its staff or its funders.

Trying to guess who was behind the ads became something of a parlor game in some Beltway circles.

Now, the mystery is solved. The two largest financial backers of Doctor Patient Unity are **TeamHealth** and **Envision Healthcare**, private-equity-backed companies that own physician practices and staff emergency rooms around the country, according to Greg Blair, a spokesman for the group.

"Doctor Patient Unity represents tens of thousands of doctors across the country who understand the importance of preserving access to lifesaving medical care and support a solution to surprise medical billing that protects patients," said Mr. Blair, who issued the statement weeks after the group was first contacted about the campaign. "We oppose insurance-industry-backed proposals for government rate setting that will lead to doctor shortages, hospital closures and loss of access to medical care, particularly in rural and underserved communities."

FACT SHEET ON 2020 SOCIAL SECURITY CHANGES

Based on the increase in the Consumer Price Index (CPI-W) from the third quarter of 2018 through the third quarter of 2019, Social Security and Supplemental Security Income (SSI) beneficiaries will receive a 1.6

Tax Rate
Employee
2019...7.65% 2020…7.65%
Self Employed
2019...15.30% 2020...15.30%

Maximum Taxable Earnings
Social Security (OASDI only)
2019…$132.900 2020…$137.70
Medicare (HI only)
No Limit

Retirement Earnings Test
Exempt Amounts
Under full retirement age
2019
$17,640 / yr $1470.00 / mo
2020
$18,240 / yr $1520.00 / mo

NOTE: One dollar in benefits will be withheld for every $2 in earnings above the limit.

Beginning the month an individual attains full retirement age:

None

Cost-of-Living Adjustment (COLA):

	2019	2020
Social Security Disability Thresholds		
Substantial Gainful Activity (SGA)		
Non-Blind	$1,220/mo.	$1,260/mo.
Blind	$2,040/mo.	$2,110/mo.
Trial Work Period (TWP)	$ 880/mo.	$ 910/mo.
Maximum Social Security Benefit: Worker Retiring at Full Retirement Age		
	$2,861/mo.	$3,011/mo.
SSI Federal Payment Standard		
Individual	$ 771/mo.	$ 783/mo.
Couple	$1,157/mo.	$1,175/mo.
SSI Resource Limits		
Individual	$2,000	$2,000
Couple	$3,000	$3,000
SSI Student Exclusion		
Monthly limit	$1,870	$1,900
Annual limit	$7,550	$7,670
Estimated Average Monthly Social Security Benefits Payable in January 2020		
	Before 1.6% COLA	**After 1.6% COLA**
All Retired Workers	$1,479	$1,503
Aged Couple, Both Receiving Benefits	$2,491	$2,531
Widowed Mother and Two Children	$2,889	$2,935
Aged Widow(er) Alone	$1,398	$1,421
Disabled Worker, Spouse and One or More Children	$2,144	$2,178
All Disabled Workers	$1,238	$1,258

Statement by Retiree Leader Richard Fiesta on the 1.6% 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 1.6% 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 that 63 million Social Security beneficiaries will receive a paltry 1.6% benefit increase in 2020.

"While any COLA (cost-of-living-adjustment) helps a little, 1.6% is not nearly to keep up with the escalating cost of prescription drugs and other expenses. One in four older Americans report that they are not taking a prescription their doctor prescribed due to cost. Retirees deserve to live in dignity in retirement without worrying about paying for basic necessities.

"To help seniors and strengthen Social Security, we need to expand the program and increase benefits. We can do this by making the wealthiest Americans pay their fair share through removing the artificial earnings cap. Doing so would strengthen the Social Security Trust Fund and provide all retirees with increased benefits and 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."

Rich Fiesta

Rhode Island Alliance *for* Retired Americans, Inc. • 94 Cleveland Street • North Providence, RI • 02904-3525 • 401-480-8381
riarajap@hotmail.com • **http://www.facebook.com/groups/354516807278/**

Will Medicare cover inpatient rehabilitation hospital care?

Dear Marci

Dear Marci,

My husband has a major surgery coming up, and his doctor said that after the surgery, he might need inpatient rehabilitation hospital care. Will his Original Medicare cover this?

-June (Fargo, ND)

Dear June,

Rehabilitation hospitals are specialty hospitals or parts of acute care hospitals that offer intensive inpatient rehabilitation therapy. Someone may need inpatient care in a rehabilitation hospital if they are recovering from a serious illness, surgery, or injury and require a high level of specialized care that generally cannot be provided in another setting (such as in your home or a skilled nursing facility).

Examples of common conditions that may qualify someone for care in a rehabilitation hospital include stroke, spinal cord injury, and brain injury. Your husband may not qualify for care if, as an example, he is recovering from hip or knee replacement and has no other complicating condition.

- Medicare-covered services offered by rehabilitation hospitals include:
- Medical care and rehabilitation nursing
  Physical, occupational, or speech therapy
  Social worker assistance
  Psychological services
  Orthotic and prosthetic services
  In order for your husband to qualify for a Medicare-covered stay in a rehabilitation hospital, his doctor must that that this care is medically necessary, meaning he must require all of the following services to ensure safe and effective treatment:
- 24-hour access to a doctor (meaning your husband requires frequent, direct doctor involvement, at least every 2-3 days)
- 24-hour access to a registered nurse with specialized training in rehabilitation
  Intensive therapy, which general means at least three hours of therapy per day (but exceptions can be made on a case-by-case basis—your husband may still qualify if he is not healthy enough to withstand three hours of therapy per day)
- And, a coordinated team of providers including, at minimum, a doctor, a rehabilitation nurse, and one therapist
  Your husband's doctor must also expect that his condition will improve enough to allow him to function more independently after a rehabilitation hospital stay. For example, therapy may help him regain the ability to eat, bathe, and dress on his own, or live at home rather than living in a living facility.

