

May 16, 2021 E-Newsletter

A Major Women's Issue: Repeal the WEP and GPO!

 **Social Security Fairness**
Repeal the Government Pension Offset/
Windfall Elimination Provision!

The Government Pension Offset and the Windfall Elimination Provision are poorly written laws that have been levied against public workers for nearly forty years. They are particularly harsh against women.

The formula for the Windfall Elimination Provision does not produce the effect that it was designed to do. It has a harsher effect on retirees who have had lower-paying jobs and lower pensions. Currently, the one way of mitigating its effects requires a level of "substantial" yearly FICA earnings for 20-30 years. This level of "substantial" earnings discriminates against

women who have been more likely to work at part time or low-paying jobs. Women are 43% of those affected by the WEP—currently nearly 780,000 thousand retired women.

Particularly egregious, the Government Pension Offset currently affects more than 700,000 retirees, 83% of them women. The GPO reduces and usually eliminates all spousal and survivor benefits. More than 70% of retirees affected get none of their earned benefits. The GPO formula results in an average loss of \$555 a month for men, but \$745 for women. A spouse who has been married for at least ten years normally earns both spousal and survivor benefits that



their marriage partner has paid into FICA for them. The GPO ignores the 10-year dependency rule and eliminates the spousal or survivor benefit based on the spouse's earning of a government pension which might not even have been earned during that marriage. The GPO continues to increase its penalties over the years for those who actually receive benefits, since, if the government pension recipient is given a raise, the law requires that person to report the raise to the Social Security Administration. If the raise is for \$30 a month, then the spousal or survivor benefit is reduced by \$20. Every other retiree gets \$30 a month cost of

living, but the GPO affected senior only gets \$10.

The WEP and GPO affect retirees in every state, and they have their harshest effects on lower income public employees: mail carriers, teachers, school bus drivers, police and fire employees with partial careers, city secretaries, and clerks. Their pensions are both taxed differently in different states and earned differently than Social Security benefits. Balancing a public pension's benefits against Social Security benefits is inherently unfair and indefensible legislation. The Windfall Elimination Provision and the Government Pension Offset must be repealed! ssfairness.org

Biden Plan Leaves out Drug Price Reductions

One of the disappointments in President Biden's new social safety-net proposal, called the American Families Plan, was that it didn't contain any mention of reining in the price of prescription drugs.

The American Families Plan, the second part of Biden's expansive "infrastructure" agenda, includes programs aimed at boosting access to child care, higher education and paid family leave.

Initial reports suggest that Biden and his aides did not want to pick a fight now with the powerful prescription drug industry, which is riding high in public opinion after producing COVID vaccines in record time. They worry that the industry's impressive lobbying clout could endanger the rest of the program.

But it appears an even bigger reason is division among the

Democratic majority as to how to spend the money that prescription drug cost reduction would save Medicare.

The disagreement seems to be over enhancing Medicare benefits or boosting the benefits of the Affordable Care Act.

According to one report, this particular disagreement is like what happened in the 1980s and '90s, when generations were pitted against each other in a sometimes-ugly way. Younger Americans, worried about rising rates of the uninsured, accused Medicare beneficiaries who wanted better benefits of being "greedy geezers."

A law Congress passed in 1988 that would have boosted Medicare benefits and added a cap on catastrophic expenses caused a backlash when Congress decided wealthier seniors should



pay for it themselves via added taxes. Seniors angry that younger people would not help foot the bill rebelled, and the entire program was repealed in 1989 before it ever took effect.

This disagreement, coupled with a major increase in lobbying efforts on the part of the big drug companies, be part of the fight over reducing drug costs this year.

The pharmaceutical industry keeps turning up the dial on lobbying, setting massive new spending records in its intensive effort to influence Congress and the Biden administration.

The industry increased its lobbying spending by 6.3 percent in the first quarter.

That's compared to the first quarter of 2020. Drug and health product manufacturers, along with their national association, spent a combined \$92 million to

lobby the federal government from January through March, according to the website Open Secrets.

That puts the industry on track to break its spending record for the second year in a row. Not only that, but its first-quarter spending was more than double what was spent by the second-highest-spending industry, electronics companies.

There are currently 1,270 registered lobbyists for pharmaceuticals and health products — more than two lobbyists for every member of Congress.

We tell you that in order to help you understand what we're up against when we fight for lower drug prices.

Your continued support is urgently needed to help us win the battle his year.

ADD
YOUR
NAME

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

Medicare requiring nursing homes to report weekly vaccination statistics

Federal health officials instituted a rule mandating long-term care facilities report residents' and staff's COVID-19 vaccinations every week to the Centers for Disease Control and Prevention (CDC) starting in two weeks.

The Centers for Medicare and Medicaid Services (CMS) announced the vaccination reporting requirement on Tuesday, directing the facilities to report the data to the CDC's National Healthcare Safety Network (NHSN), a national infection tracking system.

Officials aim to use the information to help track vaccinations in these congregate care settings and determine which might need more resources during the pandemic. At this time, the rule applies to long-term care facilities, including nursing homes, and

residential facilities for those with intellectual disabilities.

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Vaccination details for specific facilities will be available for the facilities, stakeholders and public to see on CMS's COVID-19 Nursing Home Data website once the data is collected.

Long-term care facilities already have to report COVID-19 testing, case and death data to the NHSN, but COVID-19 vaccination statistics have not previously been mandated. The requirement for COVID-19 shots reflects previously mandated reporting of influenza and pneumococcal vaccines.

Lee Fleisher, CMS chief medical officer and the director of CMS's Center for Clinical Standards and Quality, said in a statement that the mandate will



help ensure "equitable vaccine access" for Medicare and Medicaid recipients.

"Today's announcement directly aids nursing home residents and people with intellectual or developmental disabilities who have been disproportionately affected by COVID-19," he said. "Our goal is to increase COVID-19 vaccine confidence and acceptance among these individuals and the staff who serve them."

The rule intends to limit the amount of severe illness and deaths occurring in these facilities after nursing homes became breeding grounds for the virus, leading to many deaths among the vulnerable residents.

Despite representing 1 percent of the U.S. population, nursing home residents made up about one in three deaths, according to

the COVID Tracking Project's estimates. CMS said it is looking into extending the policies to psychiatric residential treatment facilities, group homes and assisted living facilities.

The federal government's move to track vaccinations in long-term care facilities comes as 83.7 percent of Americans 65 and older have received at least one shot, according **to the CDC**.

As of April 23, more than 4.8 million long-term care residents and staff received at least one dose and more than 2.8 million are fully vaccinated.

David Gifford, the chief medical officer of American Health Care Association and National Center for Assisted Living, said in a statement that the organizations "greatly appreciate" the move.

