

Want Social Security to Last? Here's How Much Your Taxes Could Go Up

The 2020 Social Security Trustees' report was just released, and it gives us a close look at the program's financial condition and where it could be heading in the future. To put it mildly, the future doesn't look bright.

The good news is that we still have quite a bit of time before Social Security would be unable to pay its promised benefits, and the program *can* be fixed. The more quickly Congress acts, the easier the fix will be on Americans' wallets. With that in mind, here's where Social Security stands today, how much more you would need to pay in taxes to fix the program for the long run, and what other ways Congress could potentially address the problem.

Where Social Security stands

First, the good news. Social Security ran a \$11 billion *surplus* in 2020, and its trust funds now have about \$2.91 trillion in them. Between payroll taxes, interest on its reserves, and taxation of higher-earning retirees' benefits, Social Security took in \$1.118 trillion and the total cost of the program was \$1.107 trillion.

Unfortunately, that's where the good news ends. The program is expected to run a deficit in 2021 for the first time in nearly 40 years, and these deficits are expected to persist (and get larger) in subsequent years. If nothing is done to change the program's direction, the reserves in the trust funds will be depleted by 2034, after which point Social



Security's income will be able to pay only 78% of promised benefits.

Here's the tax increase that would fix Social Security for 75 years

As mentioned, there is still time to right the ship. Over the next 75 years, the report projects that Social Security's actuarial deficit will be equal to 3.54% of taxable payroll.

Currently, Social Security is taxed at a rate of 6.2% each for employers and employees, up to a maximum of \$142,800 in wages for 2021. This makes the total Social Security tax rate 12.4%, so adding 3.54% would give us a new rate of 15.94%, or 7.97% each for employers and employees.

Here's what that means. Let's

say you earn \$75,000 per year. Your share of Social Security tax is currently \$4,650. If the Social Security tax rate were raised to the level that would make the program sustainable for the long run, your Social Security tax would increase to about \$5,978 -- an increase of more than \$1,300. That's a pretty hefty tax increase.

Other ways to go

To be clear, there are several other ways Congress could choose to fix Social Security, and an across-the-board tax increase isn't the most likely option. Just to name a few, here are some of the ways Congress could increase revenue or decrease expenses from the program... [Read More](#)

By 2022 only these 12 states will tax Social Security benefits

It might surprise some people to find out that **Social Security** benefits are not exempt from being taxed, taking a bite out of their potential retirement income.

Luckily, **most states don't tax Social Security** — currently 37 of them, to be exact.

But the number of states that tax Social Security will decrease by one in 2022, when West Virginia residents will be able to exclude 100% of Social Security benefits from their taxable income.

It's a phased approach: for their 2020 state tax returns, West Virginia taxpayers can shield 35% of Social Security benefits from taxable income. That number goes up to 65% in 2021, before the full 100% in 2022. "The Social Security deduction is only allowed for a married couple filing a joint return, not over \$100,000, or

\$50,000 for single individuals or a married individual filing a separate return," **explained Metro News.** [Editor's note: An earlier version of this article omitted the fact that the bill was amended during the state's legislative process, as two helpful readers from West Virginia pointed out.]

Are you currently living in one of the states that taxes Social Security benefits? Check the list at the bottom of this article to find out.

While those states will take a bite from your Social Security benefits, some of the other 37 states don't have any state income tax at all, including Alaska, Florida, Nevada, South Dakota, Texas, Washington, and Wyoming. So if you live in one of those states, this may be no big news to you.

But a heads-up: Just because your state doesn't tax your Social



Security doesn't mean those benefits can't be taxed on the *federal* level.

Provisional income is a measure used by the IRS to determine if recipients of **Social Security** are required to pay taxes on their benefits. **Calculating your provisional income** is important because it will give you an idea of whether you can expect to pay federal taxes on your Social Security benefits, regardless of which state you live in.

The tax rates for provisional income work like this: A single filer whose total is between \$25,000 and \$34,000, or a joint filer with a total is between \$32,000 and \$44,000, can pay federal taxes on up to 50% of their Social Security income.

But gathering as much information, including a state's tax laws, is helpful when faced with a decision.

If your provisional income exceeds \$34,000 as a single tax filer, or exceeds \$44,000 as a joint filer then you could pay federal taxes on up to 85% of your benefits.

And if you already don't live in one of the 13 states below, that decision may be just a little bit easier.

States that tax Social Security benefits

1. Colorado
2. Connecticut
3. Kansas
4. Minnesota
5. Missouri
6. Montana
7. Nebraska
8. New Mexico
9. North Dakota
10. Rhode Island
11. Utah
12. Vermont West Virginia (until 2022)

Coronavirus: Social Security stands on solid ground

Eric Kingson and Nancy Altman write for the **Daily News** on the **Social Security Trustees Report**, which confirms the solid ground upon which Social Security sits. Notwithstanding the pandemic, Social Security has continued to pay benefits to tens of millions of Americans.

Social Security represents about 5 percent of GDP. It will take until the end of the 21st century for it to represent 6 percent of GDP. The increase makes complete sense given that the population of older Americans is growing both in numbers and as a proportion of the population. Older adults will represent 23 percent of the population, 94 million people, by 2060.

Most other developed nations spend a far larger share of GDP on Social Security benefits. For example, Social Security

represents 11 percent of GDP in France, Germany and Portugal.

Social Security has funds to pay full benefits until 2034. (NB: That's 13 years out. And, many fewer people were working and contributing to Social Security than usual last year. With wages rising, it would not be surprising if the life of the Social Security Trust Fund grows by next year, with no Congressional intervention.) Even if additional Social Security payroll contributions in the next few years do not extend its life, it would still have funding to pay 78 cents on the dollar. Of course, that is not acceptable; and, Congress would likely make up any shortfall.

That said, Social Security benefits need to increase. More and more Americans are facing a crisis in retirement. They do



not have the income they had in the past because employer-sponsored pensions are disappearing and most people do not have enough money in their 401(k)s to maintain a decent standard of living once they stop working.

Income inequality has only grown since the pandemic. In the past, Social Security succeeded at reducing income and wealth inequality. It fostered a strong middle class. It could do so once more if wealthier Americans paid as much proportionately into Social Security as less wealthy Americans. Congress simply could **eliminate the cap on Social Security contributions**, which is now \$142,800 and then easily increase Social Security benefits.

We also need national paid family and medical leave to

improve the economic security of American families, along with guaranteed universal health care. We've had only limited progress on these fronts since Social Security's enactment—even though they were contemplated back then. Medicare, Medicaid and the Affordable Care Act have made a significant difference for some cohorts of the population. But, there's so much more to do.

