

Squeezed between small Social Security COLA's and rising inflation



Rising inflation has wiped out temporary gains in the buying power of **Social Security** benefits during the pandemic.

"As of consumer price data through March 31, 2021, Social Security benefits have once again have lost 30 percent of buying power since 2000," said Mary Johnson, Social Security policy analyst for the **Senior Citizens League**. "If inflation in 2021 continues to climb through the end of the year, this loss of buying power could deepen."

When prices rise rapidly at the same time that retirees receive a low cost of living adjustment, their **Social Security benefits** won't buy as much as before, she explained.

This shortfall can have long-term effects on retirement income needs, retiree savings, debt levels and even health, when older people can't afford prescriptions or necessary medical care.

This, in turn, causes retired households to draw down savings

more rapidly than planned, and many carry debt, especially for health-care costs. Lower-income households may go without enough food or health services such as dental care, or postpone filling medically necessary prescriptions.

Between January 2000 and March 2021, Social Security COLAs increased benefits by 55 percent, but the cost of goods and services purchased by typical retirees rose by 102 percent. The cost of propane, food and used vehicles were among the most rapidly rising costs over the past year.

For every \$100 a retired household spent in 2000, that household can buy only about \$70 worth of the same goods and services today.

◆ For example, in 2000, the average annual cost of homeowners' insurance was \$508 per year. In 2021, however, the average cost is \$1,414, an increase of 178



percent over the period.

◆ In 2000, the average Social Security benefit was \$816 per month. A retiree with \$816 could pay their entire annual homeowners insurance bill of \$508 and still have money left over. By 2021, however, COLAs increased the \$816 benefit to just \$1,246.

In 2021, more than 61 million Social Security recipients received a 1.3 percent annual COLA, which raised the average retiree benefit of \$1,523 by \$19.80 per month. However, for many retirees age 65 and up, much or even all their COLA is offset by rising Medicare Part B, supplemental and drug plan premiums, deductibles and out-of-pocket costs.

In a recent **survey**, 45 percent participants reported that after the deduction for just the Part B premium, their COLA increased their Social Security benefit by less than \$15. Eight percent reported no net increase to their benefits.

"A Social Security benefit of \$1,645 per month in 2020 would be required just to maintain the same level of buying power as in 2000," Johnson said. "The majority of the 60 million Americans who receive Social Security depend on their benefits for at least 50 percent of their total income, and one-quarter of all beneficiaries rely on it for 90 percent or more of their income."

The Senior Citizens Leagues supports legislation that would strengthen the COLA in three ways:

- ◆ Calculate COLAs based on the Consumer Price Index for the Elderly, which better reflects the spending patterns of retirees.
- ◆ Provide a modest boost in monthly benefits to retirees to make up for years when no COLA or only a negligible COLA was paid.
- ◆ Guarantee a minimum COLA of no less than 3 percent.

ADD YOUR NAME **Get The Message Out: SIGN THE GPO/WEP PETITION!!!!**

AbbVie gets a scolding from Congress but can keep raising prices

Richard Gonzalez, AbbVie's CEO, has been hard at work raising the price of its best-selling overpriced drug, Humira, along with other drugs. But, instead of passing legislation that benchmarks drug prices in the US to prices paid in other wealthy countries, Congress gave him a scolding this morning. Odds are that any pain Gonzalez feels will be offset speedily by his ability to keep raising AbbVie's drug prices.

Congress has been investigating how AbbVie prevents other companies from

selling drugs that compete with Humira, an anti-inflammatory drug, and Imbrivica, a cancer-fighting drug. Humira is the biggest selling drug in the world, costing \$70,000 for a year's treatment. And, it is not available in generic form because the company keeps finding ways to buy off competitors.

Of course, in the prescription drug world, there is no meaningful competition even when there's no strategy to prevent competition. Put differently, if there are two brand

abbvie

-name drugs that treat the same condition, both almost always cost a lot.

The U.S. House Oversight Committee **report** shows what we already know. AbbVie, like every other pharmaceutical company, spends relatively little on drug research. Rather, a vast amount of its money goes to stock buybacks and executive compensation. In the case of AbbVie, it also goes to suppressing competition and lobbying Congress. Indeed, AbbVie spent \$3 million on

lobbying in January, February and March of 2021 alone!

Many claim that AbbVie has violated antitrust laws. But, why does that matter if Congress is not prepared to regulate drug prices? Short of that, AbbVie will continue to apply for dozens more patents and keep hiking up prices for its drugs. Fool Congress once, twice, endlessly????? Shame on it.

Meanwhile, Stat reports that J.P. Morgan is bullish on AbbVie. And, for good reason.

Are there programs to help me pay for my prescription drugs?

*Dear Marci,
My medications have become quite expensive, and I am having difficulty affording them. Are there programs to help me pay for my prescription drugs?*

-Akari (Bismarck, ND)

Dear Akari,

The costs of prescription drugs can be very high, and I am sorry to hear it is causing you stress. There are some programs to help with these costs and I'm happy to tell you about them!

Extra Help is a federal program that helps pay for some to most of the out-of-pocket costs of Medicare prescription drug coverage. If you are enrolled in **Medicaid**, **Supplemental Security Income**, or a **Medicare Savings Program**, you will automatically qualify for Extra Help regardless of whether you meet Extra Help's eligibility

requirements. If you are not enrolled in these programs, the eligibility requirements (and benefits) are below:

Full Extra Help

Eligibility (for those not automatically enrolled)

- ◆ Monthly income limit: \$1,469 for an individual and \$1,980 for couples
- ◆ Asset limit: \$9,470 for an individual and \$14,960 for couples
- ◆ Benefits
- ◆ \$0 premium and deductible
- ◆ \$3.70 generic copay
- ◆ \$9.20 brand-name copay
- ◆ No copay after \$6,550 in out-of-pocket drugs

Partial Extra Help

Eligibility (for those not automatically enrolled)

- ◆ Monthly income limit: \$1,630 for an individual and \$2,198 for couples
- ◆ Asset limit: \$14,790 for an



Dear Marci

individual and \$29,520 for couples

◆ Benefits

- ◆ Premium depends on your income
 - ◆ \$92 deductible or the plan's standard deductible, whichever is cheaper
 - ◆ 15% coinsurance or the plan copay, whichever is less
- After \$6,550 in out-of-pocket drug costs, you pay \$3.70 per generic and \$9.20 per brand-name or 5% of the drug cost, whichever is greater

You can apply for Extra Help through the Social Security Administration (SSA). Visit www.ssa.gov or call 800-839-2675 to learn more. For assistance with the Extra Help application, call the Medicare Rights Center helpline at 800-333-4114.