If your husband qualifies for Medicare-covered care in a rehabilitation hospital, his out-of-pocket costs will be the same as for any other inpatient hospital stay. Keep in mind that if he enters a rehabilitation hospital after being an inpatient at a different facility, he will still be in the same benefit period. If he does not qualify for a Medicare-covered stay in an inpatient rehabilitation hospital, he may qualify for rehabilitation care from a skilled nursing facility, a home health agency, or an outpatient setting.

-Marci

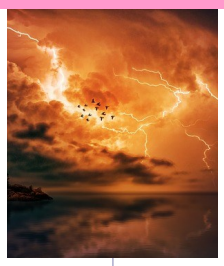
MEDICARE RIGHTS CENTER Getting Medicare right Blog

How climate change hurts vulnerable older adults

McKnight's Long-Term Care News reports on how climate change hurts vulnerable older adults. Frail older adults who are no longer living independently need to plan ahead, ideally with the help of a caregiver, for power outages and emergency evacuations. People living in nursing homes are particularly at risk of mental and physical harm.

Last month, my mother-in-law, who lives in an assisted living facility in Jacksonville, Florida was forced to evacuate her facility because of the threat of a hurricane. Lucky for her, she had family in the city who took her in. Most of the people in her assisted living facility were bussed down to Tampa–a three-hour drive–to ensure they were clear of the path of the hurricane.

In 2017, 14 nursing home residents died as a result of Hurricane Irma. Irma cut the electricity at several facilities leaving residents without any air conditioning for many days. Hurricane Harvey caused severe flooding in Texas, requiring nursing home evacuations.



Hotter climates also can incapacitate air conditioning systems, requiring emergency evacuations. These evacuations are a threat to both the mental and physical health of staff and residents.

Democratic members of the Senate Finance Committee wrote a **report** on the effects of poor planning for nursing home residents in the vicinity of Hurricanes Irma and Harvey. The report recommends appropriate planning to protect residents when emergencies strike. It advises that staff at nursing homes and assisted living facilities have evacuation processes and prioritize power restoration.

Without electricity, many frail older adults cannot function properly. They rely on equipment that requires electricity to work, such as CPAP machines, mobility scooters, dialysis machines and nebulizers. Moreover, when elevators fail, it is difficult to evacuate frail elderly patients from upper floors of a building.

In addition, without air conditioning frail older adults are more likely to become dehydrated, to get an infection or to suffer a heart problem. In cold climates, prolonged frost tends to lead to more falls and broken bones.

Mental harm can be serious. Severe weather conditions can cause depression and anxiety in older adults. The consequences can be crippling for older adults.

Everyone should plan for weather emergencies. Just Care offers advice on planning for a weather emergency **here**. At nursing homes and assisted living facilities, staff need to be trained and prepared. How will people communicate if phone service and internet are not working? People should have a place to go for emergency shelter and access to medicines. Flashlights and medical supplies are a must, along with food and water.

2020 Cost of Living Adjustment

.**(Washington, DC) –** A new analysis from **The Senior Citizens League** (TSCL) indicates that Social Security checks in 2019 are as much as 18 percent lower due to the impact of extremely low COLAs over the past ten years. From 2000 to 2010, COLAs routinely averaged 3 percent annually. People who have been receiving Social Security benefits since 2009, have only seen a COLA higher than 2.8 percent one time (in 2012).

The Social Security Administration announced today that the 2020 COLA will be just 1.6 percent, continuing the worrisome trend in which COLAs have averaged just 1.4 percent from 2000 to 2010. "Adequate COLAs are critical to retirement security," says Mary Johnson, a Social Security policy analyst for The Senior Citizens League. "Social Security is one of the only types of retirement income that provides this essential protection against rising costs. "When a retiree's costs rise faster than their COLA, the buying power of Social Security benefits erodes, leaving people with a benefit that doesn't go as far as it did when they first retired," Johnson notes. According to research by Johnson, Social Security benefits have lost 33 percent of buying power since 2000.

In 2010, 2011, and 2016 there was no COLA payable at all and, in 2017, the COLA was just 0.03 percent. Likewise, in 2018, the COLA was 2 percent, but rising Part B premiums consumed the entire increase for roughly half of all beneficiaries.

COLAs act much like interest rates on savings. Low COLAs mean Social Security benefits grow more slowly in retirement. This occurs even though many costs experienced by retirees, such out - of - pocket spending on prescription drugs — may grow several times as fast. "People who have been retired for 10 years or longer have absorbed the full financial blow of low COLAs," Johnson says. Johnson's analysis found that, over a ten - year period, average Social Security benefits of $1,075 per month in 2009 lost a total of $15,258 in financial growth from 2010 to 2019 when compared to the previous decade when COLAs averaged 3 percent. By the end of that 10 year period, average benefits were $223 per month lower than they would have been had inflation averaged the more typical 3 percent.

The Senior Citizens League supports legislation that would require a minimum COLA of no less than 3 percent, even in years when inflation falls below that amount. "Strengthening the COLA," Johnson says, "would help slow the drain of drain of retirement savings and help keep older Americans out of poverty." To learn more, visit **www.SeniorsLeague.org**.

For the first time in history, US billionaires paid a lower tax rate than the working class last year

A new book-length study on the tax burden of the ultrarich begins with a startling finding: In 2018, for the first time in history, America's richest billionaires paid a lower effective tax rate than the working class.

