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Soon-to-be Released Report Will Show That Social Security Continues to Work for America

As reporters prepare to cover the soon-to-be-released 2019 Social Security and Medicare Trustees Reports, Social Security Works provides you with this background analysis, which summarizes what are likely to be the Social Security Report's key findings (based on **last year's forecasts)**, and puts them in context. Please note that this backgrounder addresses only the Social Security cash benefits Trustees Report (Old Age, Survivors, and Disability Insurance Trustees Report), and not the Medicare Trustees Report.

In addition to reviewing this backgrounder, we invite you to speak with our president, **Nancy Altman,** who is a nationally recognized Social Security expert. (See her bio below.) We also urge you to review our **fact sheet** that discusses, among other things, misinterpretations by non-experts caused by over-emphasis of unrealistically long valuation periods.

The most important takeaways from the 2019 Trustees Report will be that (1) Social Security has a large accumulated surplus, and (2) Social Security is extremely affordable. In three-quarters of a century, in 2095, Social Security will constitute just around **6.16 percent of GDP**. That is considerably lower, as a percentage of GDP, **than Germany, Austria, France, and most other industrialized** countries spend on their counterpart programs ***today***.

The 2019 Trustees Report will project Social Security's cumulative surplus to be roughly **$2.9 trillion**. It will show that Social Security is fully funded until around 2034, **around 93 percent funded for the next 25 years, around 84 percent funded over the next 50 years, and around 84 percent funded over the next 75 years**.

(Those percentages are calculated from the 2018 report. This year's report may vary slightly, but not significantly. As soon as the report is released, this backgrounder will be updated with the latest projections and released as a fact sheet.)

Often, the release of the annual Trustees Report leads to lamentations from many observers that "Congress has no plan to address Social Security's projected shortfall." That is incorrect. It is only Congressional Republicans who have no plans – at least that they are willing to publicly embrace. That is perhaps because their preferred "solutions" involve benefit cuts, which are **overwhelmingly opposed** by voters across the political spectrum, including their own Republican base.

In contrast, Congressional Democrats have concrete plans – not just to ensure that all promised benefits will be paid in full and on time for the foreseeable future, but to address our nation's retirement income crisis by increasing Social Security's modest benefits. The **Social Security 2100 Act**, introduced by Rep. John Larson (D-CT), has over 200 cosponsors in the House of Representatives. Larson has held several hearings on the bill and intends to bring it to the House floor this spring.

Several **other bills** to protect and expand Social Security benefits have been introduced in the House and Senate, and nearly every 2020 presidential candidate serving in Congress is a member of the bicameral **Expand Social Security Caucus**….**Read More**

Social Security Trust Fund Stronger than a Year Ago

Making Prescription Drugs More Affordable Would Strengthen Medicare for the Future

The following statement was issued by Richard Fiesta, Executive Director of the Alliance for Retired Americans, regarding the Trustees reports issued today on the Social Security and Medicare Trust Funds:

"Despite unfounded 'doom and gloom' forecasts, Social Security is not in crisis. It will continue to be a robust cornerstone of a secure retirement for millions of current and future retirees.

"The Trustees report found that Social Security is even stronger than last year and can cover all payouts and expenses until 2035, a full year later than projected in the 2018 Trustees report.

"If no changes are made, the system will be able to pay retirees 75% of projected benefits after 2035. However, if we remove the cap on earnings subject to Social Security contributions for the wealthiest Americans, we can expand Social Security benefits, provide a more accurate formula for cost-of-living adjustments, and increase the system's long-term solvency.

"The Trustees also found that the Medicare Trust Fund for hospital care has sufficient funds to cover its obligations until 2026. To help strengthen Medicare, Congress and the Administration should rein in the cost of prescription drugs, which is a significant driver of health care costs. There is no reason that American consumers and taxpayers should continue to pay the highest prices in the world for medicines.

"Americans have earned their Social Security and Medicare benefits through a lifetime of hard work. We can best support current and future generations as they retire if we take common-sense steps today."

Recent Trends in Drug Pricing Show Stark Differences in Brand-Name and Generic Drug Affordability

A new **report** from the AARP Public Policy Institute (PPI) examines trends in prices for 390 generic prescription drugs widely used by older adults. The report found that retail prices for these drugs fell by an average of 9.3% between 2016 and 2017; the general inflation rate rose by 2.1% during the same period. This follows two consecutive years of substantial generic drug price decreases; the previous two years saw prices increase.

These price changes have meaningful financial consequences for people with Medicare and others who rely on generic drugs to stay healthy. According to the report, the average annual cost for one generic medication used on a chronic basis was $365 in 2017. This represents a dramatic drop since 2013, when the average annual cost of therapy was more than two times higher ($751).

These findings are in stark contrast with trends in the brand-name drug market, where price increases continue to significantly outpace inflation. In 2017 alone, brand-name drugs widely used by older Americans **increased** by an average of 8.4%.

At the same time, the average annual price of brand-name drugs is considerably higher than that for generics, and the gap between the two is widening. Brand-name drug prices were six times higher than generic drug prices in 2013 ($4,308 vs. $751) but more than 18 times higher in 2017 ($6,798 vs. $365).

