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MEDIGAP PREMIUMS GREW MORE THAN TWICE THE RATE OF THE SOCIAL SECURITY COLA

According to a new survey by The Senior Citizens League (TSCL), premiums for Medicare supplemental insurance, known as Medigap, grew more than twice as fast as Social Security cost – of – living -adjustments (COLA) in the past year. About 41 percent of survey participants who are covered by a Medigap policy report robust premium increases in the past 12 months of *at least* 6 *percent or more,* particularly for individuals who were covered by a policy for more than two years. "The Social Security COLA for 2019 is 2.8 percent, far lower than the rate that Medigap policies appear to be growing," says Mary Johnson, a Social Security and Medicare policy analyst for The Senior Citizens League.

In addition to rapidly growing Medigap premiums, retirees also must pay for premiums for Medicare Part B and their drug plans. The combination takes a bigger bite out of Social Security benefits and other retirement resources when COLAs fail to keep pace. "The financial drain on benefits is difficult to anticipate, and many retirees don't have adequate savings to begin with," Johnson says.

The disparity between growth in the COLA and Medigap premiums is likely to be worse in 2020. "Inflation is lower this year, and we are estimating that the COLA is likely to be around 1.7 percent," Johnson says. "Nevertheless, we anticipate that Medigap premiums will continue to grow several times faster for a number of reasons," Johnson adds.

Two of the most popular Medigap plans, "F" and "C," will no longer be offered for sale in 2020. "While individuals enrolled in these plans may keep their plans, we are concerned that premiums for these plans could rise significantly without younger and healthier new enrollees to spread the costs in those plans," Johnson says.

In 2019, there are a total of ten different Medigap plans, "A" through "N." Congress closed Plans "F" and "C" because they cover the Medicare Part B deductible. The thinking is that deductibles prevent "over utilization" of Medicare benefits. The Part B deductible is $135.50 this year and it rises at the same pace as the Part B premium. According to research by Johnson, Part B premiums have increased about 10 percent per year since 2000, making it one of the fastest growing costs in retirement. "Requiring retirees to pay deductibles, or higher deductibles, has the biggest financial and health impact on middle-income Medicare beneficiaries with modest means," says Johnson. "Many put off medically necessary care if they can't afford the deductible, and their health can get worse when they do," she says.

About one quarter of all Medicare beneficiaries are covered by Medigap polices. Out-of-pocket costs under Medicare are considerable, and most beneficiaries supplement their coverage either by purchasing a Medigap policy or joining a Medicare Advantage plan. Unlike Medicare Advantage, however, Medigap enrollees in most states are not able to switch to another Medigap policy during fall open enrollment, because insurers are not required to cover pre-existing conditions outside of the individual's initial enrollment period. Seventy-two percent of survey participants support extending guaranteed coverage for pre-existing conditions to Medigap, allowing Medigap enrollees greater freedom to switch to other, less costly, Medigap plans.

This is how a phone Scam works

Have you heard about the latest scam? Scammers are offering "free" genetic tests and claiming Medicare will cover it — so they can get your Medicare Number and use it to commit fraud and identity theft. They're targeting people through telemarketing calls, health fairs, and even knocking on doors.

Only a doctor you know and trust should order and approve any requests for genetic testing. If Medicare is billed for a test or screening that wasn't medically necessary and/or wasn't ordered by your doctor, the claim could be denied. That means you could be responsible for the entire cost of the test, which could be thousands of dollars.

Here's how to protect yourself:

- **Don't share your Medicare Number, Social Security Number, or other personal information** with anyone who offers to give you a "free" in-person genetic screening or cheek swab, or a DNA testing kit in the mail.
- If you get a genetic testing kit in the mail, **refuse the delivery or return to sender** unless your doctor ordered it.

If you suspect Medicare fraud, call 1-800-MEDICARE.

Learn More

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2020 Social Security benefits should rise, but checks may not

Social Security transformed the nation, providing working families a basic measure of economic security when wages are lost in the event of old age, disability that prevents substantial gainful employment, or death. One of Social Security's most important features is that its benefits are adjusted every year automatically to offset increases in inflation, so that the modest but vital benefits do not erode over time. As a result, 2020 Social Security benefits should rise.

It is crucial to understand that Social Security cost-of-living adjustments are not increases. They are intended simply to allow people to tread water, to maintain their purchasing power. Unfortunately, the government's cost-of-living adjustment for Social Security is based on inflation experienced by urban wage earners and clerical workers. That is because in 1972, when the automatic adjustments were enacted into law, the Bureau of Labor Statistics, the agency that keeps track of inflation, only prepared that one index.

Of course, retirees and people with disabilities who are unable to work full-time have very different expenditures from urban workers and even from the general population. On average, they have higher health care and prescription drug costs, which have been going up much more rapidly than general inflation. Overall, they spend less of their fixed incomes on the latest smart phones and flat screen televisions, where cost increases tend to be lower than general inflation.

Consequently, retirees and people with disabilities tend to experience higher increases in their cost of living than younger workers do. Because

they generally experience higher increases in their cost of living than workers, their Social Security adjustments are more often than not inappropriately low. As a result, Social Security beneficiaries are not even treading water, but rather losing ground. Nevertheless, even inadequate adjustments are better than none.

The actual adjustment that will take effect this January cannot be calculated precisely until October, because it is based on the inflation rate of the third quarter of this year, which runs from July 1 to September 30, compared to the third quarter of last year. Obviously, inflation during the month of September will not be known until this month ends.

Until the size of the automatic adjustment is announced in the second half of October, we won't know the precise percentage increase of Social Security benefits. However, it is possible to provide a quite accurate estimate now of what the adjustment is likely to be.