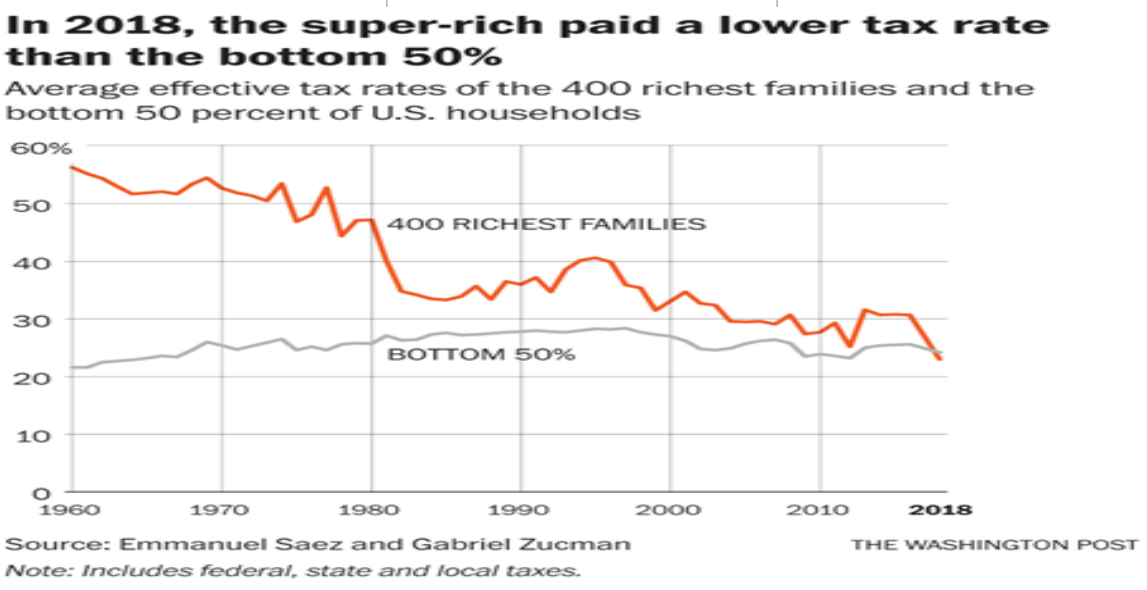
"The Triumph of Injustice," by economists Emmanuel Saez and Gabriel Zucman of the University of California at Berkeley, presents a first-of-its kind analysis of Americans' effective tax rates since the 1960s. It finds that in 2018 the average effective tax rate paid by the richest 400 families in the country was 23 percent, a full percentage point lower than the 24.2 percent rate paid by the bottom half of American households.

In 1980, by contrast, the 400 richest had an effective tax rate of 47 percent. In 1960, their tax rate was as high as 56 percent. The effective tax rate paid by the bottom 50 percent, by contrast, has changed little over time.

The analysis differs from many other published estimates of tax burdens by encompassing the totality of taxes Americans pay: not just federal income taxes but also corporate taxes, as well as taxes paid at the state and local levels. It also includes the burden of about $250 billion of what Saez and Zucman call "indirect taxes," such as licenses for motor vehicles and businesses.

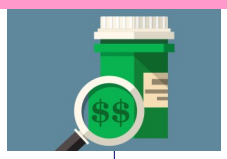
The analysis, which was the subject of a column in the New York Times on Monday, is also notable for the detailed breakdown of the tax burden of not just the top 1 percent but also the top 0.1 percent, the top 0.01 percent and the 400 richest households.

The focus on the ultrarich is necessary, Saez and Zucman write, because those households control a disproportionate share of national wealth: The top 400 families have more wealth than the bottom 60 percent of households, while the top 0.1 percent own as much as the bottom 80 percent. The top 400 families are a "natural reference point," Zucman says, because the IRS **publishes information on the top 400 taxpayers as a group**, and other sources, such as Forbes, track the fortunes of the 400 wealthiest Americans….**Read More**



Rhode Island Alliance *for* Retired Americans, Inc. • 94 Cleveland Street • North Providence, RI • 02904-3525 • 401-480-8381
riarajap@hotmail.com • **http://www.facebook.com/groups/354516807278/**

California's New Transparency Law Reveals Steep Rise In Wholesale Drug Prices



Drugmakers fought hard against California's groundbreaking drug price transparency law, passed in 2017. Now, state health officials have released their **first report** on the price hikes those drug companies sought to shield.

Pharmaceutical companies raised the "wholesale acquisition cost" of their drugs — the list price for wholesalers without discounts or rebates — by a median of 25.8% from 2017 through the first quarter of 2019, according to the Office of Statewide Health Planning and Development. (The median is a value at the midpoint of data distribution.)

Generic drugs saw the largest median increase of 37.6% during that time. By comparison, the annual inflation rate during the period was 2%.

Several drugs stood out for far heftier price increases: The cost of a generic liquid version of Prozac, for example, rose from $9 to $69 in just the first quarter of 2019, an increase of 667%. Guanfacine, a generic medication for attention deficit hyperactivity disorder (ADHD), on the market since 2010, rose more than 200% in the first quarter of 2019 to $87 for 100 2-milligram pills. Amneal Pharmaceuticals, which makes Guanfacine, cited "manufacturing costs" and "market conditions" as reasons for the price hike.

"Even at a time when there is a microscope on this industry, they're going ahead with drug price increases for hundreds of drugs well above the rate of inflation," said Anthony Wright, executive director of the California advocacy group Health Access.

