

June 6, 2021 E-Newsletter

Happy Anniversary to the Alliance



This month the Alliance for Retired Americans is celebrating its 20th anniversary. Over the years, Alliance members have blocked efforts to privatize Social Security and Medicare, added a prescription drug benefit to Medicare, protected millions of Americans' earned benefits, and elected hundreds of candidates who understand the needs of seniors. Those are just a handful of our accomplishments, and we aren't done yet.

"Together we have brought a greater understanding of multiple policy issues affecting retirees at the local, state and federal level, from Capitol Hill to the White House," said **Robert Roach, Jr.**, President of the Alliance. "We have grown to 4.4 million members and we thank each of you as we continue working to strengthen retirement security for all Americans."
"While it is important to recognize our achievements and

wins, there is much more to do. We must expand Social Security and make the wealthiest pay their fair share into the future. It's time for Medicare to cover important medical treatments including dental, hearing and vision. And we must get Congress to take on the powerful pharmaceutical corporations that raise the prices of prescription drugs every year without fail."



Robert Roach, Jr.
President, ARA



Joe Peters, Jr.
Sec.-Treasurer



Rich Fiesta,
Executive Director

Death and debt by deductibles

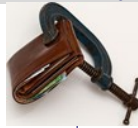
Congrats, America! Earlier this month you passed an annual milestone: Two days after Tax Day, you made it to... **Deductible Relief Day!**

What's that? It's the day where the average person with employer-based health insurance has spent enough on health expenses to finally meet their deductible.

Health insurance deductibles

have been rising so rapidly (year after year after year) that the Kaiser Family Foundation decided to track the trend to show how severely Americans are getting ripped off (and sick). **And it's bad.**

As you might guess, the Deductible Relief Day is being pushed further each year. In 2005, you had to wait until



February 28. By 2009, you wouldn't be popping champagne until March 18. In 2019, you waited two months more than that.

As the Kaiser Family Foundation noted, in 2009, the average deductible was \$533 for a single person. In 2018, it was \$1350. How? The insurance industry strategy of moving all of us into high-deductible plans

(one of the many gross abuses I saw first-hand at Cigna) has paid off well for my former employers.

In 2018, about 85% of covered workers were enrolled in a high-deductible plan, up from just 50% ten years earlier. Another way of looking at this: Average enrollee spending on deductibles more than tripled between 2007 and 2017...[Read More](#)

Biden administration aims to stop Pharma from preventing drug importation

[ABCNews.com](#) reports on a Biden administration effort to ensure states can legally import drugs from abroad. You might have guessed that big Pharma is opposing drug importation by states. In this case, Pharma is trying to block Florida's efforts to import drugs from Canada.

The Biden administration is trying to dismiss a Pharma lawsuit against state drug importation. The administration

argues that Pharma has no basis for filing a lawsuit to block state importation of drugs as the Biden administration has not approved importation to date. Interestingly, for once, the Republican governor of Florida, Ron DeSantis, is on the same side as the Biden administration.

That said, DeSantis is quick to criticize the Food and Drug Administration for not approving



state drug importation speedily. He's a politician. And, he sees an opportunity to build political support around lower drug prices.

Only Florida and New Mexico are currently seeking permission from the White House to import drugs from Canada. They believe it will save them and their residents tens of millions of dollars a year.

Meanwhile, Pharma has only a couple of lame arguments against importation of drugs. Even though the US is able to import food safely and millions of Americans have already imported prescription drugs safely, it cries "safety" like the boy who cried "wolf." Of course, importation must be from verified pharmacies, but there are thousands of them around the globe.

ADD YOUR NAME

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

'Social Security is not going bankrupt': retirement experts

Social Security provides **monthly income** to 71 million Americans **but a poll last November**, of people under age 60, found 70% believe the retirement program is going bust.

"Social Security is not going bankrupt," said Mary Beth Franklin a certified financial planner and contributing editor at Investment News. "There are long-term financing problems that we can deal with," she told a **Bipartisan Policy Center** (BPC) **webinar called**

Social Security: Myths vs. Facts.

Working Americans pay 6.2% of their income, up to \$142,800, to fund Social Security. Their employers match it. For the last 40 years, the program has intentionally collected more than it needed depositing the excess in trust funds to help fund the retirement of millions of Baby Boomers.

"Over the next few years, those trust funds are expected to run dry, that excess reserve, around 2034" Franklin said. "At that point, there would still be



enough of ongoing payroll taxes to pay about 75%, 80% of promised benefits."

The Social Security Administration (SSA) said changing demographics are part of the problem. "In 1940, the life expectancy of a 65-year-old was almost 14 years; today it is just over 20 years. By 2035, the number of Americans 65 and older will increase from approximately 56 million today to over 78 million."

And, as the U.S. population

ages the number of working Americans supporting retired Americans will decrease. "There are currently 2.8 workers for each Social Security beneficiary. By 2035, there will be 2.3 covered workers for each beneficiary," according to the SSA.

Jason Fichtner, the Chief Economist at the BPC and a former Social Security deputy commissioner said, "No one wants to live with a 20% or 25% haircut in their Social Security benefits." ...**Read More**

Texas Republicans unveil sweeping voting restrictions bill

Texas Republican state legislators on Saturday unveiled a sweeping voting restrictions bill amid efforts by Republican-led states to overhaul election laws in the wake of former President Trump's electoral loss.

The bill, S.B. 7, includes several controversial provisions that critics say would disproportionately affect poor and minority voters. It also specifically targets voting practices employed this past year in Harris County, which includes Houston, by banning drive-through voting and 24-hour voting. Those practices were used by 140,000 voters in 2020.

S.B. 7 makes it a state jail felony for local officials to attempt to send mail-in ballot applications to voters who did not request them, a practice Harris County employed in 2020. The bill also limits early voting and implements more restrictions on absentee voting, including adding more identification requirements for

those who wish to vote-by-mail.

President Biden condemned the bill in a statement, calling it "part of an assault on democracy that we've seen far too often this year—and often disproportionately targeting Black and Brown Americans."

"It's wrong and un-American. In the 21st century, we should be making it easier, not harder, for every eligible voter to vote," Mr. Biden said. "I call again on Congress to pass the For the People Act and the John Lewis Voting Rights Advancement Act. And I continue to call on all Americans, of every party and persuasion, to stand up for our democracy and protect the right to vote and the integrity of our elections."