In April, Social Security's actuaries projected that the cost-of-living adjustment beneficiaries would receive in January, 2020 would be **1.8 percent**, or about a $24 monthly increase for an average benefit, which is **$1,353.68**. However, we have now completed two of the three months of the third quarter and so can make a more accurate estimate of the size of the adjustment.

In recent months, thanks in large measure to President Donald Trump's trade war with China, the economy is slowing and inflation has been lower. Consequently, 1.8 percent is likely to be the highest the January increase will be. Depending on what happens in September, it is likely to be closer to 1.5 percent, or about $20 more a month for an average benefit.

Moreover, millions of people will not experience that full increase. Indeed, some may see no increase at all. That is because of rising health care costs. Most people with Medicare who receive monthly Social Security benefits have their **Medicare Part B premiums** deducted directly from those Social Security payments. For these people, Congress has provided that the annual increase in the Medicare Part B premium must be no larger than the Social Security cost-of-living adjustment. But it can be as large. They can't go below zero and lose some of their Social Security benefits, but they can certainly see their cost-of-living adjustment go completely to rising health care costs.

It is long past time to enact a more accurate cost-of-living adjustment for Social Security. More than three decades ago, in 1987, Congress directed the Bureau of Labor Statistics to develop a cost-of-living increase that measured inflation experienced by older adults. The Bureau complied and now each year publishes the Consumer Price Index for the Elderly, or the CPI-E. Congress should complete what it started and enact legislation that utilizes the CPI-E to adjust Social Security's benefits.

Fortunately, Democrats are squarely in favor of this change. Bills authored and co-sponsored by Democrats in both the House of Representatives and the Senate have been introduced that do just that. Indeed, one of those bills, the **Social Security 2100 Act**, authored by Rep. John Larson (D-CT), the chairman of the House Social Security Subcommittee, and cosponsored by 210 of his Democratic colleagues, is likely to be voted out of the House this fall. The bill also expands benefits across the board, while ensuring that all benefits can be paid in full and on time through the year 2100 and beyond.

And they should go one big step more. A **solid majority of House Democrats** support improving Medicare and extending it to everyone. They should pass that legislation, as well.

After a lifetime of work, Americans should have enough guaranteed Social Security to maintain their standards of living. And they should have expanded Medicare so no one is one illness away from bankruptcy.

The good news is that Social Security beneficiaries will receive a cost-of-living increase this January, small though it will be. The better news is that Democrats are fully behind not only improving the cost-of-living adjustment, but also expanding Social Security and Medicare. When that happens, all of us will be able to keep our heads well above water.

Health care information confuses people

.The **Center for Retirement Research** blog focuses on how health care information tends to confuse people more than help them. As a result, many people make poor health care choices.

In truth, information that we need to make smart health insurance choices is largely unavailable–e.g., whether a particular health plan delivers value and how one health plan ranks vis a vis others. Private health plans rarely provide helpful information on what we will need to pay for our care. And, people don't know what care they may need. So, people understandably cannot **choose health plans that save them money.**

Only older adults and people with disabilities have the choice of traditional Medicare and can guarantee themselves **access to the doctors they want to see at predictable costs**. But, they need Medicare **supplemental insurance**, which can be expensive and many older adults are hard-pressed to afford it.

It's not clear that people could ever have the health care information they need to make **rational choices** about private health plans. It might not make a material difference if health plan information were less confusing or better information were available. What would make a big difference? Giving people good affordable private health plan choices, which would require a far more heavily regulated private health insurance system than we have today.

Putting aside health insurance choices, the evidence suggests that people cannot make good choices about health care products and services. They often mistakenly believe that more expensive health care products–e.g. brand name drugs, not generics–are better. One research experiment published in **Science** found that "Expensive medications tend to make us feel better, even when they're no different than cheap generics." People may **react to a treatment differently based purely on the cost of the treatment.**

In fairness, most of us are bombarded with health care information that is virtually impossible to understand and steers us in all kinds of directions that may not be in our interest. We are left to wonder what to believe. It's therefore not surprising that people often believe that more medical tests are better than fewer tests, even **when they may not be**. And, they **skip care** because they mistakenly think they cannot afford it. They may think that a physical or MRI will cost more than it actually does.

A University of Wisconsin report finds that almost half of people who are on a tight budget skip medical tests and treatments because they don't think they can afford them. About one in three of them don't fill a prescription for the same reason. They make these decisions thinking their out-of-pocket costs are higher than they in fact are.

People also do not understand how their health insurance **deductibles and coinsurance** work. People with **high-deductible health plans** do not understand that they need to pay for the cost of their care up to the deductible amount, which is often many thousands of dollars, before their care will be covered.

It's time we stopped expecting consumers to act "rationally" when it comes to health care and guarantee everyone affordable access to the care they want and need.

Starving Seniors: How America Fails To Feed Its Aging

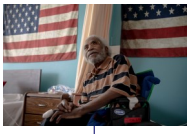
Army veteran Eugene Milligan is 75 years old and blind. He uses a wheelchair since losing half his right leg to diabetes and gets dialysis for kidney failure.

And he has struggled to get enough to eat.

Earlier this year, he ended up in the hospital after burning himself while boiling water for oatmeal. The long stay caused the Memphis vet to fall off a charity's rolls for home-delivered **Meals on Wheels**, so he had to rely on others, such as his son, a generous off-duty nurse and a local church to bring him food.

"Many times, I've felt like I was starving," he said. "There's neighbors that need food too. There's people at dialysis that need food. There's hunger everywhere."

Indeed, millions of seniors across the country quietly go hungry as the safety net designed to catch them frays. Nearly 8% of Americans 60 and older were "food insecure" in 2017, according to a **recent study released by the anti-hunger group** Feeding America. That's 5.5 million seniors who don't have consistent access to enough food for a healthy life, a number that has more than doubled since 2001 and is only expected to grow as America grays.



