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November 8, 2020 E-Newsletter

Publication 2020 Issue 45
Published in house by the
RI ARA

The US just set a staggering new Covid-19 daily case record with more than 120,000 infections

The US set a grim new Covid-19 record Thursday -- following a week marked by high case numbers -- surpassing 120,000 infections in a single day.

And it was the second day in a row the country reported more than 100,000 infections.

Health experts had warned weeks ago that the nation's daily cases would **reach six digits**, but those alarming figures hit sooner than expected. And Covid-19's death toll could reach 266,000 by the end of November, according to an ensemble forecast published Thursday by the Centers for Disease Control and Prevention.

Thursday saw at least 121,054 new cases nationwide, according to Johns Hopkins University. There were at least 1,187 reported deaths, a near 20% increase from the same day last week.

As the US continues to shatter daily case records, so too do states across the nation: Colorado, Illinois, Minnesota, Pennsylvania, Utah and Wisconsin are among those that set new daily records for infections on Thursday.

In just 10 months, more than 9.6 million people in the US have been infected with coronavirus, and **more than 234,000 have died**. Hospitalizations are also surging nationwide, with more than 53,000 people hospitalized with coronavirus on **Thursday**.

As the pandemic continues to escalate, some officials are enacting new rules to try to control the virus' spread.

States break new daily records

Ohio on Thursday saw a record number of new coronavirus infections, and it also reported its highest numbers of hospitalizations and people in intensive care. The state reported 4,961 new Covid-19 cases, with 2,075 people hospitalized and 571 in the ICU.

Dr. Deborah Birx's stern warning is a wakeup call

Every county in the state is seeing significant community spread, said Gov. Mike DeWine, who attributed the rise in cases to weddings, funerals and other social gatherings.

"It is everywhere," he said. "We can't hide from it. We can't run from it. We've got to face it."

Utah hit a daily record with 2,807 new coronavirus cases, with a rolling seven-day average of 1,943 cases. That's up from last week, when the seven-day average was 1,578, according to state epidemiologist Angela Dunn.

Gov. Gary Herbert said the report was "grim news and it's discouraging." He warned that the state would see even higher numbers in the coming weeks unless residents changed their behavior.

But he added that he didn't want to close businesses to curb the spread.

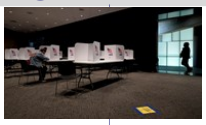
"We think that's maybe the wrong direction to go," he said. "Maybe some modifications of behavior that need to take place to keep those businesses open."

And in Minnesota, there were nearly 4,000 new infections on Thursday -- making it the third day in a row the state broke a daily high of new cases. The state's health department also reported nine days in a row where more than 100 new people were hospitalized with coronavirus….**Read More**

Voter Survey: U.S. Is On Wrong Track, COVID-19 Not Under Control

Almost two-thirds of Americans say the country is on the wrong track, a majority disapprove of the job President Trump is doing and more than half do not think the COVID-19 pandemic is under control, according to early data from AP VoteCast.

VoteCast is not an exit poll. It is a massive set of pre-election polls that runs up through when voting closes Tuesday. VoteCast is conducted nationally and in key states and surveys some 140,000 voters. By comparison, a statistically significant and rigorously conducted national poll typically surveys about 1,000 people. We will be updating with results through the night.



Just 37% of Americans said the country is on the right track, while 63% said it's off on the wrong track, according to the data.

President Trump has a 44% approval rating, while 56% disapprove of the job he's doing. These are very similar numbers to what Trump has seen throughout his presidency.

When it comes to the coronavirus pandemic, 53% said it is not at all under control.

A plurality of voters also said COVID-19 is their top issue — 42% said so, while 27% said the economy and jobs, 9% said health care more broadly and 8% said racism.

Americans also said it is more important to limit the spread of the coronavirus rather than limiting the damage to the economy by a whopping 61%-to-29% margin.

Turnout looks to be on track to be historically high. Before Election Day, more than 101 million Americans voted early. The record for highest total turnout was 137.1 million people in 2016.

The turnout rate is expected to be 65% or higher, according to Michael McDonald, a turnout expert at the University of Florida. That would be the highest rate since 1908.

And VoteCast also shows a significant jump in turnout is likely, with 15% of the electorate being voters who did not vote in 2016.

As for how people voted, 71% said they voted early or by absentee, while 29% said they are voting Tuesday.

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Will Medicare's Premium Increase Take Your Social Security COLA?

Washington, DC) – The Medicare Part B premium increase for 2021 may consume a significant portion of the annual Social Security cost-of-living adjustment (COLA) boost for most retirees, warns The Senior Citizens League (TSCL). "This may even be the case despite recent legislation to limit the Part B increase," says Mary Johnson, a Social Security and Medicare policy analyst for The Senior Citizens League.

The group bases their warning in part on a survey conducted earlier this year when the 1.6 percent Social Security COLA had just gone into effect. The standard Medicare Part B premium increased $9.10 per month from $135.50 in 2019 to $144.60— a 6.7 percent increase in 2020.

Nearly 65 percent of participants in the survey reported that, after deduction of the Part B Medicare premium, their net Social Security benefits increased by only $15 per month *or less*. Of that group, 5.7 percent said net Social Security benefit did not increase at all. Another 7.5 percent reported that their net Social Security benefit in 2020 was *less* than it was in 2019 a situation that can affect some higher income retirees.

The COLA for 2021 will be even lower — 1.3 percent — meaning there will be even less of a boost to cover the Medicare Part B increase. While the Part B premium for 2021 is expected to be announced in November, Johnson notes that years in which Medicare premiums have increased the most during 2010 through 2020, coincided with years in which beneficiaries received no, or a very low, cost of living adjustment (COLA) as shown in the

The Part B premium is likely to higher than expected, due to the impacts of COVID-19. In its September **budget update**, the Congressional Budget Office forecast that, due to higher spending for COVID-19, Medicare outlays would grow 12 percent this year — roughly two times faster than the Medicare Trustees forecast in April. That forecast was released prior to when the impacts due to COVID were fully known. Recently passed legislation restricts the increase for 2021 to the 2020 amount plus 25% of the difference between the 2020 amount and a "preliminary amount" for 2021.

While hopeful that the Part B premium increase will be modest, Johnson points to the situation in 2016. "The 16.1 percent Part B increase in 2016 was the 'restricted' amount after legislation," she notes. In 2016, there was no COLA at all, and the preliminary amount that Medicare Part B premium was first forecast to be was $159.30 per month an unprecedented **52 percent higher** than the previous year. But legislation lowered that increase to $121.80 and the final amount was 16.1 percent higher.