The national debate over exorbitant prescription drug prices — and how to relieve them — was supposed to take center stage in recent weeks, as House Speaker Nancy Pelosi released a **plan** to negotiate prices for as many as 250 name-brand drugs, including high-priced insulin, for Medicare beneficiaries. Another **plan** under consideration in the Senate would set a maximum out-of-pocket cost for prescription drugs for Medicare patients and penalize drug companies if prices rose faster than inflation.

President Donald Trump has highlighted drug prices as an issue in his reelection campaign. But lawmakers' efforts to hammer out legislation are likely to be overshadowed, for now, by presidential impeachment proceedings. In Nevada, health officials in early October **fined companies $17 million** for failing to comply with the state's two-year-old transparency law requiring diabetes drug manufacturers to disclose detailed financial and pricing information.

California's new drug law requires companies to report drug price increases quarterly. Only companies that met certain standards — they raised the price of a drug within the first quarter and the price had risen by at least 16% since January 2017 — had to submit data. The companies that met the standards were required to provide pricing data for the previous five years. In its initial report, the state focused its analysis on drug-pricing trends for about 1,000 products from January 2017 through March 2019...**Read More**

Senate Bill Would Cut Social Security Operations Again

This summer's **budget deal** between President Trump and congressional leaders offers enough total discretionary dollars to give the Social Security Administration (SSA) a much-needed funding boost in 2020, but the Senate majority plans to *cut* $2.7 billion in inflation-adjusted dollars from the appropriations bill that funds SSA operations. That bill, in turn, would reduce SSA funding by more than 2 percent in inflation-adjusted terms. The companion House **bill** would slightly increase SSA funding, but by barely enough to offset inflation in 2020 — and not nearly enough to offset years of underfunding before then. For SSA to provide high-quality service to a growing population, policymakers must boost funding substantially.

SSA's years of cuts have taken their toll. From 2010 to 2019, its operating budget fell nearly 11 percent in inflation-adjusted terms — even as the number of Social Security beneficiaries grew by 17 percent. (See chart.) As a result, SSA has lost 12 percent of its staff since 2010, hampering its ability to perform its essential services, such as determining eligibility in a timely manner for retirement, survivor, and disability benefits; paying benefits accurately and on time; responding to questions from the public; and updating benefits promptly when circumstances change.

Center on Budget and Policy Priorities

- As workloads and costs have grown — and budgets and staffing have shrunk — SSA's **service delivery** has worsened:
- Most **callers** to SSA's national 800 number don't get their questions resolved; as callers are on hold for longer periods, nearly half hang up before connecting. And a growing number get busy signals.
- Due to **understaffing**, field office **wait** times have risen in every region of the country since 2010, with millions of visitors waiting longer than an hour.
- SSA has been forced to **close** 67 field offices and shorten office hours in the rest, making it harder for taxpayers and beneficiaries to access service.
- The average wait for a disability **appeal** is 16 months, causing hardship for hundreds of thousands of workers already struggling with a life-changing disability.
- SSA has stopped mailing Social Security **statements** to most workers as legally required, citing budget constraints.
- Millions of beneficiaries await benefit adjustments due to the agency's **backlog** on its behind-the-scenes work, such as awarding benefits to widows when spouses die, issuing back payments, resolving complex claims issues, and adjusting benefits for early retirees and disabled workers with earnings. Some 3.2 million of these actions are pending, causing unnecessary hardship — and often overpayments.

Annual funding bills for the departments of Labor, Health and Human Services, and Education, which also include SSA's administrative budget, have faced large cuts since 2010. The President and Congress should provide sufficient funding in the final 2020 appropriations bill to cover SSA's essential services.

Medicare Open Enrollment in 2019

Medicare Open Enrollment begins on October 15 and runs through December 7. Whether you are enrolled in traditional Medicare and have a Part D prescription drug plan or you are in a commercial Medicare Advantage plan, your premiums and other out-pocket-costs and in-network providers are likely changing. So, it's wise to take a hard look at your Medicare options for next year.

Medicare Advantage and Medicare prescription drug health plan costs and benefits often change significantly from one year to the next. Although **you can't know whether a health plan will meet your future health care needs**, you may be able to save money by switching.

Before you make your choice, keep these facts in mind. Whichever Medicare plan choice you make, you need Medicare Parts A and B, so you must pay the Medicare Part B premium.

Traditional Medicare, the **government health insurance option**, the Medicare health plan choice for nearly seven in ten people with Medicare

- Traditional Medicare offers coverage from almost all doctors and hospitals anywhere in the country.
- Traditional Medicare generally does not require pre-authorization or a referral for medical or hospital services.

With traditional Medicare, you can fill most if not all coverage gaps with supplemental insurance—**Medicaid**, retiree coverage from a job or "Medigap," a **Medicare supplemental insurance** plan you can buy–all of which cover most or all of your deductible and coinsurance costs. Supplemental insurance protects you from catastrophic costs and allows you to budget

for your health care.

Medicare Advantage plans, commercial health plans that contract with Medicare

- Medicare Advantage plans generally limit coverage to a small group of doctors and hospitals in your community—the provider network–except in emergencies or urgent care situations. The **provider network** can change at any time with doctors and hospitals leaving and entering the network.
- Medicare Advantage plans often charge an additional premium (on top of the Part B premium), a deductible (the amount you pay before coverage begins) and a copay or coinsurance, with each health care visit. The copay or coinsurance can be very high and unpredictable, a percentage of your hospital bill, and your out-of-pocket costs for in-network care alone can be as high as $6,700 a year. Your costs can change from one year to the next. You cannot buy insurance to fill these coverage gaps.