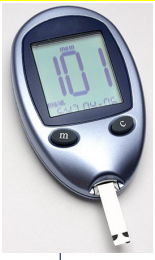
With older adults taking an average of **4.5 prescription drugs** every month, these price disparities can have significant impacts on health and economic security. Medicare Rights supports efforts to address the issue of high and rising drug prices, including by easing access to generics and improving transparency within the drug pricing system. As brand-name drug prices continue to rise, the need for reforms that will ensure Medicare beneficiary access to affordable medications is ever more urgent.

Read the full report:

Medicare Payments for Insulin Have Increased Dramatically, Report Finds

A recent Kaiser Family Foundation report highlights the dramatic increase in **Medicare spending on insulin products from 2007 to 2017**. When taking into account payments made by plans, beneficiaries, and the federal government, spending increased by 840% from $1.4 to $13.3 billion.

Although there are an **increasing number** of Part D enrollees and an **increase** in the percentage of enrollees who have diabetes—with one third (33%) of people with Medicare diagnosed with diabetes in 2016, up from 18% in 2000—these trends do not account for the steep growth in overall spending. Indeed, the study notes that the average total Medicare Part D spending *per user* on insulin products increased by 358% between 2007 and 2016 (from $862 to $3,949).



The report also finds that "the total number of Part D enrollees using any insulin therapy nearly doubled between 2007 and 2016, from 1.6 million enrollees to 3.1 million—a much smaller increase in percentage terms (86%) than the percent increase in total Part D spending on insulin over the 2007-2016 period (753%). The total number of insulin prescriptions covered by Part D also increased over these years (from 14.8 million in 2007 to 33.3 million in 2016), but the percentage increase (125%) was also substantially lower than the percent increase in total insulin spending."

In 10 Years, Half Of Middle-Income Elders Won't Be Able To Afford Housing, Medical Care

In 10 years, more than half of middle-income Americans age 75 or older will not be able to afford to pay for yearly assisted living rent or medical expenses, according to a study published Wednesday in Health Affairs.

The researchers used demographic and income data to project estimates of a portion of the senior population, those who will be 75 or older in 2029, with a focus on those in the middle-income range — currently $25,001 to $74,298 per year for those ages 75 to 84.

And it doesn't look good for that group because of the rising costs of housing and health care. The researchers estimated that the number of middle-income elders in the U.S. will nearly double, growing from 7.9 million to 14.4 million by 2029. They will make up the biggest share of seniors, at 43%.

By 2029, more than half of the middle-income seniors will have annual financial resources of $60,000 or less, even if the equity in their homes is included. Projections put the average annual assisted living and medical expenses cost in 10 years at $62,000, meaning that a majority of the middle-income seniors then will not be able to afford an assisted living facility.

Middle-income seniors are a group that Beth Burnham Mace, one of the study's authors, said has been often overlooked when policymakers and legislators think about housing and care for aging Americans.

"The low-income cohort has been taken care of by tax subsidies, while the high-income cohort is largely self-sufficient. But the middle-income seniors have been ignored," said Mace, who is chief economist at the National Investment Center for Seniors Housing and Care, a nonprofit research group.

The study's authors said they are probably underestimating the extent of the looming problem. They projected out-of-pocket medical costs of only $5,000 a year for seniors.

...Read More

Compare Medicare-for-all and Public Plan Proposals

Several bills have been introduced in the 116th Congress that would expand the role of public programs in health care. As more legislation is introduced, we will continue to update the side-by-side comparison tool. The bills range in scope from broad proposals to create a new national health insurance program for all residents to more incremental approaches that offer a public plan option in addition to current sources of coverage, private or public. These bills are grouped into four general categories:

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- Medicare-for-all, a single national health insurance program for all U.S. residents:
- Medicare for All Act of 2019 by Rep. Jayapal, **H.R. 1384**
- Medicare for All Act of 2019 by Sen. Sanders, **S. 1129**
- A new public plan option, based on Medicare, that would be offered to individuals through the ACA marketplace:
- Keeping Health Insurance Affordable Act of 2019 by Sen. Cardin, **S. 3**
- Medicare-X Choice Act of 2019 by Sen. Bennet and Sen. Kaine, **S. 981** and Rep. Delgado, H.R. 2000
- A Medicare buy-in option for older individuals not yet eligible for the current Medicare program:
- Medicare at 50 Act by Sen. Stabenow, **S. 470**
- Medicare Buy-In and Health Care Stabilization Act of 2019 by Rep. Higgins, **H.R. 1346**
- A Medicaid buy-in option that states can elect to offer to individuals through the ACA marketplace:
- State Public Option Act by Sen. Schatz, S. 489 and Rep. Luján, **H.R. 1277.**

To compare proposals, select an option from one of the columns below.

Download a side-by-side comparison of these proposals (PDF).

Download proposals introduced during the 115th Congress (PDF).

It shouldn't matter when you file for Social Security in theory. In reality, it does.

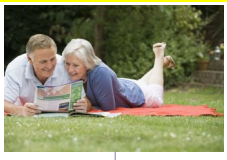
Chances are, Social Security will wind up playing a huge role in your retirement finances. Such is the case for many seniors, which is why recipients are advised to act strategically and **file at the right time**.