These Part B premium spikes are associated with the triggering of the Social Security hold harmless provision which protects about 70 percent of beneficiaries from net reductions to their Social Security benefits when the Medicare Part B premium increases more than the dollar amount of their COLA. A protected individual's Medicare Part B premium increase is reduced so that their net Social Security check won't be lower from one year to the next. But 30 percent of Medicare beneficiaries are not protected, and these people may be subject to significantly higher premiums.

In essence, there's a massive cost shift from those who are protected to those who aren't because current law does not specify how the unpaid portion of Medicare Part B premiums of those who are protected should be financed. Because program costs are spread over a much smaller number of beneficiaries, Medicare Part B premiums are much higher than they otherwise would be. Those who are not protected by hold harmless include:

- **Low-income beneficiaries who don't have Medicare premiums deducted from their Social Security checks.** About 20 percent of beneficiaries. These are people whose incomes are so low, that their Medicare Part B premiums are paid on their behalf by their state Medicaid program.
- **Higher - income beneficiaries.** Roughly 5 percent of Medicare beneficiaries, those who have modified adjusted gross incomes (MAGI) of more than $87,000 (individual filer) or married couples with incomes of $174,000 (joint filers) are required to pay income-related surcharges on their Part B premiums. The law specifically excludes this group from protection under hold harmless. These individuals are required to pay the full amount of any increase in their Part B premiums.
- **New enrollees.** About 3% of beneficiaries.
- **People who have not started Social Security.** About 2% of beneficiaries may have delayed signing up for Social Security because they have not reached full retirement age, are still working, or both.

Here's a hypothetical example of the how hold harmless protection works: A COLA of 1.3 percent would increase a $740 benefit by $9.60 per month. If Medicare Part B were to increase by $10.00 per month, then all those with $740 benefit, and, who are protected by hold harmless, would see their Part B premium reduced to $9.60 to prevent reduction of their net Social Security benefit. In future years, beneficiaries with reduced premiums would pay a little more than others to catch up to the full amount of Medicare premiums, and "That can take several years for those with lowest benefits when COLAs remain low," Johnson says.

To help older households weather the impacts of the coronavirus and to better afford Medicare Part B premium increases, Senior Citizens League is working for passage of emergency legislation to provide a more adequate COLA of 3 percent in 2021.

Your Medicare benefits and costs in 2021

We're in the midst of the annual Medicare Open Enrollment Period, but we still don't know what Medicare costs will be in 2021. We do know, however, that Congress has limited the amount Medicare Part B premiums can increase. As a result, Medicare costs should not go up a lot in 2021.

The standard Part B premium likely will increase. The standard premium was projected to increase to $153.30 from $144.60. But, Congressional legislation likely will limit the increase to less than $2.50.

However, if your annual income is $88,000 or more, your Part B premium is likely to increase even more. The Part B deductible will also likely increase several dollars from $198.

The Part A premium, deductible and coinsurance will also be higher. The deductible to be paid at the start of a Part A hospital benefit period is projected to be $1,452 in 2021, up from $1,408. **Supplemental coverage** you get in the private insurance market or through a

former employer or Medicaid, generally pays some or all of this cost. If you're in a **Medicare Advantage plan**, a private insurance plan that offers Medicare benefits, you are still responsible for paying the Medicare Part B premium. On top of that, if you need a lot of costly care, your out-of-pocket costs could be as high as $7,550 in 2021, for in-network care alone. In addition, you will have a deductible and copays for your drugs.

The standard **Part D prescription drug plan** will have a deductible of $445 in 2021. You will need to spend $6,550 before you receive catastrophic coverage. You will be responsible for 25 percent of the cost of your drugs until then. Once you reach the catastrophic coverage level, you will be liable for no more than 5 percent of the cost of your drugs.

If you have diabetes and need insulin, some plans will offer insulin with a maximum $35 out-of-pocket monthly cost. However, the premiums for these plans are likely to be higher.

Medicare Fines Half of Hospitals for Readmitting Too Many Patients

Nearly half the nation's hospitals, many of which are still wrestling with the financial fallout of the unexpected coronavirus, will get lower payments for all Medicare patients because of their history of readmitting patients, federal records show.

The penalties are the ninth annual round of the Hospital Readmissions Reduction Program created as part of the Affordable Care Act's broader effort to improve quality and lower costs. **The latest penalties** are calculated using each hospital case history between **July 2016 and June 2019**, so the flood of coronavirus patients that have swamped hospitals this year were not included.

The Centers for Medicare & Medicaid Services **announced in September** it may suspend the penalty program in the future if the chaos surrounding the pandemic, including the spring's moratorium on elective surgeries, makes it too difficult to assess hospital performance.

For this year, the penalties remain in effect. Retroactive to the federal fiscal year that began Oct. 1, Medicare will lower a year's worth of payments to 2,545 hospitals, the data show. The average reduction is 0.69%, with 613 hospitals receiving a penalty of 1% or more.

Out of 5,267 hospitals in the country, Congress has exempted 2,176 from the threat of penalties, either because they are critical access hospitals — defined as the only inpatient facility in an area — or hospitals that specialize in psychiatric patients, children, veterans, rehabilitation or long-term care. Of the 3,080 hospitals CMS evaluated, 83% received a penalty.

The number and severity of penalties were comparable to those of recent years, although the number of hospitals receiving the maximum penalty of 3% dropped from 56 to 39. Because the penalties are applied to new admission payments, the total dollar amount each hospital will lose will not be known until after the fiscal year ends on July 30.

"It's unfortunate that hospitals will face readmission penalties in fiscal year 2021," said Akin Demehin, director of policy at the American Hospital Association. "Given the financial strain that hospitals are under, every dollar counts, and the impact of any penalty is significant."

The penalties are based on readmissions of Medicare patients who initially came to the hospital **with diagnoses** of congestive heart failure, heart attack, pneumonia, chronic obstructive pulmonary disease, hip or knee replacement or coronary artery bypass graft surgery. Medicare counts as a readmission any of those patients who ended up back in any hospital within 30 days of discharge, except for planned returns like a second phase of surgery.

A hospital will be penalized if its readmission rate is higher than expected given the national trends in any one of those categories.

The industry has disapproved of the program since its inception, complaining the measures aren't precise and it unfairly punishes hospitals that treat low-income patients, who often don't have the resources to ensure their recoveries are successful.