President Biden is calling for paid family and medical leave as well as new Medicare benefits and better coverage of home and community-based care through Medicaid. The public increasingly stands firmly behind these benefits. The US—the wealthiest nation in the world—has the means to deliver these benefits. And, these benefits would go far in ensuring the well-being of all Americans.

Congress is Running out of Time

As we've previously reported, the Senate will return for votes starting on September 15 while the House won't be back to begin voting until September 20. Various Congressional committees are back at work this week, however.

With the end of the 2021 fiscal year on Sept. 30 fast approaching, they face a massive workload if they hope to finish by then. Technically, they are supposed to pass legislation funding the federal

government for fy2022. No one expects that will happen but they still must pass a "continuing resolution" which will keep the government going for an additional period, giving them time to pass the new budget. If they don't do that the government will shut down.

Then they must raise the debt ceiling so the government can borrow more money to pay its bills.

A government shut down,



while causing some problems, isn't as bad as breaching the debt ceiling. That's known as a "technical default," as some government obligations won't be met on time depending on how long the stalemate lasts. The Treasury Department would have to rely on whatever cash is left on hand and daily revenue inflows.

The first day of each month — when big payments go out for Medicare reimbursements,

military salaries, veterans' benefits, pensions for military and civilian federal employees and more — is particularly bad. The third day of each month and Wednesdays, when Social Security benefits go out, aren't great either. Interest payments to Treasury's creditors go out on the 15th and at the end of each month of beginning of the next.

Obviously, action on those legislative matters are of great concern to TSCL and to seniors in general.

Rising Food Costs Heighten Financial Insecurity Among Seniors

Food price spikes across the U.S. are forcing many senior citizens to visit food pantries or cut back on the number of meals they eat per day.

In a recent **survey** by The Senior Citizens League (TSCL), older consumers reported food to be the fastest growing expense category of their household budgets.

Due to the increases, 19% of respondents say they have visited a food pantry or applied for the Supplemental Nutrition Assistance Program (SNAP) in

2021, Mary Johnson, Social Security policy analyst for TSCL told *The Food Institute*.

"Furthermore, over 10% said they have gone back to work or taken a new job."

This is not a sustainable spending pattern for retired and disabled households, says Johnson. Social Security recipients more typically reported that housing and medical expenses were the two top cost concerns.

An Ongoing Issue



IRI **data** from 2020 shows that Baby Boomers, ages 56 to 74, account for 22% of the U.S. population and control more than half (57%) of country's household wealth. However, nearly a third reported financial insecurity.

Furthermore, many older Americans have trouble accessing a nutritious diet. A **2020 survey** by the AARP showed many elderly respondents had recently experienced one or more life crises—often major health

crises—that compromised their ability to work and to afford or access food.

The survey further noted that increasing access to SNAP is an important strategy to improve health and quality of life for vulnerable seniors. But historically, only about a third of the eligible elderly population has participated in the program.

Beginning October 1, 2021, households who are eligible for SNAP will see an average 25% increase in their monthly benefits....**Read More**

The US Surgeon General says we're thinking about the end of the pandemic in the wrong way: 'Success does not equal no cases'

- ◆ The US has likely missed its chance to rid itself of COVID-19, Surgeon General Vivek Murthy said.
- ◆ "Success does not equal no cases," Murthy told Politico, as ICUs across the country run low on beds.
- ◆ Vaccination continues to be the best way to keep people alive and out of the hospital, he said. COVID-19 is unlikely to be going away completely, US Surgeon General Vivek Murthy said in an [interview with Politico](#).

Although the US has missed the opportunity to totally eradicate the disease, he said people can still take steps to keep the situation from getting worse.

"It is really important that we convey that success does not

equal no cases," Murthy said. "Success looks like very few people in the hospital and very few dying."

Murthy's remarks come as many hospitals across the US report having zero ICU bed capacity remaining, with several treating nearly **twice as many ICU patients as they have room for.**

The continued increase in COVID-19 cases over Labor Day weekend forced many Americans to change or cancel plans, bringing what began as an optimistic summer to an end on a decidedly somber note.

"This is obviously a very difficult part of the pandemic," Murthy said.

Murthy also pointed out that the situation is particularly dire



in areas of the country that have lower vaccination rates and compliance with mask-wearing guidance.

"This is the dichotomy developing," he said. "It's almost like living in two different Americas."

Murthy also said that vaccinated people tend to overestimate the danger posed by the coronavirus Delta variant, and that unvaccinated people tend to underestimate the risk.

Guidance from the US Centers for Disease Control says that unvaccinated patients with the Delta variant are **more likely to be hospitalized** than with earlier strains, while vaccinated patients with breakthrough cases have been far less likely to require hospitalization.

Simply put: vaccines work,

Murthy said.

Over the weekend, Director of the National Institute for Allergy and Infectious Diseases Dr. Anthony Fauci told CNN that hospitals in some areas are **"perilously close"** to having to choose who gets potentially lifesaving medical treatment.

The public health agency in Austin, Texas, said the 11 counties around that city have run **out of ICU beds** as Delta variant cases surge there.

"We have vaccines that are safe and effective in protecting people who are fully vaccinated from severe illness and death," the agency said in a statement. "Each of us has the responsibility to keep our community safe."

The White House wants \$65 billion for an 'Apollo'-style pandemic preparedness program

WASHINGTON — The Biden administration on Friday unveiled a sweeping new biosecurity plan, outlining a \$65 billion proposal to remake the nation's pandemic preparedness infrastructure in the wake of Covid-19.

The new spending would represent one of the largest investments in public health in American history: During a press briefing, Eric Lander, the White House science adviser, likened the proposal to the Apollo program of the late 1960s.

The immense funding boost would target programs aimed at developing and manufacturing

vaccines, treatments, and tests more quickly. It would also provide new money for laboratory capacity, viral detection mechanisms, and early warning systems.

"For the first time in the nation's history, due to these types of advancements in scientific technology, we have the opportunity not just to refill stockpiles but to transform our capabilities," Lander said. "But we really need to start preparing now."

Indeed, the White House funding request comes with a



near-term deadline. While the spending would be spread over the coming seven to 10 years, it also

includes an ask for at least \$15 billion to be included within a forthcoming, \$3.5 trillion budget plan still pending on Capitol Hill. The White House is still in discussions with Congress, Lander said, but he was "very optimistic" that lawmakers would agree to the request.

The new spending would target a wide array of new pandemic preparedness capabilities. It would include over \$24 billion for vaccine

infrastructure, with a goal of beginning to manufacture vaccine doses meant to protect against any virus family within 100 days of a pandemic threat first emerging.