State Pharmaceutical Assistance Programs (SPAPs)

are offered in some states to help pay for

prescriptions. Each program works differently and has different requirements for eligibility. Many also require you to enroll in a Medicare Part D plan and to apply for Extra Help. SPAPs generally pay or help pay for the Part D premium and any cost-sharing, as well as offer lower costs while you are in the donut hole. Some SPAPs may also pay for drugs that are excluded from Medicare Part D or are not included in your plan's formulary. **To learn if your state has SPAP and find out if you qualify**, call your State Health Insurance Assistance Program (SHIP). You can find your SHIP by calling 877-839-2675 or visiting www.shiphelp.org.

If you do not qualify for these programs, check out **these other options and strategies for those who are having trouble affording drug costs**.

-Marci

President Will Not Propose Lowering Drug Prices in His Budget

When he ran for President last year Joe Biden made fixing health care, including Medicare and Medicaid, part of his campaign. Since becoming President, he has called on Congress to approve a plan to allow Medicare to lower spending on prescription drug costs and to strengthen Medicare, Medicaid, and the Affordable Care Act.

Unfortunately, the President's budget request, which will be released at the end of this week,

will not include specific policies or cost estimates to advance these measures according to our sources in Washington.

We are very disappointed that this is the case but the fact remains that lowering drug prices remains extremely popular because everyone hates high drug prices.

That's why TSCL will continue our work with members of Congress to get legislation introduced to lower those



prices. We believe that if we can get drug price-reduction legislation through Congress the President will sign it.

However, we need your continued support to get Congress to take action. As we reported last week, Democrats in the House of Representatives are divided on what kind of legislation they will support and Republicans have refused to support any legislation the Democrats have passed to lower

drug prices.

In the Senate, there is bi-partisan legislation that would help lower prices but Minority Leader Mitch McConnell (R-Ky.) blocked it last year when he was Majority Leader, and he still opposes it.

So, seniors must work together to pressure Congress to get legislation passed to solve this crisis. That's why we need you to support our efforts on your behalf.

New Report Confirms Rapid Expansion of Telehealth Services

In early 2020, Congress and the Centers for Medicare & Medicaid Services (CMS) added temporary telehealth flexibilities to Medicare to help beneficiaries safely obtain needed services during the pandemic.

The legislative and administrative updates broadened Medicare telehealth coverage in a number of ways. From expanding the list of allowable services and methods of communication to waiving restrictions on where patients and providers are located, the public health emergency changes have allowed more beneficiaries to receive more services via telehealth, using more types of technology, and from more locations, including their own home.

The uptake was swift. Telemedicine use, particularly in Original Medicare, grew dramatically within a matter of **weeks**. Before the pandemic, approximately 13,000 beneficiaries received telemedicine in any given week. By the end of April 2020, that

number had **skyrocketed** to 1.7 million.

Many of these telehealth policies are time-limited and will expire when the public health emergency period does, unless policymakers step in and extend them. With such decisions looming, **a new brief from the Kaiser Family Foundation (KFF)** discusses the current Medicare telehealth coverage landscape and potential next steps.

The brief confirms the rapid and widespread nature of the coverage expansions. According to KFF, one in four Medicare beneficiaries had a telehealth visit during the COVID-19 public health emergency, and most of those visits were done by phone (56%). Telehealth use was higher among Medicare beneficiaries under the age of 65 (53%), beneficiaries enrolled in both Medicare and Medicaid (55%), Black (52%) and Hispanic (52%) beneficiaries, and those with six or more chronic conditions (56%).



While Medicare Rights applauds the successes of the pandemic-specific telehealth changes, KFF's findings underscore how much is still unknown about the impact of these sudden shifts on beneficiaries and the program.

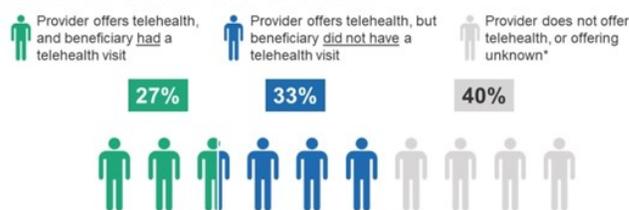
Critically, the developments during the public health emergency represent the biggest shift in Medicare telehealth policy and utilization since the services were created nearly 25 years ago. Although these flexibilities have addressed some systemic barriers, the

beneficiary experience has been mixed. Some callers to the Medicare Rights Center's national helpline have reported greater access to care, while others are being left behind.

We **continue to urge** policymakers to move forward deliberately and collaboratively, collecting and following the data, and prioritizing health equity as well as beneficiary needs and preferences. Doing so will best ensure a system that works for all people with Medicare.

Figure 1

More Than 1 in 4 Medicare Beneficiaries Had a Telehealth Visit Between the Summer and Fall of 2020



Total Number of Medicare Beneficiaries, 2020: 55.3 million

NOTE: Analysis includes community-dwelling beneficiaries only. *Also includes beneficiaries without a usual source of care. SOURCE: KFF analysis of CMS Medicare Current Beneficiary Survey COVID-19 Fall Supplement Public Use File, 2020.



Biden doubling FEMA funds for extreme weather preparations

The Biden administration will direct \$1 billion toward the Federal Emergency Management Agency's (FEMA) fund for extreme weather preparation, a 100 percent increase over existing funding levels, the White House announced Monday.

The budget increase will go to

the Building Resilient Infrastructure and Communities (BRIC) program, which provides support for local, state and tribal government preparation efforts. The increase, and the program in general, are part of an effort to "categorically shift the federal



focus" from responding to individual disasters on a case-by-case basis to "research-supported, proactive investment in community resilience," the White House said.