Senate Majority Leader Chuck Schumer **said Friday** that the Senate will vote on the **"For the People Act"** in the last week of the June work period. But the bill is unlikely to move forward



in the Senate, as most legislation requires 60 votes to advance, and Democrats have a 50-seat majority. Republicans oppose S. 1, meaning that a vote to end debate on it is all but certain to fail.

The bill would revise government ethics and campaign finance laws, and try to strengthen voting rights by creating automatic voter registration and expanding access to early and absentee voting. The legislation would also require states to overhaul their voter registration systems, limit states' ability to remove people from voter rolls, increase federal funds for election security and reform the redistricting process.

The John Lewis Voting Rights Act, named for the late congressman and civil rights icon, seeks to bolster voting rights and roll back the impacts of a Supreme Court decision that gutted a key part of the landmark

1965 Voting Rights Act.

Texas is one of several battleground states controlled by Republicans that have **pushed for big changes in voting and election laws** in the wake of Mr. Trump's electoral loss and a rise in mail-in voting due to the coronavirus pandemic.

Arizona, Florida and Texas each have growing and increasingly diverse populations and play a substantial role in the outcome of presidential contests. All three have Republican-led legislatures and governorships. Michigan has a Democratic governor, but its Republican-controlled legislature is considering several bills that could make absentee voting more difficult.

Arizona and Michigan narrowly supported President Biden in the 2020 election, while Mr. Trump won Florida and Texas. Georgia, which Mr. Biden also won, has **already passed a controversial voting law** that includes restrictions.

Progressives Target Rep. Jake Auchincloss (D-MA)

Progressives Target Rep. Jake Auchincloss with Billboard Ad For Blocking Plans to Lower Drug Prices

(Washington, DC) — Today, Social Security Works and Organize for Justice, a sister organization of Justice Democrats, launched a billboard campaign calling out Rep. Jake Auchincloss (D-MA) for siding with pharmaceutical corporations instead of his constituents.

Auchincloss, who **received**

over \$66,000 in campaign contributions from the pharmaceutical industry, recently co-led a **letter** aimed at **blocking Democratic efforts** to lower drug prices.

A truck displaying the billboard is parked outside Auchincloss's Attleboro District Office. (Auchincloss has not yet replaced former Rep. Joe Kennedy's name on the sign outside.)



"There's nothing 'moderate' or 'bipartisan' about blocking plans to lower drug prices. In fact, lowering drug prices is **incredibly popular** with voters across the political spectrum. Auchincloss is a shill for pharmaceutical corporations, and we're making sure his constituents know it," said Alex Lawson, executive director of Social Security Works.

"After all we've been through in this pandemic, it's unconscionable that Rep. Auchincloss would rather do the bidding of Big Pharma corporate donors than lower prescription drug prices for working families," said Alexandra Rojas, executive director of Justice Democrats and board president of Organize for Justice.

Medicare Home Health Coverage: Reality Conflicts with the Law

Medicare home health coverage can be an important resource for Medicare beneficiaries who need health care at home. When properly implemented, the Medicare home health benefit provides coverage for a constellation of skilled and nonskilled services, all of which add to the health, safety, and quality of life of beneficiaries and their families. Under the law, Medicare coverage is available for people with acute and/or chronic conditions, and for services to improve, or maintain, or slow decline of the individual's condition. Further, coverage is available even if the services are expected to continue over a long period of time.^[1]

Unfortunately, however, people who legally qualify for Medicare coverage frequently have great difficulty obtaining and affording necessary home care. There are legal standards that define who can obtain coverage, and what services are available. However, the criteria are often narrowly construed and misrepresented by providers and policy-makers, resulting in inappropriate barriers to Medicare coverage for necessary care. This is increasingly true for home health aide services – the very kind of personal care services vulnerable people often need to remain safely at home.

A. The Law: What Home Care Is Covered Under the Medicare Act?^[2]

Home health access problems have ebbed and flowed over the years, depending on the reigning payment model, systemic pressures, and misinformation about Medicare home health coverage. Regrettably, these problems are increasing and, if current and proposed policies and practices continue, they will only get worse. Accordingly, it is important to know what Medicare home health coverage should be under the law, especially for people with longer-term, chronic, and debilitating conditions.

1. Medicare Home Health Qualifying Criteria

Medicare covers home health services under both Parts A and B when the services are medically “reasonable and necessary,” and when:^[3]

- ◆ A physician or other authorized practitioner has established a plan of care for furnishing the services that is periodically reviewed as required;
- ◆ The individual is confined to home (commonly referred to as “homebound”). This criterion is generally met if non-medical absences from home are infrequent, and leaving home requires a considerable and taxing effort, which may be shown by the patient needing personal assistance or the help of an



assistive device, such as a wheelchair or

walker.. (Occasional “walks around the block” are allowable. Attendance at an adult day care center, religious services, or a special occasion is not a bar to meeting the homebound requirement.);

- ◆ The individual needs skilled nursing care on an intermittent basis, or physical therapy or speech-language pathology (or, in the case of an individual who has been furnished home health services based on such a need, but no longer requires skilled nursing care or physical or speech therapy, the individual continues to need occupational therapy); and
- ◆ Such services are furnished by, or under arrangement with, a Medicare-certified home health agency.^[4]

2. Medicare-Covered Home Health Services

If the qualifying conditions described above are satisfied, Medicare coverage is available for an array of home health services. Home health services that can be covered by Medicare include:^[5]

- ◆ Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;
- ◆ Physical therapy, speech-language pathology, and occupational therapy;
- ◆ Part-time or intermittent

services of a home health aide;

- ◆ Medical social services; and
- ◆ Medical supplies.

As described above, skilled nursing, physical therapy, and speech-language pathology services are defined as “qualifying skilled services” for the purpose of establishing eligibility for Medicare home health coverage.^[6] A patient must initially require and receive one of these skilled services in order to receive Medicare for other covered home health services.^[7] Home health aide, medical social worker, and occupational therapy services^[8] are defined as “dependent services,” (*dependent* upon a skilled service being in place) as are certain medical supplies.^[9]

While occupational therapy is not considered a skilled service to begin Medicare home health coverage, if the individual was receiving skilled nursing, physical or speech therapy, but those services end, coverage can continue if occupational therapy continues.^[10]

The term “part-time or intermittent” means skilled nursing and home health aide services furnished any number of days per week as long as they are provided less than 8 combined hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week....[Read More](#)

Why Retirees Are Losing Ground on Social Security

Retirees generally rely on Social Security to help them pay for necessities. That's because retirement benefits are an important source of income that's guaranteed for life.