If you need costly Medicare-covered services, so long as you have traditional Medicare and supplemental coverage you should be able to see most any doctor and use virtually any hospital with little or no out-of-pocket costs. With Medicare Advantage plans, you will have only restricted access to doctors and hospitals and your out-of-pocket costs can easily reach the $6,700 limit for in-network care. Your costs can be even higher if people are hospitalized and are forced to use out-of-network doctors, a fairly common phenomenon, or if people want to use specialists out of network. FYI: Medicare Advantage won't release data showing people's typical out-of-pocket costs.

Keep in mind that even if you need little health care services today, it's unforeseeable when you might need a lot of care.

If you're in a Medicare Advantage plan now:

- Check your health plan's Annual Notice of Change (ANOC) or Evidence of Coverage (EOC). Look at the plan's new premiums, deductibles and copays. If those are good with you, also call your doctors and check with your health plan to make sure your doctors and hospital are still in the network.

Consider your other **health plan options**, including **traditional Medicare**. One of those options may better meet your needs. You can call your **State Health Insurance Program or SHIP** for help sorting through your options. You can also call 1-800-633-4227 (1-800-Medicare) or **use this Medicare tool to understand your options.**

- Before making a switch to another Medicare Advantage plan, call the plan to confirm your understanding of costs and network doctors and hospitals.
- If you want to switch to another Medicare Advantage plan, call 1-800-633-4227 (1-800-Medicare) to let Medicare know about your decision.

If you have a Medicare Part D prescription drug plan:

- Check your Part D drug plan's Annual Notice of Change (ANOC) or Evidence of Coverage (EOC). Look at the plan's new premiums, deductibles and copays or coinsurance. If those seem good to you, check the costs for the drugs you're taking.
- It's wise to look at other drug plan options. You might find a plan that covers your drugs at lower cost. Medicare offers a **tool for comparing drug plans** based on your drug needs.

If you decide to switch plans, your new coverage will begin on January 1. Even if you don't switch now, after the open enrollment period ends, if you are enrolled in a Medicare Advantage Plan and would like to disenroll and switch to traditional Medicare, you may be able to do so **between January 1 and February 14.** To learn more and get free advice, call your State Health Insurance Assistance Program at 800-677-1116.

More Information

Four things to think about when choosing between traditional Medicare and a Medicare Advantage plan

No projected increase in standard 2108 Medicare premium, but many people may see a premium increase

Medicaid: Why it matters to all of us

Four things to know if your income is low and you have Medicare

Free and low-cost resources for people with Medicare

RI ARA HealthLink Wellness News

Hurricanes Raise Death Risk for Older Diabetics, Even Years Later

Hurricanes can harm anyone in their path, but new research suggests that seniors with diabetes face a 40% increased risk of dying within the first month after a storm hits.

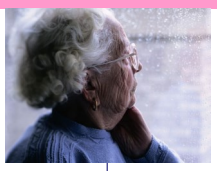
It's not just the first month they have to worry about: The study also found seniors with diabetes still had a 6% higher risk of dying even up to 10 years later.

"We compared seniors with diabetes in affected areas to those who were much less affected by storms and found two big results. One is that in overall mortality, there's a pretty big initial hit. The effect dissipated over time, but still persisted at 10 years," said study author Troy Quast. He's an associate professor of health economics in the University of South Florida College of Public Health.

Quast said the largest difference was seen in seniors who had to relocate after a big storm.

"We definitely don't have great insight into why mortality rates were higher in this group. This is speculation, but initially, people might not have access to care or might not be able to find dialysis and have trouble reestablishing healthy lifestyle habits," he said.

As for the long-term results, Quast suggested, "People who moved may just have been in a worse situation. They were in the areas hardest hit, and when you move, you have to try to reestablish your lives. If you move far enough, you might be out of your insurance network and might not have access to a primary care doctor."



The study focused on the impact of two big storms. One was Hurricane Katrina, a Category 5 hurricane that hit southeast Louisiana in August 2005. Hurricane Katrina was directly responsible for 1,800 deaths, and 1.5 million people in the Gulf of Mexico region had to evacuate.

Hurricane Rita came ashore in southwest Louisiana in September 2005. It was a Category 5 storm but it was much less deadly, causing 120 deaths. But the storm caused $18.5 billion in damages, according to the researchers.

The researchers looked at Medicare data and compared a group of 170,000 people with diabetes living in counties affected by those storms to a similar group of people with diabetes who lived in unaffected areas of Louisiana, Mississippi, Texas and Alabama.

Given these potential short- and long-term effects, how should people with diabetes prepare for a storm?

For those on insulin, Quast said protecting your insulin supply is the first step. While it's not easy after a storm has ravaged your community, he said it's important to try to maintain a healthy lifestyle.

For anyone on insulin or on dialysis, he said to find out what kind of help might be available to you before a storm. For example, he said, Florida has a special needs registry that provides extra assistance to people with special health needs.

Carol Atkinson, director of Insulin for Life USA and co-chair of the Diabetes Disaster Response Coalition (DDRC), said preparing ahead of time is the most important thing you can do.

"I can't shout long enough or strong enough. Be prepared," Atkinson said.

People often look at incoming storms and think they don't need to worry because it's looked bad before, but then the storm turns away. A resident of Florida herself, Atkinson said, "That's one of the most dangerous attitudes to have."

What should you have on hand in an emergency? The DDRC has a downloadable checklist on their website. They recommend a hard paper copy of your important prescriptions, and Atkinson said to get these laminated if you can, to protect them from water damage. She said to have enough cash on hand that you can pay for those prescriptions. She noted that after a storm ATMs and credit card machines often aren't working.