"As climate change threatens to bring more extreme events like increased floods, sea level

rise, and intensifying droughts and wildfires, it is our responsibility to better prepare and support communities, families, and businesses before disaster — not just after," the administration said in a statement. ...**Read More**

Inside Mitch McConnell's personal push to defeat Democrats' voting reforms

Every week, a group of nearly 100 conservative leaders convene for a 30-minute strategy call on a single issue: how to combat Democrats' sweeping legislation to change the way federal elections are conducted.

Two weeks ago, the keynote briefer was Sen. Mitch McConnell, who made it crystal clear that defeating the "For the People Act" is his top priority of this two-year legislative session.

McConnell has conveyed his vehement opposition to the bill repeatedly in public. What's different, conservatives say, is his personal level of commitment

behind-the-scenes to educate activists on just how damaging the legislation would be to the future electoral prospects of Republicans. To those involved, they've noticed a level of engagement from the GOP leader they haven't seen before.

"So many times the conservative movement only works with McConnell when it's a Supreme Court nomination, or a Supreme Court fight. And so we've been trying to change that with HR 1 and S 1 and really make this fight similar and more akin to a Supreme Court fight,



where it's like an all-hands-on-deck effort," said Jessica Anderson, the executive director of Heritage Action, one of the leading conservative groups mobilizing to fight President Joe Biden's agenda.

That the bills in both congressional chambers are listed with the number "1" indicates just how eager Democrats are to pass them. Senate Majority Leader Chuck Schumer has designated the overhaul of voting rights as a top priority he wants to see completed by August.

The House and accompanying Senate bill are packed with a laundry list of provisions, including the elimination of voter identification requirements and implementation of automatic voter registration and same-day voting registration.

It would end gerrymandering, the partisan process used to redraw congressional districts as well as provide matching federal dollars to candidates who pledge to swear off large campaign contributions....**Read More**

CMS Implements Waiver for Ground Ambulance Services

During the COVID-19 public health emergency, the Trump and Biden administrations have created numerous waivers of payment policies to help ensure people with Medicare retain their access to care despite the pandemic. One of the more recent additions is the **Waiver for Ground Ambulance Services: Treatment in Place** that allows ground ambulance services to be compensated for treating Medicare beneficiaries when they are forbidden from transporting them to a facility like a hospital. The waiver is retroactive to March 2020.

Many states and localities have had rules in place during

the pandemic that forbid ambulance services from transporting some 911 callers, often to reduce their risk of infection or keep from overwhelming health system capacity. But Medicare generally only pays for ambulance services if the caller is transported to a facility. This left those ambulance service providers in a bind. They could either transport the callers anyway, in violation of the rule or law, or treat the caller without transporting them—and without being paid.

The American Rescue Plan Act of 2021 gave the Biden administration the authority to create the Treatment in Place



waiver for the duration of the public health emergency. The waiver only applies when the ambulance service was furnished in response to a 911 call or its equivalent and when the patient would have been transported to a facility if not for local rules or laws. While the waiver is narrow, it may reduce out-of-pocket costs for beneficiaries in these circumstances.

Importantly, the Treatment in Place waiver and **other flexibilities** that have been established in order to improve safe access to care during the pandemic are set to expire once the public health emergency is

over. This includes various **telehealth options** as well as eased home health and nursing facility eligibility.

We urge a thoughtful consideration of the COVID-19 flexibilities to determine what changes should be retained once the public health emergency is over. The pandemic forced beneficiaries, providers, and health plans to change the way they get or provide care, and many of these changes were long overdue. Others are merely stopgap measures that should be reversed as soon as possible.

The top 4 retirement concerns—and how to handle them

Retirement has the potential to be a relaxing and fulfilling stage of life. As with any major change, though, it presents a new set of challenges that may cause anxiety. How do you manage health care costs? How do you keep from outliving your money? What if you still have debt?

By laying some financial groundwork now, you can ensure a smooth transition to retirement. Here are the four biggest financial concerns about retirement, according to a 2015 survey by Bankrate.com—and how to get a handle on them.

◆ **Paying For It:**

Health care costs are the top retirement concern for Americans. According to the survey, 28 percent of people are worried their medical expenses will be in too high. But fewer than 15 percent of those nearing retirement age have estimated how much they will spend on health care in retirement, according to a 2014 survey by Merrill Lynch and Age Wave.

◆ **Saving For It:** Today, nearly 25 percent of all 65-year-olds will live to



age 90, according to the Social Security Administration, and almost as many worry that they will outlive their money, according to the Bankrate survey.

◆ **Maintaining An Income Stream:**

Eighteen percent of Americans are worried that they won't be able to afford daily expenses in retirement, according to the Bankrate survey—and they're concerned that Social Security income either won't be available or won't cover enough of their

expenses.

◆ **Having To Much Debt:**

More than 1 in 10 Americans may worry about having too much debt in retirement. In 2015, the average 65-year-old had more than \$48,000 in debt, compared to less than \$34,000 in 2003, according to data from the New York Fed Consumer Credit Panel. During this time frame, debt increased by about 60 percent for all borrowers between 50 and 80 years old.

Where Seniors Are Most and Least Financially Secure

Where Seniors Are Most and Least Financially Secure

A 2019 report from the Federal Reserve on the economic well-being of U.S. households says that **only 37% of Americans think that their savings** are on track for retirement. The rising costs of living, medical expenses and long-term care can make it difficult to save enough for **annual retirement expenses**.

With this context in mind, SmartAsset compared data from 100 cities nationwide to identify and rank the places where

seniors are the most and least financially secure. This is SmartAsset's 2021 study on where seniors are most and least financially secure. Read the **2020 version here**.

We considered factors including average senior retirement income, percentage of seniors below the poverty line, percentage of seniors on SNAP (the Supplemental Nutrition Assistance Program, formerly called the food stamp program), percentage of seniors who own their homes, percentage of seniors with



private retirement income, percentage of seniors who are housing cost-burdened and housing costs as a percentage of senior retirement income.

For details on our data sources and how we put all the information together to create our final rankings, check out the Data and Methodology section at the end.

First, let's look at where seniors are the most financially secure. Then we'll look at where seniors are the least financially secure.

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If you're ready to be matched with local advisers who will help you reach your financial goals, **get started now**.

Congress Considers Medicare Advantage Pre-Approval Legislation

According to a report from *Modern Healthcare*, Congress is considering changes to Medicare Advantage that would “crack down on prior authorization tactics insurers use to rein in healthcare costs but can affect how providers care for patients.”

