

Message from the Alliance for Retired Americans Leaders



Ohio Pension Warrior Rita Lewis to Address Alliance Symposium

Join the Alliance virtually at our Retiree Security Symposium Seminar, which will include a videotaped address by AFL-CIO

President Liz Shuler, on Tuesday, November 15, 2022 from 9:00 - 4:00 EST. Participants will also hear from special guest and pension advocate Rita Lewis, as well as officials from the National United Committee to Protect Pensions (NUCPP), who were added to the agenda this week. Ms. Lewis is the widow of Butch Lewis, who lost much of the pension he was promised due to unfair cuts and for whom the historic Butch Lewis Act pension legislation was named. Rep. John Larson (CT) will speak about protecting and enhancing earned Social Security benefits. The current agenda is available [here](#).

"We are honored to have Ms. Lewis and other NUCPP officials speak during a session entitled, 'Broken Promises Mean Broken Lives. The Story Continues,' said Robert Roach, Jr., President of the Alliance. "The nation is in the midst of a retirement security emergency and it is essential that we protect earned pension benefits."

This educational seminar is for union leaders and staff, legislative representatives, pension advocates, academics,

lawyers and young workers and will be livestreamed by the International Association of Machinists and Aerospace Workers (IAMAW). Register here to join the event.

Top House Republican Kevin McCarthy Vows to Create Global Financial Crisis to Force Cuts to Social Security and Medicare

House Minority Leader Kevin McCarthy (R-CA), who is jockeying to become Speaker of the House if the GOP wins control in November, **said** this week that Republicans will use raising the debt limit as leverage to force cuts in spending, including Medicare and Social Security. McCarthy's remarks echoed what five House Republicans interested in top Committee assignments said recently: that next year's deadline to raise or suspend the debt ceiling is a point of leverage if their party can win the House. The **five** included Republican Reps. Jodey Arrington (TX), Buddy Carter (GA), and Lloyd Smucker (PA), who are each seeking the top spot on the Budget Committee, and Rep. Jason Smith (MO), currently the top Republican on the Budget Committee, who is seeking the top GOP spot on the tax-writing Ways and Means Committee. Rep. Kevin Hern (OK), head of the Republican Study Committee's Budget and Spending Task Force, also said the upcoming debt-limit deadline is "obviously a leverage point." "Kevin McCarthy and his colleagues are coming for our

earned benefits," said Joseph Peters, Jr., Secretary-Treasurer of the Alliance. "This threat grows even more serious when the man who may be the next speaker says it."

Despite the threats, an AARP poll released earlier this month found that only **49 percent of women aged 50 or older and 48 percent of men in the same age group** have determined who they will vote for in November. "Election Day is November 8, less than three weeks away, and a large percentage of seniors are still unaware that many GOP elected officials and candidates have threatened to cut and privatize Social Security and Medicare," added President Roach. "The Alliance will continue to educate seniors about what is at stake until the last polling location has closed on November 8, and we will continue to fight for your rights after November 8." Visit <https://vote.gov/> to check your voter registration and make your plan to vote today.

Alliance Celebrates Voting Rights Court Victory in Lehigh County, Pennsylvania

The Lehigh County Court in Pennsylvania rejected a GOP-led attempt to restrict access to ballot drop boxes in Lehigh County on Wednesday, just weeks before Election Day.

The Pennsylvania Alliance for Retired Americans **intervened** in a lawsuit by America First

Legal Foundation (AFLF) that called for the physical monitoring of drop boxes. This is a tactic that intimidates voters and has historically oppressed marginalized communities. In this case, requiring in-person monitors also would have led Lehigh County to reduce or eliminate drop boxes due to resource constraints. The lawsuit also sought to prevent the use of drop boxes outside of regular business hours, which would create obstacles for voters who work during the day or depend on family members for transportation.

In Wednesday's decision, the court determined there is no evidence of fraud associated with drop boxes from the past two election cycles; Lehigh County's use of drop boxes is secure and legal; and voters should have free and legal access to drop boxes without in-person monitoring that has historically oppressed marginalized communities. The Pennsylvania Commonwealth Court upheld the Lehigh County Court's decision on Friday.