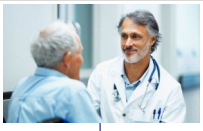
Michael Millenson, a health quality consultant who focuses on patient safety, said the penalties are a useful but imperfect mechanism to push hospitals to improve their care. The designers of the penalty system envisioned it as a way to neutralize the economic benefit hospitals get from readmitted patients under Medicare's fee-for-service payment model, as they are otherwise paid for two stays instead of just one.

"Every industry complains the penalties are too harsh," he said. "if you're going to tell me we don't need any economic incentives to do the right thing because we're always doing the right thing — that's not true."

Medicare Advantage: Will you get care from the doctors you want to see at a price you can afford?

It's **Medicare Open Enrollment** season in the midst of a novel coronavirus pandemic. If you have Medicare, you should be checking out your options for 2021. And, if you're planning to remain in a Medicare Advantage plan–a private insurance plan that contracts with the government to offer Medicare benefits–or considering enrolling in one, it's especially important to look at the tradeoffs you will be making. Once you're enrolled in a Medicare Advantage plan, it can be far more challenging and costly to get the care you need than in traditional Medicare.

For sure, it's simpler to enroll in a Medicare Advantage plan than traditional Medicare, public insurance administered directly by the federal government. With Medicare Advantage, there is an out-of-pocket cap, and you can't buy supplemental coverage to fill gaps. Also, as a general rule, your prescription drug coverage is included with your medical coverage, so you don't have to buy a separate policy.



But, it's harder to leave a Medicare Advantage plan than traditional Medicare. In most states, insurers that fill gaps in traditional Medicare, **Medicare supplement insurers** or "Medigap," are not required to sell you this coverage except when you first enroll in Medicare or you move. (There are a few other exceptions.) And, many people who need costly health care services, such as **home care, nursing home care,** or **specialty care**, find they are far better off in traditional Medicare.

Also, with Medicare Advantage, in 2021, your out-of-pocket costs for in-network care can be as high as $7,550, which the **Medicare Handbook fails to mention**. On top of that, you have out-of-pocket costs for your prescription drug coverage. In addition, you are restricted in the doctors and hospitals you can use and often need permission from your Medicare Advantage plan–"pre-authorization"–in order to be covered for specialty tests.

A **report from the Kaiser Family Foundation** finds that more than three in four people enrolled in a Medicare Advantage plan have restricted access to doctors and hospitals. On average, plans offered them access to less than half the physicians in their area. Your access to care depends significantly on where you live and the plan you choose. Fewer than one in four people are enrolled in broad-network Medicare Advantage plans, offering access to at least 70 percent of physicians in the community.

Access to certain types of specialists can be especially restricted in a Medicare Advantage plan. Kaiser found that some plans offer very little choice of certain types of specialists. What's worse is that it is virtually impossible to know in advance whether you will have access to the doctors you want to use. And, while you might be healthy when you join the Medicare Advantage plan, the whole reason to have health insurance is to protect you in the event that you develop a complex condition and need costly services.

Kaiser looked at 391 Medicare Advantage plans in 20 counties. Its findings assume that the Medicare Advantage provider directories were accurate and that the physicians listed were taking new patients. Other studies have found these provider **directories to be wildly inaccurate**, and often, providers are not taking new patients.

A $200 Debit Card Won't Do Much for Seniors' Drug Costs

If they've been listening to President Donald Trump, seniors may be expecting a $200 debit card in the mail any day now to help them pay for prescription drugs.

He promised as much this month, saying his administration soon will mail the drug cards to more than 35 million Medicare beneficiaries.

But the cards — if they are ever sent — would be of little help. Policy experts say that what Medicare beneficiaries really need, as well as younger Americans, are sweeping federal changes to close the gap between what their health insurance pays and what drugs cost them.

The nation's 46.5 million enrollees in Medicare's Part D prescription drug program — except for those who qualify for low-income subsidies — face unlimited out-of-pocket exposure to drug costs even though the Affordable Care Act finally closed the infamous "doughnut hole." After Part D enrollees have spent $6,550 and reached the catastrophic threshold in a given year, **they still must pay 5% coinsurance** on the list price of their drugs.

Congress was considering legislation to lower drug prices and cap out-of-pocket costs until early this year, when the COVID-19 pandemic took center stage. But partisan disagreement, federal budget concerns and opposition from drug manufacturers and other health care industry groups hampered the efforts.

Many observers question the value, timing and legality of Trump's drug card plan, with the promise coming just ahead of an election in which the president wants to shore up the support of older voters.

"A $200 card is better than a sharp stick in the eye, but it won't be that meaningful," said Tom Scully, the Medicare chief under President George W. Bush who in 2004 implemented a two-year, $1,200 drug card program passed by Congress as part of the law creating the Part D prescription drug benefit.

Two hundred dollars won't go very far. One million Part D plan enrollees have out-of-pocket drug spending way above the program's catastrophic coverage threshold, with average annual costs exceeding $3,200, **according to KFF**. (KHN is an editorially independent program of **KFF.)** Last year, Part D enrollees' average out-of-pocket cost for 11 orally administered cancer drugs was $10,470, **according to a 2019 JAMA study**.

"A lot of people don't have $2,000 or $3,000 to pay out-of-pocket when they go to the pharmacy," said Stacie Dusetzina, a drug policy expert at Vanderbilt University.

Steven Hadfield, 68, of Charlotte, North Carolina, has a rare blood cancer requiring treatment with Imbruvica, with a list price of $132,000 a year. He also needs two different medications for Type 2 diabetes, including insulin at $300 a bottle, a blood pressure drug and a muscle relaxer to relieve leg cramps.

He continues to work at Walmart and holds three part-time jobs. He pays more than $4,000 a year for his drugs, out of his $12-an-hour wages and monthly $1,100 Social Security check. The only way he can afford Imbruvica is through the manufacturer's copay cards….**Read More**

Donald Trump's false claim that doctors inflate COVID-19 deaths to make money

A few weeks ago, President Donald Trump had praise for doctors on the frontlines of treating coronavirus patients.

"Since the plague arrived from China, we have seen our doctors, nurses, first responders, scientists, and researchers at their very best," he said **Sept. 24**.

Trump has changed his tune. In his recent rallies, with COVID-19 cases skyrocketing and deaths climbing, he has taken to accusing physicians of inflating deaths to line their pockets.

"Our doctors get more money if somebody dies from COVID," he told supporters at a rally in Waterford, Mich., Oct. 30. "You know that, right? I mean, our doctors are very smart people. So what they do is they say, 'I'm sorry, but, you know, everybody dies of COVID.'"