A bi-partisan group of Representatives in the House has reintroduced a bill that aims to “quicken the prior authorization process and require more transparency about how often plans deny providers’ requests.”

Prior authorization reform has long been a goal of provider groups like the American Medical Association, which says physicians are increasingly being told to get approval from

insurance plans before a patient can access drugs, tests or treatments.

In a survey taken last year by the American Medical Association, 15% of physicians polled said prior authorization requirements always delayed access to necessary care for patients, while 39% said that often happened and 40% said it happened sometimes.

Prior authorization can also have an impact on physician practices, with 85% saying requirements pose a high or extremely high burden, and 40% saying they have staff who exclusively work on getting approval from insurance companies for treatment.



Insurers, on the other hand, argue that prior authorization helps reduce inappropriate care and thus reduces medical costs.

The purpose of the bill is said to be the creation of sensible rules that will result in giving transparency and oversight to the prior authorization process.

Under the bill, Medicare Advantage plans must establish electronic prior authorization programs and provide “real-time decisions” for some services that are routinely approved by insurers, to be determined by the Health and Human Services secretary.

The proposal would require Medicare Advantage plans with prior authorization requirements

to submit an annual report to the HHS secretary listing which services require prior approval and how many requests were approved, denied and overturned after initial denials in the previous plan year. They would have to tell HHS the average and median amount of time between the submission of a prior authorization request and a determination from the plan.

Plans would also need to make the information available to providers they contract with and tell beneficiaries and providers the criteria for making prior authorization determinations. The bill encourages insurers to adopt prior authorization programs that adhere to evidence-based medical guidelines.

Tips for Older Adults to Regain Their Game After Being Cooped Up for More Than a Year

Alice Herb, 88, an intrepid New Yorker, is used to walking miles around Manhattan. But after this year of being shut inside, trying to avoid covid-19, she’s noticed a big difference in how she feels.

“Physically, I’m out of shape,” she told me. “The other day I took the subway for the first time, and I was out of breath climbing two flights of stairs to the street. That’s just not me.”

Emotionally, Herb, a retired lawyer and journalist, is unusually hesitant about resuming activities even though she’s fully vaccinated. “You

wonder: What if something happens? Maybe I shouldn’t be doing that. Maybe that’s dangerous,” she said.

Millions of older Americans are similarly struggling with physical, emotional and cognitive challenges following a year of being cooped up inside, stopping usual activities and seeing few, if any, people.

If they don’t address issues that have arisen during the pandemic — muscle weakness, poor nutrition, disrupted sleep, anxiety, social isolation and



more — these older adults face the prospect of poorer health and increased frailty, experts warn. What should people do to address challenges of this kind? Several experts shared advice:

Reconnect with your physician. Large numbers of older adults have delayed medical care for fear of covid. Now that most seniors have been vaccinated, they should schedule visits with primary care physicians and preventive care screenings, such as mammograms, dental cleanings,

eye exams and hearing checks, said Dr. Robert MacArthur, chief medical officer of the Commonwealth Care Alliance in Massachusetts.

Have your functioning assessed. Primary care visits should include a basic assessment of how older patients are functioning physically, according to Dr. Jonathan Bean, an expert in geriatric rehabilitation and director of the New England Geriatric Research, Education and Clinical Center at the Veterans Affairs Boston Healthcare System... [Read More](#)

Is Your Living Room the Future of Hospital Care?

Major hospital systems are betting big money that the future of hospital care looks a lot like the inside of patients’ homes.

Hospital-level care at home — some of it provided over the internet — is poised to grow after more than a decade as a niche offering, boosted both by hospitals eager to ease overcrowding during the pandemic and growing interest by insurers who want to slow health care spending. But a host of challenges remain, from deciding how much to pay for

such services to which kinds of patients can safely benefit.

Under the model, patients with certain medical conditions, such as pneumonia or heart failure — even moderate covid — are offered high-acuity care in their homes, with 24/7 remote monitoring and daily visits by medical providers.

In the latest sign that the idea is catching on, two big players — Kaiser Permanente and the Mayo Clinic — **announced plans** this month to collectively



invest \$100 million into Medically Home, a Boston-based company that provides such services to scale up and expand their programs. The two organizations estimate that 30% of patients currently admitted to hospitals nationally have conditions eligible for in-home care. (KHN is not affiliated with Kaiser Permanente.)

Several other well-known hospital systems launched programs last summer. They join about two dozen already offering

the service, including Johns Hopkins Medicine in Baltimore, Presbyterian Healthcare Services in New Mexico and Massachusetts General Hospital.

But hospitals have other financial considerations that are also part of the calculation. Systems that have built sparkling new in-patient facilities in the past decade, floating bonds and taking out loans to finance them, need patients filling costly inpatient beds to repay lenders and recoup investments... [Read More](#)

6 Ways to Protect Your Retirement Accounts From Hackers

Imagine having \$245,000 stolen from your retirement account — and not being reimbursed for most of it. There is a growing threat to your retirement savings, and you probably are not aware of it. Thieves increasingly are targeting individual 401(k) accounts by impersonating the account owners so the crooks can steal thousands — or even hundreds of thousands — of dollars. Heide Barnett of Darien, Illinois, lost \$245,000 when a fraudster used the “forgot password” option on her 401(k) account to log into Barnett’s account. The crook

later successfully impersonated Barnett when calling the 401(k) plan’s call center, The Wall Street Journal reports. Two years later, Barnett has recovered just \$108,000 of her stolen funds. In another case, a woman from Massachusetts had \$200,000 siphoned from her account, the Salem News reports. And another woman learned that a thief had swiped \$99,000 from her 401(k) account, according to Bloomberg Tax. You might think that the 401(k) plan itself would be responsible for reimbursing the funds it released



in these situations. But that’s not necessarily the case. As the WSJ reports, federal law is murky about who is responsible for losses associated with cyber theft. And 401(k) providers may include slippery language in their terms in an effort to evade responsibility for the lost money. Even a company as respected as Vanguard says “if there’s evidence you neglected to reasonably safeguard your account, further investigation may be necessary to determine whether we can issue a reimbursement,” according to the WSJ. So, what

can you do to protect yourself? The following steps will go a long way toward keeping your retirement savings safe.