While the plight of hungry children elicits support and can be tackled in schools, the plight of hungry older Americans is shrouded by isolation and a generation's pride. The problem is most acute in parts of the South and Southwest. Louisiana has the highest rate among states, with 12% of seniors facing food insecurity. Memphis fares worst among major metropolitan areas, with 17% of seniors like Milligan unsure of their next meal.m

And government relief falls short. One of the main federal programs helping seniors is starved for money. The Older Americans Act — passed more than half a century ago as part of President Lyndon Johnson's Great Society reforms — was amended in 1972 to provide for home-delivered and group meals, along with other services, for anyone 60 and older. But its funding has lagged far behind senior population growth, as well as economic inflation.

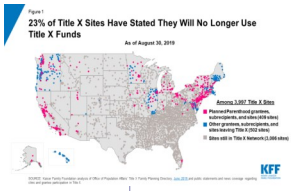
The biggest chunk of the act's budget, nutrition services, dropped by 8% over the past 18 years when adjusted for inflation, an **AARP report** found in February. Home-delivered and group meals have decreased by nearly 21 million since 2005. Only a fraction of those facing food insecurity get any meal services under the act; a **U.S. Government Accountability Office report examining 2013 data** found 83% got none.

With the act set to expire Sept. 30, Congress is now considering its reauthorization and how much to spend going forward.

Meanwhile, according to the U.S. Department of Agriculture, only 45% of eligible adults 60 and older have signed up for another source of federal aid: SNAP, the food stamp program for America's poorest. Those who don't are typically either unaware they could qualify, believe their benefits would be tiny or can no longer get to a grocery store to use them….**Read More**

Data Note: Impact of New Title X Regulations on Network Participation

Since 1970, the federal government has been funding Title X, a national grant program to support the delivery of family planning services to low-income individuals. On **March 4, 2019**, the Trump Administration finalized new regulations that made major changes to the program, which recently granted $255 million to fund approximately 4,000 clinics and service sites across the country. These new regulations prohibit any sites that receive Title X from providing abortion referrals, mandate referrals to prenatal services for all pregnant patients, and require complete financial and physical separation from abortion services. (Title X funds have never been permitted to be used to pay for abortions.) These regulations are a significant departure from the regulations that were in place, but mirror Reagan-era regulations that were upheld by the Supreme Court in ***Rust v Sullivan*** in 1991 but never fully implemented. Nonetheless, these new regulations are being legally challenged through **8 lawsuits** representing 23 States and provider organizations (including the American Medical Association and Planned Parenthood). While several of the Federal District Courts hearing the cases initially issued preliminary injunctions blocking the implementation of the regulations, the 9th Circuit Court of Appeals ruled that the regulations can be implemented as the cases make their way through the courts.



Effective July 15, 2019, Title X projects can no longer provide abortion referrals and must refer all pregnant clients to prenatal care services regardless of their wishes. OPA required all grantees to submit a **compliance plan** by August 19, 2019, documenting the steps they will take to change their programs to comply with the final rule and have stated they will respond with questions two weeks after that date. While financial separation of all abortion services from other family planning services has been required in the past, effective March 4, 2020, all clinics must have full physical separation from abortion services and other grantees and providers may opt to leave after that date. This data note provides estimates of the status of the Title X network as of August 30, 2019. Grantees and sub-recipients are continuing to make decisions about their participation in the Title X program. The most up-to-date information on the status of the Title X network can be found on **this interactive map.**

Over one in five Title X sites will no longer be using program funding

The HHS Office of Population Affairs operates the Title X program and funds "grantees" (health care organizations, state health departments, or non-profits) that apply to oversee the distribution of federal dollars to safety-net clinics (sub-recipients) and other sites to provide family planning services to low-income, uninsured, and underserved clients. In 2019, OPA funded 90 grantees that supported approximately 4,000 clinics nationwide, including specialized family planning clinics such as Planned Parenthood centers, primary care providers such as federally qualified health centers (FQHCs), and health departments, school-based, faith-based, and other private nonprofits

On August 19, 2019, Planned Parenthood **informed** OPA that all Planned Parenthood direct grantees and Planned Parenthood sub-grantees will withdraw from the Title X program. All eight direct **Planned Parenthood grantees** in the Title X program and the majority of sub-recipients have exited the program, while some sub-recipients are still in the process of withdrawing ….**Read More**

Strengthening Housing Vouchers Should Be Priority in 2020 Funding Bills

Center on Budget and Policy Priorities

The bipartisan budget agreement reached in July eliminated the threat of deep, damaging cuts under the 2011 Budget Control Act and opened the way for Congress to finalize fiscal year 2020 appropriations bills that invest in key domestic priorities.[1] One such priority should be the Housing Choice Voucher program, which helps 5 million people — most of whom are children, seniors, or people with disabilities — in more than 2 million households pay the rent and make ends meet.[2] A near-record 8.3 million renter households with very low incomes either pay more than half their income for rent or live in severely substandard housing, and only 1 in 4 eligible households receive rental assistance due to funding limitationsYet the number of households using housing vouchers has *declined* over the past two years due to funding delays and shortfalls caused by policymakers' battles over federal spending. The budget agreement creates an opportunity to reverse these harmful losses and help more renters afford decent, stable homes.

Congress should follow the path of the House-approved 2020 funding bill for the Department of Housing and Urban Development (HUD), which provides $23.8 billion for vouchers, $1.2 billion (5.4 percent) over the 2019 level. Most of this increase is necessary to renew all of the 2.2 million vouchers that households are now using and prevent cuts in the number of assisted households. (Voucher funding must rise every year to account for rising rents and other factors.) The House bill also includes $80 million to provide approximately 8,500 new vouchers for homeless veterans and at-risk families and youth. In addition, it provides $25 million to expand a promising mobility initiative designed to help families that would like to move from their current neighborhoods due to concerns such as high crime or poorly performing schools and find housing in neighborhoods with higher-quality schools and other opportunities that improve their children's long-term chances of success.