Make sure insulin (which probably has to be refrigerated) is easy to grab and put in an insulated bag if you have to leave in a hurry.

Atkinson also noted that people should realize insulin is good for about a month at room temperature. She said don't throw any insulin away until you have a new supply in hand.

She recommended having a water-safe container to keep diabetes supplies (test strips, glucose meter, insulin pump supplies, glucose tablets, water, snacks, batteries for diabetes devices, etc.) that you can easily take with you. And, she said, be sure to rotate the stock in your emergency kit to make sure it's not out-of-date.

Atkinson said people with diabetes can call the American Diabetes Association (1-800-Diabetes) to get advice after a storm. "They'll have access to the internet even if you don't," she said, which allows them to find the right help, such as the closest open dialysis center or a pharmacy that still has power.

Insulin for Life takes donations of insulin and diabetes supplies year-round. "We accept donations of all in-date, unused, safety-sealed insulin, test strips, meters, glucagon, lancets and syringes. Everything must be in date, with a minimum of 90 days left before expiring," Atkinson said.

Slow walking speed in midlife linked with faster aging

New research finds that people who tend to walk more slowly at the age of 45 present with signs of premature accelerated aging, both physically and cognitively.

Walking speed may be a powerful predictor of lifespan and health.

A recent **study**, reported on by *Medical News Today,* found that the faster a person walks, the longer they may live, with older adults benefitting the most from a brisk pace.

Medical professionals have long used gait speed as a marker of health and fitness among older adults, but the new research asks a slightly different question: Does a slow gait speed in midlife indicate and predict accelerated aging?

Line J. H. Rasmussen, Ph.D., a researcher in the department of psychology and **neuroscience** at Duke University, in Durham, NC, and colleagues set out to answer this question by examining data from 904 study participants….**Read More**

Rhode Island Alliance *for* Retired Americans, Inc. • 94 Cleveland Street • North Providence, RI • 02904-3525 • 401-480-8381

riarajap@hotmail.com • **http://www.facebook.com/groups/354516807278/**

5 Ways to Help Someone With Depression

Knowing the right thing to do or say can be really hard, especially if you've never dealt with depression yourself. But being unsure of the correct move doesn't mean you should stay quiet.

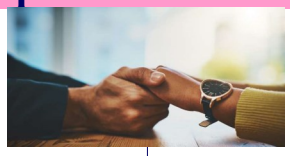
"The best way to express concern about a loved one's depression is to ask to be invited to their struggles," says psychotherapist Brandon Santan, PhD. "Let them know you notice something's going on and express empathy."

Looking for some tips to get the conversation going and offer ongoing support? Santan and Kaylin Staten, a 31-year-old from West Virginia who has struggled with depression for most of her life, lent us their thoughts. Here's their advice for how to give your loved one the care they need.

1. Don't tell them how they seem.

"When you appear combative or judgmental, a person with a mental health issue will not open up to you," says Staten, of her own experience.

How you approach the conversation can make all the difference. Instead of describing how you think the person feels (like "You seem sad," or "You seem depressed," just ask them how they're feeling or what's been on their mind. "I've found that listening and asking open-ended questions will help drive the conversation in a positive way," Staten says.



2. Listen, but don't try to solve their problems.

You might want to offer a fix or tell your loved one you know how they feel. But unless you've actually struggled with depression yourself, resist the urge to tell them what you would do, recommends Santan. The reason: If you start talking about your self, it might make your loved one clam up, Santan notes.

You can—and should—try to empathize and show your support. Just do it in a way that keeps the focus on them. "I [respond best when people] say something like, 'I cannot directly relate to that, but it sounds like that is something that's really hard to deal with,'" Staten says. Sometimes a little bit of validation can go a long way.

3. Make plans, but keep them low-key.

Even if your loved one isn't actively asking you to hang out, an offer to get together reminds them that you're thinking of them and that you care. Instead of asking them to come along to a party or club, though, suggest a one-on-one activity where there's less pressure to act upbeat or socialize with lots of people. "A walk in the park, a late afternoon movie, a quiet restaurant, or even a drive through the country would all be better," says Santan. (That's especially true if the person has substance abuse problems, since alcohol or drugs and depression don't mix well.) They might not be up for it every time, and that's okay. You can still keep asking.

4. Try not to take rejection personally.

It can be tough to shake the thought that you're doing something wrong when your loved one is withdrawn or wants to be alone a lot. But they're not pushing you away on purpose—so don't turn it into that. "It's not about you, and they're not doing it to harm you in any way. He or she honestly needs some time alone," says Staten.

What's more, suggesting that their need for space is somehow bringing you down will probably just make them feel worse. Instead of fixating on what you might be doing wrong or how you're hurting, take a step back. "Look at the whole equation and focus on the other factors in your loved one's life that may be contributing to their depression," Santan says.

5. Know when to bring in a professional.

You can't force someone with depression to go to a therapist, and trying to will usually just push them away. But you should seek help if you sense that your loved one's depression is getting worse.

Downhill signs might include a change in sleeping or eating habits, acting more isolated or withdrawn, poor self-care, not being able to take care of their usual responsibilities, or excessive crying, agitation, or irritability, Santan says. "If the depression worsens but there are no medical emergencies such as suicidal thoughts, talk with the person's medical doctor," he says.

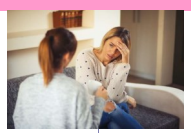
Of course, you should seek emergency medical attention ASAP if your loved one is showing any signs of thinking about suicide—like talking about wanting to die, looking for ways to commit suicide, talking about feeling hopeless or trapped, talking about being a burden to others, or behaving recklessly.