They're also supposed to be protected against inflation by periodic Cost of Living Adjustments (COLAs). Sadly, however, while retirees aren't supposed to lose buying power because of these COLAs, the reality is very different.

In fact, new data from the Senior Citizens League shows there's a vast gap between the amount by which retirees' expenses increase and their

periodic raises. And the sad truth is, this gap is likely only going to grow unless big (and unlikely) changes are made.

Social Security retirement benefits are rapidly losing value

The buying power of Social Security benefits has been **declining for decades**, but retirees took an especially big hit last year.

In fact, according to a recent survey conducted by the Senior Citizens League, 63% of retirees indicated their Social Security benefits went up by less than \$15 per month in 2020 due to last year's low COLA and the



increase in Medicare Part B premiums (which are generally paid out of Social Security checks).

During that same time period, 65% of retirees indicated their monthly household expenses increased by \$80 or more -- including 40% of retirees who said their spending went up to \$120 or more per month.

You don't need to do a lot of complicated math to figure out that if expenses rise by \$80 or more, but seniors get just \$15 more in their monthly checks, this is going to pose problems.

Why are retirees losing ground?

The reason that COLAs aren't keeping pace with the cost increases that seniors are experiencing is because of the method used to calculate these periodic raises.

Social Security's annual raise is determined by changes to the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W). The spending habits of this group don't mirror the actual spending retirees do. And the areas where seniors devote most of their income -- housing and healthcare -- have seen prices rise much faster than inflation. ...[Read More](#)

Democrats in both chambers launch public option effort

Murray and Pallone's request revives a debate on government's role in health coverage and sets up a fight with the insurance industry

Two key committee chairs in the House and Senate are taking the first step toward crafting legislation to create a public health insurance option, reviving a debate between the parties on the federal government's role in coverage and setting up a fight with the insurance industry.

Senate Health, Education, Labor and Pensions Chair **Patty Murray**, D-Wash., and House Energy and Commerce Chair **Frank Pallone Jr.**, D-N.J., issued a **request for information** Wednesday asking for input on a public option, which would establish a government-run health plan to compete with private insurers.

"Our goal in establishing a federally administered public option is to work towards achieving universal coverage, while making health care simpler and more affordable for patients and families," the pair wrote.

Democrats abandoned plans to establish a public option through the 2010 health care law, but the proposal has gained support among Democrats in the ensuing years. The debate over whether to move toward a public option or a more ambitious Medicare for All, government-run program was a defining issue of the 2020 Democratic primary, with President Joe Biden supporting a public option.

Since taking office, Biden has focused on other goals, such as expanding the size of subsidies under the 2010 health care law



and broadening eligibility for them. He did not include a public option in the economic proposals he is working to pass this year.

Democrats are also writing legislation to lower the cost of prescription drugs, which would create savings they could use to finance other priorities.

With razor-thin majorities in both the House and Senate, Democrats would have a difficult time passing legislation to enact a public option, which Republicans oppose. Democrats could use the reconciliation process to consider public option legislation, which would allow them to pass legislation without Republican support, but that would require adherence to budget rules and no defections among Senate Democrats.

The health care industry has already mobilized to oppose this type of legislation.

"Now is not the time for us to become embroiled in debates over issues like public option," Chip Kahn, president and CEO of the Federation of American Hospitals, said in a statement. "It would be a mistake to allow such distractions to stand in the way of enacting legislation that sets the pathway to all Americans having the health coverage and health care security that all of us deserve and should expect."

Democrats in both chambers have proposed different bills that would establish a public option, but Murray and Pallone indicated they would develop a new proposal....[Read More](#)

TIPS and ETFs Can Help Protect Retirees Against Inflation

Inflation is back and it's staring straight at all Americans, and especially retirees who might be living on a fixed income.

Consider: The consumer price index (CPI) for Americans 62 years of age and older has risen 3.7% for the 12 months ending April 2021, and the CPI for all Americans has increased 4.2% over the same period.

But according to **the Senior Citizens League**, Social Security beneficiaries are really behind the eight-ball. Since 2000, cost of living adjustments (COLAs) have increased Social Security benefits a total of 55%, yet typical senior expenses through March 2021 grew

101.7%.

The Senior Citizens League also noted that the average Social Security benefit rose from \$816 a month in 2000 to \$1,262.40 by 2021 due to COLA increases. However, because retiree costs are rising at a far more rapid pace than the COLA, a Senior Citizens League study found that a Social Security benefit of \$1,645.60 a month in 2020 would be required just to maintain the same level of buying power as \$816 had in 2000.

So, what can older Americans do to make sure they manage the risk of inflation and loss of



purchasing power?

Consider Using a Barbell

According to Mike

Ashton, a managing principal with Enduring Investments, retirees often get two versions of advice about investing for their golden years.

"Seniors are concerned about losing purchasing power slowly, through inflation, and so conventional advice usually advocates maintaining a fair amount of risky assets to "keep up" with those costs, while withdrawing a steady amount, the 4% rule for example," he said.

But of course, those risky

assets can move abruptly, which triggers the opposite concern, said Ashton. "Seniors are also concerned about losing purchasing power quickly, through market corrections/bear markets," he said. "And the conventional advice is to keep a 'rainy day fund' or some such idea. So, in brief, the argument is that they should be riskier than they would like to keep up with inflation, and less risky than they need to be to protect against market declines. It's not surprising that it's confusing." ...[Read More](#)

More Doctors Could be on the way to Underserved Areas of the U.S.

Modern Health Care reports that there is a push by members of Congress to bring more physicians to rural and underserved areas experiencing shortages. Lawmakers have reintroduced a plan to allow more international physician candidates to attend residency in the U.S. and stay in the country after their training if they agree to work in underserved areas.

The legislation was reintroduced Thursday and would increase the number of

slots in the program called Conrad 30. Sen. Amy Klobuchar (D-Minn.) first introduced the bill in 2019 with bipartisan support, but it failed to pass the Senate Judiciary Committee.

Minor changes were made to the bill in order to gain a broader coalition of supporters, including reauthorizing the Conrad 30 program for three year following the bills enactment, language clarifying hospital malpractice concerns, and a mandate that



directs U.S. Citizenship and Immigration Services and HHS to keep track of how the J-1 visa program is being used by states.

The American Hospital Association and American Medical Association both support the bill, but it is unclear whether the legislation's effort to raise the number of slots for residency graduates to work in the country will effectively address workforce shortages in rural communities.