1. **Create Ridiculously Strong passwords.**
 2. **Use password managers carefully.**
 3. **Don’t use text-based verification.**
 4. **Use a separate, secret phone number.**
 5. **Set up an online account with your plan provider.**
 6. **Consider spreading retirement money across multiple providers.**
- [Read More on the above](#)

One in Three Seniors Is Lonely. Here's How It's Hurting Their Health

Loneliness and social isolation are growing **public-health concerns** for people of all ages in the United States, from **young adults** to seniors. Studies have long connected loneliness to a **range of health issues** that could threaten longevity and well-being, including higher risks of **heart attacks, strokes,** depression, anxiety and early death.

Now, the latest **National Poll on Healthy Aging** finds that about a third of seniors are lonely.

“Research shows that chronic loneliness can impact older adults’ memory, physical well-being, mental

health, and life expectancy,” write the authors of the new report. “In fact, some research suggests that chronic loneliness may shorten life expectancy even more than being overweight or sedentary, and just as much as smoking.”

In the study sponsored by the AARP, researchers from the University of Michigan surveyed a group of about 2,000 Americans ages 50 to 80. More than a third of seniors in the poll said they felt a lack of companionship at least some of the time, and 27% said they sometimes or often felt isolated; most of the



people who said they lacked companionship also felt isolated, and vice versa. Almost 30% said they socialized with friends, family or neighbors once a week or less.

Women were more likely than men to report a lack of companionship, the researchers found, and living alone, not working and living in lower-income homes were all associated with feeling lonely.

Of those who said they felt socially isolated, 28% reported fair or poor physical health, compared to 13% of those who did not feel

isolated. In addition, 17% of people who called themselves socially isolated rated their mental health as fair or poor, compared to just 2% of those who said they rarely feel isolated.

Luckily, it looks like loneliness can be reversed, but researchers are still trying to determine the best way to do so, says Dr. Carla Perissinotto, associate chief of clinical programs in geriatrics at the University of California San Francisco (who was not involved in the study). “How to reverse it really depends on the reasoning for why you’re feeling lonely or why you’re isolated,” Perissinotto says...[Read More](#)

Should There Be 'Gun Retirement' for the Elderly?

Just as some elderly drivers need to give up their car keys, older gun owners may eventually face “firearm retirement.” And a preliminary study suggests they are open to the idea.

In focus-group interviews with older gun owners, researchers found that many had considered putting limits on their firearm access -- though they usually hadn’t yet laid out plans for when and how.

It’s an important issue, given that 40% of older Americans live in a home with a gun, said lead researcher Laura Prater of Harborview Injury Prevention and Research Center at the

University of Washington in Seattle.

The concern, she said, is that a significant number of those seniors have or will develop dementia or major depression. If they have easy access to a firearm, they could harm themselves, accidentally or intentionally.

No one wants to wrest firearms from the hands of older adults who can use them safely, Prater said.

The point, she stressed, is that gun owners, family members and health care providers should talk about the future -- including what should happen with



household firearms once a person’s health makes access a hazard.

“We should be treating this like a normal conversation,” Prater said, “just like you plan for other things, like driving, retirement or finances.”

A big takeaway from the interviews was that gun owners accepted the concept of firearm “retirement.”

“Older adults want to be responsible gun owners,” Prater said.

“What they weren’t open to,” she added, “was someone else making the decision for them.”

That means planning is key --

before, say, early-stage dementia advances. One place to start, Prater said, is with a “firearm inventory,” where the older adult and family members account for all firearms in the home.

Many owners, Prater noted, have multiple firearms, and family members or other caregivers are not always aware of them.

Some older adults might want a “transition period,” she said, starting with disposing of firearms that are not being used. (Local laws vary on how to do that, Prater noted.)...[Read More](#)

End-of-life decisions can be hard; time-limited trials can help

Paula Span reports for [The New York Times](#) on a health care initiative that can help make end-of-life decisions for individuals and their families a little easier. A “time-limited trial” offers treatment for ICU patients unable to speak for themselves to determine whether their conditions can improve. These types of trials help inform patients and their families as to whether prolonged life-sustaining treatment makes sense.

Patients and their families often understand the risks of ongoing treatment at what appears to be the end of life when the patient is in the hospital intensive care unit. Treatment can prolong pain and impair quality of life. But, they want to explore whether treatment has benefits. For example, a time-limited trial might determine

whether a patient was likely to remain in a coma or continue unconscious.

It’s unclear how often doctors let patients know that a time-limited trial is an option. But, doctors are becoming more aware of this concept. And, a recent JAMA Internal Medicine piece describes a study of these time-limited trials in three hospitals in Los Angeles.

Researchers trained 50 doctors on the use of time-limited trials and surveyed 200 patients, half of whom participated in time-limited trials. As a general rule, these trials occur when the medical team overseeing a patient does not believe the patient is likely to live or live a quality life that the patient would want. Yet, the patients family wants to believe that this is not the case, that their loved one’s



condition will improve.

In a time-limited trial, family members discuss their loved ones’ end-of-life desires with the medical team. The medical team, in turn, explains the interventions it can make to prolong a patient’s life, as well as the risks of these interventions. They often involve sedating the patient.

Depending upon the treatment, the medical team and the patient’s family then decide how much time they want to give the patient on the treatment. It could be anywhere from a day to several days. The medical team establishes targets over this time to assess whether the treatment is benefiting the patient. If a patient has not improved within that time, the family and the medical team agree on a plan for stopping the treatment.

The researchers found that time-limited trials improved medical team engagement with family members around end-of-life decisions. With time-limited trials, family members participated in decision making early on and in all but four percent of cases. It also put family members at greater ease regarding end-of-life decisions. Without the trials, family members failed to engage on end-of-life questions 40 percent of the time.

In addition, the time-limited trials reduced patients’ stays in intensive care units. A much smaller number of them, it appears, chose interventions. But, patients in these trials died at about the same rate as patients who did not participate in these trials.

Doctors Now Must Provide Patients Their Health Data, Online and On Demand

Last summer, Anna Ramsey suffered a flare-up of juvenile dermatomyositis, a rare autoimmune condition, posing a terrifying prospect for the Los Angeles resident: She might have to undergo chemotherapy, further compromising her immune system during a pandemic.

