

### 5 Takeaways From 'Rage,' Bob Woodward's New Book About Trump

"This is deadly stuff," President Trump said of the coronavirus in a Feb. 7 interview with the journalist Bob Woodward for his upcoming book, "Rage." But it was a vastly different story than he was telling the public at the time. Mr. Trump would later admit to Mr. Woodward that publicly, he "wanted to always" play down the severity of the virus.

Mr. Woodward conducted 18 interviews with the president for the book, which goes on sale next week. Mr. Trump also granted Mr. Woodward access to top officials inside the White House, revealing the inner workings of the president and his administration.

Here are five takeaways.  
**Mr. Trump minimized the risks of the coronavirus to the American public early in the year.**

Despite knowing that the virus was "deadly" and highly contagious, he often publicly said the opposite, insisting that the virus would go away quickly.

"I wanted to always play it down," Mr. Trump told Mr. Woodward on March 19. "I still like playing it down, because I don't want to create a panic."

And while he was saying publicly that children were "almost immune" to the virus, he told Mr. Woodward in March: "Just today and yesterday, some startling facts came out. It's not just old, older. Young people too — plenty of young people."

In April, as he began to urge the country to reopen, Mr.

Trump told Mr. Woodward of the virus, "It's so easily transmissible, you wouldn't even believe it."

**Two of the president's top officials thought he was "dangerous" and considered speaking out publicly.**

Gen. Jim Mattis, Mr. Trump's former defense secretary, is quoted describing Mr. Trump as "dangerous" and "unfit" for the presidency in a conversation with Dan Coats, the director of national intelligence at the time. Mr. Coats himself was haunted by the president's Twitter feed and believed that Mr. Trump's gentle approach to Russia reflected something more sinister, perhaps that Moscow had "something" on the president.

"Maybe at some point we're going to have to stand up and speak out," Mr. Mattis told Mr. Coats in May 2019, according to the book. "There may be a time when we have to take collective action."

Ultimately neither official spoke out.

**Mr. Trump repeatedly denigrated the U.S. military and his top generals.**

Mr. Woodward quoted Mr. Trump denigrating senior American military officials to his trade adviser, Peter Navarro, during a 2017 meeting.

"They care more about their alliances than they do about trade deals," the president said.

And in a discussion with Mr. Woodward, Mr. Trump called the U.S. military "suckers" for paying extensive costs to protect South Korea. Mr. Woodward



wrote that he was stunned when the president said of South Korea, "We're defending you, we're allowing you to exist."

Mr. Woodward also reports that Mr. Trump chewed out Mr. Coats after a briefing with reporters about the threat that Russia presented to the nation's elections systems. Mr. Coats had gone further than he and the president had discussed beforehand.

**When asked about the pain "Black people feel in this country," Mr. Trump was unable to express empathy.**

Mr. Woodward pointed out that both he and Mr. Trump were "white, privileged" and asked if Mr. Trump was working to "understand the anger and the pain, particularly, Black people feel in this country."

Mr. Trump replied, "No," and added: "You really drank the Kool-Aid, didn't you? Just listen to you. Wow. No, I don't feel that at all."

Mr. Woodward writes that he tried to coax the president into speaking about his understanding of race. But Mr. Trump would only say over and over that the economy had been positive for Black people before the coronavirus led to an economic crisis.

**Mr. Woodward gained insight into Mr. Trump's relationships with the leaders of North Korea and Russia.**

Mr. Trump provided Mr. Woodward with the details of letters between himself and the North Korean leader, Kim Jong-un, in which the two men fawn

over each other. Mr. Kim wrote in one letter that their relationship was like a "fantasy film."

In describing his chemistry with Mr. Kim, Mr. Trump said: "You meet a woman. In one second, you know whether or not it's going to happen."

Mr. Trump also complained about the various investigations into ties between his campaign and Russia, saying that they were affecting his abilities as president and his relationship with President Vladimir V. Putin of Russia.

"Putin said to me in a meeting, he said, it's a shame, because I know it's very hard for you to make a deal with us. I said, you're right," Mr. Trump said.

**Carl Bernstein: Bob Woodward's reporting reveals Trump committed 'homicidal negligence' by downplaying coronavirus**

Watergate journalist Carl Bernstein said revelations from his former colleague Bob Woodward show President Trump committed an unprecedented felony among presidents.

In reaction to newly released tapes where the president told Woodward he wanted to "always" play down the coronavirus pandemic to prevent panic, Bernstein said the facts in this case, which are "even graver than in Watergate," reveal Trump's "homicidal negligence" to prioritize political interests over a public health emergency.... [Watch the interview](#)

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# Trump's Defunding of Social Security Opens the Door to Privatization

## Top Republican Social Security Expert: Trump's Defunding of Social Security Opens the Door to Privatization

(Washington, DC) — The following is a statement from Nancy Altman, President of Social Security Works, on Donald Trump yet again pledging to slash the payroll tax, Social Security's dedicated funding, if he wins a second term:

"Over and over again, Donald Trump has said he intends to

terminate Social Security's dedicated funding if he is reelected.

Now, Andrew Biggs, a Republican insider and key architect of President George W. Bush's failed attempt to privatize Social Security, has pulled back the curtain on what Trump's apparent end game is — resurrect Bush's privatization scheme.

In an op-ed published today in MarketWatch, Biggs wrote that 'Trump's controversial proposal...opens the door' to



drastically slash Social Security and transform it into a subsistence level flat benefit, while 'signing up every worker for a retirement savings account with automatic contributions. Those contributions could be funded using the payroll taxes that no longer would be needed to fund Social Security.'

That is essentially the Bush privatization plan. Biggs is careful to assert, 'this is my plan, not President Trump's.' But it is

just coincidence that Trump called for privatizing Social Security before running for president?

For those who support Social Security, the choice is clear. A vote for the Democrats in November is a vote to expand Social Security. A vote for Trump is a vote to end Social Security as it has existed for 85 years."

# Most Adults Wary of Taking Any Vaccine Approved Before the Election

The public is deeply skeptical about any coronavirus vaccine approved before the November election, and only 42% would be willing to get a vaccine in that scenario, according to a new poll.

The results of the [poll by KFF](#) reveal widespread concern that the Trump administration will bring pressure on drug regulators to approve a vaccine before the election without ensuring it is safe and effective. (KHN is an editorially independent program of KFF.)

Six of 10 adults said they were worried the Food and Drug Administration will rush to allow a vaccine because of political pressure. The concern is held by 85% of Democrats, 35% of

Republicans and 61% of independent voters.

Resistance to taking the vaccine is strong among respondents of all stripes, with 60% of Republicans saying they would not want to be inoculated if a vaccine were available before the Nov. 3 election. Among Democrats, 46% would decline the vaccine.