The plan would include nearly \$12 billion to develop — and have on hand — a range of treatments available for any known virus family even before a particular pathogen emerged as a pandemic threat.

It would also provide \$5 billion for diagnostics that the government would aim to make available within weeks of identifying a new biosecurity threat.... [Read More](#)

Medicare Advantage to get Closer Look

Medicare Advantage plans could face increased scrutiny as policymakers try to get Medicare spending under control. The Medicare Payment Advisory Commission (MedPAC), a congressional advisory panel, wants to take a closer look at **Medicare Advantage's effect on federal spending.**

Spending per beneficiary is growing faster for people on Medicare Advantage and other

private plans than it is for people on traditional Medicare and Part D prescription drug plans, according to a MedPAC analysis. While traditional Medicare spending per beneficiary grew at a 4% rate from 2011 to 2019, private coverage like Medicare Advantage and Program of All-Inclusive Care for the Elderly plans grew 6.9% annually.



That has experts worried, as **Medicare Advantage enrollment has surged** in recent years.

More than 26 million people on Medicare are enrolled in private coverage, making up 42% of all Medicare beneficiaries and 46% or \$343 billion in federal Medicare spending, according to the Kaiser Family Foundation.

On top of that, the Centers for Medicare and Medicaid Services

could overpay Medicare Advantage plans by \$200 billion over the next decade because federal policy encourages them to **make their beneficiaries seem as sick as possible,** according to a Health Affairs article.

Policymakers are starting to run out of patience with the **Medicare trust fund headed toward insolvency** in the very near future.

One Pill Can Kill, My Son Sam's Story



Sam

My Son Sam
by Paula Verrengia
My son Sam was a typical southern California boy.

Growing up with great weather year round, he loved to be outdoors riding his bike, skateboarding, snowboarding and playing basketball. In school, he excelled in athletics and scholastics having been honored with a "Scholar Athlete" distinction. He played football for 10 years, Lacrosse for 5 years and loved to surf.

My son Sam was a loving son to me and loving grandson to his grandmother Rose. We never hung the phone up without saying "I love you" to one another and enjoyed a very close mother/son relationship. He was a great friend to all that knew him. When he died, it only took 2 days to gather over 100 people for his candlelight vigil.

When Sam was 16, he broke his arm snowboarding. In the hospital ER, he was given morphine for his pain and sent home with pain medication. He took about 5 of the pills over the course of a few days and then stopped. But by then, something triggered his brain chemistry.

It's scientifically proven that brain chemistry plays an important role in how different people react to drugs.

Unfortunately for my son, his brain chemistry responded to the morphine and pain meds.

After the snowboarding incident, my son began to smoke marijuana. Of course I objected

although California is now pot legal. He was working and going to school, still getting good grades. What I didn't know was that his friends were now getting pills, largely from their own parents' medicine cabinets. They were getting Xanax, hydrocodone, ambien, everything under the sun. Because of his brain chemistry, my son preferred the Xanax and hydrocodone. He hid this drug use from me well and we didn't really have any real problems until he was out of high school.

In his first year of college, he began using drugs more frequently. By now, heroin had made a huge return thanks to the Pharmaceutical companies pushing opioids on the unsuspecting American public. The cost of these pills skyrocketed so in response to that opioid users turned to heroin, including my son.

Sam would use drugs for 6 weeks -2 months and then stop for many months at a time. He had several relapses, but always held a job and was responsible and kind. He never turned into someone I didn't know and didn't become a criminal. He knew that using drugs hurt himself, hurt me, and his grandmother. That would be the compelling reason he would stop, detox and straighten out again.

When Sam was 22, he felt he would do better moving away from old friends and old habits. He moved to a sober living house about 25 miles south of our family home. He held two jobs, loved his roommates and

his structured atmosphere. He was happy.

Sam and one of his roommates decided to get a place of their own. His roommate was from Washington State and away from his family. After 4 months, Sam's roommate decided to move back north with his family. Sam couldn't afford to live by himself so he asked if he could move back into our family home. Of course I said yes.

On the night of 3/5/18, Sam went out with some friends to shoot pool. He was driving his friend Peter, so Sam only had one beer. While they were out, Sam's old friend Max kept sending text messages to Sam, urging him to stop by. After Sam dropped Peter off at 12:30am, he headed over to Max's house. That night, Max gave Sam some powder to snort. It contained fentanyl.

I found my son nonresponsive at 10:30am 3/6/18. The first responders tried very hard to resuscitate my son but he died at the hospital after suffering a massive fentanyl induced heart attack.

You cannot die of a fentanyl "overdose". An overdose by definition is "exceeding the recommended amount". There is no "recommended" amount of fentanyl. It is poisoning, clear and simple. My son never knew that he was being handed fentanyl. For the past 3 1/2 years I have worked to get fentanyl deaths handled as criminal investigations by police departments and the District Attorney for my county. I am happy to say that there is

progress, however slow.

Fentanyl has become a co-pandemic in the US. In 2020, over 94,000 died a drug induced death, many from fentanyl. To put some perspective on the fentanyl epidemic in California take a look at these numbers:

- ◆ **2018 California had 786 fentanyl deaths.**
- ◆ **2019 California had 1603 fentanyl deaths.**
- ◆ **2020 California had 4365 fentanyl deaths.**
- ◆ **2021 California is on pace to have over 8,000 fentanyl deaths.**

If you don't know someone who has been affected by fentanyl, it's not a matter of if, it's a matter of when you will.

One Pill Can Kill

The District Attorney's Crime Lab, which tests all narcotics seized by local law enforcement agencies, found that 92% of oxycodone pills on the street are counterfeit. Of those pills, 75% are straight fentanyl. Counterfeit pills are virtually impossible to distinguish from a prescription pill. The Crime Lab is discovering an alarming rate of not only counterfeit oxycodone, but also counterfeit OxyContin, Percocet, Xanax and Adderall.

Not to mention fentanyl in meth and heroin as well.

This story is only one of the thousands of heartbreaking stories and is in this week's E-Newsletter as a reminder of how important it is the talk to your children and grandchildren about how a life can change in a heartbeat.

"ONE PILL CAN KILL"

Democratic Majority Divisions Put Medicare Changes at Risk

As we've reported in the past, the Democrats have the narrowest of majorities in both the House and the Senate. They can't afford to lose any Democratic votes in the Senate and only 3 in the House. That's crucial because Republicans in both Houses are almost unanimously opposed to the legislation Democrats want to pass, so Democrats have to do it on their own.