This is a persistent theory that lacks any proof.

Johns Hopkins University researchers reported that the virus has killed more than 230,000 people. There is no evidence that figure is exaggerated. If anything, public health analysts say it likely undercounts the reach of the disease.

And while the government offers 20% more for the care of Medicare patients with COVID-19, the majority of doctors work for hospital systems. That means whatever higher payments might come, they don't go to them.

We recently **rated False** a similar claim from Trump that focused on hospitals….**Read More**

Early Issues Around Medicare Plan Finder Data Resolved

In the early weeks of Fall Open Enrollment, several people with Medicare and counsellors at the Medicare Rights Center reported missing data in the Medicare Plan Finder tool. In some areas, certain plan results came back with prices listed for entered prescription drugs as "Not Applicable" or "NA."

Missing information is always a problem, but in a year where additional assistance may not be as available as usual, these gaps in reported information from plans present particular challenges. At Medicare Rights, we are pleased that the Centers for Medicare & Medicaid Services has resolved this specific issue and updated plan results with accurate information about plan costs. We encourage anyone who experienced these challenges to revisit their Plan Finder results to ensure they are in the plan that has the best cost and coverage options for their unique circumstances, and to make a change if needed.

There is still plenty of time to review Medicare enrollment options for next year. People with Medicare have until December 7 to make changes that will take effect on January 1.

Again **this year**, the Kaiser Family Foundation (KFF) has found that more than half of Part D enrollees do not compare plans annually. This work builds on **previous KFF analysis** showing that only a small share of people with Medicare voluntarily switch plans. This "stickiness" may indicate that beneficiaries are satisfied with their current coverage, but it may also indicate that many people on Medicare find it difficult to compare and switch plans, are unaware of the open enrollment period, or are not confident in their ability to select a better plan. The report found that the share of people with Medicare who do not annually review their coverage options is higher among certain groups—people ages 85 and older, those with lower incomes, people with lower education levels, and those who are in fair or poor health.

It is important for these and other people with a Medicare Advantage or Part D plan to evaluate their options. Not doing so leaves one open to higher costs and coverage problems.

Medicare Rights Center will continue to monitor the Medicare Plan Finder tool. If you or a loved one encounter problems with the tool, or need help understanding your options, please contact our national helpline at 800-333-4114.

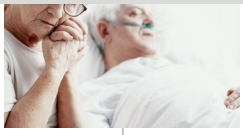
We also have several online resources to help people navigate Fall Open Enrollment, including a **free guide for consumers** as well as **questions** to ask before joining an MA plan and when comparing **Part D plans**.

Government-administered long-term care insurance is long overdue

Since the start of the novel coronavirus pandemic, more than 46,000 people have died in **nursing homes**. The private health care market is failing, and government-administered long-term care insurance, ensuring government oversight, is long overdue.

Alexander Sammon makes the case in the **American Prospect** that the private long-term care insurance market has failed Americans more than any other piece of the health insurance market. Long-term care is the term used to describe an array services and assistance provided to older adults and people with disabilities. It includes help with activities of daily living such as bathing, feeding and toiletting, as well as nursing and therapy services.

For sure, the number of deaths of older adults in **long-term care facilities** are easy to track and horrifying. Though, without good data and knowing that out-of-pocket costs keep people with complex conditions from getting medical and hospital care, it is not at all clear that the number of deaths of working people with serious illnesses and injuries stemming from their **private health insurance** is not equally chilling.



What the long-term care story reveals is how a for-profit health care market endangers people's lives by putting profits first and cannot be relied upon to guarantee our health. More than one in ten long-term care residents are no longer with us, in large part because long-term care facilities were not prepared to care for them.

At some point in your life, there is a good chance that you will need long-term care. Seven in ten people 65 and older require long-term care. Most people rely on family and friends or **Medicaid for long-term care**. Only about three percent of Americans have long-term care insurance; it is expensive, often not available to people with pre-existing conditions, and generally not worth the cost, delivering little bang for your buck.

Because the cost of long-term care is so high, private insurers are hard-pressed to profit from selling coverage and the market has shrunk considerably.

Sammon reports that Americans do not appreciate how likely it is that they will need long-term care. And, many also do not know that Medicare only covers a limited set of long-term care services: up to 100 days of care in a **skilled nursing facility** if certain qualifying criteria are met, some **home care** for people for whom leaving home is extraordinarily difficult and who need skilled nursing or therapy services, and **durable medical equipment**.

There are smart ways to provide everyone long-term care coverage through social insurance. **Washington state** enacted a social insurance program, imposing a small payroll tax on workers' salaries. It will pay out $100 a day for up to a year of in-home care. Hawaii did something similar. It's time that the federal government stepped in and offered similar or better coverage to everyone in the nation through social insurance.

31 Good Jobs for Older People: How to Make Money, Stay Active, and Thrive at Work as a Senior

Believe it or not, plenty of jobs for older people are available. And yes, you can work after retirement—for all kinds of good reasons. For example, maybe you want to earn extra money, help others, meet new people, or explore a career you've always dreamed about but never had the chance to really try out before. Or maybe you've heard that, as you grow older, having a job can provide a surprising number of benefits for your physical and mental health.

The fact is, many of today's seniors are redefining what it means to be retired—by continuing to work. They're discovering that their options for making money are as diverse as their many possible reasons for being part of the workforce. And, of course, there's much more to choose from than just full-time employment. For instance, some seniors start businesses after retirement. Others find part-time jobs.

For seniors over 65, this fact often remains a strong motivating factor: Working past your retirement age can make a big difference when it comes to funding your future elderly years.

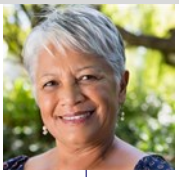
This article lists multiple jobs for senior citizens based on various kinds of motivations. (For example, are you looking for a full-time job as someone over 60 who needs to pay bills after a layoff? Are you researching part-time jobs for a 55-year-old woman in your circle of friends who wants some extra spending money? Regardless of your specific motive, you'll find plenty of ideas here.) Plus, you'll learn how having a job can help you stay happy and healthy. And you'll explore useful tips on finding a good job and getting hired as an older person.

Contents

Am I a Senior Citizen? Age, Terminology, and What "Old" Really Means

What makes someone a senior citizen? Age definitions tend to be a moving target. Some places offer **senior discounts** or memberships to people who have barely passed the half-century mark, but social programs like Medicare are generally off-limits to people under 65. So when exactly does a person become a senior citizen? Where is the boundary between middle age and old age?