New Bills Regarding Medicare/Social Security Benefits Introduced in Congress

The following legislation of interest to TSCL and our supporters has been introduced recently in Congress. Unfortunately, there is no additional information available regarding the contents of the bills other than what is printed below.

Because legislation sometimes contains provisions that we believe are actually contrary to what the title seems to imply, TSCL will look at these bills once more information is available and then make a determination as to whether we

will support any or all of them. We present them here to make you aware they are now under consideration in Congress.

H.R. 1587 - Medicare Audiologist Access and Services Act of 2021

This bill provides for Medicare coverage of certain audiologist services. Specifically, the bill expands coverage to include diagnostic and treatment services that are furnished by audiologists and that would otherwise be covered if provided by a physician,



including incidental services, regardless of whether such services are provided pursuant to a referral from, or under the supervision of, a physician or other health care practitioner.

H.R.2484 - To amend title XXVII of the Public Health Service Act and title XVIII of the Social Security Act to require pharmacies to disclose any differential between the cost of a prescription drug based on whether certain individuals use prescription drug coverage to acquire such drug.

H.R.2881 - To amend title XVIII of the Social Security Act to provide for an option for individuals who are ages 50 to 64 to buy into Medicare, to provide for health insurance market stabilization.

H.R.2654 - To amend title XVIII of the Social Security Act to provide Medicare coverage for all physicians' services furnished by doctors of chiropractic within the scope of their license.

File 2020 Tax Return with the IRS to Receive Missing Economic Impact Payments

The Internal Revenue Service (IRS) issued the third round of Economic Impact Payments (EIP) in April. Most Social Security beneficiaries and Supplemental Security Income (SSI) recipients should have received their EIPs by now. If a person is missing their first or second EIP, they need to file a 2020 tax return with the IRS and claim the 2020 Recovery Rebate Credit (RRC) as soon as possible.

Any person who did not

receive his or her EIP, or the full amount of their EIP, please read this carefully. **To get any missing first or second EIPs, file a 2020 tax return with the IRS and claim the 2020 Recovery Rebate Credit (RRC) immediately.** People should file the 2020 tax return even if they have no income to report for 2020. When the tax return is processed, the IRS will pay the RRC as a tax refund. The IRS will send any additional



third EIP amount owed in 2021 separately.

If people already filed their 2020 tax return, they do not need to do anything else.

Visit Social Security's Economic Impact Payments and Tax Credits page at www.socialsecurity.gov/coronavirus/eip/ to learn more.

For questions about tax-related topics and economic impact payments, please contact

the IRS.

Read the **IRS' April 28 press release** at <https://www.irs.gov/newsroom/nearly-2-million-more-economic-impact-payments-disbursed-under-the-american-rescue-plan-continuing-payments-reach-approximately-163-million> for more information.

For Social Security information, please visit the agency's COVID-19 web page at www.socialsecurity.gov/coronavirus/.

Medicare Rights Responds to Proposed HIPAA Changes

Today, the Medicare Rights Center submitted **comments** to the Health and Human Services Office of Civil Rights (OCR) in response to proposed changes to an important privacy rule. The rule, which clarifies and implements the Health Insurance Portability and Accountability Act of 1996 (HIPAA), is a vital protection against misuse or improper disclosure of private health information.

HIPAA requires covered entities like health care providers to make health records available to patients and keep

that information safe from casual disclosure, malicious exposure, and even hackers. Since its creation, HIPAA has been **widely misunderstood** and incorrectly applied, often improperly wielded to keep people from accessing their information rather than making it easier for patients and caregivers to **exercise their rights**.

The proposed rule would strengthen some patient protections, including shortening the amount of time they must



wait to receive access to their records. Such access can improve care coordination, alleviate

risk of duplicated or contraindicated treatment, and give patients the opportunity to correct errors.

However, the proposed rule would weaken other consumer guardrails in ways that could lessen confidentiality and patient trust. In our comments, we urged OCR not only to reject such changes but to do more to educate both covered entities and consumers about how the

rule works, what protections it does and does not offer, and how to keep information as safe as possible.

Importantly, HIPAA **has gaps** that no rule can fill. As consumers use more types of technology such as phone apps and wearables, their information becomes less private and more easily exploited for profit. We urge Congress to do more to protect the privacy and security of health information, including by extending HIPAA to cover more types of entities.

Medicare Rights Endorses Elijah E. Cummings Lower Drug Costs Now Act

On May 4, the U.S. House Committee on Energy and Commerce, Subcommittee on Health held a **hearing** on drug pricing legislation, including the recently reintroduced provisions of the Elijah E. Cummings Lower Drug Costs Now Act (**H.R. 3**). Medicare Rights submitted a statement for the hearing record in support of this important bill.

In our statement, we note that people with Medicare are uniquely impacted by prescription drug costs. Medicare Part D enrollees take an average of **four to five prescriptions per month**, and many live **on fixed or limited incomes** that cannot keep pace with high and rising drug prices. Those who can't afford their medications may be forced to go

without, putting them at risk for poorer health and quality of life, as well as for higher out-of-pocket and program costs down the line.

Legislation is urgently needed to lower prescription drug prices, strengthen Medicare, and promote beneficiary well-being. H.R. 3 would significantly advance these goals, in part by authorizing Medicare to negotiate prices for certain drugs; imposing inflationary rebates; and restructuring Part D to cap beneficiary costs, reduce the federal government's liability, and better align pricing incentives.

According to **prior estimates**, these and other changes would save Medicare nearly \$500 billion over 10 years. Unlike the



previously passed version of H.R. 3, the bill currently before the Committee does not

reinvest these dollars into Medicare. We strongly urge lawmakers to again allow H.R. 3's prescription drug savings to pay for much-needed coverage improvements and beneficiary protections, such as expanded access to Medicare's low-income assistance programs; new Medigap enrollment rights; and the addition of a comprehensive dental, vision, and hearing benefit to Medicare Part B.

We also continue to support modernizing the Medicare Part D appeals process in any drug pricing bill. Though intended to help people access needed care, the system today is inefficient

and ineffective. Improvement strategies include strengthening data collection and oversight; requiring independent redeterminations; raising the cost threshold for the specialty tier and allowing tiering exceptions; and updating plan communications with enrollees, including at the pharmacy counter.

To that end, we specifically **support** legislation introduced in the 116th Congress, the bipartisan Streamlining Part D Appeals Process Act (**H.R. 3924**). This commonsense bill would give people with Medicare more timely information about their plan's coverage decision and eliminate unnecessary administrative steps, lessening burdens systemwide.