That matters because there are

two other legislative measures the Democrats want to pass before the end of this month:

President Biden's infrastructure bill and a reconciliation (tax and spending) bill. The reconciliation bill is what will set the parameters for funding the government for the next fiscal year.

To make matters worse for them, the Democrats are divided on how to proceed with those



bills and unless they can come to an agreement those measures will go nowhere.

The reconciliation bill is one of the most complex tax and spending bills ever contemplated, with virtually no area of the budget or tax code left untouched. The Democrats want it to contain measures that are extremely important to seniors, including dental, hearing and vision benefits being

covered by Medicare. They are hoping to craft it in such a way as to only need 51 votes for passage.

They also hope to include prescription drug price reductions in this legislation, something most Republicans have so far refused to support and which the drug industry is spending million in lobbying efforts to stop.

Minister for Seniors at Famed Church Confronts Ageism and the Shame It Brings

Later life is a time of reassessment and reflection. What sense do we make of the lives we have lived? How do we come to terms with illness and death? What do we want to give to others as we grow older?

Lynn Casteel Harper, 41, has thought deeply about these and other spiritual questions. She's the author of an acclaimed [book on dementia](#) and serves as the minister of older adults at Riverside Church in New York City, an interdenominational faith community known for its commitment to social justice. Most of the church's 1,600 members are 65 and older.

Every Thursday from September to June, Harper runs

programs for older adults that include Bible study, lunch, concerts, lectures, educational sessions and workshops or other forms of community-building. She also works with organizations throughout New York committed to dismantling ageism.

I spoke with Harper recently about the spiritual dimension of aging. Our conversation, below, has been edited for length and clarity.

Q: What does a minister of older adults do?

A large part of my job is presence and witness — being with people one-on-one in their homes, at the bedside in hospitals or nursing homes, or on



the phone, these days on Zoom, and journeying with them through the critical junctures of their life. Sometimes if people are going through really difficult experiences, especially medically, it's easy for the story of the illness and the suffering to take over. Part of my role is to affirm the other dimensions. To say you are valuable despite your sickness and through your sickness. And to affirm that the community, the church is with you, and that doesn't depend on your capacity or your abilities.

Q: Can you give me an example of someone who reached out to you?

I can think of one today — a

congregant in her 70s who's facing a surgery. She had a lot of fear leading up to the surgery and she felt there could be a possibility she wouldn't make it through.

So, she invited me to her home, and we were able to spend an afternoon talking about experiences in her life, about the things that were important to her and the ways she'd like the church to be there for her in this time. And then we were able to spend some time in prayer

Q: What kind of spiritual concerns do you find older congregants bringing to you..

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Don't let your supermarket choose your health plan

Nona Tepper reports for [Modern Healthcare](#) on a new health insurer strategy to enroll more Medicare Advantage members. Anthem is partnering with Kroger to offer Medicare Advantage plans in several cities. If you want to be able to see the doctors of your choice without a private health plan second-guessing your doctors, don't let your supermarket choose your Medicare health plan.

The Medicare Advantage market is growing like a weed. Medicare Advantage plans are sprouting up and Medicare Advantage enrollment is growing. But, Medicare

Advantage plans could be offering little to people with costly and complex conditions and we would not know because so much of what they do is deemed proprietary.

Kroger and Anthem likely both benefit from a partnership. Kroger gets more traffic in its stores and at its pharmacies and additional health care income. Anthem gets the ability to use Kroger supermarkets as a venue for the delivery of primary care services at low cost; it doesn't have to invest in real estate. Right now the supermarket market is growing at a much



slower rate than the Medicare Advantage market.

We don't yet know the exact form this partnership between Kroger and Anthem will take. It is set to launch in 2022. But, Anthem has 2.7 million subscribers to its Medicare Advantage and Medicare Supplemental insurance products. Kroger has more than 2,300 pharmacies and 200 health clinics.

For sure, Kroger and Anthem will learn a lot more about their customer base from their partnership. Will it improve health for these people and

reduce health care costs. The jury is out.

Will it improve Kroger's profits, perhaps. With fewer people going to the grocery store given the pandemic, it arguably it has more room in its stores to devote to health care, where profit margins are higher.

Will it reduce Anthem's marketing costs for new enrollees in its Medicare Advantage plans? Most likely, yes. The average marketing costs for each new member in 2019 was between \$500 and \$2,300. Even still, Medicare Advantage plans earned an average of \$222 a month for each member.

Grandfamily housing: A means to support multigenerational caregiving

Grandparents are increasingly caregiving for grandchildren and other young relatives. Carly Stern reports for [The New York Times](#) on a growing trend of multigenerational caregiving and housing that sometimes goes with it. Grandfamily housing supports multigenerational caregiving; we need more of it.

Today there are some 2.3 million grandparents caring for children. Some of them are lucky to find affordable multigenerational housing options in new communities, such as Bridge Meadows in Oregon, [the Fiddlers Annex](#) in

Smithville, Tennessee, the [Grandparent Family Apartments](#) in the Bronx, NY, and [Plaza West](#), in Washington, D.C.

These new multigenerational communities help older adults with low incomes living with younger relatives. They provide mental health and other social supports.

Grandfamily housing is quite new. There's not a whole lot of data available on them. We know only that multigenerational housing is in very short supply. There are about 2.7 million kids being raised in grandfamilies and



only 19 known grandfamily housing communities. Public-private partnerships fund most of these initiatives.

Only about one third of grandparents in grandfamilies get housing assistance of any kind. It is particularly hard for grandparents to get support if they are not the legal guardians of the children they are caring for. Without assistance, it is challenging for many of them. One in four are raising children with disabilities.

As it is, housing costs can be exorbitant and eat into a sizable

portion of people's income. More than ten million older adults spend more than 30 percent of their income on housing. Many grandparents in grandfamilies cannot live in senior care facilities because these facilities do not allow kids. Their need for housing and social supports is profound.

Congress has introduced legislation, [The Grandfamily Housing Act](#), that would expand the number of grandfamily communities and would pay for renovations to help ensure grandfamilies live safely.

Caregiving has become increasingly common, challenging and costly

We are an aging population. And, caring for older adults is costly. Not surprisingly, family caregiving is becoming increasingly common and challenging. It is unreasonable to assume that most older Americans have family and friends who will be able to care for them when they are unable to care for themselves and still make ends meet. Congress should step in to put in place systems and protections that ensure older adults get the care they need without overburdening family and friends.

Anne Helen Petersen reports for **Vox** that nearly 42 million people in the US are volunteer caregivers for adults over 50. They represent almost 17 percent of the population. Many of these caregivers are so

stretched that they are hard-pressed to make ends meet.