"We are relieved that this blatant scheme to suppress the vote in Lehigh County was stopped in its tracks," said Richard Fiesta, Executive Director of the Alliance for Retired Americans. "There is nothing more sacred than the right to vote, and the Alliance will always fight to ensure every older voter can make their voices heard at the polls."



Robert Roach, Jr.
 President, ARA



Rich Fiesta,
 Executive Director, ARA

GOP promises to gut your Social Security, Medicare if they take power

It used to be a truism that no elected office-holders would dare to tamper with Social Security if they wished to keep their jobs

That must not be true any longer, judging from the surge in threats to the revered program coming from the GOP lately.

In its latest manifestation, four Republicans angling to become chair of the House Budget Committee in a Republican House talked openly about holding the federal debt ceiling hostage to an agreement on "entitlements" — that is, Social Security and Medicare — plainly aimed at cutting benefits.

Republicans have a list of eligibility reforms, and we don't like the tax increases.

Republicans have a list of eligibility reforms, and we don't like the tax increases.

Rep. Jodey Arrington (R-Texas)

In fact, the Republicans are proposing to deny benefits to millions of Americans, all in the name of "strengthening and shoring up" those programs, as House Republican Whip Steve Scalise (R-La.) **described the proposals** for Fox News on Oct. 16. More on that in a moment.

In interviews with Bloomberg, the four laid out their vision. Rep. Buddy Carter (R-Ga.) said the GOP's focus in budget cutting has "got to be on entitlements."

Rep. Jodey Arrington (R-Texas), told Bloomberg that the party caucus would oppose options for shoring up Social Security's fiscal condition that included tax increases, but would look kindly on raising the eligibility age for that program and Medicare.

"Republicans have a list of eligibility reforms, and we don't like the tax increases," Arrington said.

Meanwhile, House Minority Leader Kevin McCarthy (R-Bakersfield) — who's hoping to become Speaker if the GOP wins control of the House — added his voice to the GOP chorus calling for using the debt ceiling as "leverage" to achieve their budget goals.

McCarthy was cagey about whether he would tie the debt ceiling to benefit cuts, **telling Punchbowl News in an**

interview that he would not "predetermine" the options. But his fellow Republicans were not so evasive in their Bloomberg interviews.

"The debt limit is clearly one of those tools that Republicans ... will use to make sure that we do everything we can to make this economy strong," Rep. Jason Smith (R-Mo.), the ranking member of the Budget Committee, said. This isn't the first time that the GOP has tried to depict Social Security and Medicare as enemies of sound fiscal policy. **Senate Minority Leader Mitch McConnell spelled it out** in 2018. Sen. Joni Ernest (R-Iowa) talked openly about making cuts **"behind closed doors."** Sen. Marco Rubio (R-Fl.) cooked up a plan for family leave funded by **raiding future Social Security benefits.**

Let's examine this talk and gauge its potential impact on Americans of all ages.

First, the debt ceiling.

As I've reported almost more times than I can remember, the debt ceiling is **the single most infantile feature** of American policy-making. It's also one of the most commonly misunderstood, which is exactly what gives the GOP the opportunity to wield it as a weapon. Republicans assert that the ceiling, which caps the Treasury's issuance of federal debt but can be raised by congressional vote, places a hard limit on federal spending and that raising it encourages more waste.

It does nothing of the kind. The debt ceiling was not originally meant as a limit on the Treasury's authority to issue debt, but rather as a way to give it *more* latitude to borrow. It was enacted in 1917, when Congress grew weary of having to vote on every proposed bond issuance, which it considered a pain in the neck. So it chose instead to give the Treasury blanket authority to float bonds, subject to a stopgap limitation.

The ceiling was never designed to keep Congress from enacting any spending bills or deficit-building tax breaks it wished. Raising the debt ceiling does



nothing to increase spending; it merely authorizes borrowing for debts already incurred by Congress.