Though your Social Security benefits are determined based on your top 35 years of earnings, the age at which you file for them could cause that number to go up, go down, or stay the same. If you claim Social Security **at full retirement age**, or FRA, you'll get the exact monthly benefit your earnings record renders you eligible for. Here's what FRA looks like:

YEAR OF BIRTH	FULL RETIREMENT AGE
1943-1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
1960	67

Date Source: Social Security Administration .

That said, you certainly don't have to file for Social Security at FRA. You can start collecting benefits as early as age 62 and reduce them in the process, or you can **delay benefits** past FRA and boost them by 8% a year up until age 70.



Many seniors rack their brains trying to land on the right age to file for Social Security, because they know how much it'll impact their benefits. But in theory, you actually shouldn't have to worry about when you file.

Social Security's breakeven setup

One **lesser-known fact** about Social Security is that the program is designed to pay you the same total lifetime benefit regardless of when you initially file. The logic is that filing ahead of FRA will reduce your benefits, but that reduction will be offset by the greater number of individual payments you collect in your lifetime. On the flipside, filing after FRA will raise your benefits, but you'll collect fewer individual payments to counteract that boost.

As such, it technically shouldn't matter when you file for Social Security. In reality, however, it does, and here's why: This breakeven formula only works when you live an average life expectancy. If you expect to pass away sooner than the typical senior, then it generally pays to claim Social Security as early as possible, because in doing so, you'll come away with a larger lifetime payment. And if you expect to outlive your peers, then it usually pays to do the opposite -- file for benefits as late as possible.

Here's how this might play out in terms of actual numbers. Imagine you're entitled to a $1,500 monthly benefit at an FRA of 67. Filing at 62 will reduce your monthly benefit to $1,050, but you'll collect 60 more payments. If you live until roughly 78 1/2, you'll pretty much break even with about $209,000 in lifetime Social Security income. If you pass away at 75, however, you'll come out about $20,000 ahead by filing at 62 instead of 67.

Now let's run the opposite scenario, where you delay benefits until age 70, thereby increasing each monthly payment from $1,500 to $1,860. You'll break even with $279,000 in total Social Security income at age 82 1/2. But if you live until age 85, you'll come out about $11,000 ahead by filing at 70 instead of 67. And if you live until 90, filing at 70 will allow you to come out over $32,000 ahead.

That's why your health must play a role in your decision to file for Social Security. If it's great, you might consider delaying benefits as long as possible. If it's poor, you might think about filing as soon as you're eligible. Or, you might land somewhere in the middle. The key, however, is to run different scenarios to see which ones allow you to come out ahead. Even though Social Security is *designed* to pay you the same total lifetime benefit regardless of the filing age you land on, many seniors ultimately find that the program doesn't actually work that way in practice.

New Tax Law Had Little Effect on the Number of Retirees Who Pay Taxes on Social Security Benefits

The new tax law appears to have had little to no effect on relieving the taxation of the Social Security benefits received by retired taxpayers, according to early results of a new survey by The Senior Citizens League (TSCL). "Almost half of all retiree households, about 46% of survey respondents, report that they paid taxes on a portion of their Social Security benefits for the 2018 tax year that just ended," says Mary Johnson, a Medicare and Social Security policy analyst for **The Senior Citizens League**. "According to our data, since 2015 the average number dropped just 1 percent from 51 percent to 50 percent of retiree households who report paying taxes on their Social Security benefits," Johnson notes.

The results didn't come as a total surprise. While 2018 was the first full tax year affected, the 2017 Tax Cuts and Jobs Act, made no changes to the taxation of Social Security benefits. "Even retirees with very modest incomes can be subject to a tax on a portion of their Social Security benefits," says Johnson. A growing number of retirees are affected by the taxation of Social Security benefits, because the income thresholds are fixed, and not adjusted annually, like income tax brackets. In 1984 when the taxation of Social Security benefits began, less than 10 percent of Social Security recipients paid tax on benefits. Now it's about five times more. The Senior Citizens League is working to enact legislation that would raise the income thresholds that subject Social Security benefits to taxation.

From 50 percent to 85 percent of the Social Security benefits can be subject to taxation, depending on income. Single filers with incomes of $25,000 or more, and joint filers with incomes of $32,000 or more are affected. The tax is determined by adding nontaxable interest income to the adjusted gross income, and one half of Social Security benefits.

A new Social Security bill in Congress, the *Social Security 2100 Act* **(H.R 860)** **(S. 269)**, would eliminate the tax for millions of older taxpayers, by making substantial changes to the income thresholds. The bill would raise the current income thresholds for taxation of Social Security benefits to $50,000 for single filers and $100,000 for joint filers, effective for tax year 2020. Lifting the income thresholds that subject Social Security benefits to taxation is strongly supported by older taxpayers. The bill would make up for the loss of revenue, by other payroll tax changes.

Amid Opioid Prescriber Crackdown, Health Officials Reach Out To Pain Patients

A pharmacist in Celina, Tenn., was one of 60 people **indicted on charges of opioid-related crimes last week**, in a multistate sting. John Polston was charged with 21 counts of filling medically unnecessary narcotic prescriptions.

He was also Gail Gray's pharmacist and the person she relied on to regularly fill her opioid prescriptions.