After an agonizing three-day wait, the results of a blood test came back in her online patient portal — but she didn’t understand them. As hours passed, Ramsey bit her nails and paced. The next day, she gave in and emailed her doctor, who responded with an explanation and a plan.

For Ramsey, now 24, instant access to her test results had been a mixed blessing. “If there’s something I’m really nervous about,” she said, “then I want interpretations and answers with the result. Even if it takes a few days longer.”

On April 5, a [federal](#) rule went into effect that requires health care providers to give patients like Ramsey electronic access to their health

information without delay upon request, at no cost. Many patients may now find their doctors’ clinical notes, test results and other medical data posted to their electronic portal as soon as they are available.

Advocates herald the rule as a long-awaited opportunity for patients to control their data and health.

“This levels the playing field,” said [Jan Walker](#), co-founder of OpenNotes, a group that has pushed for providers to share notes with patients. “A decade ago, the medical record belonged to the physician.”

But the rollout of the rule has hit bumps, as doctors learn that patients might see information before they do. Like Ramsey, some patients have felt distressed when seeing test results dropped into their portal without a physician’s explanation. And doctors’ groups say they are confused and concerned about whether the notes of adolescent patients who don’t want their parents to see sensitive information can be



exempt — or if they will have to breach their patients’ trust.

Patients have long had a [legal right](#) to their medical records but often have had to pay fees, wait weeks or sift through reams of paper to see them.

The rule aims not only to remove these barriers, but also to enable patients to access their health records through smartphone apps, and prevent health care providers from withholding information from other providers and health IT companies when a patient wants it to be shared. Privacy rules under the Health Insurance Portability and Accountability Act, which limit sharing of personal health information outside a clinic, remain in place, although privacy advocates have [warned](#) that patients who choose to share their data with consumer apps will put their data at risk.

Studies have shown numerous benefits of note sharing. Patients who read their notes [understand](#) more about

their health, [better remember](#) their treatment plan and are more likely to [stick to their medication](#) regimen. Non-white, older or less educated patients [report even greater benefits](#) than others.

For Sarah Ford, 34, of Pittsburgh, who has multiple sclerosis, reading her doctor’s notes helps her make the most of each visit and feel informed.

“I don’t like going into the office and feeling like I don’t know what’s going to happen,” she said. If she wants to try a new medication or treatment, reading previous notes helps her prepare to discuss it with her doctor, she said.

The new rule will have less impact on Ford and [the more than 50 million patients](#) in the U.S. whose doctors had already made their notes available to patients before the rule kicked in. [However, only about a third of patients with access](#) to secure online health portals were using them....[Read More](#)

Many Americans Take Meds That Weaken COVID Vaccine Response

A small but significant percentage of Americans take medications that can hamper their immune system and its response to COVID-19 vaccines, researchers say.

Their analysis of data from more than 3 million adults under 65 with private insurance found that nearly 3% take immunosuppressive drugs. Those include chemotherapy medications and steroids such as prednisone.

Two-thirds took an oral steroid at least once, and more than 40% took steroids for more than 30 days in a year, according to findings published May 20 in the journal *JAMA Network Open*.

Growing evidence suggests

that immunosuppressive drugs may reduce effectiveness of COVID vaccines, increasing patients' risk of severe illness and hospitalization if they get infected.

"This study gives us previously unavailable information about how many Americans are taking immunosuppressive medications," said lead author Dr. Beth Wallace, a rheumatologist at Michigan Medicine-University of Michigan in Ann Arbor.

It also shows that many Americans continue to take oral steroids, which have serious side effects, she said. Other medicines can often be substituted, she



added.

The new study comes at a time when doctors are beginning to realize that people on immunosuppressants may have a slower, weaker response to COVID vaccination, and, in some cases, no response at all.

"We don't have a full picture on how these drugs affect the vaccine's effectiveness, so it's difficult to formulate guidelines around vaccinating these patients," Wallace said.

Researchers are investigating several strategies, including temporarily halting use of immunosuppressive medications around the time of COVID-19 vaccination and giving an extra "booster" shot.

It's also unclear what people taking immunosuppressive medications should do to protect themselves now that the U.S. Centers for Disease Control and Prevention has relaxed masking and distancing guidelines for vaccinated people.

"The CDC acknowledges this cohort might not be as protected as other fully vaccinated people, but there are no set recommendations for what precautions they should take," Wallace said. "For now, this is going to be an individual decision people make with their doctor."

More research is needed to assess COVID vaccine response in these patients.

Healthy Living Helps Prevent Dementia, Even If It Runs in the Family

For people worried about developing dementia due to their family history, a preliminary study offers some good news: A healthy lifestyle might curb your risk.

Researchers found that older adults with healthy habits had a lower risk of developing dementia, versus the less health-conscious -- even if a parent or sibling had suffered from the brain disease.

Lifestyle choices did not erase the impact of genes. But among people with a family history of dementia, living well seemed to mitigate the excess risk.

Those who followed at least three of six healthy habits had a

roughly 35% lower risk of dementia than their counterparts with less-healthy lifestyles.

Those key six were:

- ◆ Eating plenty of fruits and vegetables, and limiting processed meats and refined grains
 - ◆ Getting at least 150 minutes of moderate-to-vigorous exercise per week
 - ◆ Not smoking
 - ◆ Drinking only in moderation
 - ◆ Getting six to nine hours of sleep each night
 - ◆ Avoiding obesity.
- "Genes are not everything,"



said researcher Angelique Brellenthin, an assistant professor of kinesiology at Iowa State University.

"You might reduce your risk of dementia by taking relatively simple steps."

They're simple, Brellenthin added, in the sense that people do not have to run marathons or be model-thin to see benefits.

"Maybe right now, for example, you're getting 5.5 hours of sleep at night," she said. "You can work your way to six hours."

Brellenthin plans to present the findings Friday at an American Heart Association meeting being held online. Studies reported at meetings are generally

considered preliminary until published in a peer-reviewed journal.

The findings do, however, add to previous evidence that lifestyle can counter some of the ill effects of genes on dementia risk.