A report by the Association of American Medical Colleges shows the U.S. will have a shortage of 139,000 physicians by 2033. Rural areas are especially vulnerable. Only 11% of physicians practice in rural facilities, while 20% of the U.S. population live in rural areas. Neither of these statistics take into account the exodus of physicians from the workforce following the COVID-19 pandemic.

CMS Announces Long-Awaited Medicare Plan Finder Improvements

This week, the Centers for Medicare & Medicaid Services (CMS) announced plans to improve and update the **Medicare Plan Finder** (MPF) and the **Health Plan Management System** (HPMS). HPMS is the system that Medicare Advantage and Part D plans use to provide data about their plan offerings to Medicare, and the MPF is the online tool that allows beneficiaries to evaluate, compare, and enroll in those plans. The changes will be in place for the start of the

Medicare Open Enrollment Period starting on October 15 for 2022 plans.

Many of the forthcoming MPF changes **reflect suggestions** that Medicare Rights and other advocates have made over the years to increase the tool's functionality and the beneficiary's experience. For example, we are pleased to see that users will soon be able to find in-network and preferred pharmacies from the "plan results" page, that print options will be updated to allow printing



of the "plan results" and "plan compare" pages, and that Medicare will

discontinue the out-of-pocket preview for Medicare Advantage (not Part D) annual costs. This last change will eliminate the existing, confusing metric, which does not use any personalized information or claims data to predict utilization of services and does not take Medigap into account in the assessment of the Original Medicare preview, creating a potentially misleading

comparison.

We applaud CMS's continued efforts to examine and improve the MPF and other tools that people with Medicare rely upon to make the best enrollment decisions for themselves and their families.

Medicare Plan Finder is available on [Medicare.gov](https://www.Medicare.gov).



Majority of Adults Age 50 and Older Oppose Medicare and Social Security Benefit Cuts to Pay for Federal Budget Deficit

A new AARP **survey** of adults age 50 and older shows overwhelming opposition to Medicare and Social Security benefit cuts. While only 3% of respondents said the federal budget deficit is "not a problem at all," 85% "strongly oppose" reducing earned Medicare and Social Security benefits to help pay for it. This was true across party lines: 87% of Democrats and 88% of Republicans strongly oppose cutting Social Security, while 87% of Democrats and 86% of Republicans strongly oppose reducing that program's benefits.

The survey comes as some in Congress are examining ways to lower national debt levels, which have risen in recent years primarily due to legislative

changes like the **2017 tax cuts** and the ongoing COVID-19 response.

One such proposal, the TRUST Act, would fast track bills to cut Medicare and Social Security. It would set up closed-door commissions called "Rescue Committees" that would draft legislation to address Medicare and Social Security trust fund solvency. If approved by just seven Rescue Committee members, such a proposal would receive expedited consideration in the House and Senate—lawmakers would be unable to make any changes or have a meaningful public debate. Medicare Rights has consistently opposed this approach, including as part of COVID-19 relief efforts.

At the same time,



the **Republican Study Committee**, a group of over 150 conservative House Republicans, just unveiled a **ten-year spending plan** that would slash \$2.5 trillion from Medicare; \$708 billion from Social Security; and \$3.3 trillion from the Children's Health Insurance Program, the Affordable Care Act, and Medicaid.

As AARP **notes**, "While older Americans care about the nation's long-term fiscal health, we also know they want to make sure the promises made to all Americans regarding Social Security and Medicare are honored. Indeed, Social Security and Medicare had little to do with the recent run-up of debt and deficits in the wake of

COVID-19. In fact, Social Security provided a stable source of income, and Medicare provided critical health coverage, **at a time when it was most needed**. Rather than being part of the problem during the pandemic, Social Security and Medicare have been a big part of the solution. These key programs should not be seen as budgetary scapegoats for an increase in debt they did not cause."

Medicare Rights urges lawmakers to protect and strengthen these critical earned benefits.

Tell Congress: Oppose the TRUST Act and safeguard Social Security and Medicare now and in the future.

Sanders Hopes to Fix Doctor Shortage

Sen. Bernie Sanders (I-Vt.), has announced that he will seek legislation to increase the number of doctors being trained in the U.S.

Sanders, who is Chairman of the Subcommittee on Primary Health and Retirement Security of the Senate Health, Education, Labor and Pensions Committee, announced last week that he'll introduce legislation to add 14,000 Medicare graduate medical education slots over seven years, potentially training thousands of new doctors each

year.

As chairman of that subcommittee he is perfectly placed to get legislation introduced and sent to the Senate floor for a vote.

According to *Bloomberg News*, "Public health groups say the U.S. faces a shortage of at least 54,000 primary care and specialty doctors over the next decade.

"Sanders said his legislation would reserve half of the new slots to train new primary care



doctors.

"David J. Skorton, president and chief executive officer of the Association of American Medical Colleges (AAMC), said his group has asked for 3,000 slots to be added each year to Medicare's graduate education program. That program, along with others, pays hospitals to train medical school graduates to become doctors."

The U.S. is facing a doctor shortage because the 65-and-older population grew by over a

third (13,787,044 people) during the past decade, putting pressure on the U.S. health system. At the same time, 40% of active physicians will reach 65 in the next 10 years, putting many into retirement, according to AAMC data.

This is important legislation that must be passed soon since it takes many years to fully train doctors. TSCL looks forward to reviewing Senator Sanders' bill when it is introduced.

This Is the Best Age to Retire, According to Social Security

When should you take **Social Security**? There's no right or wrong answer, but one of them is the best time for you. The age when you activate this benefit will determine how much you receive monthly -- which could greatly impact how much of your working income gets replaced.

The age at which you start will also play a role in how much you get in total benefits from this system during your lifetime. And if you're looking to hedge your

bets on how long you might live, then taking benefits at your full retirement age may be in your best interest.

How does your age impact your benefit?

If you take Social Security at your full **retirement age** (FRA), you'll receive your standard benefit. But you can take it as early as age 62 or delay it until age 70. If you take it early, you'll receive less for every year that



you take it sooner, and you'll get an increase in your benefit for every year that you delay it. So if your standard benefit at your FRA at age 66 is \$2,500, your reduced benefit at age 62 will be \$1,875 and your delayed benefit at age 70 will be \$3,300.