The wariness may reflect the ongoing political jockeying over a vaccine, and it may also be influenced by strains of general anti-vaccine sentiment in the populace. The Trump administration has suggested a vaccine could be ready by November, and the Centers for Disease Control and Prevention

has instructed states to be prepared to distribute a vaccine by Nov. 1.

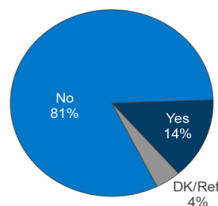
Democrats have raised fears that President Donald Trump is trying to accelerate vaccine approval to boost his reelection

chances. Forty-three percent of the public approves of Trump's handling of the pandemic — an improvement since July, when just a third liked his response.... [Read More](#)

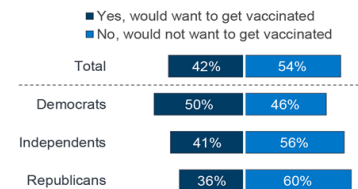
Figure 10

## Most Do Not Expect A Vaccine Before The November Election, Just Four In Ten Would Get A Vaccine If It Was Available Before Then

Do you think a vaccine for coronavirus will be widely available in the U.S. before the presidential election in November?



If a coronavirus vaccine was approved by the U.S. FDA before the presidential election in November and was available for free to everyone who wanted it, do you think you would want to get vaccinated?



SOURCE: KFF Health Tracking Poll (conducted August 28-September 3, 2020). See [topline](#) for full question wording.



# Congress Should Boost Social Security Benefits and Increase the Amount of Wages Subject to Payroll Tax

Eighty-three percent (83%) of the participants in a recent survey by The Senior Citizens League (TSCL) agree that Congress should boost Social Security benefits by 2 percent. The same survey found that 72 percent (72%) respondents think that Social Security's financing should be strengthened by applying the payroll tax to all earnings, not just the first \$137,700 of wages as is currently the case under law.

"This is an extremely high level of agreement among retirees of varied political persuasions," says Mary Johnson, a Social Security policy analyst for The Senior Citizens

League (TSCL). "In recent years, The Senior Citizens League has found broad support for these two changes to Social Security, yet Congress has failed to take action on this issue," Johnson notes.

The online survey found that participants support boosting Social Security benefits by 2 percent and tying the annual cost-of-living adjustment (COLA) to a Consumer Price Index (CPI) that more closely represents the price changes experienced by retirees, such as the Consumer Price Index for the Elderly (CPI-E). Only 5 percent were opposed to boosting Social Security benefits, and 12 percent



were uncertain. "A Social Security benefit boost will be needed, especially in 2021 due to the impacts of the recession on the annual inflation adjustment," Johnson says. Although there was a large jump in the CPI data for the month of July, consumer price data are only beginning to turn around from a deep drop — especially in energy and oil prices — that began early this year.

Johnson estimates that the 2021 COLA would still be one of the lowest ever paid. Her current estimate of the COLA is just 1.1% with August and September data still to come

in. Johnson notes that she has recently received dozens of emails from retirees who report rising costs during the pandemic with most mentioning higher Medicare premiums, and out of pocket costs, particularly for prescription drugs.

The Senior Citizens League is advocating for boosting benefits and enacting an emergency COLA of no less than 3% for 2021 to help older households weather the impacts of the coronavirus, and to head off another round of Medicare Part B premium increases that outstrip the amount they receive in their annual inflation adjustment in 2021.

# Can public health insurance lower health care costs?

With millions of Americans staying away from the doctor and hospital during this pandemic, the private health insurance industry has delivered **big profits** to its shareholders. At the same time, it is threatening to raise rates significantly, making it near impossible for many people to get good affordable coverage. Vice-President Biden is proposing to provide Americans with a public health insurance option as an alternative to private health insurance, if he is elected president. Can public health insurance lower health care costs?

In a nutshell, public health insurance puts the public health first. Unlike private health insurance in the US, public health insurance does not have a profit incentive. It is publicly accountable. And, as with traditional Medicare, the government determines the terms of coverage—how much to pay, for what services, and when, as well as out-of-pocket costs, if any. But, these features don't mean that a public health insurance plan can compete successfully with private health

insurance and bring down health care costs.

The choice of public health insurance, sometimes called a public option, is not likely to help Americans unless Congress better regulates private health insurers. To bring down costs, the public option needs to compete on a level playing field with private health insurance. What would that look like?

Right now, private health insurers, including Medicare Advantage plans, have many ways to design their health plans to maximize profits. They can exclude top specialists from their networks in order to deter people with costly health conditions from enrolling in their plans. They can **delay and deny care inappropriately** to people in poor health to push them into **disenrolling** and switching to a different health plan. That's called "lemon dropping." They can require people to get **prior authorizations and referrals** in order to get certain care.

Private health plans also can rely on coverage rules that are far more restrictive than coverage



rules in traditional Medicare or another public health plan. Yes, public and private health plans might offer the same benefits, such as cancer care, rehab services and hospital care. But, they might not pay for the same services. For example, a private health plan might not cover a certain cancer treatment or might only cover a treatment if certain conditions apply. It might pay for a very limited number of rehab services. Or, it might not pay for some **emergency services**.

A health plan's coverage rules can lead to **inappropriate delays and denials** of care. But, private health insurers establish coverage rules that are proprietary, not subject to public scrutiny. We don't know how restrictive they are or which private insurers are the worst offenders. But, we know that many private health plans **deny their members coverage** for a lot of services.

For the playing field to be level between public health insurance and private health insurance, public and private health plans would have to follow the same

coverage rules, not simply offer the same benefits. That's how private health insurance works in other wealthy countries. The government sets the rules as to what is covered and when, and they are open to public scrutiny.

There is no evidence that allowing private health insurers to set their own coverage rules has any benefits. Their coverage rules cannot be analyzed and evaluated. Indeed, the evidence cuts the other way, with some lawsuits revealing that private health insurers can rely on coverage rules that are **not in compliance with standard medical treatment protocols**.

In sum, so long as private health insurers can set their own coverage rules, they can make it hard for people with costly conditions to get care. They can lead people in poor health to disenroll. That's what Medicare Advantage and other private health insurers sometimes do today. They **push their members who need a lot of care into traditional Medicare**, the public option, which drives up its costs.

## Hospital care: Three major inequities

A post in **Medicine and Social Justice** by Josh Freeman highlights three major inequities in the US health care system when it comes to hospital care. He argues that these inequities stem from the fact that hospitals compete for money rather than to promote the health of Americans. This needs to end.