Nearly three in ten (28 percent) caregivers are unable to save money. More than one in five caregivers are assuming more debt and/or have no short-term savings. More than one in ten of them cannot pay for essentials such as rent and food.

More than one in four caregivers are young, either millennials or Gen Z. Increasingly, they provide care in their homes.

The workload for caregivers has grown in just ten years in part because people are living longer. Caregiving involves cooking and cleaning as well as medication management, bathing and providing transportation. Only three in ten caregivers pay



others to help with caregiving. Caregiving takes a huge toll on people's mental and physical health as well as finances. And, there's no system in place to help caregivers. Most people don't even think of themselves as caregivers. They think of their work as helping out their loved ones.

Family caregivers are effectively invisible, which makes their situation all the harder. They often step in to help because they believe they have no choice. AARP believes more than half of them find themselves in that situation. Paid caregiving is unaffordable. Caregiver coordination is also taxing.

What is to be done? One elder care expert believes that, at

a minimum, the federal government should at the very least manage a web site that details caregiver resources by state and community. More money should be available for **Area Agencies on Aging**, as well. These "Triple As" provide resources to older adults.

What is really needed is a comprehensive federal long-term care program. The **budget reconciliation bill** does set aside money for community and home-based services for people with Medicaid. That is a beginning, but not enough.

We also need to improve nursing home care and pay caregivers better wages and benefits for the work they perform.

What will a new Medicare dental benefit cover?

The budget reconciliation bill working its way through Congress includes a Medicare dental benefit. If a dental benefit makes it into the final budget legislation, what will it cover? Margot Sanger Katz reports on this new benefit for **The New York Times**, exposing how critical this benefit could be because millions of older Americans cannot afford dental care today today.

Because of Medicare's lack of dental benefits, older adults often lose their teeth. About 20 percent have no teeth. Almost half of them don't see the dentist each year. Without teeth, malnutrition rises, physical health

deteriorates, and mental health is at risk.

Even Medicaid does not always pay for dental services. Dental services are not a mandated benefit. So, a lot of states do not cover these services. Some states cover only emergency services.

It's still not clear whether Congress will pass a Medicare dental benefit or what it will cover if it does. A comprehensive benefit would easily cost more than \$50 billion a year. A partial benefit will be of little help to a lot of people with Medicare as they won't be able to afford the out-of-pocket costs to make sure of the benefit.



And, some dentists are pushing back and suggesting that they do not support the benefit for fear of Medicare setting low rates for their services.

As it is, dentists have been successful at keeping dental therapists from performing basic and essential dental services. Dental therapists are trained to fill cavities, perform teeth cleanings and extract teeth. They also charge lower rates for these services than dentists. But, most states do not allow dental therapists to practice except under the supervision of dentists.

People in Medicare Advantage often have a dental benefit.

However, the benefit appears to be modest at best. The available data suggests that most enrollees can't use it because out-of-pocket costs are often so high. Medicare Advantage plans could benefit from a new infusion of capital if Congress pays them more to offer richer dental benefits. But, that won't help enrollees unless their costs are affordable.

If you need affordable dental care right now, contact your local **federally qualified health center**. These primary care facilities, which operate in thousands of sites across the country, often offer free or low-cost dental services.

Americans' COVID Medical Bills Are Set to Rise

COVID-19 care is likely to get more expensive for Americans with the expiration of insurers' temporary waivers on costs associated with treating the illness.

Earlier in the pandemic, patients didn't have their normal co-payments or deductibles for emergency room visits or hospital stays for COVID-19, and most tests were also free, *The New York Times* reported.

As the pandemic continues to rage nationwide, federal law still

requires that insurers cover testing at no cost to patients when they have a medical reason for seeking care, such as exposure to the disease or a display of symptoms.

However, more of the tests now being sought by Americans are for monitoring and don't qualify as a medical reason, the *Times* reported.

For example, the federal rules for free coronavirus tests have exemptions for routine workplace and school testing.



Some patients have already received bills as high as \$200 for routine screenings, according to patient documents submitted to a *Times* project tracking the costs of COVID-19 testing and treatment.

However, "insurers are confronting the question about whether the costs of COVID treatment should fall on everyone, or just the individuals who have chosen not to get a vaccine," Cynthia Cox, a vice president at the Kaiser Family

Foundation who has researched how insurers are covering COVID-19 treatment, told the *Times*

Some of the highest bills are likely to be faced by COVID patients who require extensive hospital care, and most of those patients are now unvaccinated. A recent Kaiser Family Foundation study found that 72% of large health plans are no longer making COVID-19 treatment free for patients. **Read More**

Kidney Damage Another Consequence of 'Long COVID,' Study Finds

People hospitalized for COVID-19, and even some with milder cases, may suffer lasting damage to their kidneys, new research finds.

The study of more than 1.7 million patients in the U.S. Veterans Affairs system adds to concerns about the lingering effects of COVID -- particularly among people sick enough to need hospitalization.

Researchers found that months after their initial infection, COVID survivors were at increased risk of various types of kidney damage -- from reduced

kidney function to advanced kidney failure.

People who'd been most severely ill -- requiring ICU care -- had the highest risk of long-term kidney damage.

Similarly, patients who'd developed acute kidney injury during their COVID hospitalization had higher risks than COVID patients with no apparent kidney problems during their hospital stay.

But what's striking is that those latter patients were not out of the woods, said Dr. F. Perry



Wilson, a kidney specialist who was not involved in the study.

They were still about two to five times more likely to develop some degree of kidney dysfunction or disease than VA patients who were not diagnosed with COVID.

"What stood out to me is that across the board, you see these risks even in patients who did not have acute kidney injury when they were hospitalized," said Wilson, an associate professor at Yale School of Medicine in New Haven, Conn.

There is some question about the degree to which the kidney problems are related to COVID specifically, or to being sick in the hospital, according to Wilson. It's unclear, for instance, how their kidney function would compare against that of patients hospitalized for the flu.

But the study found that even VA patients who were sick at home with COVID were at increased risk of kidney problems....[Read More](#)

FDA Advisory Panel Set to Meet on Booster Shots

The U.S. Food and Drug Administration will hold a key advisory panel meeting on coronavirus booster shots on Sept. 17, a mere three days before the Biden administration plans to begin offering third shots for Americans.

While the public session could add clarity to what some feel has been a confusing decision-making process, it also could fuel more controversy over the administration's plan.

Panel member Paul Offit, a vaccine expert at Children's Hospital of Philadelphia, has questioned whether boosters are

needed at this time because data indicates the vaccines still work well against severe COVID-19. But administration officials have stressed that protection is waning.