If you live to the age of 75, taking it at age 62 will get you \$292,500 in lifetime income. If you take it at age 66, you'll get \$270,000, and if you delay to age

70, you'll get \$198,000. If your life expectancy extends to age 80, you'll receive \$405,000 if you take it at age 62, \$420,000 if you take it at age 66, and \$396,000 if you take it at age 70. If you live until the age of 85, you'll draw \$517,500 in lifetime income if you take it at age 62, \$570,000 from taking it at age 66, and \$594,000 if you take it at age 70....[Read More](#)

Fight for Lower Drug Prices Heats up in Congress

For the last couple of weeks we've also reported on a hearing by the House Committee on Oversight and Reform regarding the prices that drug companies are charging for some of their drugs that are critical for the health of many seniors.

The hearing examined in particular the drug company AbbVie, which makes Humira and Imbruvica, two drugs widely used by seniors.

The committee found that AbbVie inflated prices for the drugs while its executives pocketed growing bonuses. The committee's two-year investigation found that AbbVie "pursued a variety of tactics to increase drug sales while raising prices for Americans, including exploiting the patent system to extend its market monopoly, abusing orphan drug protections to further block competition, and

engaging in anticompetitive pricing practices."

According to the committee's report, AbbVie has raked in more than \$100 billion in net revenue from those two drugs since 2013, which the committee said was "driven in large part by AbbVie executives' decision to repeatedly raise the prices of Humira and Imbruvica." The company's top executives pocketed \$480 million in compensation during that span, "much of which was directly linked to revenue increases," the report said.

Now, it turns out, AbbVie is helping to fund ads attacking legislation that would lower prescription drug costs.

"AbbVie is one of 33 member companies of the industry's top lobbying group, PhRMA, which raised nearly \$450 million from



membership dues in 2018, the most recent year for which data is available. But AbbVie's political action committee is one of just two pharmaceutical company PACs to donate the maximum \$40,000 to PhRMA's federal PAC since 2013, a potential indicator that AbbVie was highly motivated to influence legislation," according to a report on *Salon.com*.

It turns out that PhRMA "spreads that money around to political campaigns across the country as well as other trade groups like the American Action Network (AAN), a conservative dark money group that launched a \$4 million ad campaign to defeat the Democrats' H.R. 3 proposal, which would allow Medicare to negotiate lower prices for prescription drugs and cap out-of-pocket drug costs at

\$2,000," again, according to the *Salon.com* report.

The report adds that, "The pharmaceutical industry has already shattered records this year, spending an unprecedented \$92 million to lobby the federal government in the first three months of this year, according to the CSP, including \$8.7 million from PhRMA. Stephen Ubl, the CEO of PhRMA, criticized H.R. 3 last month, claiming it would 'destroy an estimated one million American jobs.' The U.S. Chamber of Commerce, the biggest lobbying spender this year, has also come out against the bill, comparing it to 'government price controls' and claiming it would cost hundreds of thousands of jobs....[Read More](#)

Here's Why Seniors on Social Security Could Get a Huge Raise in 2022

From gasoline to groceries, the price of common goods seems to be going nowhere but up. We can thank supply chain issues and inflation for that. But while inflation is often regarded as a bad thing -- because, after all, it makes things cost more -- it could work to seniors' benefit in the near term.

Could seniors be in line for a big Social Security raise?

Each year, **Social Security** recipients are eligible for a cost-of-living adjustment, or COLA. COLAs are calculated based on data from the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W), which measures fluctuations in the cost

of common goods and services. When inflation strikes and the CPI-W rises, seniors on Social Security are given a raise. But when the CPI-W drops or stays flat, seniors can be denied a COLA.

Over the past few months, we've seen our share of inflation, to the point where a lot of people are feeling the pain at the pump and at the supermarket. And if that trend continues, it could result in seniors getting a big Social Security raise for 2022.

Now one thing to keep in mind is that COLAs are calculated based on third quarter data from the CPI-W only. If inflation begins to decline over the



summer, it will impact the raise seniors get. But if the past few months are any indication, seniors could finally be in line for a decent boost to their Social Security benefits.

A welcome change?

Over the past few years, COLAs have been fairly stingy due to minimal movement in the CPI-W. In 2021, seniors got a 1.3% raise. The year prior, it was 1.6%. And there have been three different instances since 2010 when seniors got no COLA at all.

Of course, wishing for a robust COLA going into 2022 also, to an extent, means wishing that inflation holds steady and that

the cost of common goods remains high. And that's why generous COLAs are really a mixed bag. While seniors may be able to look forward to more money next year, on the flipside, they may be spending more money than ever just to cover basic living costs. And given that Social Security has, for many years, done a **poor job** of enabling seniors to maintain their buying power, that's not exactly a great situation.

Plus, Social Security COLAs are often, at least partially, wiped out by Medicare premium increases -- an unavoidable **healthcare** expense....[Read More](#)

Pandemic Leads Doctors to Rethink Unnecessary Treatment

Covid-19 is opening the door for researchers to address a problem that has vexed the medical community for decades: the overtreatment and unnecessary treatment of patients.

On one hand, the pandemic **caused major health setbacks for non-covid patients** who were forced to, or chose to, avoid tests and treatments for various illnesses. On the other hand, in cases in which no harm was done by delays or cancellations, medical experts can now reevaluate whether those procedures are truly necessary.

Numerous studies have shown that overtreatment causes **unnecessary suffering and billions of dollars in unnecessary health care costs**.

But never before, said

researcher Allison Oakes, has there been such a large database to compare patients who received a particular test or treatment with those who did not.

Oakes was a principal author of an October **paper** in Health Affairs by the Research Consortium for Health Care Value Assessment. The paper noted that covid provided an important new measurement — examining outcomes for patients who received treatment before hospitals canceled care because of covid and those who had their care canceled.

Areas ripe for study, said Oakes: colonoscopies done on patients older than age 85; hemoglobin blood work for Type 2 diabetes patients; semi-elective surgeries, such as knee



arthroscopy for articular cartilage surgery; and yearly dental X-rays. All were done less often because of covid, she said.

"There are two sides of the pie: low-value care and care that people get in trouble if they don't get," said Oakes, who expects researchers to take advantage of all the data provided from covid on "both types of care."

One recent **study** looked at Veterans Affairs patients who had elective surgeries canceled because of covid. The study found they were no more likely to visit hospital emergency departments than patients who had undergone those surgeries in 2018.

Dr. Heather Lyu of Brigham and Women's Hospital and Harvard Medical School said

much testing and care was cut back by patients' fears of contracting covid in a medical setting and because medical facilities and staffers were fighting just to keep up with covid cases.