Other areas in the HUD funding bill also merit additional resources. For instance, the House bill boosts funding for public housing, homeless assistance grants, and the Family Self-Sufficiency program. Added investments in these areas would preserve badly needed public housing, help more individuals and families move from homelessness into stable homes, and support families' efforts to work and increase their incomes.

Vouchers Are Effective, Yet Funding Delays and Shortfalls Have Led to Cuts...**Read More**

John Oliver: Racism and sexism in medicine

Most Americans respect doctors. Still, racism and sexism in medicine is not uncommon. John Oliver explores this topic in **Last Week Tonight**.

Biases in medicine, as in every profession, abound. In medicine, however, biases, can have a tremendous impact on health outcomes. Oliver reports that women and people of color often have a very different relationship to our health care system than white men. "People have biases, and doctors are people. And they may have come up in a system that intentionally, or not, has often discounted the experiences of a major portion of the population."

Sexism in medicine is real. Women have challenges getting needed health care. One study shows that if you are a woman, you are **less likely to get a referral for a knee replacement**. Another study shows that women over 50 who are critically ill are **less likely to receive life-saving interventions** than men. Still another shows that women who go to the ER with terrible stomach pain are **less likely to receive pain medicine** than men. A woman's pain may be dismissed as emotional imbalance.

Some doctors do not appreciate that women may experience different symptoms from men for a particular condition. For example, **women's heart attack symptoms** are different from men's. Because some doctors are unaware, **women who come to the hospital with heart attack symptoms** are far more likely to be misdiagnosed than men. One study found they were seven times more likely to be misdiagnosed than men.

At the systemic level, doctors literally may know less about women's bodies than they do about men's bodies. Women's bodies have not been studied as extensively as men's; for decades women could not participate in research trials. Instead, researchers simply assumed that women's bodies were fundamentally the same as men's bodies, notwithstanding hormonal differences.

Racism in medicine is also severe. Just look at life expectancy differences between black men and white men. By one estimate, because of racial disparities in health care, there are **83,570 unnecessary deaths of black men each year**.

There is tremendous misinformation about African Americans when it comes to health care. Oliver reports that studies show that some doctors believe there are biological differences between African Americans and white Americans, including with regard to skin, blood, and nerve endings. One in four doctor residents think black people have thicker skin than white people.

Many studies show that black Americans have less chance of getting the care they need than white Americans for hip fractures, prostate cancer and **pneumonia**, among other conditions. One study showed that blacks were 34 percent less likely to be prescribed opioids for pain than whites.

Racism and sexism in medicine contribute to poor health outcomes. Also, poor treatment of women and people of color can lead women and people of color to forsake needed treatment.

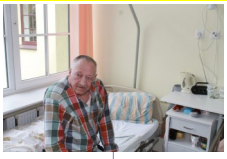
Oliver recommends that doctors and medical students should get bias training. We also need more diversity in the medical field. Patients need to advocate for themselves. How? Wanda Sykes, a guest on Oliver's show, suggests that you bring a white man to the hospital or doctor's office with you. And, ask the white man to repeat everything you say. That just might get your voice heard!

Assisted living facilities present serious risks for some people

In a New York Times op-ed, Geeta Ananad warns against expecting **assisted living facilities** to meet the needs of aging parents once they lose their independence. Rather, she explains that assisted living facilities can present serious risks to older adults who are not able to function independently.

To be sure, most people have no desire to end up in a nursing home, even if they offer 24-hour care. Ananad argues that an assisted living facility is not a substitute. Most of us will not be self-reliant until the day we die. And, if we cannot care for ourselves, we likely should not be in an assisted living facility.

Don't believe the marketing hype about assisted living facilities. They appear to be a good investment–with close to 15 percent annual returns, of late. But, assisted living facilities likely are not where you want your parents or for that matter yourself and the people you love, to live out their lives.



Assisted living facilities have the advantage of offering older adults companionship, activities and social interactions that they often cannot get at home. As people need more care, however, it becomes harder to rely on an assisted living facility, as much as you might like to. Once you need help walking or toiletting, or become mentally impaired, assisted living facilities are generally ill-equipped to meet your individual needs.

Half of assisted living facility residents are over 85 and **more than four in ten have dementia**; they need fulltime attention, which is generally not available to them. For most people who are not independent, the "24-hour" monitoring an assisted living facility offers is not enough to provide needed assistance and to ensure people are safe. According to Eric Carlson, the directing attorney for Justice in Aging, the assisted living facility system is broken.

Unlike with **nursing homes**, the federal government neither licenses nor oversees assisted living facilities. And, states do a poor job of regulating them. Assisted living facilities often do not have adequate staffing or properly trained staff and generally are not even required to have medical directors to review care for patients. (NB: **Nursing homes** must be licensed and meet strict regulatory standards and still they **too often do not deliver the care people need**.)

The average cost of staying in an assisted living facility is nearly $6,000 a month. The cost will only increase if regulations require more staffing and more trained staff.

Ananad proposes a Japanese model for paying for long-term care–a mandatory national long-term care insurance system, which the government helps pay for and is also supported by payroll taxes and premiums. Better still, **Medicare for All**, a single-payer cost-effective universal health care system, would spread the cost of long-term care across the entire population.

New Medicare rule requires insurers to tell people their out-of-pocket drug costs before they fill a prescription

Even though health care costs can be sky high, people often have little clue what their copay will be in advance of getting a service or filling a prescription, which leads many to skip care. Unfortunately, insurers have not been required to let them know in advance what their out-of-pocket costs will be. A new Medicare rule, effective 2021, will require **Medicare Part D insurers** to tell people their out-of-pocket drug costs before they fill a prescription.