"I take pain medicine first thing in the morning. I'm usually up most of the night with pain," she said. "I hurt all the time."

Living in a mountainous community on the Tennessee-Kentucky line, Gray has coped with a degenerative disk disease for more than 15 years, requiring multiple back surgeries. She says the chronic pain is totally debilitating without powerful opioids.

But with her druggist shut down, her high-dose prescriptions have been questioned by the other pharmacy in town.

"They wouldn't take me because I was red-flagged on my dose," she said.

The dozens of indictments across Appalachia left thousands of patients who are dependent on opioids to function on a daily basis scrambling, from Ohio to Alabama. **Over 50 of those indicted** were doctors, nurses or other medical professionals. So as agents were in the field making arrests, the Justice Department also coordinated with local agencies to deploy health workers to look for desperate patients.

U.S. Assistant Attorney General Brian Benczkowski said the enforcement was coordinated with health agencies and addiction treatment providers.

"That plan is designed to ensure that affected patients have continued access to care and are, at the same time, directed to legitimate medical professionals in the area," he said at a press conference in Cincinnati last week.

Amid an ongoing crackdown on overprescribing doctors in Appalachia announced in October, patient advocates have been increasingly concerned for pain patients and those abusing prescription drugs. Being suddenly cut off from medications they depend on can be dangerous. Patients could become so desperate from withdrawal symptoms that they may resort to street drugs and could overdose.

But this time, in Tennessee, the health department is working to connect people who need pain treatment to legitimate pain clinics. And the substance abuse department began plastering messages online just as the indictments were unsealed, giving patients a hotline to call.

"This is the first time that we have had this type of heads-up," said Marie Williams, who oversees Tennessee's substance abuse agency.

With previous stings that resulted in the closure of pain clinics, Williams said, her staffers have gotten, perhaps, one day to prepare. This time, it was nearly a month.

Overdose prevention specialists have been deployed to train families on how to use reversal drugs like Narcan. They've also been taping up flyers on shuttered clinic doors.

Williams said she hopes many who may have become addicted to painkillers will see the loss of their opioid supplier as a turning point…. **Read More**

U.S. health officials unveil experiment to overhaul primary care

Federal health officials on Monday unveiled a new **primary care experiment** that seeks to pay doctors for providing stepped-up services that keep patients healthy and out of the hospital, an effort they say will transform basic medical services for tens of millions of American patients.

The initiative, called CMS Primary Cares, includes five new payment options for small and large providers, allowing them to take varying levels of financial responsibility for improving care and lowering costs. It broadly seeks to change how primary care is delivered in the U.S. by rewarding doctors for improving management of patients with chronic illnesses such as diabetes and high blood pressure, and averting expensive trips to the hospital.

Health and Human Services Secretary Alex Azar called the program "an historic turning point in American health care" that is projected to enroll a quarter or more of the 44 million Americans served by traditional Medicare.

"This initiative will radically elevate the importance of primary care in American medicine," Azar said, adding that it will "move [the nation] toward a system where providers are paid for outcomes rather than procedures, and free up doctors to focus on the patients in front of them, rather than the paperwork we send them."

The effort to implement value-based care is a popular talking point in American medicine, but has yet to be fully implemented. This new initiative is the most sweeping attempt to date to change primary care, an area that accounts for about 3 percent of costs but influences the trajectory of illnesses that account for a much greater percentage of expenses.

Whether this experiment will induce large numbers of providers to participate, or result in significant changes, remains to be seen. Participation is voluntary, so officials will have to convince large numbers of primary care physicians that it will benefit them. They projected Monday that a quarter of primary practices will join. The federal Centers for Medicare and Medicaid Services will allow primary care practices to apply for the new programs this summer, with the goal of implementing them in 2020.

The initiative may spur physicians to **increase the use of technology**, telehealth services, and remote patient monitoring to deliver stepped-up care to patients. It does not expressly say that Medicare will pay providers for responding to weekend emails or text messages from chronically ill patients, or for doing online or in-home visit to address emergent problems as soon as they arise. But those are the kinds of measures health officials want to encourage primary care doctors to take.

"Providers will have greater flexibility to spend these resources how they want, allowing them to come up with innovative ways to care for patients — and receive significant savings if they keep patients healthier than expected," Azar said.

The need for reforming America's system of paying for health care was reinforced by recent **CMS projections** that U.S. spending on medical services will grow **5.5 percent annually** over the next eight years, reaching nearly $6 trillion by 2027. That would equate to 19.4 percent of the nation's total economic output.

But transforming to a value-based system of care is especially difficult because it requires setting a clear and universal definition of what value is, and then figuring out how to measure it. The task also requires adjusting for variability among providers' populations of patients — some doctors take care of sicker patients, overall, than others — as well as differences in the size of their practices and the underlying social and economic needs of their patients….**Read More**

Pharma Lobby Nears Spending Records With Drug Prices Under Fire

Large drug makers and the industry's primary trade group neared previous spending records on lobbying in the first three months of the year as President Donald Trump and Congress increased pressure to rein in the cost of medicine.