"There are some procedures, tests, and exams that cannot be delayed in any situation," Lyu said in an email. For example, she pointed to the screening, surveillance and treatment of cancer patients.

However, she said other tests and treatments can be delayed or canceled without negative effects. Lyu oversaw a **2017 survey** of 2,000 physicians, with half the doctors saying the percentage of unnecessary medical care was higher than 20.6% and half saying it was lower.....**Read More**

Little-Known Illnesses Turning Up in Covid Long-Haulers

The day Dr. Elizabeth Dawson was diagnosed with covid-19 in October, she awoke feeling as if she had a bad hangover. Four months later she tested negative for the virus, but her symptoms have only worsened.

Dawson is among what one doctor called "waves and waves" of "long-haul" covid patients who remain sick long after retesting negative for the virus. A significant percentage are suffering from syndromes that few doctors understand or treat. In fact, a yearlong wait to see a

specialist for these syndromes was common even before the ranks of patients were swelled by post-covid newcomers. For some, the consequences are life altering.

Before fall, Dawson, 44, a dermatologist from Portland, Oregon, routinely saw 25 to 30 patients a day, cared for her 3-year-old daughter and ran long distances.

Today, her heart races when she tries to stand. She has severe headaches, constant nausea and



brain fog so extreme that, she said, it "feels like I have dementia." Her fatigue is severe: "It's as if all the energy has been sucked from my soul and my bones." She can't stand for more than 10 minutes without feeling dizzy.

Through her own research, Dawson recognized she had typical symptoms of postural orthostatic tachycardia syndrome, or POTS. It is a disorder of the autonomic nervous system, which controls involuntary functions such as heart rate,

blood pressure and vein contractions that assist blood flow. It is a serious condition — not merely feeling lightheaded on rising suddenly, which affects many patients who have been confined to bed a long time with illnesses like covid as their nervous system readjusts to greater activity. POTS sometimes overlaps with autoimmune problems, which involve the immune system attacking healthy cells. Before covid, an estimated 3 million Americans had POTS.....**Read More**

Americans' Lung Health: The Poor Suffer Most

The health of your lungs may have a lot to do with the size of your bank account, a new, large study indicates.

The finding follows a six-decade look at lung disease risk among more than 215,000 American children and adults.

In general, poorer Americans continue to have worse lung health than their wealthier peers. In some cases, the gap between rich and poor is widening.

"We examined long-term trends in socioeconomic inequalities in Americans' lung

health," explained study lead author Dr. Adam Gaffney. "Specifically, we looked at the prevalence of lung symptoms like shortness of breath, lung disease diagnoses like asthma or COPD [chronic obstructive pulmonary disease] and lung volumes." (The latter refers to the amount of air retained in the lungs during different phases of breathing.)

The bottom line: "Differences in lung health between rich and poor Americans have persisted over the last six decades, and, in



some instances, actually gotten bigger," said Gaffney, an assistant professor in medicine at Harvard Medical School and a pulmonary and critical care specialist at the Cambridge Health Alliance in Boston.

The study appears in the May 28 issue of *JAMA Internal Medicine*.

Investigators pored over survey data amassed by the U.S. Centers for Disease Control between 1959 and 2018. Participants ranged in age from 6

to 74.

The surveys asked about smoking habits and lung health. Lung function testing was also carried out.

After matching responses to income and educational background, the study team concluded that while wide disparities in lung health existed in the 1960s, by certain measures gaps in risk have expanded....**Read More**

Many Pre-Surgery Tests Are Useless, So Why Are Hospitals Still Using Them?

Patients facing relatively simple outpatient surgeries are nonetheless being told to undergo a number of preoperative tests that just aren't necessary, a new study reports.

More than half of a group of patients facing low-risk outpatient surgery received one or more tests -- blood work, urinalysis, an electrocardiogram (EKG), a chest X-ray -- prior to their operation.

One-third of patients underwent at least two tests, and roughly 1 in 7 patients had three or more tests before their simple surgery, said lead researcher Dr. Nicholas Berlin, a surgeon and

health policy expert at the University of Michigan Institute for Healthcare Policy and Innovation.

These tests are still being requested even though "we've known for almost a decade that there's pretty broad consensus that preoperative testing before low-risk surgery provides no benefit to patients," Berlin said. "We have no reason to believe that's improving patient outcomes. It's just unnecessary waste in our health care system."

Wasteful care that doesn't contribute to the patient's well-being accounts for an estimated



\$75 billion to \$100 billion of unnecessary health care expenditures in the United States each year, Berlin said.

But the researchers don't think hospitals are ordering these tests to make a quick buck.

The most common unnecessary tests were an EKG or blood work to either check for blood cell counts or provide a basic metabolic panel for the patient, the study found. Two more expensive tests, cardiac stress and lung function testing, were relatively uncommon among patients slated for easy surgeries.

"The tests we're looking at individually are not that expensive," Berlin said.

Instead, these tests are likely being performed out of habit, an overabundance of care, or to cover the hospital in case of a lawsuit, said Dr. Stephen Esper, an anesthesiologist with the University of Pittsburgh Medical Center and medical director of the UPMC Centers for Perioperative Care.

"It is not an attempt for any other gain by the physician's office," said Esper, who wasn't part of the study. "The intention is to do right by the patient."...[Read More](#)

Don't Delay Lung Cancer Surgery, Study Suggests

Surgery soon after a diagnosis of early-stage lung cancer is crucial in reducing the risk of recurrence and death, a new study finds.

"Patients with early-stage cancer have the best chance for survival," said senior author Dr. Varun Puri, a thoracic surgeon and professor of surgery at Washington University School of Medicine in St. Louis. "That's why it's critical for patients to promptly seek treatment within 12 weeks after they've been diagnosed."

But some patients postpone surgery. They have a variety of reasons for doing so, including getting second opinions, economic or social factors, or even family events such as

child's wedding or a vacation, researchers noted.

Since last year, concerns about contracting COVID-19 in the hospital also led patients to delay surgery.

But this study of more than 9,900 U.S. patients (average age: 67) with stage 1 non-small cell lung cancer who had surgery between October 2006 and September 2016 found that waiting more than 12 weeks after diagnosis with a CT scan was associated with increased odds of recurrence and death.

The majority (70%) of patients had surgery within 12 weeks. On average, those who had surgery within 12 weeks



lived 7.5 months longer than those who did not -- 76.1 months versus 68.6 months.