The new Medicare rule is designed to help ensure that people do not skip needed care because they mistakenly assume it is unaffordable. When they go without care, as they too often do, it can lead to worse health outcomes. Medicare's new rule should help doctors decide which medications to prescribe, in part based on their affordability for patients.

But, there is compelling reason to question whether the new Medicare rule will work as intended. Studies suggest that giving people more health care information only **confuses them more**. And, there are so many factors that go into people's out-of-pocket costs, it is hard to imagine that they will all be taken into consideration.

Implementing the Medicare rule will be challenging. For sure, the rule should help some patients. At the very least, doctors will know if a Part D plan covers a particular drug.

But, will insurers factor deductibles into the cost equation? And, will they tell doctors when patients are better off paying for drugs out of pocket than using insurance? **Insurers make money** off high copays in these instances. Also, will insurers know when patients have access to **coupons providing drug discounts**?

Moreover, where you fill a prescription can affect your costs. Can and will insurers steer people toward lower-cost medicines? Most important, will Medicare's new rule mean people will in fact fill more prescriptions and be better off?

Private health insurers don't let you budget for your care

Kaiser Health News reports that people with the wherewithal to shop around for affordable health care can easily end up with bigger bills than they expected.

Unlike **traditional Medicare**, private health insurers don't let you budget for your care.

No one should have to shop around to ensure that their health care is affordable. Most people needing care have better things to worry about than whether their insurer, doctor, or hospital will charge them a fair price. Still, private health insurance companies force Americans to shop for care if they want to keep their costs down.

Kaiser reports that even people with private health insurance who try to budget for their care may not succeed at keeping their costs down. One couple, the Balzer's, planned a laparoscopic hernia repair operation for after they had had a baby and had met their insurance deductible. Wolfgang Balzer also called the hospital and the doctors for cost estimates.

Still, the Balzer's could not get an accurate sense of their costs. The anesthesiologist's office would not return his phone calls. The hospital's actual bill was more than 50 percent higher than its estimate. And the surgeon's bill was more than twice the estimate. With insurance, the Balzer's owed $2,304.51, $800 more than they expected.

The Balzer's challenged their bill, a time-consuming and stressful process. The procedure had gone exactly as expected, and there was no reason the bill should have been higher than estimated. The Balzer's learned that neither hospitals nor doctors are required to give accurate estimates of patients' costs.

The Kaiser reporter inquired about the Balzer's charges, and the hospital ended up writing them off, six months after the surgery. That's the good news. The bad news is that most of us do not have a reporter following up on our health care charges.

In other countries, where patients must pay a piece of the cost, providers are expected to give them accurate cost estimates. And, people's out-of-pocket costs are nowhere near as high as they are here. It's time to fix our broken health care system.

Who's Most Likely to Scam a Senior? The Answer May Surprise You

As people age and their mental capacities decline, they can often be targeted by scammers seeking easy cash.

But more often than not, this "financial abuse" comes not from a stranger, but from a trusted family member, research from the University of Southern California (USC) shows.

"Despite the high rates of financial exploitation perpetrated by scammers targeting older adults, we found that family members were the most commonly alleged perpetrators of financial abuse," said lead study author Gail Weissberger. "In fact, across all abuse types, with the exception of sexual abuse and self-neglect, abuse by a family member was the most commonly reported."

Weissberger is a postdoctoral scholar at USC's School of Medicine. Her team analyzed nearly 2,000 calls to the National Center on Elder Abuse (NCEA) resource line, created to help people seeking information on how to spot or report elder abuse.

More than 41% of the calls reported alleged some form of abuse was taking place, and of those cases, nearly 55% involved financial abuse.

Of all the abuse-related calls, family members were the alleged perpetrators in nearly 48% of calls in which the researchers could determine a relationship.

Financial abuse was the most common type of abuse by family members (nearly 62%), followed by emotional abuse (35%), neglect (20.1%), physical abuse (12%) and sexual abuse (0.3%)…..**Read More**

RI ARA HealthLink Wellness News

Eat better, spend less on health care

So long as the US population is aging, health care costs will continue to increase no matter what happens with health care reform. An **op-ed** in the New York Times, by Dariush Mozzafarian and Dan Glickman, argues that the food we eat drives up health care costs. If Americans ate better and became healthier, we would spend far less on health care.

Today, tens of millions of Americans suffer from one or more chronic conditions. Close to one third of the US population, more than 100 million adults, have **pre-diabetes** or **diabetes**. More than one third of the population, more than 120 million adults, have **cardiovascular disease**. And three quarters of the adult population is **obese**. These chronic conditions are responsible for hundreds of billions of dollars in health care spending, as well as lost productivity. (Note: Medicare covers a **diabetes prevention program, weight-loss counseling** and **nutrition counseling**.)

We know that people who eat healthy diets feel better and have lower health care costs. But, that's different from knowing how to change people's diets so that they eat better, especially when the food industry giants invest heavily in getting people to eat unhealthy diets. What would it take to improve population health through better nutrition?

The authors suggest a number of ways to improve people's diets. They propose that electronic health records include nutrition; health care providers could focus more on eating well and prescribe people fruits and vegetables; health care providers also could design healthy meals for people in poor health. One recent study shows that, for each person in poor health, these **healthy meals alone would save $9,000 a year** in health care costs.

Of course, behavior change, whether for a health care provider or a patient, is challenging. And, the food industry will do what it can to make change in people's eating habits difficult. The food industry has done a great job of keeping **sugary beverages** and **junk food** from being taxed more, even though these foods have no health benefits and drive up health costs.

The authors also suggest that the government subsidize the cost of healthy foods, such as vegetables, fruits, nuts, beans, whole grains and fish. They suggest government regulatory safety standards for **processed foods** to reduce sugar, sodium and transfats, if not voluntary action by industry. And, SNAP, which helps about 12 percent of Americans with the cost of food, could focus more on a healthy diet.