"Do whatever is necessary to keep them safe, regardless of whether or not you think they want that kind of help," says Santan. Call 911, go to the nearest emergency room, or contact the National Suicide Prevention Lifeline at 1-800-273-TALK.

Why Telling Someone With Anxiety To 'Just Breathe' Isn't Always Helpful

If you've ever been to therapy or live with anxiety or stress, you probably understand the importance of mindful breathing. **Deep breathing** can slow and help control your heart rate as well as quiet your mind.

But just because breathing exercises can help some, that doesn't mean it's the go-to strategy for everyone in every anxious moment. Here, therapists who frequently see patients for anxiety explain why casually telling someone to "take a deep breath" sometimes isn't a solution or even useful:



When you're deep in a spiral of anxious thoughts, hearing someone with even the best of intentions tell you to breathe can feel like they're belittling your experience. **Melissa Fisher Goldman, a** California-based therapist, said that people often have a knee-jerk reaction to someone else's anxiety and reflexively want to stop it out of an assumption that they're helping.

"Sometimes when somebody is anxious it's not the right moment to say, 'Take a deep breath,'" Goldman said. "You're implying their feeling is not OK and that it's time to calm down, like there's some easy fix. But sometimes we're not ready or we don't even want to be 'out' of whatever emotion we're having."

This is especially important with stigmatized emotions like anxiety, she noted, because it can create shame around a valid feeling. Plus, being rushed to suppress an emotion can have unintended consequences.

"We want to make sure that we process and honor the feeling that we're having. When we push a feeling down, it tends to come back bigger later," Goldman said….**Read More**

Over 50? Here's Why Skipping the Flu Shot Can Be Really Dangerous

Adults over 50 are at higher risk of flu-related complications. A doctor explains what older people should know about the flu vaccine to avoid getting sick.

The idea of **getting a flu shot** may conjure images of kiddie Band-Aids and school health forms, but immunization is just as important for older folks as it is for younger populations. While **the Centers for Disease Control and Prevention** (CDC) recommends that everyone over the age of 6 months get an annual flu shot, the vaccination is especially important for older adults. That's because this group is at high risk for serious flu-related complications like **pneumonia**.

Problem is, many older adults aren't convinced they need a flu shot. "The most common misconception is that it doesn't work," says **Amesh Adalja, MD,** board-certified infectious disease physician and senior scholar at the Johns Hopkins University Center for Health Security. "While it's true that the flu vaccination [isn't one of the most effective] vaccines, it is the chief means of **preventing the flu**."

"The benefits of the flu shot are overwhelming," says immunologist and epidemiologist **Aaron Glatt, MD,** chairman of the department of medicine at South Nassau Communities Hospital. "It may help you be less contagious and less sick, if not preventing the flu altogether."

Ready to get vaccinated? Keep reading to learn everything you need to know about the flu shot, especially if you're on the other side of 50.

Getting a flu shot could save your life.

Contracting the flu can be dangerous as you age. According to **the CDC**, people aged 65 and older make up about 70 to 90 percent of seasonal flu-related deaths and between 50 and 70 percent of flu-related hospitalizations. The reason: Your immune system weakens as you get older, lowering your ability to fight off viruses and bounce back after illness.

On top of that, older individuals may suffer from conditions such as **diabetes,** COPD, and cancer, which lower their immunity and put them at an increased risk for the flu, according to a September 2018 report from the **National Foundation for Infectious Diseases**.

You have a few flu vaccination options.

While the CDC maintains that the standard flu vaccine can benefit all age groups, there are specific formulations that are targeted to older folks to increase their protection from influenza. If you're 65 or older, you have two options: the high-dose flu vaccine and the adjuvanted flu vaccine.

The high-dose flu vaccine is aptly named—it has four times the amount of antigen as the regular flu shot, which leads to higher antibody production and lower chances of contracting the flu. (An antigen is a substance that stimulates the immune system to produce protective antibodies.) According to **the CDC**, adults 65 and older who received the vaccine had 24 percent fewer influenza infections compared to those who got the standard vaccine.

The adjuvanted vaccine is the same as the standard flu vaccine, but it has an additive called MF59, which helps promote a stronger immune response to the flu, according to **the CDC.** In other words, it helps the body do a better job of fending off influenza viruses.

"There's no head-to-head data comparing the adjuvanted vs. high-dose formulations (though the high-dose version has been around a little longer) so older adults can really choose one or the other depending on local availability," notes Dr. Adalja.

The vaccine you choose may have additional side effects.

The high-dose and adjuvanted flu vaccines may have more **side effects than the standard flu vaccine,** according to the CDC. These may include soreness, redness, or swelling at the injection site, headache, muscle ache, and a reduced interest in normal activities. Dr. Glatt most commonly hears patients complain of soreness, which can last for a few days. It's important to note, he says, that the **flu vaccine does not cause the flu**—if you happen to fall ill after vaccination, it's likely because you were already incubating the illness.

There's more you can do to avoid getting sick.

Getting vaccinated is the best way to prevent the flu, but there are other steps you can take including: getting proper rest, washing your hands frequently, not touching your eyes, nose, and mouth, avoiding close contact with people who are sick, and encouraging your loved ones to get vaccinated, too.

U.S. urges shared decisions with pain patients taking opioids

U.S. health officials again warned doctors Thursday against abandoning chronic pain patients by abruptly stopping their opioid prescriptions.

The U.S. Department of Health and Human Services instead urged doctors to share such decisions with patients. The agency published steps for doctors in a six-page guide and an editorial in the Journal of the American Medical Association.