Though the stated purpose of the meeting is to review **booster data** on the Pfizer vaccine, it will likely to deal with broader questions about booster shots, the *Washington Post* reported: Those include who should get booster shots and when, and what is this country's obligation to other countries who are scrambling for first and second



doses of the vaccines. The panel's recommendations are not binding. But a split

between the FDA's expert panel and agency officials could make it more difficult for the agency to approve boosters.

If the committee concludes boosters *are* needed, it could strengthen the agency's hand in approving a third Pfizer shot and later doing the same for boosters by Moderna and Johnson & Johnson, the *Post* said. The two-shot Pfizer regimen received full FDA approval last week, while the Moderna and Johnson &

Johnson vaccines are still given under an emergency use authorization.

Peter Marks, director of the FDA's Center for Biologics Evaluation and Research, told the *Post* that "a transparent, thorough and objective review of the data by the FDA is critical so that the medical community and the public continue to have confidence in the safety and effectiveness of COVID-19 vaccines."...[Read More](#)

Plus
[Top Federal Health Officials Ask White House to Scale Back on COVID Boosters](#)

Telehealth's Limits: Battle Over State Lines and Licensing Threatens Patients' Options

If you live in one state, does it matter that the doctor treating you online is in another? Surprisingly, the answer is yes, and the ability to conduct certain virtual appointments may be nearing an end.

Televisits for medical care took off during the worst days of the pandemic, quickly becoming commonplace. Most states and the Centers for Medicare & Medicaid Services temporarily waived rules requiring licensed clinicians to hold a valid license in the state where their patient is located. Those restrictions don't keep patients from visiting doctors' offices in other states, but problems could arise if those same patients used telemedicine.

Now states are rolling back many of those pandemic workarounds.

Johns Hopkins Medicine in Baltimore, for example, recently scrambled to notify more than 1,000 Virginia patients that their telehealth appointments were "no longer feasible," said Dr. Brian Hasselfeld, medical director of digital health and telemedicine at Johns Hopkins. Virginia is among the states where the emergency orders are expiring or being rolled back.

At least 17 states still have waivers in effect, according to a [tracker](#) maintained by the Alliance for Connected Care, a lobbying group representing



insurers, tech companies and pharmacies.

As those rules end, "it risks increasing barriers" to care, said

Hasselfeld. Johns Hopkins, he added, hosted more than 1 million televisits, serving more than 330,000 unique patients, since the pandemic began. About 10% of those visits were from states where Johns Hopkins does not operate facilities.

The rollbacks come amid a longer and larger debate over states' authority around medical licensing that the pandemic — with its widespread adoption of telehealth services — has put front and center.

"Consumers don't know about these regulations, but if you all of a sudden pull the rug out from these services, you will definitely see a consumer backlash," said Dr. Harry Greenspun, chief medical officer for the consultancy Guidehouse.

Still, finding a way forward pits high-powered stakeholders against one another, and consumers' input is likely to be muted.

State medical boards don't want to cede authority, saying their power to license and discipline medical professionals boosts patient safety. Licensing is also a source of state revenue....[Read More](#)

UTIs, Sepsis, Staph: COVID Is Upping Rates of Other Hospital Infections

The COVID-19 pandemic has spurred a resurgence in other infections that strike hospitalized patients, a U.S. government study finds.

The study, by the U.S. Centers for Disease Control and Prevention, highlights the broad toll the pandemic has taken. It found that rates of several types of hospital-acquired infections rose after the pandemic reached U.S. shores in 2020.

More hospital patients suffered potentially deadly infections related to medical devices, including ventilators and tubes placed in blood vessels compared to the same period in 2019. There was a similar rise in antibiotic-resistant staph infections, which can

infiltrate the bloodstream and lungs.

The trend is disconcerting, in part, because U.S. hospitals had been making steady progress in preventing those infections before the pandemic.

"What we've learned during this pandemic is that the impact of COVID-19 is far-reaching," said Dr. Arjun Srinivasan, associate director of the CDC's health care-associated infection prevention programs.

The unfortunate fact, he said, is that COVID-19 created a "perfect storm" of circumstances that fed the increase in hospital-acquired infections.

There was the sheer number of patients flooding many hospitals -- people who were very ill and



often required intensive care. Plus, Srinivasan said, those patients commonly had preexisting medical conditions and often needed to stay on ventilators and other medical devices for prolonged periods -- all of which raise the risk of infections.

Add to that the challenges faced by health care providers.

Earlier in the pandemic, Srinivasan said, "we didn't have enough gowns, we didn't have enough masks, we didn't have enough respirators."

As a result, protective equipment meant to be thrown away after one use was sometimes being reused. And, Srinivasan said, health care workers were falling ill or

needing to quarantine -- which fed staffing shortages and added to providers' exhaustion.

"This is, in no way, saying that health care workers failed to do their job," Srinivasan stressed. "This was a failure of the system."

The findings -- published Sept. 2 in the journal *Infection Control & Hospital Epidemiology* -- are based on data from a national surveillance system that tracks health care-linked infections. CDC epidemiologist Lindsey Weiner-Lastinger led the study.

Researchers found that in the early part of 2020, those infections were generally declining compared to the same period in 2019. That changed with the pandemic... [Read More](#)

All Those Steps Every Day Could Lead to Longer Life

Miami publicist Robin Diamond is "step-obsessed."

She aims for 10,000-plus steps every day using her Apple watch and even bought a treadmill during the COVID-19 quarantine to make sure she reaches her daily goal. The 43-year-old has lost 15 pounds since April 2019 and feels better than ever before.

"Walking saved my sanity and restored my body," she said.

Now, a new study suggests that all those steps may also add years to her life.

Folks who took about 7,000 steps a day had a 50% to 70% lower risk of dying from all causes during after 11 years of follow-up when compared with people who took fewer steps each day. These findings held for



Black and white middle-aged men and women. And quicker steps weren't necessarily any better, the study showed. Step intensity, or the number of steps per minute, didn't influence the risk of dying.

The study, led by Amanda Paluch, an assistant professor at the University of Massachusetts' department of kinesiology,

appears in the Sept. 3 issue of the journal *JAMA Network Open*.

"Step-counting devices can be useful tools for monitoring and promoting activity in the general public and for patient-clinician communication, Paluch said. "Steps per day is a simple, easy-to-monitor metric and getting more steps/day may be a good way to promote health."... [Read More](#)

Major Study Finds No Serious Health Issues From Pfizer, Moderna Vaccines

An ongoing study of more than 6 million Americans found no serious side effects linked to mRNA COVID-19 vaccines.

"These results from our safety surveillance are reassuring," said Dr. Nicola Klein, director of the Kaiser Permanente Vaccine Study Center in Oakland, Calif. She spoke in a Kaiser Permanente news release.