Hospitals should have as their first priority delivering high-value health care. As it is, **rural hospitals** are hanging on for their lives, usually losing money. But, in big cities, where you find the majority of hospitals, doctors and patients, hospitals are focused on bringing in the revenues.

What do hospitals do to maximize revenues? They open "Cancer Centers" and "Heart Centers" and "Centers for Orthopedic Surgery." They give the maternity ward and other primary care services short shrift. Yes, cancer, heart and

orthopedic surgery centers are good things. But, if there are a lot of hospitals in a metropolitan area, every one of them does not need these specialty care centers. Right now, there are too many of them in urban settings. There is a need for more basic, lower cost care.

Our health care system is not designed first and foremost to meet the needs of the people it serves. If it were, there wouldn't be as many cancer centers in big cities. There would be more primary care and mental health providers.

In addition, people don't receive hospital care because they can't afford it. They are uninsured or "underinsured," which means that they have coverage but out-of-pocket costs are so high that they skip or delay care. Competition is not working; rather, it creates these



inequities:

1. Only the well-insured and well off are able to get care. Hospitals don't want to serve people who can't pay for their services.
2. The emphasis is on the most profitable services. It is not easy to find hospitals that have well-funded centers for primary care, maternity and mental health services.
3. Much care is only available in major cities. Hospitals in rural America and small towns are dying, closing their doors.

In sum, when it comes to health care, we discriminate against people with poor insurance and low incomes, we discriminate against people with health care needs that don't pay well, and we discriminate against people who don't live in a major metropolis.

One **recent study** found that

mortality rates increase in rural communities that lose their hospitals. Inpatient deaths increase by 8.7 percent. There is no measurable impact on mortality rates in urban settings.

The solution is simple. We should pay hospitals based on a global budget in order to change their incentives and not make profitable services their first priority. And, we should guarantee everyone in the US health care coverage.

In the meantime, we should increase the amount we pay for primary and mental health care services and decrease the amount we pay for specialty care. People should be able to get whatever care they need, regardless of the amount health care providers are paid for the care. And, if you're donating money to a hospital, earmark it to cover primary care services or the cost of care for the uninsured.

## Here's how Trump could bigfoot the FDA and get a vaccine out ahead of the science

In 1905, the agency that would later become part of the US Food and Drug Administration approved its first vaccine. Now the FDA has more than 80 licensed vaccines, and for each there has been an established scientific protocol to make sure it's safe and effective.

But this is 2020, the year when nothing is normal.

Despite **reassurances from federal officials**, there are fears that the typical pathway for review and approval of the Covid-19 vaccine will be eschewed, or at least bent, because of political pressure.

Two former FDA commissioners tell CNN that while they think it's very unlikely that President Trump could pressure scientists into authorizing or approving a Covid-19 vaccine, it's possible.

Trump has said he thinks a vaccine could be available by

Election Day on November 3, repeating the possibility again at a rally Thursday.

"It will be delivered before the end of the year, in my opinion, before the end of the year, but it really might even be delivered before the end of October," Trump said. "How do you like that? Wouldn't that be nice? And you know why? Not because of the election. It'd be nice because we want to save people."

Such early expectations from the President make some experts nervous.

"What I'm concerned about is there could be a gray zone where a vaccine looks partially protective and it goes on the market without a full formal review process," said Dr. Peter Hotez, a vaccinologist at Baylor College of Medicine.

How vaccines are evaluated Currently, three large, US-



funded clinical trials for coronavirus vaccines are underway by pharmaceutical companies Pfizer, AstraZeneca and Moderna.

Each trial involves 30,000 adults who have volunteered to participate. Half will get two doses of the vaccine, and half will get two doses of a placebo, which is a shot of saline that does nothing. The two doses are spaced several weeks apart.

Both the participants and the researchers are "blinded," which means neither knows who got the vaccine and who got the placebo.

Then the wait begins.

During the trial, volunteers go about their daily lives. Researchers check in with them regularly, and record who gets sick with Covid-19.

The researchers have to feed their data to a group called

the Data and Safety Monitoring Board, an independent group of experts set up by the National Institutes of Health.

Members of this board are the only people allowed to take a look at which volunteers got the vaccine and which received the placebo, and the members only do so under specific circumstances.

When a certain number of study participants become ill with Covid-19, the DSMB takes a look at how many of those sick volunteers received the vaccine and how many received the placebo.

For example, for Moderna, that first look -- called an interim analysis -- occurs when 53 study subjects become sick with coronavirus, according to Ray Jordan, a spokesman for the company...**Read More**

## FDA Sets Up Vaccine Safeguards to Counter Pressure From Trump

An unsubstantiated claim two weeks ago by President Donald Trump -- that the "deep state" was slowing approval of a Covid-19 vaccine -- has set off an effort by government officials and private industry to ensure the White House doesn't interfere with a methodical, careful scientific process.

Food and Drug Administration leaders are insulating the agency's vaccine reviewers from outside political pressure by sticking by June guidelines that set the standard for what it will take for a vaccine to pass through the agency, said one official familiar with the planning, who asked for anonymity discussing private deliberations.

They're also making clear to FDA staff that the political noise shouldn't influence the agency's decisions. FDA Commissioner Stephen Hahn last week sent an email to all 17,000 staff, promising that the agency would adhere to the science in a vaccine review. He has also met with leaders of the health agency's various departments, including the one that reviews

vaccines, to reassure them.

The agency is attempting a careful balance. It must act as quickly as possible to save lives but needs to avoid being rushed into sending an unproven vaccine out to the American people, undermining trust in the safety of medicine. That's why pharmaceutical companies including Pfizer Inc., Moderna Inc. and Johnson & Johnson **plan to announce** a pledge Tuesday not to submit vaccine applications to the FDA without robust safety and efficacy data, according to people familiar with the matter.

Whether or not the joint pledge reported by Bloomberg and others last weekend blunted Trump's push for a speedy vaccine, on Monday he repeated his prediction that a vaccine would be ready by Election Day, Nov. 3 — but insisted it wasn't a prediction.

"I said that vaccines will be on the market before the end of the year," Trump said in a news conference. "What I said is, by



the end of the year, but I think it could even be sooner than that. It could be in the month of October, actually. It could be before November."

"I'm saying that because we want to save a lot of lives. With me, it's the faster the better," Trump said. "If we get the vaccine early, that's a great thing, whether it's politics or not."

That's a far cry from his Aug. 22 tweet, which called Hahn out directly. The "deep state" is a term used by Trump to describe employees of government agencies that he believes are manipulating policy to work against his interests.

Trump has a history of publicly pressuring the agency, **saying** in March that the malaria drug hydroxychloroquine was approved to treat the coronavirus even before the agency had authorized it for emergency use, a decision it later withdrew.