Forty-two percent of patients had a recurrence of cancer in the six years after surgery, but it was more common in patients who had surgery after 12 weeks. Each week of delay was associated with a modest increase in the risk of recurrence, according to findings published May 27 in the journal *JAMA Network Open*.

"Physicians and patients want to know more about the safety of delaying surgery. The risks have been poorly understood because previous studies have used imprecise definitions for

the date of cancer diagnosis. The goal of our study was to provide more uniform data, which we did by tracking patients from most recent CT scan diagnosis to day of surgery," Puri said in a university news release.

Lung cancer is the second most common type of cancer (after skin cancers) and the leading cause of cancer death in the United States. Non-small cell lung cancer accounts for 84% of all lung cancer cases and the five-year survival rate is 25%, according to the American Cancer Society.

Experimental Treatment Offers New Hope Against Lupus

An experimental antibody therapy may help ease skin symptoms from the autoimmune disease lupus, a small preliminary trial suggests.

Researchers found that a higher-dose version of the drug spurred a "clinically meaningful" symptom improvement for 87% of patients after one month.

But they also stressed that the findings are based on a small "phase 1" trial -- a type of study designed primarily to gauge a treatment's safety.

The safety findings were "encouraging," and there were

"some hints of clinical benefit," said lead researcher Jodi Karnell, a senior director of research at Horizon Therapeutics, the company developing the drug.

Now, she said, larger trials are needed to confirm that the therapy works.

The drug, known for now as VIB7734, is a monoclonal antibody -- a lab-made protein that acts like an immune system antibody. Such antibodies can be directed against specific substances in the body that are involved in a disease process.



Lupus is caused by an autoimmune reaction, where the immune system mistakenly attacks the body's own tissue.

The most common form is systemic lupus, which can spur inflammation throughout the body, including the skin, joints, kidneys, blood vessels and brain.

Another form, called cutaneous lupus, affects only the skin, causing rashes and sores, often on the face and scalp.

There are treatments for those skin symptoms, including anti-inflammatory corticosteroids; antimalarial medications, which alter the immune response; and immune-suppressing drugs like methotrexate.

But those treatments can have significant side effects, and they don't always work, Karnell pointed out.

"There's a large unmet need," she said.

In the United States alone, about 1.5 million people have lupus, according to the Lupus Foundation of America...[Read More](#)

More hospitals providing care at home

Julie Appleby reports for **Kaiser Health News** that, down the road, a lot of hospital care may be able to happen in the comfort of your home. Already, Medicare pays for some **hospital care at home**. And, many hospitals are exploring how to move a lot of inpatient hospital care to people's homes.

Hospitals would be able to serve more patients. To some extent, they would be able to do so virtually. And, they would save money on capital costs. Insurers would not have to spend as much on care, so it should bring costs down, though it is not clear by how much.

◆ **Who would benefit?** As many as three in ten

hospital patients. People with pneumonia, heart failure and other non-acute conditions. People needing surgery or care in an intensive care unit (ICU) would continue to receive care in hospital.

◆ **How would it work?** People would be monitored around the clock, remotely. Health care professionals would visit them as needed.

◆ **Who would see patients at home?** Hospitals would need a large number of nurses, paramedics and technicians.

◆ **Is hospital care at home as safe as hospital care in**



hospital? Many experts believe it is. In fact, they believe it can improve health outcomes. It can reduce the need for hospital readmissions and nursing home care.

◆ **What would the ideal home setting be?** Most likely, patients would need a full-time caregiver at home with them to provide needed caregiving help, along with the ability to be in a private setting. Hospitals could provide aides to help with bathing etc.

◆ **Would every hospital provide care at home?** Likely not. Some hospitals would want to fill their inpatient beds in order

to maximize their revenues. Medicare started paying for **hospital care at home** in November. It wanted to protect older adults with non-COVID conditions from contracting COVID-19 in hospital. To date, Medicare is paying 100 hospitals to provide care at home.

That said, Medicare coverage of hospital care at home will end when the pandemic is over. And, Medicare has been paying the same rate for hospital care at home as it pays for hospital care in-hospital. If Medicare continued covering this care, it's hard to imagine it would keep paying current hospital rates.

Having OCD May Triple a Person's Odds for a Stroke

Adults with obsessive-compulsive disorder, a common mental health condition known as OCD, may have more than triple the risk of having a stroke, according to a new report from Taiwanese researchers.

As to why, the study authors aren't sure.

The investigators speculate that other mental health problems suffered by OCD patients — "comorbidities" such as schizophrenia, bipolar disorder and major depression — might add to their risk as might other health conditions, such as high blood pressure and type 2 diabetes.

"But OCD was an independent risk factor for ischemic stroke after

adjustment for stroke-related comorbidities, including metabolic disorders and other severe mental diseases," said study co-author Tai-Long Pan. He is a professor in the School of Traditional Chinese Medicine at Chang Gung University in Taoyuan.

"Clinicians should closely monitor cerebrovascular disease and related risks in patients with OCD," he said.

The researchers stressed that this study doesn't prove OCD



causes strokes, only that there seems to be a connection.

For the study, Pan's team compared Taiwanese national health data for more than 28,000 adults with OCD and 28,000 without the condition.

Over 11 years, people with OCD were over three times more likely to have a stroke compared with those without OCD. People aged 60 and older were at greatest risk, the data showed.

The study authors said the stroke risk remained even after they accounted for other factors, such as obesity, heart disease, smoking, high blood pressure,

high cholesterol and type 2 diabetes.

An ischemic stroke is caused by a blockage in an artery supplying blood to the brain. No difference was found in the risk for hemorrhagic stroke (caused by bleeding in the brain). Nor were medications to treat OCD linked to an increased stroke risk.

"To keep a healthy life, [lifestyle habits] such as quitting smoking and regular exercise may be crucial in stroke prevention," Pan said. "How to help our patients achieve this goal needs the help from everyone, including family and friends..." [Read More](#)

Osteoporosis Might Also Raise a Woman's Odds for Hearing Loss

It's a connection most women may not be aware of, but a new study suggests osteoporosis may raise your risk of hearing loss, and the drugs often used to treat thinning bones won't lower that risk.

According to researcher Dr. Sharon Curhan, data from her team's new study suggests that "osteoporosis and low bone density may be important contributors to aging-related hearing loss."

That means that healthier lifestyles "could provide important benefits for protecting

bone and hearing health in the future," said Curhan.