More people are choosing lower-cost Medigap plans

One of the great things about traditional Medicare is that if you can afford a comprehensive Medicare supplemental insurance policy, "Medigap," you do not have to worry about out-of-pocket costs for services that Medicare covers. The catch is that the cost of that supplemental insurance policy can be high. Allison Bell reports for **ThinkProgress** that, increasingly, people are opting for lower-cost Medigap policies.

Signing up for traditional Medicare and buying a lower-cost Medigap policy is actually a smart alternative to Medicare

Advantage, through which people get their Medicare benefits through private insurers. With **Medicare Advantage**, depending upon the plan you choose, your out-of-pocket costs for in-network care alone can be as high as \$7,550; the average is about \$5,500. And, in Medicare Advantage, you can't buy a policy to protect you from those costs, much less for your out-of-pocket costs for out-of-network care.

Many people choose **traditional Medicare** over Medicare



Advantage because they do not want to restrict their access to doctors and hospitals. But, because Medicare does not have an out-of-pocket limit, to protect themselves from financial risk, they usually buy a Medigap policy if they don't have retiree coverage or Medicaid to fill gaps.

A new poll shows that about one in three people who enroll in traditional Medicare choose Plan N. Plan N fills most gaps but does not cover physicians' excess charges if you see doctors who do not take assignment. The

good news is that about 90 percent of doctors take assignment—accept Medicare's approved rate as payment in full, so having coverage for physicians' excess charges is often not necessary. And, plan N costs less than other Medigap options.

Still, about two in three people who enroll in traditional Medicare choose Plan G, which covers all out-of-pocket costs with the exception of the Part B deductible. The advantage of Plan G is that when you need health care, you don't need to worry about the cost.

How GoodRx profits by lowering people's drug costs

As most people taking prescription drugs know, even with insurance coverage, out-of-pocket costs can be extraordinarily high. GoodRx lowers people's drug costs on some drugs. In the process, GoodRx also helps itself quite a bit, profiting because Congress still hasn't reined in drug prices and insurers don't see a need to get their members the best possible price for their drugs.

A story in **Fortune** explains that even generic drugs can end up costing people with health insurance coverage a considerable amount out of pocket. Where you get your drugs matters. According to Kaiser Health News, **chain pharmacies**, like CVS, tend to charge more than other pharmacies. Millions of people buy their drugs from **abroad** to save a lot of money.

The generic version of Nexium, esomeprazole, cost one Texan man \$490 for a three-month supply, with insurance. Instead of taking it, he googled to try to find it at a lower cost. He found it for \$17 out of pocket without insurance at Kroger, through GoodRx, with the coupon it offers.

GoodRx also helped this

Texan man fill a different prescription that would have cost him \$36 for a month's supply. Through GoodRx, he could get it for less than half that cost, \$16.60. Of course, using this method of getting drugs, keeps him from meeting his drug deductible and insurance out-of-pocket cap.

GoodRx fills an enormous need in the US, helping to make drugs affordable for people who otherwise might not take them. As it is, one Gallup poll suggests that **58 million people** forgo needed medicines every year because of the cost.

GoodRx also profits handsomely from its business, which brings together literally more than 200 million price points every day. It had \$550 million in revenue in 2020. Its profits were about \$55 million in the first six months of 2020.

GoodRx works through **Pharmacy Benefit Managers** (PBMs), the middlemen that determine which drugs are on an insurer's formulary and what you must pay out of pocket for them. The PBMs and GoodRx generate revenue whenever you fill a prescription.

GoodRx

GoodRx makes most of its money and gives people the greatest savings on low-cost generic drugs.

Different PBMs benefit from providing GoodRx these deals and pay GoodRx for each referral it gives a customer filling a prescription.

Patients with insurance can benefit in any number of ways. If the insurer denies them coverage for a drug, for example, they can use GoodRx to get the drug at less cost than they would have to pay at the pharmacy. As many as **half of older adults** with low incomes have been told by their health plans that a drug their doctor prescribed was not covered.

But, the fact that people need GoodRx to supply them coupons so that they can afford their drugs, with or without insurance, is positively insane. What about all the people who don't know about GoodRx? Why shouldn't Americans be able to get their drugs for free or at a very low cost directly at their pharmacies, as they can in virtually all other wealthy nations? And, since they can't, why aren't insurers responsible for ensuring people pay the lowest price for their drugs? Instead, they're profiting

from this system while taking people's money for coverage people can't afford.

And GoodRx is driving up costs at the same time it is making drugs available to people at lower cost. People pay a little more for their drugs with the GoodRx coupon so that GoodRx benefits. Why should we have so many layers of profit-taking in the system, so much waste? Why hasn't Congress simply lowered prescription drug prices for everyone?

A **2018 study** published in the Journal of the American Medical Association found that, when people fill prescriptions, more than one in five times (22 percent) their copays are more than the cost of the drugs. That is a travesty. It's a way PBMs maximize their profits. And the PBMs are owned by the insurers.

And, as much as it helps people, GoodRx is part of the PBM problem. One independent pharmacist claims that GoodRx gives a discount that is sometimes still higher than the pharmacy's cash price. But, people don't know. That's how GoodRx profits. And, all it does is use its algorithms to steer people to lower cost drugs.

GAO finds US drug prices more than four times those in France

The US Government Accountability Office just released a **new report** at the behest of **Senator Bernie Sanders** that finds that Americans can pay more than four times more for prescription drugs than people in Australia, Canada and France. In short, people with basic health conditions such as blood clots, emphysema and bronchitis pay a lot more for life-saving medicines than people in other wealthy countries.

Senator Sanders is drafting legislation that would bring down drug prices and prevent pharmaceutical companies from gouging people in the US. Every other country negotiates drug prices. We need to as well.

Sanders and 17 other Senators, along with scores of House

members, also called for President Biden to include legislation that lowers prescription drug prices in the American Families Plan. Americans should not be paying more for their medications than people in other wealthy countries. Biden did not put forward a specific proposal to lower drug prices, but he spoke of his support for lowering prices as part of the American Families Plan.

Senator Sanders wants the projected \$450 billion in Medicare savings from lower drug costs over 10 years to go towards additional Medicare benefits, including vision, hearing and dental benefits. He also supports adding an out-of-pocket cap to traditional Medicare.