The need for a periodic vote to raise the ceiling merely gives Republicans a chance to posture about Democratic spending proposals. Since a vote on the debt ceiling will be necessary next year, that's what's happening now. In 2011, I observed that the debt ceiling had been raised by congressional votes **91 times since 1960**, generally without discussion. That included **seven times under George W. Bush** and three times (by then) under Barack Obama. That year, Republicans took majority control of the House of Representatives, and the debt ceiling morphed into the raw material of a political stunt.

The economic consequences of breaching the debt ceiling are dire. Payments on existing debt would be halted, as would Social Security checks, Medicare reimbursements to doctors and hospitals and paychecks to military families.

Ruining the U.S. government's unblemished history of always paying its debts would instantly raise its borrowing costs, placing a heavier burden on its budget and slashing the value of government securities held by individuals and pension funds, not to mention investors in other countries.

Every so often in the debt ceiling battles, Republicans get at least a bit of what they ask for. It's never good for the public. The 2011 version resulted in the sequester, an automated austerity regime aimed at suppressing non-defense spending.

The sequester was a gun Congress held to its own head, designed to be so lethal that our lawmakers wouldn't dare to pull the trigger in the form of draconian budget cuts. No one told the trigger finger. So the budget cuts went into effect.

The sequester pared gross domestic product by 1.2% and cost as many as 1.6 million jobs over its first two years.

Tens of thousands of 3- and 4-year-olds were barred from Head

Start, perpetuating the cycle of poverty and poor educational attainment faced by their families. Unemployment benefits were cut by an average of 15% nationwide. (Congressional pay and benefits, naturally, were exempt from those cutbacks.)

Now let's examine the GOP proposals for Social Security and Medicare. According to **the party's model federal budget**, they include raising the eligibility age for Social Security and Medicare to as high as 70.

This idea is both ignorant and insane. The current full retirement age for Social Security is 67, for those born in 1955 or later, but workers can start collecting as early as age 62. (They get reduced monthly benefits for life if they do so, but higher benefits for life if they wait as long as age 70.)

Most workers don't wait until their full retirement age to start collecting benefits, almost always because they can't — they need the money and can't continue working. **According to program statistics**, about 37% start taking benefits at 62, and more than half do so before their full retirement age. Only about 6.7% can afford to wait until age 70. In other words, force people to wait, and more than 98% of future beneficiaries would be left behind.

The GOP defends this proposal by pointing to the increase in life expectancy for those reaching 65 — "the average life expectancy for men reaching 65 increased from 77.7 to over age 82.9," they write in their budget — implying that the average American spends a longer period collecting retirement than in the past. The average, however, masks a lot of diversity.

The life expectancy tables issued by the Centers for Disease Control and Prevention show that the figures cited by the GOP apply chiefly to white males. For Black males, the average life expectancy is only 81 — two years short of the white male cohort. Would the Republicans adjust for this discrepancy? They don't say, so the answer is probably no....**Read More**

New Senate Bill Threatens Lower Drug Prices

With Election Day just a month away it is a good time to restate that TSCL is a non-partisan organization. We do not pick sides between Democrats and Republicans, nor do we endorse candidates.

However, what we do is endorse or oppose legislation no matter which elected official, or party supports it. If we believe the legislation is good for seniors, we support it. If it's bad for seniors, we oppose it.

TSCL supporters are no doubt aware that we supported the legislation passed by Congress a number of weeks ago that, for the first time, will lower prescription drug prices. Unfortunately, the bill was highly partisan – it received no Republican votes in either house of Congress - and while we would prefer to support legislation that has the support of both parties, which was not an option.

Now, we must report that last Friday, Senate Republicans introduced a bill that would roll back the drug pricing reforms,

including the measures allowing Medicare to negotiate drug prices for the first time in the program's history. It also repeals the cap that was placed a \$2,000 out-of-pocket cap on annual drug costs for seniors on Medicare, as well as a \$35 monthly copay for insulin.

Republican Sens. James Lankford (Okla.), Mike Lee (Utah), Cynthia Lummis (Wyo.), and Marco Rubio (Fla.) introduced the "Protecting Drug Innovation Act," saying they wanted to pull back government authority over the prices of drugs covered by Medicare.

"Prescription drug prices are too high for many critical drugs, which demonstrates the need for more competition and more options for consumers," Lankford, who sits on the Senate Finance Committee, said in a statement.