While Trump's public comments about the vaccine timeline are pressure

enough, the FDA thus far has had little interference from the White House behind the scenes, according to officials who asked not to be identified. Hahn meets weekly with top health officials involved in the virus response, as well as with John Fleming, assistant to the president for planning and implementation.

Hahn has nonetheless emphasized to the White House and the Health and Human Services Department the public health importance of not allowing a vaccine review to be perceived as politicized, according to one of the officials.

For its part, the White House denies any effort to rush the process, with one official saying neither Trump nor any of his advisers have requested that any vaccine be brought to market that isn't safe and effective, having gone through the scientific rigor the U.S. expects from any of its vaccines....**Read More**

## The wrong choice of Medicare Advantage plan could kill you

Older adults and people with disabilities have the choice of private health plans that offer Medicare benefits, sometimes called Medicare Advantage plans. Through an analysis of mortality rates at different Medicare Advantage plans, Jason Abaluck, a Yale economist, **found** that the wrong choice of Medicare Advantage plan could kill you. The government would save thousands of lives if it terminated contracts with Medicare Advantage plans that have high mortality rates.

After studying mortality rates in hundreds of Medicare Advantage plans over several years, Abaluck determined that people who choose the wrong Medicare Advantage plan have a much higher risk of dying. He suggests that giving people the ability to choose between a plan that has their primary care

doctor in network and one that saves them money is crazy. And, who knows which of these plans will prolong people's lives and which will shorten them?

Abaluck recognizes that people cannot make good choices. He further recognizes that the private health insurance market is broken. The Medicare Advantage plans have very little reason to put money towards keeping people healthier. In fact, some have mortality rates as high as eight percent; others have mortality rates of two percent.

Abaluck looked specifically at what happened to people's mortality rates when they switched out of one Medicare Advantage plan and into a different Medicare Advantage plan. He found that a Medicare Advantage plan's mortality rate



had a direct effect on whether a person lived or died.

To be clear, people have no clue what the

mortality rate is for a given Medicare Advantage plan. That data is not publicly reported.

And, **star-ratings of Medicare Advantage plans** are of no help.

Abaluck says that Medicare Advantage plans with higher premiums and better drug coverage tend to have better health outcomes. But, these two factors alone will not tell you whether you have a better chance of survival in a particular Medicare Advantage plan.

What's the solution? Abaluck recommends that the government terminate contracts with Medicare Advantage plans that have the highest mortality rates. The better solution: Terminate all Medicare Advantage plans, eliminate out-

of-pocket costs in traditional Medicare and move everyone into traditional Medicare or, better still, **Medicare for All**.

**Ten ways Medicare Advantage plans differ from traditional Medicare**

**Four things to think about when choosing between traditional Medicare and Medicare Advantage plans**

**Medicare ratings of Medicare Advantage plans a farce**

**Ten ways Medicare Advantage plans differ from traditional Medicare**

**People with serious health needs more likely to disenroll from Medicare Advantage plans**

## Millions of Americans Believe a Dangerous Social Security Myth That Could Cost Them Thousands

Your choice about when you claim Social Security retirement benefits shapes the amount of income you have throughout your later years.

Unfortunately, millions of Americans, including nearly 7 in 10 of those closest to retirement, are laboring under a dangerous misconception that could lead to the wrong choice. Here's what it is.

Americans don't understand the truth about this key Social Security rule

According to recent research from **Nationwide Financial**, 45% of millennials, 49% of Gen Xers, and 69% of baby boomers believe if they claim their benefits early, the amount be recalculated at full retirement age and their checks will increase. This is simply not true.

When you file for Social Security benefits prior to FRA -- which is based on birth year and is between 66 and 67 -- you're subject to early claiming penalties. For each of the first three years ahead of FRA, they'll shrink your checks by 5/9 of 1%

per month. Those who start their benefits even earlier face an additional penalty of 5/12 of 1% per month.

While the math is complicated, the bottom line is you reduce benefits by 6.7% per year for each of the first three and an additional 5% for any prior year.

When you incur an early filing penalty, your benefit isn't recalculated at FRA to eliminate it -- your benefits are permanently reduced. For those who claim at 62 with a full retirement age of 66, benefits will be 25% smaller. If you'd have received the average **\$1,503 benefit**, you would instead get \$1,127 per month.

And while all retirees get periodic **cost-of-living adjustments** to help benefits keep pace with inflation, those COLAs won't catch you back up to where you'd have been if you hadn't claimed early. In fact, they're based on a percentage of your average benefit so all future



raises will be smaller, too, since you're starting with a lower base amount. You can avoid this costly mistake

When you know the truth about how early filing affects your benefit amount, you can make an informed choice about whether you're willing to accept a permanent reduction in benefits.

While claiming early due to the misconception your benefits will be recalculated is sure to leave you disappointed, there are situations when filing for **Social Security** ASAP makes good sense. If you're worried you won't live very long, for example, getting more checks early on may maximize your lifetime benefits even if each check is smaller. But you need to make your decision after you have the facts.

If you've already claimed benefits ahead of your FRA under the mistaken assumption they'll be recalculated and you'll get higher checks later, you may

have a few options for fixing the problem.

If it's been less than 12 months since you filed for benefits, you could withdraw your claim -- but would have to pay back all the money you've received so far. If not financially infeasible, taking this step would serve as a reset and it would be as if your early claim never happened.

You could also **work enough to stop your benefit**, as earning wages above an annual threshold will result in a forfeiture of some benefits if you haven't yet hit your FRA. When benefits are withheld because of higher earnings, a recalculation *does* happen at your FRA and you receive higher future checks to make up for the missed benefits.

Neither of these options works for everyone, though, so it's best to make the right choice about when to claim from the start. Now you can do that since you won't be one of the millions of Americans who doesn't understand the implications of your choice.

## Majority expect to see coronavirus vaccine in 2021: poll

A majority of voters say they expect a coronavirus vaccine will be available to the public by next year, according to a new Harvard CAPS-Harris survey released exclusively to The Hill on Friday.

Sixty-three percent of respondents said they think a vaccine for the virus will be available in 2021, while 37 percent said they believed it would be available by the end of the year.

The findings come after it was revealed Thursday that the Centers for Disease Control and Prevention (CDC) requested in a letter to state governors last week to speed up applications for building permits for vaccine distribution sites that would be

operational just before November's elections.

"The normal time required to obtain these permits presents a significant barrier to the success of this urgent public health program," CDC Director Robert Redfield wrote in a letter. "CDC urgently requests your assistance in expediting applications for these distribution facilities and, if necessary, asks that you consider waiving requirements that would prevent these facilities from becoming fully operational by November 1, 2020."