She's with the Channing Division of Network Medicine at Brigham and Women's Hospital in Boston, and is also affiliated with Harvard Medical School.

The researchers were inspired by a recent study that bisphosphonates, a class of drugs that prevent bone loss, might prevent noise-induced hearing damage in mice.

"We wanted to investigate whether bisphosphonates alter risk of hearing loss in adults, in



addition to whether there is a longitudinal association between osteoporosis or LBD [low bone density] and risk of subsequent hearing loss," Curhan explained in a Harvard news release.

Her team analyzed data from nearly 144,000 women who were followed for up to 34 years as part of the decades-long Nurses' Health Studies. These two large ongoing prospective cohorts of female registered nurses were established in 1976 and 1989.

Participants self-reported hearing loss on questionnaires

completed every two years. The researchers also incorporated data on participants' hearing sensitivity.

They found that the risk of subsequent moderate or worse hearing loss was up to 40% higher in study participants who had osteoporosis or low bone density. Unfortunately, taking bisphosphonates did not reduce the risk.

Only an association between hearing loss and osteoporosis was seen, and not a cause-and-effect link... [Read More](#)

Dental fraud: How to protect yourself

Daryl Austin writes for Kaiser Health News about dental fraud. Yes, dentists sometimes identify problems with your teeth in order to be able to perform services that are in fact unnecessary. It's a way to generate revenue off of trusting patients. How can you protect yourself?

One dentist described how he was fired from his practice back in the 1990s because he told a patient that she did not need a porcelain cap on a tooth that another dentist in his practice had said was needed. Dental care fraud continues to this day.

Because Medicare does not

cover dental services and Medicare Advantage plans generally only cover a small piece of the cost, older adults and people with disabilities tend to have to pay for dental services completely or, almost completely, out of pocket. Prices can vary tremendously, so it's smart to shop around. And, if a dentist recommends a costly service, get a second opinion before getting the service to make sure it is really necessary.

Health care fraud is estimated to be quite common. As much as 10 percent of all health care spending could be for fraudulent



claims according to a study by the National Health Care Anti-Fraud Association. Why is health care fraud so prevalent with dental care?

In the dental space, dental practices are being bought by big corporations and private equity firms. They care about maximizing profits. To that end, they might encourage dentists to perform costly procedures that might be unnecessary. Their dentists can follow their directions or fear being fired.

One unnecessary expensive dental treatment to avoid in most

cases is quadrant. It could help you if you have severe gum disease. But, it can also wear away your gum tissue, and your gum tissue will not come back. In other cases, dentists recommend crowns when all a patient needs is a filling. Or, dentists might suggest a mini-implant, which has a high failure rate. A regular implant generally is what is needed.

Before going along with your dentist's recommended treatment, ask about your alternatives. And, find out what your costs will be.

Nearly 14% of older adults with dementia are prescribed medicines

About 14% of older adults with dementia filled prescriptions for multiple medications that target the central nervous system (CNS), or the brain and spinal cord, according to a recent study. The use of multiple medications, called polypharmacy, can increase the risk of serious side effects. Taking combinations of CNS-active drugs can lead to an increased risk of falling, breathing issues, and heart problems. In addition, some CNS-active drugs can affect thinking and memory — a side effect that is especially troubling in people

with dementia. The NIA-supported study, led by researchers at the University of Michigan, was published in *JAMA* on March 9.

Medications affecting the CNS are used to treat depression and other mental health conditions, prevent seizures, and reduce pain. Older adults who have dementia sometimes have behavioral and psychological symptoms, such as agitation or delusions. Health care providers may prescribe CNS-active drugs to treat those symptoms, but



evidence of the drugs' effectiveness for the symptoms is limited. To better understand how many people with

dementia received a combination of these drugs, researchers looked at Medicare claims data on more than 1 million adults ages 77 to 88 who had dementia. The researchers analyzed the number and timing of prescriptions filled to estimate the number of people who likely took combinations of the drugs.

The researchers found that 13.9% of these adults filled

prescriptions for three or more CNS-active drugs for more than 30 days in a row. More than half of those adults had the drugs for more than 180 days. The researchers also found that people who were prescribed a combination of CNS-active drugs had higher rates of insomnia, mental health conditions, and pain not associated with cancer and seizure disorders. However, the researchers could not, based on the claims data, determine whether the drugs were prescribed to treat those conditions....[Read More](#)

What to know about late onset multiple sclerosis

Multiple sclerosis (MS) is a chronic condition that can result in a wide range of symptoms throughout the body. Although most people with MS are aged 20–40 years when symptoms appear, the condition can sometimes develop in later life. When MS appears in older adults, doctors may refer to it as late onset multiple sclerosis (LOMS).

MS is an **autoimmune disorder** that affects the **central nervous system**. In people with autoimmune conditions, the immune system mistakenly attacks healthy cells as though they were pathogens.

With MS, the immune system attacks the myelin sheath that surrounds and protects nerve fibers. This attack causes scarring, or sclerosis, which impairs the smooth flow of

electrical impulses from the brain to the target nerve. As a result, the body can no longer carry out certain functions.

Most people with MS get a diagnosis between the ages of **20 and 40 years**. However, the condition can present outside of this age bracket. Diagnosing older adults with MS can be challenging because people may mistake their symptoms for the typical signs of aging.

In this article, we look at the symptoms, causes, diagnosis, and treatment of late onset MS. We also discuss how to live with the condition.

Late onset MS definition

LOMS is the term for MS that manifests in older age, typically after the age of 50 years. Some doctors may also refer to it as later-onset MS.



LOMS may present **slightly differently** to MS in a younger person. For instance, some symptoms

may occur more frequently in LOMS, there may be fewer relapses, and the progression of disability is generally faster. It can be difficult to diagnose MS at any age, but it is typically harder with LOMS, as doctors must consider other age-related causes when making a diagnosis.

Symptoms

Other than appearing later in life, the symptoms of LOMS are often the same as those of regular onset MS.

Common symptoms of MS **include:**

a squeezing sensation around the torso, also known as MS hug or **dysesthesia**

- fatigue

- difficulty walking
 - weakness
 - dizziness
 - balance issues
 - spasticity
 - numbness and tingling
 - vision problems
 - bladder dysfunction
 - sexual problems
 - bowel problems
 - pain and itching
 - difficulty with problem-solving, attention, and focus
 - emotional changes
 - depression
- Research** suggests that the key symptoms of LOMS are motor dysfunctions, sensory disturbances, and visual impairments....[Read More](#)