If you're wondering about the



extent of the differential in drug prices between the US and other countries,

here's some interesting data: In 2020, Americans spent 4.36 more than the French for certain drugs, 4.25 more than Australians and 2.82 more than Canadians. Moreover, even though Canada does not have universal prescription drug coverage, people in the US spend as much as eight times more at the pharmacy for prescription drugs than they would for the same drugs at Canadian pharmacies. Here are some examples:

- ◆ Hepatitis C and liver infections: Eplusa (28 tablets), is \$36,743 in the US; \$17,023.63 in Canada.
- ◆ Hepatitis C: Harvoni (28

tablets) is \$46,570.33 in the US; \$19,084.54 in Canada

- ◆ Blood clots: Xarelto (30 tablets), is \$558.33 in the US; \$85.44 in Canada

- ◆ Chronic obstructive pulmonary disease (COPD) and other lung diseases that make it hard to breathe: Incruse Ellipta Inhalation Powder (30 inhalations) is \$411.33 in the US; \$53.31 in Canada

Australians pay no more than a \$28.09 copay for a month supply of these prescription drugs. French people pay no more than \$34.03 for these prescription drugs. High income older Canadians with prescription drug coverage have copays of no more than \$4.67.

KFF COVID-19 Vaccine Monitor - April 2021

Most adults nationally say they have gotten at least one dose of a COVID-19 vaccine, and few say they haven't but want to do so right away, posing a new challenge for the nation's vaccination efforts. The latest report also explores parents' intentions for their kids and confidence in vaccines' safety.

Key Findings

◆ With eligibility for COVID-19 vaccination now open to all adults in the U.S., the latest KFF COVID-19 Vaccine Monitor shows that while the pace of vaccine uptake has continued rapidly over the past month, enthusiasm may be reaching a plateau. The share of adults who say they've gotten at least one dose of a vaccine or intend to do so as soon as possible inched up from 61% in March to 64% in April, while the share who want to "wait and see" before getting vaccinated – a group that had been steadily decreasing in size since over several months – remained about the same in April (15%) compared to March (17%). Among Republicans, a group that has been slower to embrace the vaccine, over half now say

they've gotten at least one dose or will do so as soon as they can. The share of Republicans who say they will "definitely not" get vaccinated decreased from 29% in March to 20% in April but remains substantially larger than the share among Democrats or independents.

◆ In the wake of news about blood clots possibly linked to the Johnson & Johnson COVID-19 vaccine and the subsequent pause in the use of this vaccine, less than half the public expresses confidence in the safety of the Johnson & Johnson vaccine, and concerns about potential side effects have increased among those not yet vaccinated, especially women. Hispanic women are particularly likely to say that the news of these blood clots caused them to rethink their vaccination decision. Despite this, the trajectory of vaccine uptake and enthusiasm does not appear to have slowed

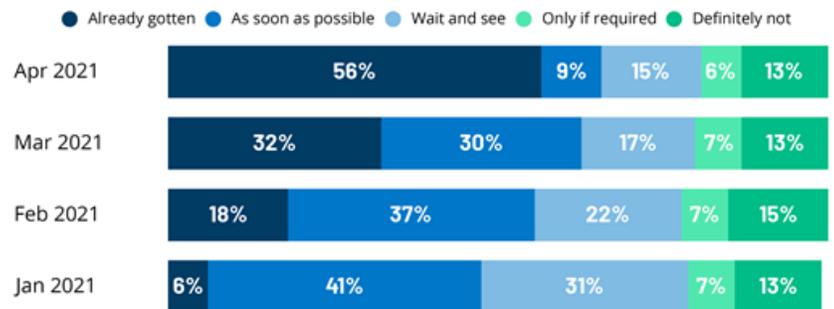
disproportionately among women over the past month. Two-thirds (66%) of women say they've been vaccinated or will do so as soon as possible, compared to 63% of men

◆ Among those who are open to getting vaccinated but have not yet tried to get an appointment, reasons range from safety concerns to logistical barriers to questions about eligibility, and vary widely by vaccination intention. Those who say they want the vaccine as soon as possible mainly cite logistical concerns and information needs; those in the wait and see group mainly express

safety concerns or a lack of research, and those who say they'll get the vaccine only if required mainly say they don't feel they want or need the vaccine. By contrast, when those who say they will "definitely not" get vaccinated are asked if there is anything that might change their mind, the answer is a resounding "no."

◆ While side effects and safety top the list of concerns for those who haven't gotten vaccinated for COVID-19, we continue to find that lack of information and access are barriers for some individuals, particularly people of color... [Read More](#)

Over Half Of Adults Report Receiving A COVID-19 Vaccine, But Demand May Be Slowing As Eager Group Shrinks



Inflation: A \$1,404 Gift to Some, an Obstacle to Others in Retirement

Inflation rarely evokes a positive connotation. And rightfully so. The concept of a dollar being worth less tomorrow than it is today is a scary thought. Hyperinflation can bankrupt an economy -- or in the case of 1920s Germany, sow the seeds for war.

However, moderate inflation isn't necessarily a bad thing. In fact, inflation routinely got above 4% during the economic boom of the 1950s. By the end of 2021, The Federal Reserve sees unemployment falling to just 4.5% and inflation rising to 2.4% -- which could save U.S. households holding debt an average of \$1,404. Here's why rising inflation could be a good thing if you have debt but a bad thing if you're [in retirement](#).

Why inflation is rising

In just one year, the U.S. has gone from virtually 0% inflation and 15% unemployment to 2.6% inflation and 6% unemployment. There are a few reasons for this.

Low interest rates and stimulus checks make it easier to purchase goods and services such as homes, cars, consumer goods, and much-needed vacations. The result: [a surge in the housing market](#) (which is now at a 10-year high), not to mention a [global chip shortage](#).

With the vaccine distribution well underway and the U.S. economy roaring back to life, the demand for experiences not felt in over a year is outpacing supply. Baseball stadiums



operating at 50% capacity are having no issues selling out, so they can raise prices.

Bars and restaurants that have struggled for months are inclined to up prices, and consumers are happy to oblige. After skipping their annual summer vacation in 2020, many Americans are expected to let loose this year, which means businesses like airlines, cruise companies, and resorts have the green light to raise prices.

A blessing for those with debt Prices rising throughout different sectors of the economy is the essence of inflation. You and I are experiencing it right now. However, inflation paired with low unemployment means wages should rise too. As

business improves, companies large and small look to hire more workers, which makes it easier to find a job or lobby for a raise. In its [March 2021 report](#), the National Federation of Independent Business (NFIB) noted that a record-high 42% of business owners had job openings they couldn't fill, 28% raised compensation (the most in the past year), and 17% plan on raising compensation in the next three months.

Rising wages illustrate the benefits of inflation for [paying down debt](#). Let's say someone making \$20 an hour gets a 5% raise to \$21 an hour... [Read More](#)

Retirement scams to watch out for

Scams are on the rise. In 2018, the Federal Trade Commission announced it had collected **1.4 million fraud reports** and that people had reported losing \$1.48 billion to fraud—a 38% increase over the previous year. Younger people reported losing money to fraud more often than older people, with 43% of responders in their 20s confessed to losing money to scams. Only 15% of those in their 70s reported the same thing, but older people tended to lose more: The median

loss for individuals in their 70s was \$751; it was \$400 for people in their 20s.