In the 1990s, overprescribing started the first wave of the nation's overdose crisis. Opioids — previously used mostly for patients with cancer, at the end of their lives or with pain after surgery — began to be prescribed for long-term pain such as backaches. Drug companies promoted that use, even as evidence grew of addiction and overdose.

Later, insurers and hospitals misinterpreted cautions about opioids in ways that harmed some patients. Some turned to street drugs such as heroin or fentanyl after doctors stopped prescribing.

In April, the Food and Drug Administration added new label advice to drugs such as OxyContin, Vicodin and dozens of generic pills after reports of suicide and other serious harm in patients who were physically dependent on opioids suddenly having the medicine stopped or their dose rapidly decreased.

In the new guide, health officials said slow, voluntary reductions of opioid doses can improve quality of life without worsening pain. Tapering the drugs slowly can take months or years.

If the Doctor Asks for Your Social Security Number, Do This

You're filling out forms at a doctor's office, hospital, or other health care facility and come to a line asking for your Social Security number.

Should you write those nine digits down?

Generally, no, say privacy experts. "Having Social Security numbers at the doctor's office is a data breach risk, and it's one that's increasing," says Pam Dixon, executive director of the nonprofit World Privacy Forum.

If stolen, your SSN offers thieves easy access your personal health and financial information, and they could possibly **steal your identity**.

This makes SSNs much sought-after commodities on the black market. In fact, the 2018 Identity Fraud Study from Javelin Strategy & Research, found that for the first time, more SSNs than credit card numbers were stolen last year.

And sensitive information like Social Security numbers is taken in more than 70 percent of hospital data breaches, according to a recent study in the Annals of Internal Medicine.

Plus, for the most part—there are a few exceptions—health care providers don't really need your SSN, though some may want it to track you down if billing issues arise.

"So, when my health care provider asks for my Social Security number, I leave the line blank and recommend other patients do so as well," says Dena B. Mendelsohn, senior policy counsel for Consumer Reports.

But what if a health care provider, doctor's office receptionist, office manager, or hospital employee insists? Here's our advice.

Know the Law

Generally, you're under no obligation to provide your SSN to health care providers (but they're not obligated to take you as a patient either). **Health insurers** will likely ask for it, and you do have to offer it up if you're entering a VA hospital.

And as of last April, the rollout of the new non-SSN Medicare ID cards was completed. Medicare IDs cards used to include Social Security numbers, but now have an 11-character Medicare Beneficiary Identifier (MBI), that's a mix of letters and numbers.

If you use Medicare, you have to share your MBI with health care providers. According to Medicare, you need to protect the new card as you would a credit card, giving the number only "to doctors, pharmacists, other health care providers, your insurer, or people you trust to work with Medicare on your behalf." (And watch out for **phone, mail, and internet scams** that request your MBI.)

Note that until the end of 2019, health care providers can use either new Medicare IDs or the old ones to communicate with or seek payment from the Center for Medicare & Medicaid Services (CMS). After that, there are a few limited exceptions for use of the older Medicare cards.

How to Just Say No

If you're asked to provide your SSN—and simply leaving the space blank doesn't get you a pass—politely push back.

You can also express your concern, noting that you're hesitant to share your Social Security number because you're worried about **identity theft**. And ask why the health care facility requires the number, suggests Eva Velasquez, president and CEO of the Identity Theft Resource Center (ITRC), a nonprofit group that helps fraud victims.

"When I encountered this problem and asked why they needed it, the receptionist said 'we don't need it, we just haven't changed the form,'" she says. "So some of it is just an organizational failure."

In some cases, your health care provider may say they need your Social Security number simply because they have a field in their computerized medical records that must be filled in. The solution? Ask them to use zeros.

If you're told it's so they can track you down in case of billing problems, offer an alternative, such as your cell phone. But Dixon cautions about sharing other information, like your driver's license. "You want to keep as many of the numbers that define you out of circulation," she says.

Quiz the staff on their security practices and repeat your concerns to the doctor if you still don't get satisfaction. "If your provider or their front **desk** staff insists on using your Social Security number, ask them why and how they will protect that information," says Mendelsohn.

You can't be sure your health care provider's security practices are sufficiently robust. Research published this year in JAMA Internal Medicine, which looked at the causes of 1,138 breaches of protected health information, found that 53 percent were "attributable to the health care entities' own mistakes or neglect," according to the authors.

Finally, consider moving on, "If the answer you get is not satisfactory, you may ask yourself whether this is the right provider for you," Mendelsohn says.

A Healthy Heart May Lead to a Healthy Brain

There are recent studies showing that heart healthy habits may also be good for your brain. Researchers indicated that seniors who score high on the American Heart Association (AHA) healthy habits ("Simple 7") reduced their risk of developing dementia later on in life. Although the study did not conclude that the heart healthy habits were the actual cause, the researchers do support heart healthy behavior for middle age individuals. Specifically, they said that many cardiovascular risk factors are modifiable and, as a result, they may help shape the risk of dementia.

The American Heart Association's "Simple 7" rules are: **(1) Stop smoking; (2) Eat Better; (3) Get Active; (4) Lose Weight; (5) Manage your Blood Pressure; (6) Control your Cholesterol; and (7) Reduce your Blood Sugar.**

Cigarette smoking is responsible for about 1 in every 5 deaths in the United States each year. It's the main preventable cause of death and illness in the United States. Chemicals in cigarette smoke can harm your blood cells. They also can damage your heart function and the structure and function of your blood vessels. Smoking harms nearly every organ in the body including the brain…. **Read More**