A vaccine before the presidential election could stand to benefit President Trump, who has received backlash for his



administration's response to the pandemic. "Trumps approval on the vaccine while

improved is still only at 43 percent and that has depressed his vote," said Harvard CAPS-Harris polling director Mark Penn. "Further virus improvement and an approved vaccine would beat expectations and might reshape opinion but it's hard to shake the belief that the virus is the new normal."

However, the same survey found that only 26 percent of respondents said they believed the vaccine would be available before November. Seventy-four percent said they believed the vaccine would be available after

the election.

The Harvard CAPS-Harris Poll online survey of 1,604 registered voters was conducted Aug. 31 to Sept. 2. It is a collaboration of the Center for American Political Studies at Harvard University and The Harris Poll.

The Hill will be working with Harvard CAPS-Harris Poll throughout 2020.

Full poll results will be posted online later this week. The survey is an online sample drawn from the Harris Panel and weighted to reflect known demographics. As a representative online sample, it does not report a probability confidence interval.

## Just Because I'm 90 Doesn't Mean I'm Ready To Die — Or Disposable

"As long as I'm still creative ... as long as I still enjoy life, nobody has the right to write me off."

I've been a senior citizen for a quarter of a century and I still sculpt, read and write essays. I speak five languages, and I use email and WhatsApp to communicate with family and friends in Finland, China, Norway, England, Israel, Russia, Thailand and throughout the U.S. I run a foundation I created that assists immobile seniors. I attend classes, and I'm organizing a philosophy club via Zoom that discusses ethics, forgiveness, anger, creativity and various other topics.

Certainly now, my routine has changed. COVID-19 has shut down everything in one shot. At age 90, I have lived through a lot of history, but I've never seen a situation like this. My daughter was concerned that in the city I would be a lot more exposed while facing a lower level of care. I left Brooklyn and am now with her, my son-in-law and teenage grandson, secluded and safe, upstate in the Peekskill mountains. My only outings, masked and gloved, are to the nearest labs for regular blood tests.

Who knows in which direction the changes to come will take us. What I've seen so far is that the

crisis has brought out the best in good people and the worst in bad people. What I see now is that cooperation and empathy on a massive scale are needed to bring the world back on track.

Some people may suggest that if I were to die of the coronavirus, I at least have lived a full life. And yes, I have lived a full life.

I was born in China to Jewish parents who left Russia after World War I to seek refuge from anti-Semitism, famine and pogroms. I spent the first 20 years of my life in China, surviving the Japanese occupation of my town, Tientsin, during World War II. Then, I spent the next 30 years in Israel. I taught Hebrew to Jewish immigrant children, served in the Air Force and worked as a graphic artist. I got married and raised two daughters. Finally, my husband's work took us to the U.S. in 1979. I was 50 years old and unaware that this would be the start of a period during which I would grow and flourish as an artist.

In my 60s, I created five large outdoor sculptures in Israel for institutions such as Tel-Aviv University and the Ghetto Fighters Museum of Resistance. At age 70, I began to find my



voice as a writer and collaborated on "The Defiant," my husband's memoir about fighting Nazis as a partisan in Eastern Europe. At 82, I created a nonprofit organization, the Rose Art Foundation, which has donated 800 Geri-recliners to immobile patients in facilities throughout the U.S. Even now, during the coronavirus pandemic, I get requests from patients whose quality of life has been changed by these donations. Last year, at 89, I published my second book. And there is still much to do.

I'm not disposable, and I'm saddened that there are people who think age dictates whether a human life is worth saving. I can tell you that I, and my loved ones, want me to live for many years to come. I want to attend my grandson's high school graduation and see which college he'll attend. I want to see my older grandson, who is married, become a father. I want to continue my joyful life. I am unable to travel as extensively as I once did, but I want to visit Israel again. Just because I'm 90 doesn't mean I don't have things to learn and skills to hone.

I have more physical limitations and ailments than I choose to mention but that won't stop me. I'm growing as an

artist. Last September I began a three-month class at the Brooklyn Clay Studio, learning to glaze and fire in the kiln. In February, before social distancing was put in place, I sought a new approach, visited Urban Glass in Brooklyn and found a teacher to show me the process. My twin sister passed away 15 years ago so when the quarantine is over, I hope to finish a sculpture that represents our relationship.

Our lives, our dreams, our productivity don't end when we turn 65, an age that society decided was "old enough." Senior citizens can be productive and contribute to the world, bringing to it their added dimension of age and experience. I think no limit should be set on when a person's life is no longer valuable.

I'm 90 and I'm waiting for the quarantine to end. As long as I'm still creative and surrounded by the love of family and friends, as long as I still enjoy life, nobody has the right to write me off.

**"What I've seen so far is that the crisis has brought out the best in good people and the worst in bad people.**

**I'm not disposable, and I'm saddened that there are people who think age dictates whether a human life is worth saving."...**

## Dozens of U.S. Hospitals Poised to Defy FDA's Directive on COVID Plasma

Dozens of major hospitals across the U.S. are grappling with whether to ignore a federal decision allowing broader emergency use of blood plasma from recovered COVID patients to treat the disease in favor of dedicating their resources to a gold-standard clinical trial that could help settle the science for good.

As many as 45 hospitals from coast to coast have expressed interest in collaborating on a randomized, controlled clinical trial sponsored by Vanderbilt University Medical Center, said principal investigator Dr. Todd Rice.

Officials at some hospitals said they are considering committing only to the clinical trial — and either avoiding or minimizing use of convalescent plasma through an emergency use authorization **issued Aug. 23** by the federal Food and Drug Administration.

The response comes amid concerns that the Trump administration pressured the

FDA into approving broader use of convalescent plasma, which already has been administered to **more than 77,000 COVID patients in the U.S.** President Donald Trump characterized the treatment as a “powerful therapy,” even as government scientists called for more evidence that COVID plasma is beneficial.

A National Institutes of Health panel this week **countered the FDA's decision**, saying that the therapy “should not be considered the standard of care for the treatment of patients with COVID-19” and that well-designed trials are needed to determine whether the therapy is helpful. Data so far suggests the treatment could be beneficial, but it's not definitive.

“It's an important scientific question that we don't have the answer to yet,” said Rice, an associate professor of medicine and director of VUMC's medical intensive care unit.



Convalescent plasma uses an antibody-rich blood product taken from people who have recovered from a viral infection and injects it into people still suffering in the hopes that the therapy will jump-start their immune systems, boosting their ability to fight the virus. The approach has been used on an experimental basis for more than a century to fight other virulent diseases, including the 1918 flu, measles, Ebola, SARS and H1N1 influenza.