A 2019 study of nearly 200,000 British adults looked at whether participants carried gene variants that make people vulnerable to Alzheimer's or other forms of dementia. And among those who did harbor the genes, healthy habits seemed to reduce their excess dementia risk....[Read More](#)

A Healthier Heart Might Make You Smarter

In new evidence that illustrates that health issues rarely exist in a vacuum, a new study finds a link between heart health and brain function. Existing evidence suggests that having heart disease raises one's risk of dementia, and vice versa, but a team of researchers based in London wanted to find out if this connection could be seen in a healthier population.

For the study, nearly 30,000 mostly healthy adults in the United Kingdom had MRI scans to assess their heart health. The participants also completed thinking ("cognitive") tests,

measuring their ability to solve logic and reason-based problems, and showing how fast the brain processes information. Performing well on these tests is associated with better brain function.

The results revealed that those who excelled on the cognitive tests were more likely to have a healthier heart than those who tested poorly, said study co-author Nicholas Harvey, a professor of rheumatology and clinical epidemiology at the University of Southampton in the United Kingdom.



"We found that better scores for the two cognitive tests that we used, indicating better brain

function, were associated with heart measures, from the cardiac [MRI] scans, which indicated a healthier heart," Harvey said. "Thus, having a healthy brain is associated with having a healthy heart, and vice versa."

The study was published online May 14 in the *European Heart Journal — Cardiovascular Imaging*.

Risk factors such as age, smoking, high blood pressure, alcohol intake and exercise level

can affect one's risk of developing problems such as heart disease and dementia. Thus, it was important to determine if these factors were responsible for the brain-heart connection or if these organs were independently associated.

While the potential mechanisms linking heart and brain health are not fully mapped out, it is clear that these systems are tightly connected, said Dr. Joseph Diamond, director of nuclear cardiology at Long Island Jewish Medical Center, in New Hyde Park, N.Y.[Read More](#)

Gluten Doesn't Trigger 'Brain Fog' for Women Without Celiac Disease: Study

Going gluten-free is a trend that touts benefits for the mind and body, but a new study finds no evidence that gluten is bad for your brain.

Among nearly 13,500 middle-aged women, researchers found no connection between eating wheat, barley or rye (the sources of gluten) and mental ability.

According to the study authors, the only folks who benefit mentally from avoiding gluten are those with celiac disease, who can't digest it.

"Those without a history of a true gluten sensitivity from celiac disease should not pursue a gluten-free diet under the assumption that they will improve their brain health," said lead author Dr. Andrew Chan, a professor of medicine at Harvard Medical School and

vice chair of gastroenterology at Massachusetts General Hospital, both in Boston.

"This is in contrast to some anecdotes and popular press that gluten was harmful and could contribute to cognitive decline or so-called 'brain fog,'" he said.

Participants in the study had all taken part in the Nurses' Health Study II, an investigation of risk factors for chronic diseases in women. As part of that study, both dietary data and mental function were assessed. Tests of mental ability covered speed, attention and memory. None of the women had celiac disease.

Based on these data, Chan and his team found no effect from gluten on mental ability. They



assume they would find the same result among men, he said.

"We found that among individuals

without a history of celiac disease, a low-gluten diet was not associated with any improvement in cognitive function," Chan said. "The evidence is simply not there to support modifying one's diet for this purpose."

According to Harvard University, the gluten-free food industry grew 136% between 2013 and 2015, with almost \$12 billion in sales during 2015, and most people who buy the products don't have celiac disease. People without celiac disease who adopt a gluten-free diet may have an increased risk for obesity and metabolic

syndrome, a cluster of conditions that increase the risk of heart disease, stroke and type 2 diabetes.

Samantha Heller, a senior clinical nutritionist at NYU Langone Health in New York City, looked over the findings and agreed that gluten won't rot the brain.

"Ignore the fear-mongering and misinformation about gluten being a brain poison," she said. "People who do not have a medical reason to avoid gluten, such as celiac disease, a wheat allergy or non-celiac gluten sensitivity, may eat foods containing gluten without fear of these foods causing cognitive impairment or brain inflammation."...[Read More](#)

Poison Centers Warn Against Gas Siphoning

A rash of gasoline-related poisoning calls has led U.S. poison experts to warn against gas siphoning.

Gasoline hoarding and siphoning in some East Coast states has led to a significant increase in gasoline-related emergencies, the Association of Poison Control Centers said.

Recent concerns about limited gasoline supplies due to the shutdown of a major pipeline led some people to try to stockpile gasoline.

There was a 45% increase in

gasoline ingestions from May 10-12, according to the National Poison Data System.

Most of those cases involved people between the ages of 13-59, and more than three-quarters of the cases were managed outside of hospitals.

In response, the U.S. Consumer Product Safety Commission warned that people should not fill plastic bags with gasoline. When gasoline is not stored in proper fuel-approved containers, it can



be hazardous if inhaled. Inhalation resulted in 25% of gasoline exposures in May, according to the poison data system.

Most of the gasoline exposure calls to poison centers resulted in minimal to no symptoms. However, such exposure can lead to coughing, shortness of breath, chemical pneumonia, chemical burns and unconsciousness, the poison experts warned in an association news release.

If you have questions or

suspect you have been poisoned by gasoline, contact your local poison center at 1-800-222-1222. Poison experts (nurses, doctors and pharmacists) are available to answer your call at any time.

To protect against poisoning, text POISON to 797979 to save the Poison Help Hotline as a contact in your mobile phone. You can also save the Poison Help Hotline number, 1-800-222-1222, on your mobile phone, and display the Poison Help Hotline contact number throughout your home.

Mammography Rates Plummeted During Pandemic

There was a sharp drop in mammography breast cancer screening during the COVID-19 pandemic, and the decline was especially severe among American women of color and those living in rural areas, new research shows.

Those trends could cost lives in years to come, because "detecting breast cancer at an early stage dramatically increases the chances that treatment will be successful," said study lead author Ofer Amram. He's an assistant professor of medicine at Washington State University's Elson S. Floyd College of Medicine in Spokane.

One breast cancer expert who wasn't connected to the study agreed.

"The pandemic significantly reduced the frequency of breast cancer screening, which will likely lead to an increase in breast cancer mortality," warned Dr. Paul Baron, chief of breast surgery at Lenox Hill Hospital in New York City.

"Every effort should be made to reach those who did not have their mammograms in 2020," he said.

In the study, Amram's group compared the number of



screening mammograms at MultiCare, a not-for-profit health care system in Washington state, between April and

December of 2019 and then again during the same months in 2020.