Government has a big role to play in helping people to eat healthy diets. But, no presidential candidates are talking about food policy and few journalists are asking about it. Government action in this area may be a long time coming.

Markers of abnormal liver function linked to Alzheimer's disease

Abnormal liver enzyme levels detected by commonly used blood tests may be linked to Alzheimer's disease diagnosis and multiple biomarkers of the disease, according to a recent study. The findings were published July 31 in *JAMA Network Open*. Led by NIA-supported scientific teams at Duke University and Indiana University, the research was based on the rationale that abnormal changes in liver enzymes are associated with heart disease and metabolic disorders like diabetes, which are known risk factors for Alzheimer's.

This study set out to examine the relationship between altered levels of liver enzymes, indicating abnormal liver function, and diagnosis of Alzheimer's, including multiple imaging and cerebrospinal fluid markers of the disease, in 1,581 participants of the NIA-supported **Alzheimer's Disease Neuroimaging Initiative**. The study was conducted by teams from the Alzheimer Disease Metabolomics Consortium, a component of the NIA-led **Accelerated Medicines Partnership–Alzheimer's Disease Target Discovery and Preclinical Validation Project**.

The analysis included results for 407 people who were healthy controls, 862 with memory concerns or mild cognitive impairment, and 312 people diagnosed with Alzheimer's disease. The researchers observed that abnormal levels of liver enzymes were associated with diagnosis of Alzheimer's and correlated with poor memory and thinking scores in those with the disease. Abnormal levels were also associated with increased levels of amyloid in the brain, detected by positron emission tomography imaging, and reduced amyloid and elevated levels of tau in cerebrospinal fluid. **Accumulations of amyloid-beta and tau** are hallmarks of Alzheimer's disease. In addition, the researchers found that abnormal liver enzyme levels were linked to reduced glucose metabolism and greater shrinkage in the parts of the brain involved in memory and thinking.

This study adds to the growing body of evidence that metabolic disturbances play a role in Alzheimer's disease processes. However, the study could not address whether abnormal levels of liver enzymes cause the disease or are a consequence. Further studies aimed at teasing out the relationship between liver dysfunction and Alzheimer's disease could open new diagnostic and therapeutic avenues.

This research was funded in part by NIA grants R01AG046171, RF1AG0151550, U01AG024904, R01AG19771, P30AG10133, P30AG10124, K01AG049050, and R03AG054936.

Reference: Nho K, et al. **Association of altered liver enzymes with Alzheimer disease diagnosis, cognition, neuroimaging measures, and cerebrospinal fluid biomarkers.** *JAMA Network Open*. 2019;2(7):e197978. doi: 10.1001/jamanetworkopen.2019.7978.

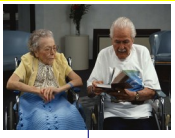
For Seniors, 'Silent Strokes' Are Common Post-Surgery Threat: Study

Silent strokes are common in seniors who have had surgery, and may double their risk of mental decline within a year, a Canadian study reports.

While an obvious (or "overt") stroke often causes symptoms such as weakness in an arm or speech problems, a silent (or "covert") stroke is apparent only on brain scans.

The new study included more than 1,100 seniors in North and South America, Asia, New Zealand and Europe who had elective, non-heart surgery and an MRI brain scan within nine days afterward.

One in 14 were found to have had a silent stroke, suggesting that 3 million seniors a year worldwide suffer a covert stroke after surgery, according to the study published recently in *The Lancet*.



"We've found that 'silent' covert strokes are actually more common than overt strokes in people aged 65 or older who have surgery," said study co-principal investigator Dr. PJ Devereaux. He's a cardiologist at Hamilton Health Sciences and professor at McMaster University in Hamilton, Ontario.

For the study, the researchers followed patients for one year after surgery, and found that those who had a silent stroke were more likely than others to have mental ("cognitive") decline, delirium, an overt stroke, or a mini-stroke (transient ischemic attack) during that time.

According to study co-principal investigator Dr. Marko Mrkobrada, "Surgeons are now able to operate on older and sicker patients thanks to improvements in surgical and anesthetic techniques. Despite the benefits of surgery, we also need to understand the risks," he said in a McMaster University news release.

Mrkobrada is an associate professor of medicine at University of Western Ontario in London, Ontario.

Dr. Brian Rowe, of the Canadian Institutes of Health Research (CIHR), said in the news release that the new study offers valuable information.

It "provides important insights into the development of vascular brain injury after surgery, and adds to the mounting evidence of the importance of vascular health on cognitive decline," he said. Rowe is scientific director of the Institute of Circulatory and Respiratory Health at CIHR.

More information

The American Stroke Association has more on **silent stroke.**

Do antibiotics raise the risk of rheumatoid arthritis?

New research suggests that antibiotics may raise the risk of rheumatoid arthritis by altering the gut microbiota.

About **1.3 million** adults in the United States are living **with rheumatoid arthritis** (RA), an autoimmune condition that causes **inflammation** of the joints.

Researchers do not yet fully understand what drives RA, although they suspect a combination of genetic and environmental factors.

Some of the potential **triggers** of RA include hormonal changes and exposure to certain types of dust or fibers, as well as some viral or bacterial infections.

New research points to the use of **antibiotics** and the changes that such use may lead to in a person's gut microbiota as potential causes of RA.

Lindsay Hall, group leader at the Quadram Institute on the Norwich Research Park in the United Kingdom, is the last and corresponding author of the new study, which appears in the journal ***BMC Medicine***.

Studying RA and antibiotics

Hall and team started from the observation that according to previous studies, using antibiotics, particularly in childhood, significantly raises the risk of developing infections and inflammatory bowel conditions.