Last month, NIH officials awarded \$34 million to Rice's study, **the Passive Immunity Trial of the Nation for COVID-19**, dubbed PassItOnII, which has also received funding from country music superstar Dolly Parton. The trial, which aims to enroll 1,000 adult hospitalized patients, could meet its goals by the end of October. If it shows evidence of likely benefit to COVID patients, it could immediately change clinical practice, Rice said.

Half of the participants will receive convalescent plasma with high levels of disease-fighting antibodies from a stockpile of more than 150 units of the product already collected, Rice said. The other half will receive a placebo solution.

Though the trial launched in April, enrollment has been slow. The funding allows enlistment at more than 50 sites nationwide. That has spurred new conversations about joining the trial — and about not employing the controversial authorization issued by the FDA, said Dr. Claudia Cohn, director of the Blood Bank Laboratory at the University of Minnesota Medical School. She expected her institution to decide this week.

“I'd rather frame it as not rejecting the FDA, but simply taking the longer view,” said Cohn, who is also medical director for the AABB, an international nonprofit focused on transfusion medicine and cellular therapies... **Read More**

## Vaccine Search Progresses, But Is It Too Fast?

Why volunteer for a vaccine clinical trial? Duty, love and a willingness to experiment, participants say

To meet standards of safety and effectiveness, each potential COVID vaccine has to be tested in thousands of people, most of whom will get two shots.

Ether Aviles wants to help her special-needs students and her nine nieces and nephews.

Joseph Shilisky believes the world needs ordinary people like him to step up.

Robert Huebner likes to be among the first, whether it's the first to try a new computer game, a new restaurant, or — now — a new vaccine.

All three are among the early volunteers in clinical trials to test potential COVID-19 vaccines. Vaccine developers have already shown basic safety, with no severe reactions in early trials. And they've shown their

candidate vaccines trigger the kind of immune response they want to see.

But to meet scientific standards of safety and effectiveness, each candidate has to be tested in thousands of people, most of whom will get two shots apiece of a vaccine that's still unproven.

Three of these Phase 3 trials have started already in the U.S.: one by Pfizer and BioNTech; another by AstraZeneca paired with Oxford University; and the third by biotech firm Moderna, which got a development assist from the U.S. government.

If all seven candidate vaccines now funded by the federal government make it to Phase 3, they will need a combined total of at least 210,000 volunteers, half receiving active vaccine and half a placebo.



The participants won't know whether they got the actual vaccine until their trial ends in about two years. In the meantime, they are left wondering whether their lack of a sore arm or fever means they received the placebo or just got lucky.

Some Phase 3 volunteers are eager to get the active vaccine.

Raymond Grosswirth, 71, of New York state hopes to be able to protect his wife of 26 years. Two years ago, she was in the hospital for months with pneumonia that turned septic, and he doesn't want her catching COVID-19.

Dusta Eisenman doesn't care. She just likes the idea of participating in a trial with the potential to help hundreds of millions of people. “If I got the placebo, then I will go and get the actual shot when ready,” said

Eisenman, 44, of San Jose, California.

Vaccination is the only way to stop a pandemic like this — with a virus that is extremely contagious and infectious before symptoms show up, if they ever do.

But it's proving a challenge to find enough volunteers.

While the first few trials may be OK, with Moderna reportedly having signed up 13,000 volunteers since late July, many more people will be needed for the others.

Dr. Jim Kublin, who runs a federally funded **COVID-19 clinical trial registry** at the Fred Hutchinson Cancer Research Center in Seattle, said he had hoped to have 1 million people sign up by the end of August. Instead, because of a late start on their advertising campaign, only about 360,000 have volunteered so far... **Read More**

People are living longer than ever before, staying active and healthy into their 80s and 90s, which has changed how seniors are viewed, supported and treated in our society. As a result, there are more resources, health and treatment options, and residential and care settings than were available to past generations. There has also been a shift in focus from housing seniors to assuring a meaningful quality of life. This outlook acknowledges that seniors remain vital members of our communities, and their needs and interests matter.

### Typical Health Challenges

Older adults face different health risks than their younger counterparts, and will require a different types of care. Depending on the severity of these health issues, a person may have to change their lifestyle, including where they live and the level of support they need to manage their health.

### Impacting Short-Term Illnesses and Injuries

- ◆ **Flu** – an infection that includes fever, headache, fatigue and more. It often leads to dehydration, pneumonia and can worsen conditions including asthma and heart disease.
- ◆ **Pneumonia** – a lung infection that has a variety of unpleasant symptoms including coughing, fever, chest pains, nausea, and more.
- ◆ **Shingles** – a rash with shooting pains that is related to the chickenpox. It is extremely painful and continuous.
- ◆ **Falls** – can occur from tripping over carpet or furniture and slippery floors. Millions of seniors are treated in emergency room each year due to falls.

These seemingly small problems can have a life-changing impact on a senior. As we age, we lose our ability to fight infections, making these illnesses dangerous, and even deadly. Brittle bones can fracture during falls, which can also lead

to serious problems. When seniors are bedridden due to a short term illness or fall, they lose muscle mass, become weaker, and may not fully recover even with physical therapy or other treatments.



### Impacting Long-Term Disease and Conditions

- ◆ **Heart Disease** – encompasses a variety of issues including high blood pressure, strokes, angina and more. It is the leading cause of death among seniors, heart disease can worsen as we age due to inactivity and unhealthy diet.
- ◆ **Arthritis** – a painful disease of the joints that can limit a person's activity level, which may cause additional health problems.
- ◆ **Cancer** – is the broad term for more than 100 different disease that are caused when cells grow out of control, creating tumors and other problems. Cancer is the second leading cause of death among seniors and preventative care and early detection should be a priority. Seniors are especially prone to developing colon cancer and should be proactive in testing for this disease.
- ◆ **COPD and other Respiratory Illnesses** – is one that affects the proper function of the lungs and related breathing processes. It is the third leading cause of death among seniors and must be actively managed to preserve health and quality of life, as well as reduce the risk of developing pneumonia.
- ◆ **Alzheimer's Disease and Dementia** – is the deterioration of brain matter resulting in memory loss and cognition problems. Often an exact diagnosis is difficult, but in most cases there are limited treatment options and the focus is on delaying symptom progression rather than a cure.
- ◆ **Sundowning Syndrome** – related to dementia and

Alzheimer's disease, sundowning refers to the connection between the setting sun and an increase in

confusion, anxiety, aggression or other behaviors by a senior. It is sometimes an early warning sign that the person is experiencing some level of dementia that has not yet been diagnosed.