They found a big drop: The number of completed screenings fell by almost half, from almost 56,000 in 2019 to around 27,500 in 2020.

Declines in screenings were even greater among Hispanic women (a 64% decline) and American Indian and Alaska Native women (61%) compared to white women (49%). Rates also fell by 59%

among rural women compared with 50% among urban women.

The researchers also found that women who were covered by Medicaid and those who had to pay for screening out of pocket had greater declines in screening than those with commercial or government-run insurance programs.

"Health care providers need to double down on efforts to maintain prevention services and reach out to these underserved populations, who faced considerable health disparities even before the pandemic," Amram said in a university news release...[Read More](#)

Stair Climbing a Big Step Up for Heart Patients' Health

If you are a heart patient, could climbing the stairs be a good workout alternative to the gym, particularly during a pandemic?

It looks that way, two new studies show.

Researchers noted that less than a quarter of heart patients stick to exercise regimens and that common reasons for not doing so include lack of time, equipment and access to gyms.

"Brief, vigorous stair climbing and traditional moderate-intensity exercise both changed fitness, which is a key predictor of mortality after a cardiac event," said lead researcher Maureen MacDonald, a professor in the department of

kinesiology at McMaster University in Hamilton, Ontario, Canada.

"We've shown stair climbing is a safe, efficient and feasible option for cardiac rehabilitation, which is particularly relevant during the pandemic when many people don't have the option to exercise in a gym," she said in a university news release.

MacDonald and her colleagues randomly assigned coronary artery disease patients who'd had a cardiac procedure to either traditional moderate-intensity exercise or vigorous stair climbing.

The stair climbing involved



three rounds of six flights of 12 stairs, separated by recovery periods of walking. The participants chose their own stepping pace.

Both groups of patients had improved heart-lung fitness after four weeks of

supervised training and maintained those levels for another eight weeks of unsupervised training.

They also had substantial muscular improvement, according to the studies. They were published in the June issue of the journal *Medicine & Science in Sports & Exercise* and recently in the journal *Frontiers*.

"These patients who had undergone a coronary bypass or stent procedure had muscle that was compromised, compared to age-matched healthy controls," said study co-author Stuart Phillips, also a professor in the department of kinesiology at McMaster.

The findings show that heart patients can still repair and build lost muscle.

"Even in just a short period, whether it was moderate-intensity, continuous training or high-intensity stair climbing, there were beneficial adaptations in muscles after a cardiac procedure," Phillips said in the release. "The improvements were clear."

As Pandemic Eases, Many Seniors Have Lost Strength, May Need Rehabilitative Services

Ronald Lindquist, 87, has been active all his life. So, he wasn't prepared for what happened when he stopped going out during the coronavirus pandemic and spent most of his time, inactive, at home.

"I found it hard to get up and get out of bed," said Lindquist, who lives with his wife of 67 years in Palm Springs, California. "I just wanted to lay around. I lost my desire to do things."

Physically, Lindquist noticed that getting up out of a chair was difficult, as was getting into and out of his car. "I was praying 'Lord, give me some strength.' I kind of felt, I'm on my way out — I'm not going to make it," he admitted.

One little-discussed, long-term toll of the pandemic: Large numbers of older adults have become physically and cognitively debilitated and less able to care for themselves during 15 months of sheltering in place.

No large-scale studies have documented the extent of this phenomenon. But physicians, physical therapists and health plan leaders said the prospect of increased impairment and frailty in the older population is a growing concern.

"Anyone who cares for older adults has seen a significant

decline in functioning as people have been less active," said Dr.

Jonathan Bean, an expert in geriatric rehabilitation and director of the New England Geriatric Research, Education and Clinical Center at the Veterans Affairs Boston Healthcare System.

Bean's 90-year-old mother, who lives in an assisted living facility, is a case in point. Before the pandemic, she could walk with a walker, engage in conversation and manage going to the bathroom. Now, she depends on a wheelchair and "her dementia has rapidly accelerated — she can't really care for herself," the doctor said.

Bean said his mother is no longer able to benefit from rehabilitative therapies. But many older adults might be able to realize improvements if given proper attention.

"Immobility and debility are outcomes to this horrific pandemic that people aren't even talking about yet," said Linda Teodosio, a physical therapist and division rehabilitation manager in Bayada Home Health Care's Towson, Maryland, office. "What I'd love to see is a national effort, maybe by the CDC [U.S. Centers for Disease



Control and Prevention], focused on helping older people overcome these kinds of impairments."

The extent of the need is substantial, by many accounts. Teodosio said she and her staff have seen a "tremendous increase" in falls and in the exacerbation of chronic illnesses such as diabetes, congestive heart failure and chronic obstructive pulmonary disease.

"Older adults got off schedule during the pandemic," she explained, and "they didn't eat well, they didn't hydrate properly, they didn't move, they got weaker."

Dr. Lauren Jan Gleason, a geriatrician and assistant professor of medicine at the University of Chicago, said many older patients have lost muscle mass and strength this past year and are having difficulties with mobility and balance they didn't have previously.

"I'm seeing weight gain and weight loss, and a lot more depression," she noted.

Mary Louise Amilicia, 67, of East Meadow, New York, put on more than 100 pounds while staying at home round-the-clock and taking care of her husband Frank, 69, who was hospitalized with a severe case of covid-19 in

early December. While Amilicia also tested positive for the virus, she had a mild case.

"We were in the house every day 24/7, except when we had to go to the doctor, and when he got sick I had to do all the stuff he used to do," Amilicia told me. "It was a lot of stress. I just began eating everything in sight and not taking care of myself."

The extra weight made it hard to move around, and Amilicia fell several times after Christmas, fortunately without sustaining serious injuries.

After coming home from the hospital, Frank couldn't get out of a chair, walk 10 feet to the bathroom or climb the stairs in his house. Instead, he spent most of the day in a recliner, relying on his wife for help.

Now, the couple is getting physical therapy from Northwell Health, New York state's largest health care system. Just before the pandemic, Northwell launched a "rehabilitation at home" program for patients who otherwise would have seen therapists in outpatient facilities. (Medicare Part B pays for the treatments.)

The program is serving more than 100 patients on Long Island, in Westchester County and in parts of New York City.[Read More](#)