The short answer is that it varies. But while there is no universally accepted standard regarding the age at which people become senior citizens, most Western industrialized nations consider the onset of old age to be at age 60 or 65. That's when most Americans retire and become eligible for assistance programs based on age.



But there's more to age than just a number. This article examines the different meanings behind the terms and concepts associated with getting older and explores how people's perceptions of age have changed over time.

Contents

Medicare for first responders: Current rules and future proposals

First responders attend natural and technological disasters.

The job can be highly stressful, with the workers undertaking a high degree of risk as exposure to hazards are parts of their job description, according to the **Substance Abuse and Mental Health Services Administration (SAMHSA)**.

In terms of their health, **SAMHSA** has also found that first responders experience higher rates of **depression, post-traumatic stress disorder (PTSD)**, suicidal ideation, and substance use disorder compared to the general population.

First responders also have physically demanding jobs that **often lead to early retirement**. As a result, they experience gaps in insurance coverage until they reach the age at which they qualify for Medicare.

Members of Congress have proposed legislation that would make Medicare available to first responders who have served their community and others.

First responders and Medicare

Currently, first responders can receive Medicare coverage under the same stipulations as all Americans. Specifically, when a United States citizen turns age 65, they are eligible for Medicare benefits.

There are some current exceptions to the age requirement for Medicare, but they are more health-related than occupation-related.

For example, a person under age 65 may qualify for Medicare if:

- they have **amyotrophic lateral sclerosis (ALS)**, also known as **Lou Gehrig's disease**
- they have end stage renal disease (ESRD) and therefore require dialysis
- they have a certified disability and are receiving Social Security benefits

Providing Medicare coverage for an occupation such as first responders would be an example of expanded coverage that is not related to a health concern.

Until Congress passes proposed legislation, first responders have Medicare coverage options that are similar to the rest of the American population. However, the lawmakers have proposed legislation that would potentially change this coverage.

A new legislative proposal

On September 26, 2019, a bill was introduced by Senator Sherrod Brown (D-OH) titled the **Expanding Health Care Options for Early Retirees Act**. Another name for the act is "Medicare Buy-In Option for First Responders 50 to 64 Years of Age Who Are Separated From Service Due to Retirement or Disability."

Under the bill, a person would be able to obtain Medicare benefits if they:

- were a first responder separated from their job due to retirement or disability
- are a citizen or national of the U.S. or an alien who is lawfully admitted for permanent residence
- are a qualified, retired, or disabled first responder between the ages of 50–65.

Once the bill was introduced, it was referred to the Senate Finance Committee. On December 10, 2019, the first subcommittee hearings were held, which is the last noted movement of the bill, according to **Congress.gov**.

Since the bill's introduction, several national organizations have endorsed it. These include:

- Fraternal Order of Police
- International Association of Firefighters
- National Association of Police Organizations
- National Sheriffs Association
- National Troopers Coalition

National Conference on Public Employee Retirement Systems

Under the bill, qualifying retirees would also be eligible for help paying for monthly Medicare costs from tax credits or other benefits from their former employer or a pension plan, if applicable.

Grandparenting During a Pandemic

ACCORDING TO A RECENT survey by GrandkidsMatter, 42% of grandparents say their relationship with their grandchildren has stayed the same during the pandemic. Meanwhile, 31% said it became stronger, and 27% reported that it became weaker.

Is there a playbook for grandparenting during a pandemic? We seem to be writing a new one. I know this personally, having three kids with six grandchildren, all long distances away.

According to the study, grandparents' physical health, mental outlook and emotional state impacted their responses. The "became weaker" group scored lower in health and were more likely to feel depressed, tired and hopeless. The "stayed the same" group had the highest mental acuity. Younger grandparents were significantly more likely to "become stronger" in their relationship. I interpret that as meaning "new" enthusiastic grandparents hellbent on enjoying their young grandkids.

Separation Scenarios

Being separated is certainly a big factor during this time. It's interesting: On one hand, some grandparents who were visiting when the pandemic hit suddenly became live-in grandparents. That helped their kids tremendously, and also provided a way for the grandkids and grandparents to grow closer. They could help mentor them and asisst them with school work. But over an extended period of time, you can wear out your welcome….**Read More**

Seniors Form COVID Pods to Ward Off Isolation This Winter

Over the past month, Dr. Richard Besdine and his wife have been discussing whether to see family and friends indoors this fall and winter.

He thinks they should, so long as people have been taking strict precautions during the coronavirus pandemic.

She's not convinced it's safe, given the heightened risk of viral transmission in indoor spaces.

Both are well positioned to weigh in on the question. Besdine, 80, was the longtime director of the division of geriatrics and palliative medicine at Brown University's Alpert Medical School. His wife, Terrie Wetle, 73, also an aging specialist, was the founding dean of Brown's School of Public Health.

"We differ, but I respect her hesitancy, so we don't argue," Besdine said.

Older adults in all kinds of circumstances — those living alone and those who are partnered, those in good health and those who are not — are similarly deliberating what to do as days and nights turn chilly and coronavirus cases rise across the country.

Some are forming "bubbles" or "pods": small groups that agree on pandemic precautions and will see one another in person in the months ahead. Others are planning to go it alone.

Judith Rosenmeier, 84, of Boston, a widow who's survived three bouts of breast cancer, doesn't intend to invite friends to her apartment or visit them in theirs.

"My oncologist said when all this started, 'You really have to stay home more than other people because the treatments you've had have destroyed a lot of your immune defenses,'" she said.

"There's a good chance I'll be alone on Thanksgiving and on Christmas, but I'll survive," she said. ….**Read More**

New Report Issued About Mask Wearing

Back in April, President Trump picked out a single computer model of coronavirus spread to use for guidance about the coronavirus. It turns out that that model initially had rosier estimates than others, and it projected many fewer Covid-19 deaths.

However, the statisticians behind it at the University of Washington have since changed their methods, and they now estimate that doing away with social distancing measures could entail vast numbers of deaths, and that widespread mask-wearing in public could save tens of thousands of lives.

Their new estimate says that universal masking in the U.S. could save some 130,000 lives by the end of February.

White House officials and public health leaders said they don't expect a vaccine to be widely available until March or April, which means wearing masks and other non-pharmaceutical measures will likely be the only option to reduce the spread of the virus until the end of February.

We urge you to keep wearing a mask if you been doing so, and if you haven't, please start – for your own safety and the health and safety of those around you.

Avoid Injury While Caregiving at Home

Caring for a loved one can be rewarding, but it can also lead to injury.