Klein is also a leader of Vaccine Safety Datalink (VSD), which studies patient records for 12 million Americans. The project is supported by the U.S. Centers for Disease Control and Prevention.

The *Journal of the American Medical Association* published Datalink's first comprehensive findings on Sept. 2.

The study found no serious health effects that could be tied

to the Pfizer-BioNTech or Moderna COVID-29 vaccines. Monitoring will continue for two years.

The findings span mid-December 2020 through June 26, 2021. Researchers compared specific side effects in the first three weeks after mRNA shots with those three to six weeks later. In all, 6.2 million people were studied after the first dose and 5.7 million after the second dose.

The researchers looked for 23 potential health problems that have followed other vaccinations or had been reported by patients.

These included neurological disorders such as encephalitis and myelitis, seizures and Guillain-Barré syndrome, as well as cardiovascular problems such



as acute heart attack, stroke and pulmonary embolism. Others examined included Bell's palsy, appendicitis,

anaphylaxis and multisystem inflammatory syndrome.

None rose to a level that was statistically significant after mRNA COVID shots, the analysis found.

Researchers highlighted their findings about cases of confirmed myocarditis and pericarditis among young people, which has become an outcome of concern. Myocarditis is an inflammation of the heart, and pericarditis is inflammation of the sac surrounding it.

The study found 34 such cases in patients between 12 and 39 years of age -- 85% were male and 82% were hospitalized for a

median time of one day, meaning half were hospitalized longer, half for a shorter time. Nearly all recovered by the time the review took place, the researchers said.

They calculated that in the 12- to 39-year-old age group, there is a risk of 6.3 additional cases of myocarditis per million in the week after vaccination. That's significantly less than the risk linked to COVID-19 itself, the study authors noted.

"The results of this study are a great example of how seriously CDC takes vaccine safety, and how thorough and transparent we are in our safety monitoring efforts," said Dr. Tom Shimabukuro, deputy director of CDC's Immunization Safety Office.

Risk of Long COVID Falls by Half in 'Breakthrough' Cases

(HealthDay News) -- In a finding that should reassure Americans who have already lined up to get their coronavirus shots, a new study shows the risk of long COVID-19 is halved in fully vaccinated adults if they do get a breakthrough infection.

Researchers analyzed data from people who provided information for a COVID symptom study in the U.K. between Dec. 8, 2020, and July 4, 2021, including 1.2 million who'd received one vaccine dose and more than 971,000 who'd received two doses (fully vaccinated).

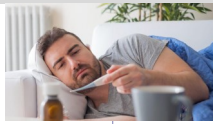
Fully vaccinated adults had a 49% reduced risk of long COVID, a 73% reduced risk of hospitalization and a 31% reduced risk of acute symptoms, the study showed.

The most common symptoms among fully vaccinated adults

were similar to those in unvaccinated people: loss of smell, cough, fever, headaches, and fatigue. But compared to the unvaccinated, fully vaccinated adults had milder and fewer symptoms, and were half as likely to have multiple symptoms in the first week of illness.

Sneezing was the only common symptom that occurred more often in vaccinated adults, according to the study published Sept. 1 in *The Lancet Infectious Diseases* journal.

It also found that people who lived in the poorest areas had a greater risk of infection after a single shot. People with frailty and other health conditions that limited their independence were up to two times more likely to get COVID-19 after vaccination, and of getting sick.



"In terms of the burden of long COVID, it's good news that our research has found that having a double

vaccination significantly reduces the risk of both catching the virus and, if you do, developing longstanding symptoms. However, among our frail, older adults and those living in deprived areas, the risk is still significant and they should be urgently prioritized for second and booster vaccinations," said lead researcher Claire Steves, from Kings College London.

"Vaccinations are massively reducing the chances of people getting Long COVID in two ways. Firstly, by reducing the risk of any symptoms by 8 to 10 fold and then by halving the chances of any infection turning into long COVID, if it does happen," said Tim Spector, lead

investigator of the COVID symptom study.

"Whatever the duration of symptoms we are seeing that infections after two vaccinations are also much milder, so vaccines are really changing the disease and for the better," he said in a Kings College news release. "We are encouraging people to get their 2nd jab as soon as they can."

British Health and Social Care Secretary Sajid Javid said the new findings are encouraging.

"This research is encouraging, suggesting vaccines are not only preventing deaths but could also help prevent some of the longer lasting symptoms," he said in the news release. "It is clear vaccines are building a wall of defense against the virus and are the best way to protect people from serious illness."

Back Surgery

Back surgery is a booming business. About 500,000 Americans undergo surgery each year for low back problems alone. According to the Agency for Healthcare Research and Quality (AHRQ), we spend more than \$11 billion each year on operations to relieve back pain. Unfortunately, it doesn't always buy relief.

For patients with serious structural problems or disease, back operations are often highly successful. But surgery is not the

treatment of choice for most people with low back pain, according to a report from Johns Hopkins Medicine. Fewer than 5 percent of people with back pain, according to Johns Hopkins, are good candidates for surgery.

Is back surgery right for you? A little homework may help you avoid a costly mistake. Here are the questions that the Johns Hopkins report recommends that you ask:

What is the source



of your back pain?

If no doctor can locate a structural cause for your pain, back surgery won't work, according to the Johns Hopkins report. Conditions frequently treated by surgery include nerve damage, spinal tumors, infections, or deformity. Other candidates are a spine weakened by fractures or disease, or persistent leg pain caused by spinal stenosis, a narrowing of the spinal column that causes pain, weakness, numbness and

tingling in the legs along with back pain. Second opinions are often a good idea in these cases.

Surgery can also be used successfully to treat herniated or "ruptured" disks, but it is often unnecessary. Not only do many people have herniated disks without knowing about it or experiencing pain, but more than 80 percent of people with the condition get better without surgery in 6 to 12 weeks, according to the Johns Hopkins report....[Read More](#)

Medicines and Sex: Not Always a Good Mix

For both men and women, it takes a complicated chain of events to move from arousal to a satisfying orgasm. The mind has to stay focused, nerves have to stay sensitive, and blood has to flow to all the right places. Unfortunately, many things can break the chain -- including, perhaps, the pills in your medicine cabinet.

Medicines often work by altering blood flow and brain chemistry, so its no surprise that they can affect sexual function, and not always for the better. Medications can shut down a person's sex drive, delay orgasms, or prevent orgasms

entirely. Medications are also a leading cause of erectile dysfunction in men.