The Pharmaceutical Research and Manufacturers of America trade group, which represents 37 drug companies, spent $9.91 million in the first quarter, up from $6.03 million during the last quarter of 2018, and just shy of its record a year earlier, according to disclosures filed with Congress before a Monday deadline.

Drug companies are facing an unprecedented threat to their pricing practices as the president and lawmakers from both parties have targeted the high costs of drugs. That has become one of the few areas of bipartisan agreement in an otherwise divisive political climate.

The Trump administration has proposed new rules and approved a slew of new generic drugs, sending a signal that more ambitious changes may be needed to lower pharmaceutical prices for Americans. That's spurred drugmakers to **reveal** prices of their prescription drugs on websites for the first time in a bid to avoid being forced to make even more public disclosures in TV ads.

Two of the world's biggest insulin producers **started** offering bigger discounts -- prompting Congress to call for more action and criticize the companies for waiting for so long.

Quarterly Increases

AbbVie Inc., **AstraZeneca Plc**, **Bayer AG**, **Biogen Inc.**, **Bristol-Myers Squibb Co.**, **Merck & Co. Inc.**, **Novartis AG**, **Pfizer Inc.** and **Sanofi** all bolstered their first-quarter spending compared with the fourth quarter, according to the filings.

Novartis hiked its spending an eye-popping 450 percent to $3.2 million from $580,000, and that figure was also about 5 percent above what it spent a year earlier, the filings show. Merck spent $2.74 million in the period, more than 200 percent more than in the last quarter of 2018, but that figure was down more than 17 percent compared with the year before, when it was one of several companies to **set** a group record.

AstraZeneca, Biogen and Bristol-Myers all spent more than their year-earlier levels. Those companies and AbbVie, Merck, Novartis, Pfizer, Sanofi, **Johnson & Johnson** all disclosed lobbying on drug pricing, among other issues…..**Read More**

RI ARA HealthLink Wellness News

FDA Approves New Osteoporosis Treatment

Many aging Americans face the risk of fractures due to osteoporosis. Now, they have a new means of fighting back, thanks to the U.S. Food and Drug Administration's approval of a new treatment on Tuesday.

The FDA gave its OK to Evenity, an injected therapy developed by drug giant Amgen. Evenity (romosozumab) is a type of therapy known as a monoclonal antibody, and it helps build new bone by blocking the effect of a protein called sclerostin, the agency explained.

Evenity's approval was limited, however: It's only meant for use against osteoporosis in women at a high risk of fracture.

"These are women with a history of osteoporotic fracture or multiple risk factors for fracture, or those who have failed or are intolerant to other osteoporosis therapies," the FDA said in a news release.

The move to restrict use is needed, the FDA said, because the new drug does come with risks.

"Evenity may increase the risk of heart attack, stroke and cardiovascular death, so it's important to carefully select patients for this therapy, which includes avoiding use in patients who have had a heart attack or stroke within the previous year," said the FDA's Dr. Hylton Joffe. He directs the FDA's Center for Drug Evaluation and Research's Division of Bone, Reproductive and Urologic Products.

A special boxed warning will outline Evenity's heart risks on its labeling, the FDA said. Other common side effects include joint pain and headache.

A dose of Evenity requires two injections, one immediately following the other, given once a month by a health care professional. And the bone-forming effects of the treatment "wanes after 12 doses, so more than 12 doses should not be used," the FDA said.

Still, the therapy does seem effective for some women. In one trial of over 11,000 postmenopausal women with osteoporosis, a year of Evenity cut their odds for a spinal fracture by 73% compared to placebo, the FDA noted, and the benefit appeared to continue over two years….**Read More**

The Earlier You Develop Type 2 Diabetes, the Greater Your Heart Risks

Young adults and women with type 2 diabetes are at increased risk of developing heart disease -- and dying from it, a new study says.

The findings suggest "we need to be more aggressive in controlling risk factors in younger type 2 diabetes populations and especially in women," said lead author Dr. Naveed Sattar.

Sattar is a professor of metabolic medicine at the University of Glasgow in Scotland.

He and his colleagues analyzed data collected between 1998 and 2014 from more than 318,000 type 2 diabetes patients in Sweden. They also looked at data on a control group of more than 1.5 million without the disease, and compared the two for about five years.

They found that people diagnosed with type 2 diabetes before age 40 fared the worst. They had the highest increased risk of stroke, heart attack, heart failure, a heart rhythm disorder called atrial fibrillation, and death.

Women generally had higher increased risk of heart disease and death than men in most categories.

The findings on seniors were less worrisome. The researchers found that increased risk of death, regardless of cause, for people diagnosed with type 2 diabetes at age 80 or older significantly decreased and was the same as those of similar age without diabetes.

The study was published April 8 in the journal *Circulation*.

"Our study shows the differences in excess diabetes risk are tied to how old the person is when they are diagnosed with type 2 diabetes," Sattar said in a journal news release.

Far less effort and resources could be spent screening people 80 and older for type 2 diabetes unless symptoms are present, he added.

"Furthermore, our work could also be used to encourage middle-aged people at elevated diabetes risk to adopt lifestyle changes to delay their diabetes by several years," Sattar said.

The researchers noted that the study followed a mostly white European population, so further studies are needed to assess the role of heart disease in non-white populations with type 2 diabetes.