More recent studies have suggested that antibiotics may also increase the risk of autoimmune conditions such as **type 1 diabetes**, autoimmune liver disease, and juvenile idiopathic **arthritis**.

Furthermore, the authors note, other studies in mice have shown that germ-free rodents do not go on to develop inflammatory arthritis, while human studies have found differences in the composition of the gut microbiota between people with and without the condition.

All of the above suggests that the microbiota plays an important role in the development of this inflammatory condition. So, Hall and team set out to "investigate the association between antibiotic prescriptions and the onset of RA using a large, U.K. based" dataset.

Antibiotics may raise RA risk by 60%...Read More

Memory boost: One-off exercise as effective as 12 weeks' training

Researchers are well-aware of the benefits that exercising brings to the mind and body. But how long do these positive effects last, especially where the brain is concerned? And how frequently should we exercise?

A large body of recent research has demonstrated that exercise can bring an impressive amount of benefits to health and well-being.

For instance, accumulating evidence suggests that exercise can help **relieve depression and help maintain metabolic health** and **brain health**.

The positive effects of exercise on the latter, particularly on memory and other cognitive abilities, is of particular interest to researchers who focus on preventing age-related and clinical cognitive decline.

Some of the main questions that researchers ask are: How much exercise does a person need in order to boost brain health, and how long do these positive effects last? And, more specifically: What are the effects of exercise on the cognitive abilities of older people?

These are some of the questions that a new study from the University of Iowa has recently tackled. The research findings, featured in ***Medicine & Science in Sports & Exercise***, bring us a better understanding of the ways in which exercise can help keep the mind sharp.

Potential for instant benefits

For the first part of the current study, the researchers wanted to find out how a single bout of exercise influenced working memory in older adults. Working memory is the form of short term memory that plays a key role in decision making processes….**Read More**

Dodge Dementia With Healthy Lifestyle

Seniors, here's a recipe for preventing dementia: eat well, exercise and don't smoke.

The only catch, according to a new study? If you carry genes that leave you vulnerable to the memory-robbing disease, lifestyle might not be enough.

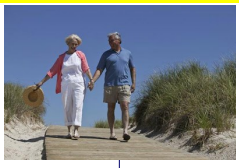
In the study, researchers found that of over 6,300 adults aged 55 and older, those with healthy habits had a lower risk of being diagnosed with dementia over the next 15 years. That was true, at least, for people at low or intermediate risk of dementia because of their genes.

Among people who carried high-risk genes, there was no evidence that lifestyle swayed the odds of developing dementia.

The findings, published Aug. 26 in the journal *Nature Medicine*, support a number of past studies suggesting that heart-healthy habits may also protect the brain.

But they are at odds with some past research, too: Other studies have suggested that lifestyle choices do, in fact, make a difference for people at high genetic risk for dementia.

The reasons for the differing findings are unclear. But the age of the study participants could be a factor, according to lead researcher Dr. Silvan Licher, of Erasmus MC-University Medical Center, in Rotterdam, the Netherlands.



People in his study were about 69 years old, on average, when their lifestyle habits were measured. But it might be healthy habits earlier in life -- middle-age or sooner -- that are critical for countering a high genetic risk for dementia.

So, the point is not to discourage anyone from following a healthy lifestyle, Licher stressed.

"These results should not alter the message about the importance of a healthy lifestyle to lower the risk of dementia," he said.

If anything, he added, the findings offer "an extra incentive" to adopt healthy habits now instead of later. The benefits, Licher noted, are numerous -- including lower risks of heart disease and stroke.

For the study, the researchers assigned participants into groups based on the genes they carried. The investigators used two different approaches to do that. In one, they focused on the APOE gene; certain variants of that gene are linked to a relatively higher risk of Alzheimer's disease. In the second, they considered an array of genes that have been tied to dementia risk -- assigning each participant a "polygenic" score.

Licher's team also scored the participants based on certain lifestyle and health factors: exercise habits; diet and alcohol intake; smoking; and whether they had diabetes, depression or were socially isolated.

Over the next 15 years, people with a "favorable" lifestyle score were less likely to develop dementia -- if they were not at high genetic risk, the findings showed.

The difference was clear, for example, among people with low-risk APOE scores: Those with a favorable lifestyle had a much lower rate of dementia -- less than 13%, versus 32% of those with an unhealthy lifestyle.

A similar pattern turned up among people at intermediate APOE risk, which the majority of study participants were.

The picture was different for people at high APOE risk. About 18% of those with a healthy lifestyle developed dementia, versus 19.5% of those with unhealthy habits.

It's hard to know the reasons for that finding -- or why it conflicts with some past studies, according to Rebecca Edelmayer, director of scientific engagement at the Alzheimer's Association.

But she agreed that the message about lifestyle remains unchanged. "We have a body of evidence suggesting that adopting a healthy lifestyle is not only good for cardiovascular health, but for brain health, too," Edelmayer said.

Ultimately, she added, it will take clinical trials to get more solid answers.

The Alzheimer's Association is currently funding a trial, called U.S. Pointer, which is testing a combination of measures -- including exercise, mental stimulation, and better control of blood pressure and diabetes. It's looking at whether those steps can help prevent mental decline in older adults believed to be at increased risk.

It would be much harder to run a similar trial in middle-aged adults -- since it would take many years to see any effects, Edelmayer noted. But in general, she said, it's thought that people stand to benefit the most by making healthy changes as early as possible.

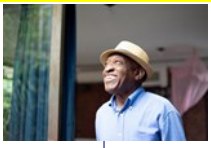
"It's never too early to start," she said.

People with higher optimism more likely to live 'exceptionally long lives'

New research finds that individuals with higher optimism tend to live longer and also have greater odds of living 85 years and more.

A recent ***PNAS*** paper describes how the researchers assessed the link between higher optimism and longer lifespan, with a particular focus on the chances of reaching "exceptional longevity."