To keep yourself in good physical shape while caregiving, the American Academy of Orthopaedic Surgeons (AAOS) offers some tips for careful lifting:

--Keep your head and neck in proper alignment with your spine. Your head, neck and back should be as straight as possible.

--Maintain the natural curve of your spine, bending with your hips and knees rather than from your back.

--Avoid twisting your body when carrying a person.

--Always keep the person who is being moved close to your body.

--Keep your feet shoulder-width apart to maintain your balance.

--Use the muscles in your legs to lift and/or pull.

--Properly lifting your loved one is important to avoid back, neck and shoulder strains and injuries," explained Dr. Charla Fischer, an orthopedic spine surgeon and spokesperson for the AAOS.

"Pulling a person into a seated position in bed is a common activity that may cause muscle strain, as well as transferring a person from a bed to a wheelchair and leaning over a person for extended periods of time. Understand your risk of injury, so you can avoid getting hurt, and use proper lifting techniques to help prevent these injuries," she said in an AAOS news release.

For those lifting someone from a bed to a wheelchair, Fischer offered the following advice for avoiding injury:

Put the chair close to the bed and ensure the wheels are locked. Place one arm under the person's legs and your other arm under the person's back. Move the person's legs over the edge of the bed while pivoting their body. Keep a strong stance with your feet shoulder-width apart, your knees bent and your back in a natural, straight position.

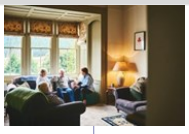
"Never lift more than you can handle," Fischer advised. "Do not twist when lifting, to avoid back strain. Face the person and hold them close to you, lean back, and shift your weight or pivot direction if necessary. Take your time, and don't rush. Lifting belts can help for these types of movements."

How to Choose a Nursing Home: Qualities to Look For

It takes a bit of detective work to find the right nursing home fit for your loved one.

This article is based on reporting that features **expert sources**.

CHOOSING A NURSING HOME for a family member is the difficult job no one ever warned you about. You're tasked with securing a facility that will provide compassionate, high-level care to ensure your loved one's health, safety and well-being. How can you possibly find strangers who will care for your loved one as you would?



Asking for recommendations from friends and doctors is a good start. You'll get much further with information from both the **U.S. News Best Nursing Homes tool** and Medicare's Nursing Home Lookup to check ratings regarding:

♦ The kind and amount of nurse staffing the home provides.

♦ The home's diligence in meeting state health and safety standards.

The home's performance in key medical and behavioral measures, such as the percentage of residents receiving annual flu shots and whether residents get sufficient help with daily activities.

But it takes more research to find the right fit. "I always encourage families to dig deeper and find anecdotal, informal information," says Nancy Avitable, an aging life care manager and owner of an aging life care practice in New York.

The coronavirus pandemic makes the deep dive challenging. In-person nursing home tours are either limited or simply not allowed, depending on your community and the nursing home's policies….**Read More**

Do you know what the eggplant emoji means? Neither do these people.

From **presidential candidates** to **NFL champions**, texts or tweets, emojis have turned into a crucial part of communication for all. You might even say they play a role in our **social well-being**. With close to **2,400** individual characters currently approved through the Unicode Consortium, our messages to one another can now include hearts, rocket ships, or cups of coffee. But here's the problem: **Do we always understand the meaning of these emojis?**

While a thumbs-up or middle finger emoji may be easy to decode, many characters often leave recipients guessing. In interviewing Americans over the age of 55 in South Florida and conducting a similar online poll, **we're able to outline what people do or don't understand about the most popular emojis on the market.** Curious to see what's being interpreted by older adults who live in **55+ communities** or who enjoy other **senior living options**? Continue reading to find out.

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RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

FDA is hiding information on supplements that are dangerous

The FDA regulates dietary supplements, including beauty products, sexual enhancement products, and workout supplements. But, it does not make a determination about the safety or efficacy of these supplements before they become available to the public. Because these supplements can literally kill people, the FDA is supposed to disclose reports of harm from supplements. Why is the FDA hiding information about supplements that are dangerous?

To protect Americans, the FDA has a database, **CAERS**, that is supposed to include information on supplements that are reported dangerous, including product complaint reports. CAERS is open to public scrutiny because Americans should know when a supplement is dangerous.

But, Consumer Reports has found that the Trump administration is not disclosing information about many supplements that are dangerous; prior administrations have also not done so to the extent required. According to Consumer Reports, the CAERS database does not disclose the names of hundreds of manufacturers of products that have been reported to cause harm. Rather, the FDA is giving many manufacturers an exemption, putting the businesses of manufacturers ahead of the safety of Americans.

The FDA has always exempted a small class of products from being reported for public view (<5 percent) in an effort to encourage manufacturers to report consumer complaints to the FDA. The FDA appears now to be applying this exemption far more broadly, counter to FDA policy. With products that cause death or hospitalization, a manufacturer must let the FDA know. And, the FDA is supposed to make that information available to the public. Also, when an individual or a physician submits a report about a product, the product's name is supposed to appear in the CAERS database.

After analyzing documents released because of a Freedom of Information Act request, Consumer Reports found that the FDA exempted more than 400 supplements, even though they were reported to have caused hospitalizations or deaths. The FDA is now saying that these reports were "mislabeled," acknowledging that the products should have been disclosed.

The CAERS database came into being in 2003 to make consumers aware of safety issues from supplements. But, in 2015, the FDA began exempting 15 percent of product names from public view. During the Trump administration, those exemptions have doubled to more than 30 percent of product names.

Millions of Americans take supplements on a daily basis. And, many swear by them. But, there is **little scientific evidence that they provide benefits** in most cases. And**, lots of evidence** that they can cause **serious harm**.

On top of the failure of the CAERS database to disclose information critical to the health and safety of Americans, the CAERS database is hard to search. The FDA also operates a FAERS database in which adverse events related to drugs are reported. That database is easily searchable.

Staying Active as You Age Not a Guarantee Against Dementia

Experts in healthy aging often cite the importance of leisure activities -- hanging out with friends, playing games, taking classes -- in maintaining your brain health as you grow older. But a new study calls into question whether those enjoyable pursuits actually protect you against dementia.

Researchers found no link between middle-aged folks taking part in leisure activities and their risk of dementia over the next two decades, according to findings published online Oct. 28 in the journal *Neurology*.

However, they did discover that some people later diagnosed with dementia will stop participating in leisure activities years before they are diagnosed.

"We found a link between low level of activity in late life and dementia risk, but that this is probably due to people giving up activities as they are beginning to develop dementia," said lead researcher Andrew Sommerlad, a principal research fellow in psychology at University College London. "Dementia appeared to be the cause, rather than consequence, of low levels of leisure activities."