- ◆ **Osteoporosis** – low bone mass that places a person at higher risk of a fracture or break when experiencing a fall or other impact. This disease category also includes spinal stenosis, which is a weakening and curving of the spine. The loss of activity due to this disease can worsen its affects and create additional health problems.
- ◆ **Parkinson's Disease** – this progressive neurological disorder occurs when specific cells in the brain begin to die, limiting a person's coordination and ability to control their movements. It commonly occurs among the elderly and has no cure, with treatment focused on managing symptoms and slowing the progression of the disease.
- ◆ **Multiple Sclerosis** – Although most people are diagnoses with MS before they reach age 50, many live with this disease well into their 80s, with symptoms changing over time. Seniors with MS experience many of the issues associated with general aging, but more intensely, including muscle weakness, balance issues, cognitive impairment, vision problems and fatigue. Decreased mobility from this disease increases risk of heart disease and urinary tract infections.
- ◆ **Diabetes** – results when the body experiences sustained high blood sugar levels due to decreased insulin levels. It can be fatal if left untreated but the symptoms can be managed through diet and exercise.

◆ **Obesity** – this issue can have many causes, the most common of which are diet and lifestyle. However many common medications, such as steroids and beta-blockers, can cause a person to gain weight. Obesity creates additional health problems including Type 2 diabetes, hypertension, heart disease, certain cancers, stroke, kidney disease and more.

◆ **Depression** – can have many causes and impacts seniors differently than other populations. When left undiagnosed and untreated, depression can worsen preexisting conditions, cause heart attacks and even result in suicide.

◆ **Anxiety** – affects more older adults than depression, and is more likely to go undiagnosed. Generalized anxiety disorder (GAD) is most common, although phobias, panic disorders, and obsessive compulsive disorders can also develop. All of these disorders hinder a person's ability to function in their life.

Every one of these conditions can significantly impact independence, quality of life, and the level of care necessary for management or improvement of symptoms, treatment and overall physical and mental wellbeing. Each person's needs are different and the challenge is finding the best solution for their circumstances.

### Other Important Terms

As you evaluate basic health care services and residential options, there are common terms that are important to know and understand. These are:

- ◆ **HIPAA**
- ◆ **Medicare**
- ◆ **Medicaid**

Understanding Medicare and Medicaid coverages can be confusing, but fortunately many healthcare and residential care providers are experts on these issues and can help you make the best choice given your circumstances....[Read More](#)



## Kidneys Might Affect Mental Status As You Age

(HealthDay News) -- Young adults with kidney problems may be at increased risk for mental decline in middle age, a new study suggests.

"Our study shows that if your kidney function starts declining as early as your 30s, you may perform like someone nine years older on certain cognitive tests 20 years later," said study author Sanaz Sedaghat, from Northwestern University Feinberg School of Medicine in Chicago. "Yet many people can have a decline in kidney function without being aware of it."

The study included more than 2,600 people with an average age of 35 at the start of the study. They had blood and urine tests to assess kidney function every five years for 20 years, and the tests were used to estimate their risk of kidney failure at each visit.

Based on the test results, the participants were assigned to three groups: no episodes of kidney failure risk, one episode of kidney failure risk, and more than one episode of kidney failure risk.

At the end of the study period,



the participants were given thinking and memory tests.

Over the study's two decades, 427

participants had one or more episodes of kidney failure risk and were in the higher risk group. Controlling for other factors that could affect thinking skills -- such as high cholesterol, high blood pressure and diabetes -- the high-risk group scored an average of four times lower on the end-of-study thinking tests than those with no risk.

The findings were published online Sept. 2 in the

journal *Neurology*.

"Recent studies indicate that even losing just a small amount of kidney function can be toxic for the brain and increase the risk of cognitive decline," Sedaghat said in a journal news release. "Our study adds to the evidence and suggests preserving kidney function in young age needs to be investigated as a potential strategy to keep thinking skills sharp in midlife."

### More information

The National Kidney Foundation has more on [kidneys](#).

## 2020 Flu Shot Strategy: Get Yours Early In The Season

Get set for 2020's mega-campaign against the flu amid the COVID-19

pandemic: immunization drives in the parking lots of churches and supermarkets, curbside inoculations outside doctors' offices, socially distanced vaccine appointments held indoors, with breaks in between for disinfecting.

These are just some of the ways health providers say they will give tens of millions of flu shots this fall — arguably the most important U.S. effort to prevent influenza's spread among Americans in a century.

Flu shots will be in stock at doctors' offices, pharmacies and supermarkets by early September. And though what's normally thought of as flu season in North America doesn't really begin until October and peaks between December and February, because of changes wrought by COVID-19, now is the time to start thinking about when, how and where you'll get immunized against the flu this year.

"If you usually get the shot at the office but you're working from home, for example, you'll need a new plan, says [Lori Uscher-Pines](#), a senior policy researcher with the Rand Corp. "And if you usually drop in to the pharmacy or the supermarket for your shot while you're out and about anyway, you'll need a new plan this year if, these days,

you're just not 'out and about.'"

But do make a plan. "No year is a good year to get the flu, but this year — with COVID-19 also raging — it's especially bad," says [Mark Thompson](#), an epidemiologist in the Influenza Division at the Centers for Disease Control and Prevention.

"People who can avoid the flu will help reduce the burden on a U.S. health care system already overwhelmed by COVID-19," Thompson says.

Emergency rooms and urgent care clinics are often flooded with flu patients during winter months, he explains. So getting a flu shot can help prevent those visits — and thereby prevent the co-mingling of flu patients and COVID-19 patients, who can infect each other and spread their viruses to other ER patients.

"This year, more than ever, we're trying to get out the message that flu is no benign disease and you should do everything you can to prevent it," says [L.J. Tan](#), the chief strategy officer at the Immunization Action Coalition, a nonprofit group in St. Paul, Minn., that provides educational information for physicians and consumers on immunization. "In particular, get your flu vaccine. Take flu off the table."

In most years, some who get the flu would reasonably choose to ride it out, feeling miserable



for a week or so, or even shorten the illness by taking one of several prescription drugs approved to treat the illness, says [Dr. Steven Pergam](#), an associate professor in the Vaccine and Infectious Disease Division at the Fred Hutchinson Cancer Research Center in Seattle.

But this year, "even people who never see a doctor for the flu might be prompted to book an appointment or head for the ER if they feel flu-like symptoms coming on," Pergam says.

That's because the **flu** and **COVID-19** can **share many (though not all) symptoms**, including fever, chills, cough, sore throat, muscle or body aches, headaches and fatigue. Loss of taste and smell, which can happen with COVID-19, does not occur with the flu.

The flu is dangerous in its own right, hospitalizing and killing tens of thousands of people each year and sidelining millions more for days to weeks.

"And even if *you* might only have a few days of feeling poorly," Pergam says, "transmitting the flu to babies, older people and people with compromised immune systems risks severe illness or death for them."