Why is your doctor prescribing costly drugs?

Recently Peggy, an Indiana woman and reader of this column, sent me a lengthy email about her 94-year-old mother who is rapidly spending down her minimal savings to pay for prescription drugs.

Peggy didn't hold out much hope that prices would come down before it was too late for her mom. But she succeeded in lowering her mom's drug costs and what she learned along the way can be helpful to others strapped by high pharmaceutical bills.

Her mother is typical of many women in old age who have only a tiny financial cushion to absorb the continual price hikes imposed by the drug makers. She was raised during the Depression, didn't work much outside the home, lived in a condo her son bought, and then moved to an **assisted living facility** almost two years ago.

The facility's $3,100 monthly fee plus **drug copays** bit into her savings, which totaled about $30,000 when she moved to assisted living. Government benefits earned by Peggy's father who served in the Korean War, a very small pension from a former employer, and **Social Security benefits** cover all but about $600 of the assisted living fee. The rest comes from her savings, which now are about half of what they were in 2017….**Read More**

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Quick Test Helps Predict Hospital Readmission Risk After Heart Attact

For elderly heart attack survivors, how well they perform on a simple mobility test could help predict whether they will be back in the hospital within a month, researchers say.

Nearly one in five of these heart patients are readmitted with complications such as heart failure, bleeding or irregular heart beat within 30 days after leaving the hospital.

The new study included more than 3,000 heart attack patients, average age 81, at 94 U.S. hospitals. Within 30 days of leaving the hospital, about 18% had been readmitted, the findings showed.

Before they left the hospital, patients' thinking, vision, hearing and mobility were assessed. In the mobility assessment, the seniors were timed on how long it took them to rise from a chair, walk 10 feet and then return to the chair.

This "Timed Up and Go" test was the only functional assessment associated with readmission within 30 days.

Patients who took longer than 25 seconds to complete the test were nearly twice as likely to be readmitted than those who did it in under 15 seconds, the researchers found.

Other more traditional risk factors -- including chronic lung disease and heart rhythm disorders -- were also associated with readmission, according to the study published April 23 in the journal *Circulation: Cardiovascular Quality and Outcomes*.

"Heart attack is one of the conditions specifically identified by Medicare as a priority for readmissions reduction, but so far it's been challenging to predict specifically which patients with heart attack will get readmitted," study author Dr. John Dodson said in a journal news release.

Dodson is director of the New York University Geriatric Cardiology program in New York City.

He suspects that poor performance on the mobility test is a sign of vulnerability to such stresses as infection, falls and recurrent heart events. Dodson also said that "there's considerable overlap between impaired mobility and something called the frailty syndrome, which is generally thought of as an increased vulnerability to these stresses."

But other factors, such as performance of the health system, are important in gauging readmission risk, and the "findings will need to be replicated in future studies," he added.

More information

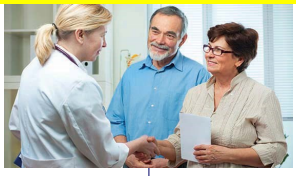
The American Heart Association has more **on heart attack recovery.**

Diagnosing Lewy Body Dementia

It's important to know which type of Lewy body dementia (LBD) a person has, both to tailor **treatment** to particular **symptoms** and to understand how the disease will likely progress. Clinicians and researchers use the "1-year rule" to help make a diagnosis. If cognitive symptoms appear at the same time as or at least a year before movement problems, the diagnosis is dementia with Lewy bodies. If cognitive problems develop more than a year after the onset of movement problems, the diagnosis is Parkinson's disease dementia.

Regardless of the initial symptoms, over time people with LBD often develop similar symptoms due to the presence of Lewy bodies in the brain. But there are some differences. For example, dementia with Lewy bodies may progress more quickly than Parkinson's disease dementia.

Dementia with Lewy bodies is often hard to diagnose because its early symptoms may resemble those of Alzheimer's or a psychiatric illness. As a result, it is often misdiagnosed or missed altogether. As additional symptoms appear, it is often easier to make an accurate diagnosis.



The good news is that doctors are increasingly able to **diagnose LBD** (PDF, 80K) earlier and more accurately as researchers identify which symptoms and biomarkers (biological signs of disease) help distinguish it from similar disorders.

Difficult as it is, getting an accurate diagnosis of LBD early on is important so that a person:

- Gets the right medical care and avoids potentially harmful treatment
- Has time to plan medical care and arrange legal and financial affairs
- Can build a support team to maximize quality of life

While a diagnosis of LBD can be distressing, some people are relieved to know the reason for their troubling symptoms. It is important to allow time to adjust to the news. Talking about a diagnosis can help shift the focus toward developing a care plan.

Read more about diagnosing dementia, including tests and who can make a diagnosis.

There are no tests that can definitively diagnose LBD. Currently, only a brain autopsy after death can confirm a suspected diagnosis. However, researchers are studying ways to diagnose LBD earlier and more accurately during life. The use of certain imaging, blood, cerebrospinal fluid, and genetics tests is being studied.

Talking to both patients and caregivers helps doctors make a diagnosis. It is important to tell the doctor about any symptoms involving thinking, movement, sleep, behavior, or mood. Also, discuss other health problems and provide a list of all current **medications,** including prescriptions, over-the-counter drugs, vitamins, and **supplements**. Certain medications can worsen LBD symptoms.