These results appear to run counter to the "use it or lose it" theory of brain health, in which numerous prior studies have linked continued engagement in social activities, mental stimulation and physical exercise to a lower risk of dementia.

"Previous studies have tended to look at leisure activities in late life and find an association, but because dementia develops slowly over many years, these studies may not be able to identify the true nature of the relationship," he said.

Sommerlad said that other factors more directly related to physical health might wind up being more important to protecting the aging brain.

"We do not question the wider benefits of taking part in leisure activities, for promoting enjoyment, quality of life, and general physical and mental health, but other measures have better evidence specifically for dementia prevention," Sommerlad said. "These are treating health problems like diabetes and hypertension, reducing smoking and alcohol intake, physical activity, treating hearing problems, and having social contact with others."

For the new study, Sommerlad and his colleagues analyzed data gathered as part of a long-term health study of London-based civil servants that began in 1985.

The researchers looked at data from 8,280 people (average age 56) whose health was tracked for an average of 18 years. Their participation in leisure activities was assessed at the study's start, five years later and again 10 years later.

Leisure activities included reading, listening to music, using a home computer for fun, taking evening classes, participating in clubs, attending live events or movies, gardening, and playing card or board games. Do-it-yourself home improvements, artistic endeavors, religious activities, going down to the pub, and visiting friends and relatives were also examined.

The researchers found no relationship between a person's participation in more leisure activities at the start of the study and their dementia risk nearly 20 years later.

They only found a relationship when leisure activities in late life were assessed.

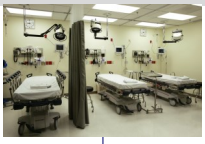
People who took part in more leisure activities around age 66 were less likely to be diagnosed with dementia over the next eight years than those with less participation. Essentially, for every three leisure activities enjoyed monthly or two enjoyed weekly, people were 18% less likely to be diagnosed with dementia eight years later.

Coronavirus: Are hospitals prepared for the flu season?

Now that we are more than eight months into the novel coronavirus, you might think that hospitals in the United States, the wealthiest nation in the world, would have the supplies they need to provide health care services through the flu season.

HealcareDive reports that you might want to think again.

Hospitals are doing better when it comes to personal protective equipment for their workers, but they are likely to struggle to secure the supplies they need to address the flu and COVID-19 this fall. Many will not be prepared for an influx of patients.



The federal government now has a Strategic National Stockpile. And, many states are requiring hospitals to stockpile PPE. But, these requirements could end up creating shortages, if the need is in other locations. They also cost hospitals a lot of money.

Right now, accessing the stockpiles is challenging. There is no good coordination. Hospitals do not know who has what or how much inventory. And, there are no rules for determining who should be able to access the stockpiles and under what circumstances.

The problem is bigger than hospitals systems or regions of the US or even the entire nation. It extends to Europe and Asia. The global supply chain is weak. Time well tell the size of the problem as we get deeper into flu season and the novel coronavirus continues to rage.

On top of that, one in five hospital executives are right now **extremely concerned** about their hospitals' financial viability. Another half of hospital executives are moderately concerned. They will remain concerned until there is a COVID -19 vaccine.

The **Kaiser Family Foundation** reports that hospital admissions are falling again. They are 10 percent lower than projected. And, of course, that affectsFlu their bottom lines.

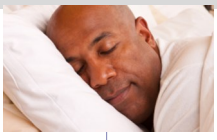
Beware of Blood Pressure Changes at Night

If your blood pressure changes a lot overnight -- either rising or falling -- you may have an increased risk of heart disease and stroke, a new study from Japan reports.

When systolic blood pressure (the top number) jumps up by 20 mm/Hg or more during the night, the risk of heart disease and stroke goes up by 18% and the risk of heart failure increases by 25%.

If people consistently had higher blood pressure readings at night, but normal readings during the day, the risk of heart failure more than doubled. The researchers, writing in the journal *Circulation*, dubbed this a "riser pattern."

On the other hand, for people with a drop in blood pressure of more than 20%, the study team noted a more than twice the risk of stroke. They called this group "extreme dippers."



"Nighttime blood pressure is increasingly being recognized as a predictor of cardiovascular risk," study lead author Dr. Kazuomi Kario said in a journal news release. He's chair of cardiovascular medicine at the Jichi Medical University in Tochigi, Japan.

Dr. Raymond Townsend, an expert volunteer for the American Heart Association, said blood pressure is typically higher in the morning and lower in the afternoon and evening.

Compared to the overall daytime blood pressure pattern, "blood pressure is generally about 10% to 20% lower during sleep. Sleep time offers a relatively pure look at blood pressure. Most factors that influence blood pressure are minimized during sleep," he explained.

But health care professionals usually rely on in-office blood pressure measurements taken during the day to diagnose high blood pressure and to figure out whether or not a blood pressure medication is working or not, the researchers said. These daytime measurements may miss high blood pressure that happens at night. They can also miss big dips in blood pressure.

Dr. John Osborne, director of cardiology at State of the Heart Cardiology in Dallas, said, "When we measure blood pressure in the office, we're mainly getting daytime blood pressure. Seeing what happens at night can give us a much deeper insight."

Osborne said this study "is another signal that we really need to incorporate ambulatory blood pressure monitoring into the evaluation of high blood pressure. If we only see blood pressure during the day, it dramatically reduces our ability to assess overall risk."

Ambulatory blood pressure monitoring allows doctors to see blood pressure levels over a 24-hour period, according to the American Academy of Family Physicians. Patients are fitted with a blood pressure cuff and sent home with a portable monitor that automatically inflates at regular intervals. The machine also records each blood pressure reading it takes in a day.

The current study included more than 6,300 Japanese adults. Their average age was 69. Almost half were men, and more than three-quarters were on blood pressure lowering medications. The average follow-up time was four years….**Read More**

More than one in three older adults could be taking inappropriate drugs

Should you be taking all the medications you are taking? With medicine, sometimes less is more. Judith Garber writes for the **Lown Institute** on a **new study** in the Journal of the American Geriatrics Society, which finds that more than one in three older adults could be taking inappropriate drugs.

At least once a year, you should **take a bag with all your medicines**, prescriptions, over-the-counter medications and supplements, to your doctor's office to confirm that you should be taking them all. Or, in this time of Covid-19, take photos of all the bottles and share them with your doctor in a telehealth checkup. Medicare covers **telehealth**. You might find that your doctor says you no longer need one or more of them or that there are some potentially harmful interactions from taking all of them.