If you've noticed a drop in your ability to have or enjoy sex, talk to your doctor about possible causes. Be sure to bring a list of every medication you're taking. A simple change of drugs or doses could be all it takes. But never stop taking a prescription drug or change dosages on your own. Your doctor can help you determine if a drug you're taking is the problem -- and help you switch to another medication safely.



What drugs can affect sexual function?

SSRIs (antidepressants) You may have noticed that television ads for common antidepressants such as Paxil (paroxetine) or Zoloft (sertraline) mention "certain sexual side effects." The full story is that for some people, SSRI antidepressants can put desire on hold and make it difficult to achieve orgasm. A study of nearly 600 men and women treated with an SSRI, published in the Journal of Sex and Marital Therapy, found that roughly one in six patients reported new sexual problems. The number-

one complaint? Delayed or absent orgasms. Many patients also reported declines in desire. Overall, men were more likely than women to report sexual problems while on SSRIs.

As reported in The American Family Physician, other studies have found that up to one-half of patients taking SSRIs have reported sexual problems. Study results vary depending on the patients studied and the questions asked, but the final message is the same: Sexual side effects caused by SSRIs are common....[Read More](#)

Caring for a Parent with Alzheimer's

Susan Spiker could never have imagined that at age 27, with a busy married life and two young sons, she would simultaneously become a caregiver to her mother. But six years ago, at age 61, Betty Spiker was diagnosed with Alzheimer's disease (AD).

"For quite a while after my mother's diagnosis, I think I was in denial," says Spiker, who was 33 when we spoke, in Atlanta, Georgia. "For a year or so, I really believed she had been misdiagnosed and might not get any worse."

But as the disease continued to erode her memory and thought processes, Betty Spiker became increasingly dependent on her daughter. "Sometimes I felt

angry she had gotten this terrible disease and resented the fact that it was having a profound effect on my life, too," the young woman recalls. "Instead of enjoying motherhood, I was going to doctors, running errands, researching Alzheimer's disease."

More than 5 million people are afflicted with AD today; by 2050, the number could be between 11 to 16 million, according to the Alzheimer's Association. As more than half of all people with AD live at home, many families face enormous challenges in long-term care. Their loved ones must be cared for by relatives and



friends day and night over as many as 20 years. In fact, a report from the National

Family Caregivers Association found that Alzheimer's disease is one of the top three reasons (along with stroke and heart disease) that adult children become caregivers to aging parents.

The typical caregiver for someone with Alzheimer's disease spends 40 hours a week or more on such care and has been doing so for more than a year. This is the proverbial "36-hour day," as loved ones need increasing levels of help with everything from bathing and using the toilet to feeding

themselves; in the late stage of Alzheimer's, people are often incontinent and completely disabled.

For Susan Spiker, whose mother moved in with her family three years ago, the progression of AD means full-time caregiving. "She is at the point where I have to bathe and dress her and assist her in the bathroom. However, we are fortunate that she is sweet and mild-tempered, and the disease has yet to affect her personality. She just cannot remember where the bathroom is, what town we live in, how to turn on her bedroom light, and so on."...[Read More](#)

Rising Ragweed Levels Mean Fall Allergy Season Is Near

(HealthDay News) -- While some may think of scents like cinnamon or pumpkin spice when the season turns to fall, others are breathing in something much less pleasant.

Autumn is also allergy season for those sensitive to ragweed.

"A spike in ragweed tends to mark the informal start of the fall allergy season, which typically begins in mid-August," said Dr. Rachna Shah, an allergist with Loyola Medicine in Maywood, Ill. "This time of the year, we see less tree and grass allergens and more mold and weed allergens." Shah, who oversees the Loyola Medicine Daily Allergy Count, shared some information

and tips to help those whose allergies are emerging now.

Seasonal treatment protocols should begin as soon as possible, Shah advised. They can take a week or more to kick in. These include prescriptions, over-the-counter allergy medications and steroid nasal sprays.

"Allergy symptoms can worsen asthma, causing breathing difficulties, so it's important that you have all of your asthma tools," Shah said in a health system news release. "Make sure that your inhaler is up to date, not expired, that you have additional inhalers and refills on hand, and that you are taking preventive



measures."

Keep windows closed on high allergy days and rinse off or change clothes after being outside. Modify activities on days when allergen levels are particularly high. Pollen counts are particularly high from dawn to 10 a.m., so shift outdoor activities to later in the day.

"Patients who are still suffering from allergy symptoms after adhering to their treatment protocols, taking preventive measures and/or modifying daily activities should be evaluated by a physician," Shah noted.

Symptoms of seasonal allergies include itchy eyes, itchy nose, sneezing, runny nose, nasal

congestion, headaches, ear itching or popping, postnasal drip and throat irritation. Some allergy symptoms mirror those of COVID-19, so seasonal allergy sufferers should be especially vigilant when adhering to treatment plans and precautions, Shah recommended.

"We saw some allergy symptoms overlapping with COVID-19 during the height of the pandemic last year, including congestion, runny nose, headaches and throat irritation," said Shah. "As we face another spike in COVID-19, it's a good reminder to have your preventive allergy treatment plan in place."

Postponing Retirement Might Help Keep Dementia at Bay

Early retirement may sound appealing, but a recent study hints that putting it off a few years might help older adults retain more of their mental sharpness.

Using data on more than 20,000 older Americans, researchers estimated that if all of those people waited until age 67 to retire, their collective cognitive health would benefit.

"Cognition" refers to a person's ability to think, reason, plan and remember, among other vital brain functions. Research suggests that various factors over a lifetime — from education

level to exercise habits to heart health — can affect a person's rate of cognitive decline, and risk of dementia, later in life.

For the [new study](#), researchers wanted to estimate the possible impact of later retirement on people's cognitive functioning.

In theory, spending more years on the job would be protective — in a "use it or lose it" kind of way, explained lead researcher Jo Mhairi Hale of the University of St. Andrews, in Scotland.

"Those who keep working are



'forced,' let's say, to stay cognitively engaged, while those who retire may choose to be

involved in cognitively engaging activities, but not necessarily," Hale said.

Her team started with data on more than 20,000 Americans aged 55 to 75 who took part in a long-running health survey called the Health and Retirement Study. It included standard questions that gauge memory and other brain functions.

Many respondents were still working, at least part-time, while about 45% were retired.

The researchers used statistical methods to estimate what would happen if all study participants were "forced" to delay retirement until at least age 67.

In real life, there is a whole host of factors that could sway both a person's cognitive health and retirement age. And some people might retire earlier because their mental acuity is declining.

Hale said the Health and Retirement Study examined a "plethora of life-course factors," so that allowed her team to account for some of that complexity...[Read More](#)