Senior citizens targets for fraud for many reasons, according to the FBI. First, seniors often have large “nest eggs,” own their own homes, or have good credit, making them appealing targets for con artists. In addition, seniors may take longer to realize that they’ve been scammed and they take longer to



report it, both of which make it easier for scammers to succeed. Finally, individuals who grew up during the 1930s, ‘40s, and ‘50s tend to be more polite and trusting, characteristics fraudsters exploit. In light of this, Stacker rounded up 20 retirement scams seniors should watch out for. Using independently verified sources, we highlight some of the most common and dangerous scams that target the

elderly. From Medicare scams, to reverse mortgage scams, to counterfeit anti-aging product schemes, these scams can be both financially and emotionally draining. Those who believe they have been victimized by a scam should file a complaint with their local police department, as well as with the Federal Trade Commission. A complete **list of where to report scams**, based on the type of fraud involved, can be found on USA.gov.

13 Cell Phone Plans for Seniors

Take advantage of cell phone senior discounts for those age 55 and older. Owning a smartphone can be expensive, especially once you include texting, data and mobile hotspot connections. However, many communication companies have a variety of

options and prices to accommodate different needs, including phone plans designed specifically for **senior citizens**. The top cell phone plans for seniors are:

- ◆ T-Mobile Unlimited 55+ Plan.



- ◆ Verizon 55+ Unlimited Plan.
- ◆ GreatCall Wireless.
- ◆ Consumer Cellular.
- ◆ AT&T Senior Nation.
- ◆ Sprint Unlimited 55+.
- ◆ Boost Mobile Unlimited.

- ◆ Ting Mobile Flex.
- ◆ Mint Mobile 15 GB Prepaid Plan.
- ◆ US Mobile Custom Plan.
- ◆ Republic Wireless.
- ◆ Snapfon.
- ◆ Cricket Wireless.

Dear Marci: What is the Medicare Savings Program?

*Dear Marci,
I have heard that some people don't have to pay their Medicare premiums because they enrolled in a Medicare Savings Program. Can you explain this program?
-Donald (Bozeman, MT)*

Dear Donald,
Medicare Savings Programs (MSPs) help pay your Medicare costs if you have limited income and savings. There are three main programs, each with different **benefits** and **eligibility requirements**. To qualify for an MSP, you must have Medicare Part A and meet income and asset guidelines (note that these guidelines vary by state, and some states do not count assets when determining MSP eligibility). Below are the benefits of each MSP, as well as the baseline federal income and asset limits. Most states use these limits, but some states have different guidelines.

- ◆ **Qualified Medicare Beneficiary (QMB)**
- ◇ **Benefits**
- Pays for **Medicare Parts A**

- **and B premiums**
- **Eliminates cost-sharing** for Medicare-covered services
- ◇ **Eligibility**
- Monthly income limit: \$1,094 for an individual or \$1,472 for a couple
- Asset limit: \$7,970 for an individual or \$11,960 for a couple
- * Note: If you owe a premium for Part A and are not yet enrolled, and you meet QMB eligibility guidelines, your state may have a process to allow you to enroll in premium Part A and QMB at the same time. Contact your **State Health Insurance Assistance Program (SHIP)** to learn more.
- ◆ **Specified Low-income Medicare Beneficiary (SLMB)**
- ◇ **Benefits**
- Pays for Medicare Part B premium
- ◇ **Eligibility**
- Monthly income limit: \$1,308 for an individual or \$1,762 for a couple

- Asset limit: \$7,970 for an individual or \$11,960 for a couple
- ◆ **Qualifying Individual (QI) Program**
- ◇ **Benefits**
- Pays for Medicare Part B premium
- Eligibility
- Monthly income limit: \$1,469 for an individual or \$1,980 for a couple
- Asset limit: \$7,970 for an individual or \$11,960 for a couple
- In addition to the above benefits, the three MSPs also:
- Allow you to enroll in Medicare Part B outside of usual enrollment periods
- Eliminate your **Part B late enrollment penalty**, if you have one
- Automatically enroll you in the **Extra Help program**
- Before applying for an MSP, you should call your local Medicaid office for application steps, submission information (online, mail, appointment, or through community health centers and other organizations), and other state-specific guidelines. Call

your **State Health Insurance Assistance Program (SHIP)** to find out if you are eligible for an MSP in your state.
-Marci



The month of May is National Mental Health Awareness Month. This year, the **National Alliance on Mental Health (NAMI)** is amplifying the message, “You Are Not Alone.” Millions of people are affected by mental illness each year, and according to NAMI, 1 in 5 adults in the U.S. experience mental illness in their lifetimes. For illnesses that affect so many, it is important to share resources and “acknowledge that it’s okay to not be okay.” **Click here** for NAMI’s tips on finding a mental health professional. You can also call the NAMI helpline at 800-950-NAMI (6264) to find answers to your questions, support, and practical next steps. Call the National Suicide Prevention Lifeline at 800-273-TALK (8255) if you or someone you know is in crisis, whether they are considering suicide or not, to speak with a trained crisis counselor 24/7.

Telemedicine Is a Tool — Not a Replacement for Your Doctor’s Touch

Earlier in the pandemic it was vital to see doctors over platforms like Zoom or FaceTime when in-person appointments posed risks of coronavirus exposure. Insurers were forced — often for the first time — to reimburse for all sorts of virtual medical visits and generally at the same price as in-person consultations.

By April 2020, **one national study** found, telemedicine visits already accounted for 13% of all medical claims compared with 0.15% a year earlier. And covid hadn’t seriously hit much of the country yet. By May, Johns Hopkins’ neurology department was conducting **95% of patient visits virtually** compared with just 10 such visits weekly the year before, for example.

Covid-19 let virtual medicine out of the bottle. Now it’s time to tame it. If we don’t, there is a

danger that it will stealthily become a mainstay of our medical care. Deploying it too widely or too quickly risks poorer care, inequities and even more outrageous charges in a system already infamous for big bills.

The pandemic has demonstrated that virtual medicine is great for many simple visits. But many of the new types of telemedicine being promoted by start-ups more clearly benefit providers’ and investors’ pockets, rather than yielding more convenient, high-quality and cost-effective medicine for patients.

“Right now there’s a lot of focus on shiny objects — ideas that sound cool — rather than solving problems,” said Dr. Peter Pronovost, a national expert in medical innovation at



University Hospitals Cleveland Medical Center, who has written **about finding the value of virtual medicine**. “We know precious little about its impact on quality.”