Caregivers may be reluctant to talk about a person's symptoms when that person is present. Ask to speak with the doctor privately if necessary. The more information a doctor has, the more accurate a diagnosis can be.

For More Information About Diagnosing LBD

NIA Alzheimer's and related Dementias Education and Referral (ADEAR) Center
1-800-438-4380 (toll-free)
adear@nia.nih.gov
www.nia.nih.gov/alzheimers

The National Institute on Aging's ADEAR Center offers information and free print publications about Alzheimer's disease and related dementias for families, caregivers, and health professionals. ADEAR Center staff answer telephone, email, and written requests and make referrals to local and national resources.

Lewy Body Dementia Association
1-404-975-2322
(toll-free LBD Caregiver Link)
1-844-311-0587
www.lbda.org

Increased muscle power may prolong life

Increasing muscle strength is good, but increasing muscle power may be even better for enjoying a longer life, according to a recent study.

Professor Claudio Gil Araújo, who is the director of research and education at Exercise Medicine Clinic — CLINIMEX in Rio de Janeiro, Brazil, led the new study.

Muscle power differs from muscle strength in that it relies on generating force and velocity while coordinating movement. For example, lifting a weight one time requires strength, but lifting it several times as quickly as possible requires power.

The study involved 3,878 nonathlete participants who were 41 to 85 years old. Each participant took a maximal muscle power test between 2001 and 2016 using an upright row exercise.

The researchers determined each participant's maximal muscle power by taking the highest value that they achieved over two or three attempts with increasing weight and then calculating the power exertion per kilogram of body weight.

They then separated the participants into quartiles according to their maximal muscle power, with quartile one being low and quartile four being high. They also analyzed the participants separately based on their sex.

The team followed the participants for an average of 6.5 years after this initial measurement, during which time, 247 men and 75 women died. The researchers found that those who had maximal muscle power above the median for their sex had higher survival rates than those in the lower quartiles.

In fact, the participants in quartile one had a risk of dying that was 10 to 13 times higher than that of those in quartiles three and four, while the risk for those in quartile two was still four to five times higher.

"Rising from a chair in old age and kicking a ball depend more on muscle power than muscle strength, yet most weight-bearing exercise focuses on the latter," he says.....**More**

CPAP Brings Longer Life for Obese People With Sleep Apnea: Study

There's good news for the millions of obese Americans with sleep apnea: Researchers report the use of the CPAP mask may greatly increase their chances for a longer life.

Use of the continuous positive airway pressure (CPAP) mask was tied to a 62% decline in the odds for death over 11 years of follow-up.

That benefit held even after factoring in health risk factors such as heart disease, weight, diabetes and high blood pressure, said a French team of investigators led by Dr. Quentin Lisan, of the Paris Cardiovascular Research Center.

They noted that prior randomized clinical trials had not been able to find a survival benefit for CPAP, but they now believe those trials were simply too short for the effect to emerge.

In the new study, the benefit to longevity only "appears six to seven years after initiation of CPAP therapy," the team reported in the April 11 issue of the journal *JAMA Otolaryngology-Head and Neck Surgery*.

An expert who penned an accompanying editorial said the findings should help doctors and patients, because many people with sleep apnea balk at the notion of wearing a mask to bed each night.

"Every knowledgeable sleep specialist has had difficulty in convincing some patients of the need to treat their obstructive sleep apnea with these devices," wrote Dr. Clete Kushida, a sleep medicine researcher at Stanford University in California.

As Kushida noted, more than 55.6 million Americans over the age of 40 are thought to suffer the snoring and repeated nighttime awakenings of obstructive sleep apnea, which is often tied to obesity and age.

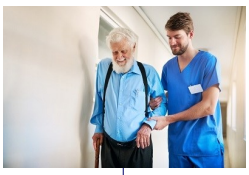
Sleep apnea isn't just an annoyance: It's also been tied to higher risks for heart disease, heart failure and stroke.

CPAP is the leading remedy for the condition. But can it actually extend users' lives?

To find out, Lisan's group crunched the numbers from the Sleep Heart Health Study, which began in the late 1990s and has followed more than 6,400 Americans 40 and older for decades. The study was funded by the U.S. National Institutes of Health.

The sub-analysis conducted by the French team focused on 392 participants who were severely obese and were diagnosed with severe obstructive sleep apnea. About four-fifths of the participants were men….**Read More**

Liver Frailty Index could identify cirrhosis patients at highest risk of death while waiting for transplants



Cirrhosis is a common liver disease, affecting about 1 in 400 adults in the United States annually. Cirrhosis can lead to liver failure or end-stage liver disease, which requires a liver transplant for survival. But up to 25 percent of people who are on waitlists for liver transplants die before receiving one. A new way to measure physical frailty in people with cirrhosis of the liver may help to better identify patients who are most at risk of dying while waiting for a transplant, according to a new study. The research by an NIA- and NIDDK-supported team of investigators was published in the Jan. 17 issue of *Gastroenterology*.