Public health experts are also concerned about people having both the flu and COVID-19 at the same time. "We don't know

yet whether that could compound either illness, but why take the risk?" says Dr. [Ashish Jha](#), director of the Harvard Global Health Institute.

Preliminary CDC data for the 2019-2020 flu season, which ended in May, found the flu to be a factor in at least 18 million visits to health providers in the U.S., 410,000 hospitalizations and as many as 64,000 deaths.

Still, of all Americans **eligible for a flu shot** (that's nearly everyone over 6 months old), more than half don't get immunized in a typical year, according to CDC data. Among the reasons people give: worry about side effects (serious ones are very rare), worry that the shot will give them the flu (it won't), a belief that the flu isn't all that serious (it can cause severe illness and death) and an aversion to vaccines in general.

The **flu vaccine** — whether given via a shot or a **nasal spray** — isn't perfect. It's designed toward the end of each flu season — February for the Northern Hemisphere and September for the Southern Hemisphere — based on the four most prevalent strains of the flu circulating at each time. The expectation of those designing the vaccine, often right, is that those will be the most common strains that people in each hemisphere will face in the following flu seasons...[Read More](#)

## Top Adviser To Operation Warp Speed Calls An October Vaccine 'Extremely Unlikely'

The Centers for Disease Control and Prevention is asking states to have a plan in place to distribute a COVID-19 vaccine as soon as late October — but that doesn't mean an effective treatment will be ready quite so soon.

In separate interviews Thursday with NPR, the chief scientific adviser to the Trump administration's vaccine development effort and the former director of the CDC's office of public health preparedness cautioned that an effective vaccine is likely still months away.

Dr. Moncef Slaoui is one of two men that President Trump has put in charge of **Operation Warp Speed**, which has a goal of developing a COVID-19 vaccine by January. The former GlaxoSmithKline executive said having states prepared is "the

right thing to do" in case a vaccine does become ready, but he acknowledged that having one by October or November was "extremely unlikely."

"There is a very, very low chance that the trials that are running as we speak" could be ready before the end of October, **Slaoui said**.

"And therefore, there could be — if all other conditions required for an Emergency Use Authorization are met — an approval. I think it's extremely unlikely but not impossible. And therefore, it's the right thing to do, to be prepared in case."

Slaoui said that he "firmly" believed a vaccine could be ready by the end of the year and that "we may have enough vaccine by the end of the year to immunize probably I would say



between 20 [million] and 25 million people." He said immunizing the U.S. population as a whole would take until "the middle of 2021." His assessment follows new CDC guidance, **first reported** by *The New York Times* on Wednesday, for states to prepare to distribute a vaccine to health care workers and other high-risk groups within a matter of weeks. In another letter, CDC Director Robert Redfield asked governors to **fast-track permits and licenses** in an attempt to make vaccine sites operational by Nov. 1, just two days before the presidential election.

Dr. Ali Khan, former director of the Office of Public Health Preparedness and Response at the CDC, called that timetable unlikely.

"I do not believe that this is going to be ready in a matter of weeks," he said.

Khan, now dean of the College of Public Health at the University of Nebraska Medical Center, said the CDC's guidance was less a prediction, and more a typical action the agency takes to ensure that once a vaccine is ready, states can use it.

"This is something that the CDC is appropriately doing, which is making sure that the states are prepared," Khan said. "It's a complex process that involves, how do you allocate vaccines, how do you distribute the vaccine, how do you administer the vaccine, how do you ensure equitable access for the vaccine. So the CDC and the states do this all the time."

...**Read More**

## 1 in 20 Older Americans Smoke Pot Regularly, Survey Finds

(HealthDay News) -- Marijuana use is on the rise among older Americans, with one in 20 saying they had used within the previous month, according to a new study.

About 5% of men and women aged 55 and older said they'd used marijuana or hashish in the previous month between 2016 and 2018, according to an annual federal government survey on potentially risky behaviors.

Use was twice as high among men, with about 6.7% reporting cannabis use during that three-year period compared to 3.5% of women.

There could be several explanations, an author of the new study said.

"It could be there are more people using marijuana for medical conditions. It could be there are more using it for recreational uses. It could be more people acknowledging use, in an environment when it's easier to say that you use products when talking to someone from the government," said co-researcher Bill Jesdale, an assistant professor at the University of Massachusetts Medical School, in Worcester.

Survey results found that reported cannabis use increased yearly between 2016 and 2018, rising from 4.2% of people 55 and older in 2016 to 5.9% in 2018.

Use among men rose from 5.5% in 2016 to 8.3% in 2018, while use among women went from 3.2% to 3.9%, the survey showed.

The largest increases occurred in the 11 states where recreational use of pot is legal, but pot use among seniors went up almost everywhere else as well, Jesdale said.

In all, 33 states have passed laws broadly legalizing marijuana in some form.

"Of course, we saw an increase in cannabis use in states where adult use is legal, and we saw an increase in states where medicinal use is legal, but we also saw an increase in states where there is no legal provision for use of cannabis," Jesdale said.

"Whether that's some sort of spillover effect as people see neighboring states loosening up and they start to feel more comfortable with it and interested in trying it out, it's hard to know," he added.



There are a number of concerns related to the increase in seniors using pot, said Pat Aussem, who reviewed the findings.

She's associate vice president of consumer clinical content development at the Partnership to End Addiction in New York City.

"Aside from recreational use, older adults are using marijuana for pain relief, neuropathy, anxiety, depression, insomnia and a host of other medical conditions," she said. "The evidence supporting its use is sparse, as the marketing of it is way ahead of research with the exception of chronic pain, spasms related to multiple sclerosis, and nausea and vomiting resulting from chemotherapy."

One concern is that seniors who toked at Woodstock might not be ready for the increased potency of today's carefully cultivated marijuana, Aussem said.

Seniors also tend to take more medications than younger folks, increasing the risk that their pot might interact with their prescriptions in harmful ways,

she added.

"There are hundreds of medications that interact with marijuana. For example, there is a concern that use of marijuana may increase the risk for bleeding in older adults on blood thinners," Aussem said. "There are only a handful of states that mandate pharmacist involvement in medical marijuana dispensing, so many older adults are on their own to figure out product selection, dosing, drug interactions and adverse effects."

These states highlight the need for more medical research on marijuana, to better inform seniors who are interested in trying pot either for fun or medicinally, she said.

"Seniors often seek guidance from their primary care doctors, but physicians are typically not equipped to guide patients with respect to choosing the right strain, dosing level and method of administration," Aussem said. "Even when speaking to a doctor to get a medical marijuana card, many seniors are surprised to learn that they may get a few recommendations, but not the prescription they are accustomed to getting."