Even so, the financial world is abuzz with investment opportunities. In the first six months of 2020, telehealth companies **raised record amounts** of funding, with **five start-ups each raising** more than \$100 million.

There are now telehealth apps that target niche markets like the mental health **of pregnant women**. Others provide medicines, like HIV prevention pills, after a virtual consultation with their doctors. You can even do a digital eye appointment, meet with your dentist virtually to monitor your oral health and orthodontic progress, and send a

dermatologist a photo of a suspicious mole.

With telemedicine generously reimbursed, many practices are offering — **even encouraging** — patients to visit virtually. But, intentionally or not, that choice becomes a revenue multiplier, adding to patient expense.

When he noticed a curious rash, a relative was first directed to a practice’s telemedicine portal and billed \$235 for a five-minute video appointment. Since rashes are often hard to evaluate in two dimensions, he was told he needed to see a doctor in person for the diagnosis and then was charged \$460 more for that visit. I worry that pandemic-era reimbursement practices have taken traditionally free screening calls and rebranded them as billed visits, with no value added....**Read More**

Women Get Help Later Than Men When Heart Attack Strikes

When young women land in the emergency room with chest pain, they wait longer and get less treatment than their male counterparts, a preliminary study finds.

Using a federal survey of U.S. hospitals, researchers found that younger women with chest pain were treated less urgently than men their age. That included a lower likelihood of receiving standard tests for diagnosing a heart attack.

Chest pain can have a range of causes, including minor issues like muscle strain and acid reflux.

But it’s also the most common symptom of heart attack in both women and men, said study co-author Dr. Harmony Reynolds, a cardiologist at NYU Langone Health in New York City.

It’s not clear why young women were treated differently for their chest pain. But implicit biases on the part of some medical professionals could be at work, Reynolds said. The old stereotype that heart attack is a “man’s disease” still persists.

The study is far from the first to uncover a gender gap in heart attack treatment. Others have shown that women get fewer of the recommended medications for post-heart attack care, and face a higher risk of dying within a few years of a heart attack.

The new findings add to the bigger picture, in part, by focusing on younger adults, said lead researcher Dr. Darcy Banco, an internal medicine resident at NYU Langone.

While heart attacks are more common among older adults, they do strike at younger ages, too.

In fact, Banco said, recent years have seen some “concerning trends” among younger Americans -- particularly women.

A study published in February found that since 2010, heart disease deaths have been rising among U.S. women under 65. The researchers pointed to “worsening epidemics” of



obesity and type 2 diabetes as likely culprits.

And over the past two decades, about one-third of women hospitalized for a heart attack were under 55, according to the American College of Cardiology (ACC).

The current study focused on ER care, using data collected from U.S. hospitals between 2014 and 2018.

It found that women were just as likely as men to arrive by ambulance, but their cases were less often judged as “emergent.” On average, women waited about 11 minutes longer for care.

That might sound like a small difference, but minutes matter in heart attack treatment, Banco pointed out.

According to medical guidelines, all patients arriving in the ER with possible heart attack symptoms should receive an electrocardiogram (EKG) within 10 minutes. EKGs record the heart’s electrical activity, and are the standard initial test in diagnosing a heart attack.

Yet young women in this study of 18- to 55-year-olds were less likely to receive an EKG at all: About 74% did, compared to 79% of men. Women were also less often seen by a consultant, like a cardiologist (8.5% versus 12%), or placed on cardiac monitoring (25% versus 30%).

Banco will present the findings Saturday at the ACC’s annual meeting, being held online. Studies reported at meetings are generally considered preliminary until they are published in a peer-reviewed journal.

Dr. Ileana Piña, a volunteer medical expert with the American Heart Association, was unsurprised by the findings.

“The perception that women don’t get heart disease is still out there,” said Piña, a clinical professor of medicine at Central Michigan University.

She said examples abound where women’s symptoms are written off as stress or indigestion. That’s despite the fact that heart disease is the No. 1 killer of both men and women, Piña said....**Read More**

Obesity Raises Odds for Many Common Cancers

Being obese or overweight can increase the odds of developing several types of cancers, new research from the United Kingdom reveals.

But shedding the excess pounds can lower the risk, researchers say.

Reducing obesity cuts the risk for endometrial cancer by 44% and uterine cancer by 39%, and could also prevent 18% of kidney cancers and 17% of stomach and liver cancers, according to the study.

"It all depends on keeping the weight off," said lead researcher

Carlos Celis-Morales of the BHF Institute of Cardiovascular and Medical Sciences at the University of Glasgow in Scotland. He noted that many people lose weight only to regain it back -- and then some.

"What we need is kind of a long-term healthy weight and people that achieve that will reduce the risk," Celis-Morales said. "That is why it's so important that people improve the quality of their lifestyle in order to keep a healthy body weight."



He cautioned, however, that this study can't prove that excess weight causes cancer or that losing weight prevents it, only that there seems to be a strong connection between excess weight and cancer risk.

For the study, Celis-Morales and his colleagues drew on data from the U.K. Biobank on more than 400,000 men and women who were cancer-free.

The investigators wanted to know the risk of developing and dying from 24 cancers based on six markers of obesity: body fat

percentage, waist-to-hip ratio, waist-to-height ratio, waist and hip circumferences and body mass index (BMI), an estimate of body fat based on height and weight.

No matter which way it was measured, obesity increased the odds of developing 10 of the most common cancers, the study found. A larger waist and hips, BMI or percentage of body fat all provided similar cancer risk....[Read More](#)

Heart Risk Factors Show Up Earlier in U.S. Black Women

Young Black American women have high rates of lifestyle-related risk factors for heart disease, a new study indicates.

The findings show the need to help them adopt healthy eating and physical activity habits, as well as make it easier for them to access health care, the researchers said.

"Young people should be the healthiest members of our population, with normal body weight and normal blood pressure," said study author Dr. Nishant Vatsa, an internal medicine resident at Emory University Hospital in Atlanta.

"Diet and exercise play a major role in blood pressure and weight. Primary care providers, prevention-based clinics and community organizations can

facilitate interventions proven to mitigate these risk factors," Vatsa said.

"Providers that treat young Black women need to be mindful of cardiovascular preventive care and be armed with resources and education."

In the study, Vatsa's team analyzed data gathered between 2015 and 2018 from 945 Black women enrolled in a community health screening project in Atlanta. The average body mass index (BMI -- an estimate of body fat based on weight and height) in all age groups was 30, which is considered obese.