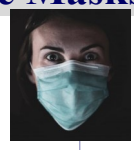
The data show that older adults often are taking a lot of medications that jeopardize their health. Most older adults take five or more medicines, including supplements and over-the-counter medicines. This increases the likelihood that they will end up in the emergency room or hospitalized.

Researchers looked at the drug intake of 218 million older adults over a four-year period and found that more than one in three were prescribed a potentially inappropriate drug. There are a large number of possibly inappropriate drugs for older adults, including benzodiazepines, sedative hypnotics, skeletal muscle relaxants, and first generation (sedative) antihistamines.

The researchers further found that certain types of people were at greater risk of taking potentially inappropriate drugs, including women, people with lower incomes, people with chronic conditions and people with poor mental health.

Doctors should consider deprescribing certain medicines that can be particularly harmful to older adults. They include anti-cholinergic drugs, benzodiazepines, and proton pump inhibitors. If you are taking any of these medicines, talk to your doctor about whether you should continue to take them.

Don't Believe the Myth: Face Masks Don't Lower Oxygen Levels



Face masks: Yes, they may not be the most pleasant item to wear, but they are not depriving people of needed oxygen, a new study confirms.

The findings should counter a common anti-mask myth -- that donning a face mask is unhealthy.

Claims that masks reduce oxygen supplies, cause carbon dioxide "intoxication" and weaken the immune system have gained steam, fueled in part by social media.

At hte same time, medical authorities — including the World Health Organization and the American Lung Association — have issued statements debunking those myths. But the claims persist.

So researchers at McMaster University in Canada set out to test the notion out: They gave 25 adults (average age: 76.5 years) portable pulse oximeters to measure their blood oxygen levels while wearing a face mask, as well as before and after.

The investigators found no concerning signs of hypoxia, or reduced blood oxygen.

Of course, "this supports what we already knew," said Dr. Aaron Glatt, an infectious disease specialist who was not involved in the study. "There's no decrease in oxygen from wearing a mask."

Some people may feel uncomfortable wearing a mask, noted Glatt, a spokesman for the Infectious Diseases Society of America. But that's no excuse not to do it, he said.

"I look at masks like seat belts," Glatt said. "They're not necessarily comfortable, but they protect you."

For the study, Dr. Noel Chan's team outfitted each participant with three-layered, disposable, nonmedical face masks. Volunteers wore them during their normal daily routine, or at rest, and used the pulse oximeter to track their oxygen levels for an hour before wearing the mask, while wearing it for an hour and for an hour afterward.

Overall, there were no concerning declines in blood oxygen saturation. On average, oxygen saturation was 96.1% before participants masked up, and then slightly higher while they wore masks and afterward — at 96.5% and 96.3%, respectively.

The findings were published online as a research letter in the Oct. 30 issue of the *Journal of the American Medical Association.*

"Our study does not support claims that masks are dangerous," Chan said.

Chan acknowledged that the study was small and had limitations. For example, it excluded people with heart or lung diseases that could cause them to have breathing problems even at rest.

But it did focus on older adults, who would probably be more vulnerable to any decrease in oxygen levels from mask-wearing, Chan said. Yet no issues turned up.

"This is just one small study," Chan said, "but I hope it provides people with some reassurance."

One question people often have is whether they can exercise with a mask on. In this study participants were not exerting themselves, so it's not clear whether that would have caused a dip in their oxygen levels.

Glatt said people can forgo a mask if they are out for a walk or a run, and no one else is nearby.

"If you're going to encounter other people, though, wear a mask," he said.

The U.S. Centers for Disease Control and Prevention advises most people to wear a face mask when they are out in public — one that has at least two layers of fabric and is secured over the mouth and nose. Some exceptions are children under age 2 and people with medical conditions that make it hard to breathe.

Chan said that people should talk to their doctor if they have questions about any personal health conditions and the safety of masks.

One in 10 older adults binge drinks, increasing health risks

About 1 in 10 older adults engages in binge drinking, putting them at greater risk for falls and other medical problems. That's according to new research

"We focus so much on young people and their risky drinking," said senior author Joseph Palamar, an associate professor in the department of population health at NYU Langone Health.

"But this research reminds us that we also have to keep an eye on the older population."

Palamar and colleagues analyzed data on 10,927 people over age 65 who participated in the National Survey on Drug Use and Health between 2015 and 2017.

An estimated 10.6 percent of the participants reported **binge drinking** — defined as five or more drinks at once for men, and four or more for women — within the previous 30 days, the study found.

"A lot of patients don't realize that as they get older, their body becomes more sensitive to alcohol," said lead study author Dr. Benjamin Han, an assistant professor in the department of medicine's division of geriatric medicine and palliative care at NYU Langone Health. "They still think they can drink the same way, but the risks increase quite a bit." ...**Read More**

Alzheimer's blood test diagnosis moves closer to reality, scientists say

An experimental blood test was highly accurate at distinguishing people with **Alzheimer's disease** from those without it in several studies, boosting hopes that there soon may be a simple way to help diagnose this most common form of dementia.

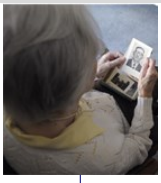
Developing such a test has been a long-sought goal, and scientists warn that the new approach still needs more validation and is not yet ready for wide use.

But Tuesday's results suggest they're on the right track. The testing identified people with Alzheimer's vs. no dementia or other types of it with accuracy ranging from 89 percent to 98 percent.

"That's pretty good. We've never seen that" much precision in previous efforts, said Maria Carrillo, the Alzheimer's Association's chief science officer.

Dr. Eliezer Masliah, neuroscience chief at the U.S. National Institute on Aging, agreed.

"The data looks very encouraging," he said. The new testing "appears to be even more sensitive and more reliable" than



earlier methods, but it needs to be tried in larger, more diverse populations, he said.

The institute had no role in these studies but financed earlier, basic research toward blood test development.

Results were discussed at the Alzheimer's Association International Conference taking place online because of the coronavirus pandemic. Some results also were published in the Journal of the American Medical Association.

More than 5 million people in the United States and many more worldwide have Alzheimer's. Current drugs only temporarily ease symptoms and do not slow mental decline.

The disease is usually diagnosed through tests of memory and thinking skills, but that's very imprecise and usually involves a referral to a neurologist. More reliable methods such as spinal fluid tests and brain scans are invasive or expensive, so a simple blood test that could be done in a family doctor's office would be a big advance.….**Read More**