Current methods of determining the individuals most at-risk for serious complications or death while waiting for transplant have relied on lab test results or the presence of physical complications like hepatic encephalopathy (HE, temporary problems with brain functioning and cognition due to a buildup of toxins in the blood) or ascites (abdominal swelling due to a buildup of protein-rich fluids).

However, cirrhosis is often accompanied by a cluster of related side effects, such as muscle wasting, poor nutrition, and decreased physical function. ….**Read More**

How to avoid harm from prescription drug overload

Written by Shannon Brownlee

Medications can treat symptoms, prevent disease, and even extend our lives. But can taking too many drugs be harmful? A **new report from the Lown Institute** finds that millions of older Americans are at risk of harm from the **side effects** of multiple prescription drugs, an epidemic experts are calling "Medication Overload."

Over the past few decades, the number of medications Americans are taking has skyrocketed. Currently, 42 percent of Americans age 65 and over take five or more drugs compared to just 13 percent in the mid-1990s. Nearly 20 percent of older Americans take ten or more medications.

Taking five or more medications should be seen as a red flag for potential harm. Each additional prescription drug increases the risk of serious side effects, such as **delirium**, **falls**, and bleeding. Last year, five million older Americans – one in ten – sought medical treatment for an adverse drug event. More than a quarter million were hospitalized. It's very likely that you or someone you know has experienced harm from too many medications, whether it is physical harm from drug side effects or mental exhaustion from managing a laundry list of medications.

Fortunately, patients, families, and caregivers can take steps to reduce medication overload.

While our culture reinforces the idea that there's "a pill for every ill," patients, families, and caregivers can and should question that assumption. The best way to prevent harm from medication overload is to avoid taking unnecessary medications in the first place.

Before adding another medication to your regimen, ask your doctor these questions:

- What is this medication for?
- How will we know when the medication is working or not working?
- When should I stop taking this medication?
- Can I start on a lower dose and see if that works?
- Are there side effects I should watch out for if I take this medication?

If you believe that you, or a family member, are experiencing harmful side effects from medication overload, or are having trouble managing too many pills, ask your primary care provider for a "prescription checkup." This checkup is an opportunity to discuss any side effects you're concerned about, and identify any unnecessary or potentially harmful medications you can stop or taper. If possible, bring a full list of the medications you (or your family member) are taking to the visit.

Engaging in conversations about medications with your doctor is an essential part of reducing medication overload, but it is by no means the only solution. (For a full list of recommendations for addressing medication overload, **see the Lown Institute report**.) Health professionals, policymakers, and patients must come together to tackle this problem, for the sake of the health and well-being of millions of Americans.

This post was co-written by *Judith Garber, a health care policy and communications fellow at the Lown Institute and co-author with Brownlee of* ***"Medication Overload: America's Other Drug Problem."***

Patients Experiment With Prescription Drugs To Fight Aging

Dr. Alan Green's patients travel from around the country to his tiny practice in Queens, N.Y., lured by the prospect of longer lives.

Over the past two years, more than 200 patients have flocked to see **Green** after learning that two drugs he prescribes could possibly stave off aging. One 95-year-old was so intent on keeping her appointment that she asked her son to drive her from Maryland after a snowstorm had closed the schools.

Green is among a small but growing number of doctors who prescribe drugs "off-label" for their possible anti-aging effects. Metformin is typically prescribed for diabetes, and rapamycin prevents organ rejection after a transplant, but doctors can prescribe drugs off-label for other purposes — in this case, for "aging."

Rapamycin's anti-aging effects on animals and metformin's on people with diabetes have encouraged Green and his patients to experiment with them as anti-aging remedies, even though there's little evidence healthy people could benefit.

"Many of [my patients] have Ph.D.s," said Green, who is 76 and has taken the drugs for three years. "They have read the research and think it's worth a try."

In fact, it's easier for patients to experiment with the drugs — either legally off-label or illegally from a foreign supplier — than it is for researchers to launch clinical trials that would demonstrate they work in humans.

No rigorous large-scale clinical trials have been conducted aimed at aging. The FDA so far has not agreed that a treatment could be approved for delaying the onset of aging or age-related diseases, citing questions about whether research can demonstrate an overall effect on aging rather than just on a specific disease.

Given such reservations, pharmaceutical companies have little incentive to fund costly, large-scale trials. Also, both metformin and rapamycin are generic and relatively cheap.

"There's no profit," said **Matt Kaeberlein**, a professor of pathology at the University of Washington medical school whose team received a $15 million grant from the National Institutes of Health to study the effects of rapamycin in dogs, but has noted the lack of funds for studies in people. "Without profit, there's no incentive."

Supplements with **purported anti-aging effects** routinely enter the market with little scrutiny and less evidence.

Yet, late last year, the NIH rejected a $77 million grant **proposal** by a prominent group of researchers to determine whether metformin could target multiple age-related diseases at once. It was the second rejection of the ambitious but unorthodox bid.

"We're going to keep trying," said a lead author of the metformin proposal, Stephen Kritchevsky, a co-director of the Sticht Center for Healthy Aging and Alzheimer's Prevention. "These things take time."

Less is known about rapamycin's anti-aging effects and its possible side effects in the general population, including the possibility it could lead to insulin resistance. Yet a litany of studies show that rapamycin extends animal life spans….**Read More**