Systolic blood pressure -- the top number in a reading and a measure of the force of blood pushing against artery walls during a heartbeat -- was higher than normal among younger



women and increased with age.

Average systolic blood pressure among those aged 20 to 39 was 122 mm Hg, while 120 mm Hg is considered normal by the American College of Cardiology and American Heart Association. Middle-aged and older women had an average systolic blood pressure of nearly 133 and 142, respectively.

Obesity and high blood pressure are major risk factors for heart disease, and both are affected by lifestyle factors such as diet and exercise.

Nearly one-third of women aged 20 to 39 said they ate fast food at least three times a week, and 2 of 5 had a higher-than-recommended daily salt intake.

Those rates were also high in middle-aged women but lower

among those over 60, according to the study to be presented May 16 at the American College of Cardiology (ACC) virtual annual meeting. Such research is considered preliminary until published in a peer-reviewed journal.

"We're finding obesity and elevated blood pressure are present in women even at younger ages, which is worrisome," Vatsa said in an ACC news release. "Thus, interventions like educating young women about healthy dietary choices and the benefits of exercise, improving access to health care and enhancing the ability for people to adopt healthy practices -- such as increasing access to healthy foods and safe areas for physical activity -- need to start early."

State of Mind Matters for Survival After Heart Attack

The study included 283 heart attack survivors, aged 18 to 61 with an average age of 51, who completed questionnaires that assessed depression, anxiety, anger, stress and post-traumatic stress disorder (PTSD) within six months of their heart attack.

Based on this information, the researchers ranked the study participants as having mild, moderate or high mental distress.

Within five years after their heart attack, 80 of the 283 patients had another heart attack or a stroke, were hospitalized for

heart failure or died from heart-related causes, the findings showed.

Rates of such outcomes were 47% for patients with high distress, compared to 22% for those with mild distress, according to the study, which is scheduled for presentation May 16 at the American College of Cardiology (ACC) virtual annual meeting. Such research is considered preliminary until published in a peer-reviewed journal.

"Our findings suggest that



cardiologists should consider the value of regular psychological assessments, especially among younger patients," lead author Dr. Mariana Garcia, a cardiology fellow at Emory University in Atlanta, said in an ACC news release.

"Equally importantly, they should explore treatment modalities for ameliorating psychological distress in young patients after a heart attack, such as meditation, relaxation techniques and holistic

approaches, in addition to traditional medical therapy and cardiac rehabilitation," Garcia added.

According to the researchers, the study is the first to examine how mental health affects the outlook for younger heart attack survivors.

The findings are similar to previous studies focusing on older adults, and add to evidence that mental health is a crucial part of recovery after a heart attack....[Read More](#)

1 in 4 Heart Attacks Arrive With 'Atypical' Symptoms

A quarter of heart attack patients have atypical symptoms and are less likely to receive emergency care, Danish research reveals.

These patients are also more likely to die within 30 days than those with chest pain.

Atypical heart attack symptoms include breathing problems, extreme exhaustion and abdominal pain.

"Atypical symptoms were most common among older people, especially women, who called a non-emergency helpline for assistance," said study author Amalie Lykkemark Møller, a doctoral student at Nordsjællands Hospital in Hillerød, Denmark. "This suggests that patients were unaware that their symptoms required urgent attention."

For the study, she and her colleagues analyzed data on heart attack-related calls to a 24-hour medical helpline and an

emergency number in Denmark between 2014 and 2018. They were looking for adults 30 and older who were diagnosed with heart attacks within 72 hours of the call.

Of the 8,336 heart attacks they found, a specific primary symptom was recorded for 7,222. Chest pain was the most common (72%).

Twenty-four percent of patients had atypical symptoms, with breathing problems being the most common.

Rates of chest pain were highest among 30- to 59-year-old men who called the emergency number and lowest among women over 79 who called the non-urgent helpline. Atypical symptoms occurred mainly in older patients, especially women who called the helpline.

Among callers with chest pain, 95% were sent help through the



emergency number, compared to 62% of those with atypical symptoms. Seventy-six percent of helpline callers with chest

pain were sent a dispatch, compared to 17% of those with atypical symptoms, the analysis found.

It also revealed that 5% of patients with chest pain died within 30 days of calling the emergency number, as did 3% of those who called the non-urgent helpline.

That compared with 23% of emergency callers who had atypical symptoms and 15% of those who called the helpline.

After accounting for factors that could affect the results, including age, sex, education, diabetes, previous heart attack, heart failure and chronic obstructive pulmonary disease, researchers pegged 30-day death rates at 4.3% for patients with chest pain and 15.6% for those

with atypical symptoms.

The findings were published May 6 in the *European Heart Journal – Acute Cardiovascular Care*.

"Taken together, our results show that heart attack patients with chest pain were three times more likely to receive an emergency ambulance than those with other symptoms," Møller said in a journal news release.

"People with atypical symptoms more often called the helpline, which could indicate that their symptoms were milder, or they were not aware of the severity," she said. "Vague symptoms may contribute to health staff misinterpreting them as benign."

The American Heart Association outlines the **warning signs of a heart attack**.

The #1 Cause of High Blood Pressure, According to Science

There are many ways you can help manage the deadly condition.

The #1 Cause of High Blood Pressure, According to Science.

Nearly every time you walk into a doctor's office or hospital, one of the first things they do is check your blood pressure. High blood pressure (aka hypertension) is when the force

of blood flowing through your blood vessels is consistently too high, per the CDC—and, there's a good chance yours is.

Approximately half of Americans suffer from hypertension, which is the primary or contributing cause of around 500,000 deaths per year. What exactly is it and



what is the number one cause?

Here is everything you need to know about high blood pressure.

- ◆ **What Is High Blood Pressure**
- ◆ **What Happens If You Have It?**
- ◆ **How Do I Know I Have It?**

- ◆ **Here Are the Top Contributing**
- ◆ **What Is the Number One Cause?**
- ◆ **How to Prevent It**
- ◆ **What to Do If You Notice Symptoms**
- ◆ **...Read More**

Are You Taking a Med That's Raising Your Blood Pressure?

Nearly one in five Americans with high blood pressure use medications that can cause blood pressure to spike, a preliminary study shows.

The researchers said the findings are concerning, given how many people have difficulty controlling their high blood pressure.

"A large number of Americans are not meeting their blood pressure goals," said lead researcher Dr. John Vitarello, an internal medicine resident at Beth Israel Deaconess Medical Center, in Boston.

This study points to medications as one possible

culprit. Vitarello said doctors and patients should be aware of that.

Looking at data from the U.S. National Health and Nutrition Examination Survey (NHANES), Vitarello's team found that about one-fifth of Americans with high blood pressure were using medications that can raise those numbers.