The team carried out the study because most research on exceptional longevity has tended to focus on the effect of "biomedical factors."



More recently, however, scientists have become interested in the role of nonbiological factors.

"While research has identified many risk factors for diseases and premature death," says first and corresponding author Lewina O. Lee, Ph.D., assistant professor of psychiatry at Boston University School of Medicine, "we know relatively less about positive psychosocial factors that can promote healthy aging."

She and her colleagues defined optimism as the "general expectation that good things will happen or the belief that the future will be favorable because one can control important outcomes."

They suggest that because it may be possible to alter optimism using relatively straightforward therapeutic techniques, their findings have strong implications for public health.

"Our study contributes to scientific knowledge on health assets that may protect against mortality risk and promote resilient aging," Lee adds.

What the study found

For the analysis, the team brought together data on 69,744 females in the Nurses' Health Study (NHS) and 1,429 males in the Veterans Affairs Normative Aging Study (NAS).

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Even Age 80 Is Not Too Late to Begin Exercising: Study

Even seniors who never exercised regularly can benefit from a workout program, researchers say.

A new study found that men in their 70s and 80s who had never followed an exercise regimen could build muscle mass as well as "master athletes" -- those of the same age who had worked out throughout their lives and still competed at the top levels of their sports.

The U.K. researchers took muscle biopsies from both groups in the 48 hours before and after a single weight-training session on an exercise machine. The men were also given an isotope tracer before the workout in order to track how proteins were developing in their muscles.

It was expected that the master athletes would be better able to build muscle during exercise, but both groups had an equal capacity to do so, the University of Birmingham team found.

The study was published Aug. 30 in the journal *Frontiers in Physiology*.

"Our study clearly shows that it doesn't matter if you haven't been a regular exerciser throughout your life, you can still derive benefit from exercise whenever you start," lead researcher Leigh Breen said in a university news release. He's a senior lecturer in exercise physiology and metabolism.

"Obviously a long-term commitment to good health and exercise is the best approach to achieve whole-body health, but even starting later on in life will help delay age-related frailty and muscle weakness," Breen said.

Current public health advice about strength training for older people tends to be "quite vague," he noted.

"What's needed is more specific guidance on how individuals can improve their muscle strength, even outside of a gym-setting through activities undertaken in their homes -- activities such as gardening, walking up and down stairs, or lifting up a shopping bag can all help if undertaken as part of a regular exercise regimen," Breen said.

More information

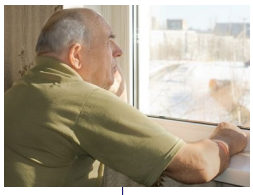
The U.S. National Institute on Aging has more about **exercise and physical activity**.

How You Can Help Head Off Alzheimer's Disease

There are a number of things you can do to reduce your risk of Alzheimer's disease, according to an expert.

"People think Alzheimer's is an entirely genetic disorder, but most often, it's not," said Dr. Charles Duffy, a neurologist at Penn State Health Milton S. Hershey Medical Center in Hershey, Pa. "The two biggest risk factors for developing Alzheimer's are a person's age and prior head injury, including trauma or strokes."

Diet and exercise can play a large role in preventing Alzheimer's. People should walk for at least 60 minutes a day, three to five days per week, Duffy advised.



"Eating fresh fruits and vegetables, nuts, fish and whole grains have a significant impact on delaying the onset and reducing the rate of progression of dementia," he said in a Penn State news release.

It's also important to get enough sleep -- seven to eight hours a night -- and to stay mentally engaged by talking with friends and neighbors, reading, doing word puzzles and engaging in other mind-stimulating activities.

A good relationship with a primary care doctor is also important, because it can also help you prevent or manage conditions such as heart disease, diabetes or high blood pressure.

"These conditions can predispose older adults to developing disorders like Alzheimer's," Duffy said.

Symptoms of Alzheimer's may include: difficulty finding car keys, handling money or managing complex tasks like driving a car or cooking a meal; vision changes; trouble finding words; repeating statements or questions; poor judgment; loss of spontaneity; or a change in personality.

If someone has symptoms, urge him or her to see a doctor immediately, Duffy said. Alzheimer's has no cure, but medications can treat its symptoms and slow its progression.

"It's heartbreaking for me to see people who don't get diagnosed until they've lived with Alzheimer's for years," Duffy said.

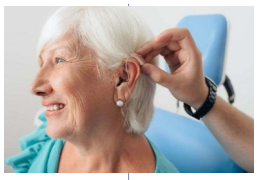
More information

The Alzheimer's Association has more on **Alzheimer's disease**.

The Hidden Risks of Hearing Loss and How You Can Avoid Them

Hearing loss is an invisible impairment that affects millions of people across the country and around the world. While it often goes undetected or untreated, it can have significant effects on quality of life, posing risks to physical safety, **cognitive abilities**, psychological health, family and social and relationships, and economic and occupational status.

About 48 million Americans have some degree of hearing loss, according to the **Hearing Health Foundation**. That number doubled from 2000 to 2015 and is projected to reach 73 million by 2060. Globally, the incidence has increased 44%, and hearing loss is the second most common health issue in the world.



One potential reason for the rising rate is increased longevity: Hearing loss is more common among older adults. About 1 in 3 people between 65 and 75 have hearing loss, and 2 in 3 people over the age of 75 are have impaired hearing. But hearing loss occurs even in children, and about 26 million people between the ages of 20 and 69 have hearing deficits.

Causes of hearing loss include noise pollution from loud music and urban or industrial environments, misuse of headphones and earbuds, certain medical conditions, and even certain medications. Hearing loss is **a potential side effect** of over 200 prescription and over-the-counter medications. Tinnitus, a disorder marked by ringing in the ears that frequently results in hearing loss, is noted as a potential side effect of **450 medications**.

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