The most commonly implicated drugs were antidepressants; nonsteroidal anti-inflammatory drugs (NSAIDs), including ibuprofen (Motrin, Advil) and naproxen (Aleve); and steroid medications



used to dampen inflammation and immune activity in conditions such as lupus and rheumatoid arthritis, or after an organ transplant.

Asked whether doctors usually caution high blood pressure patients about such medications, Vitarello said "it's probably not happening enough."

He said a key takeaway is that doctors should regularly review which medications patients are using.

For their part, people with high blood pressure should keep track of their readings at home,

Vitarello said. If their numbers are not under control, he added, it's worth asking their doctor whether any other medications they take could be a factor.

In some cases an alternative might be possible, Vitarello suggested, such as acetaminophen (Tylenol) in place of an NSAID, for example.

In fact, acetaminophen should be the painkiller of choice for people with high blood pressure, said Dr. Eugene Yang, chairman of the Prevention of Cardiovascular Disease Council for the American College of Cardiology (ACC)...**Read More**

Lots of Sugary Drinks Doubles Younger Women's Colon Cancer Risk

Rates of colon cancer among young Americans are on the rise, and a new study suggests that drinking too many sugary beverages may be to blame -- at least for women.

Women who drank two or more sugar-sweetened beverages such as soda, fruity drinks or sports and energy drinks per day had double the risk of developing colon cancer before the age of 50, compared to women who consumed one or fewer sugary drinks per week.

"On top of the well-known adverse metabolic and health consequences of sugar-sweetened beverages, our

findings have added another reason to avoid sugar-sweetened beverages," said study author Yin Cao, an associate professor of surgery at the Washington University School of Medicine in St. Louis.

The study included more than 95,000 women from the ongoing Nurses' Health Study II. The nurses were aged 25 through 42 when the study began in 1989 and provided information on their diet every four years for nearly 25 years.

Of these, 41,272 reported on what, and how much, they drank in their teen years. During 24



years of follow-up, 109 women developed colon cancer before turning 50.

Having a higher intake of sugar-sweetened drinks in adulthood was associated with a higher risk of the disease, even after researchers controlled for other factors that may affect colon cancer risk such as a family history. This risk was even greater when women consumed sodas and other sugary drinks during their teen years.

Each daily serving in adulthood was associated with a 16% higher risk of colon cancer, but when women were aged 13 to 18, each drink was linked to a

32% increased risk of developing colon cancer before 50, the study found.

But substituting sugar-sweetened drinks with artificially sweetened beverages, coffee or milk was associated with a 17% to 36% lower risk of developing colon cancer before age of 50, the study found.

"Reducing sugar-sweetened beverage intake and/or replacing sugar-sweetened beverages with other healthier beverages would be a better and wiser choice for long-term health," Cao said... [Read More](#)

Many Americans Wrong About Sun's Skin Cancer Dangers

You might think everybody knows how to protect themselves from the sun's harmful rays, but a new survey reveals that one-third of Americans lack a basic understanding of sun safety and skin cancer.

That's the surprising takeaway from an American Academy of Dermatology (AAD) survey of 1,000 U.S. adults.

Fifty-three percent of respondents didn't realize shade offers protection from the sun's ultraviolet (UV) rays, and 47% incorrectly said a base tan would prevent sunburns or were unsure.

Thirty-five percent said tanning is safe as long as you don't burn or were unsure, and 31% were unaware that tanning causes skin cancer.

"These findings surprised us and demonstrate that misperceptions about skin cancer and sun exposure are still prevalent," said AAD president Dr. Kenneth Tomecki, a board-certified dermatologist.

"As dermatologists who see firsthand the impact that skin cancer, including melanoma — the deadliest form of skin cancer



— has on our patients and their families, it's concerning to see that so many individuals still do not understand how to protect themselves from ultraviolet exposure," Tomecki said in an AAD news release.

The survey revealed that people born after 1996 (Generation Z) had the greatest misunderstandings about sun exposure, followed closely by those who were born between 1981 and 1996 (millennials).

"These are striking results when it comes to younger

generations' knowledge about basic sun exposure," Tomecki said. "Gen Z and millennials have a lifetime of potential damaging sun exposure ahead of them, so now is the time to close the knowledge gap and ensure they are aware of how easy it is to practice sun-safe behavior."

Of Gen Z respondents, 42% were unaware that tanning causes skin cancer; 41% didn't know that UV rays are reflected by snow, water and sand; and 33% didn't realize they could get sunburned on a cloudy day... [Read More](#)

Failing Kidneys Could Bring Higher Dementia Risk

Chronic kidney disease may carry an increased risk of dementia, according to a Swedish study.

In people with chronic kidney disease, the bean-shaped organs gradually lose their ability to filter waste from the blood and eliminate fluids.

"Even a mild reduction in kidney function has been linked to an increased risk of cardiovascular disease and infections, and there is growing evidence of a relationship between the kidneys and the brain," said study author Dr. Hong Xu, a postdoctoral researcher at the Karolinska Institute in Stockholm.

For the study, her team analyzed health data from nearly 330,000 older people in Stockholm. None had dementia

or had undergone kidney transplants or dialysis when the study began.

During an average five-year follow-up, 6% were diagnosed with dementia. As kidney function decreased, the rate of dementia increased, the researchers found.

Rates of dementia were more than four times higher among those with a kidney filtration rate below 30 mL per minute, compared to those with a normal filtration rate of 90 to 104 mL per minute, according to the study authors.

After adjusting for other dementia risk factors (such as smoking, alcohol use, high blood pressure and diabetes), the researchers concluded that compared to people with normal kidney function, people with



filtration rates of 30 to 59 mL per minute had a 71% higher dementia risk. People with filtration rates below 30 mL had a 162% higher risk.

The investigators also analyzed blood test data on nearly 206,000 study participants who had multiple blood tests over one year to estimate how fast kidney function declined.

A faster decline in kidney filtration rates was also associated with a higher risk of a dementia diagnosis, according to findings published online May 5 in the journal *Neurology*.

The researchers said 10% of the dementia cases in the study could be attributed to a kidney filtration rate of 60 mL per minute or less. That's a higher percentage of dementia cases

than attributed to other risk factors like heart disease and diabetes.

Xu noted that the risk of dementia, as with chronic kidney disease, increases with age.

"With no effective treatments to slow or prevent dementia, it is important to identify possible modifiable risk factors," she said in a journal news release. "If we could prevent or delay some cases of dementia by preventing or treating kidney disease, that could have important public health benefits."

While the study links kidney function to the development of dementia, it does not prove cause and effect, Xu added.

About 15% of U.S. adults have chronic kidney disease.