If passed, Lankford's bill states it would make it so that the drug pricing reduction measures "had never been enacted."



"Unfortunately, the Democrats' new government drug price control in their so-called 'Inflation Reduction Act' creates even more barriers to effectively bringing down the cost of prescriptions, particularly for senior adults on Medicare," added Lankford.

In his own statement, Senator Lee argued that price controls, "... exacerbate the problems they seek to resolve. Mandating fixed prescription drug prices will ultimately result in the shortening of American lives," the Utah senator said.

White House press secretary Karine Jean-Pierre lambasted the bill on Twitter, saying it puts "special interests before working families."

"Their new bill is a giveaway to Big Pharma at the expense of seniors by ending Medicare's new ability to negotiate lower drug prices," Jean-Pierre said. "Their vision for the country is extreme and out of touch with working families across the

country."

TSCL has fought for legislation to reduce prescription drug prices for years and although the new law is far from perfect, it the first time Congress has ever passed a law to reduce drug prices.

The big drug companies fought the new bill by spending millions of dollars to oppose it, including giving money to the campaigns of many members of Congress to try and influence their votes.

Although several Republican Senators have expressed concern about the high costs of prescription drugs, when they held the majority, they were unable to come up with a bill to fix the problem that all Republicans members would support. In fact, then-Senate Majority Leader Mitch McConnell refused to allow any drug price-reducing legislation come up for a vote.

We urge TSCL supporters to contact their Senators and ask them what their position is on this new bill and then urge them to oppose it.

New Kaiser Family Foundation Resource Provides Overview of Part D Benefit

This week, the Kaiser Family Foundation (KFF) released a Medicare Part D **fact sheet** providing an overview of plan availability, enrollment, and costs.

About **49 million** people with Medicare are enrolled in Part D plans. Next year, there will be 801 stand-alone prescription drug plans (PDPs) to choose from, a 5% increase from 2022. The number of PDPs will vary across states, from 19 in New York to 28 in Arizona. This is in addition to the **ever-growing** number of Medicare Advantage plans that cover prescription drugs (MA-PDs).

The Part D Low-Income Subsidy (LIS) program helps nearly **13 million** low-income Medicare beneficiaries pay their Part D premiums and cost-sharing. In 2023, LIS enrollees will have access to 191 premium-free "benchmark" plans, a 4% reduction compared to 2022. The number of benchmark plans per state will range from three to eight. While LIS enrollees can select any plan offered in their

area, if they choose a non-benchmark plan, they may be required to pay some monthly premium costs.

The 2023 Part D base beneficiary premium is **\$31.50**, roughly 2% lower than in 2022. But actual premiums paid by Part D enrollees will continue to vary considerably, from a low of \$1.60 in the Oregon/Washington region to a high of \$201.10 in South Carolina. KFF also notes that "even within a state, PDP premiums can vary; for example, in Florida, monthly premiums range from \$8.40 to \$170.10. In addition to the monthly premium, Part D enrollees with higher incomes (\$97,000/individual; \$194,000/couple) pay an **income-related premium surcharge**, ranging from \$12.20 to \$76.40 per month in 2023 (depending on income)."

The Part D benefit has several coverage and payment phases—including a deductible, an initial coverage phase, a coverage gap phase, and catastrophic coverage. In 2023, enrollees will enter the



coverage gap after their total drug costs reach \$4,660 (up from \$4,430 in 2022). Once in the coverage gap, they will pay 25% of the cost for both brand-name and generic drugs. They will reach catastrophic coverage after spending \$7,400 total (up from \$7,050 in 2022), at which point they will pay significantly less per prescription: either 5% or \$4.15/\$10.35 for each generic and brand-name drug, respectively.

Medicare Rights encourages Part D enrollees to review their coverage annually, as plans can change their pricing, benefits, and formularies each year. Any updates should be outlined in the Annual Notice of Change (ANOC), which plans must send by September 30. They may do so via email, but enrollees wanting a hard copy can call the plan to request one. Reviewing the formulary is also a good idea. A complete copy should be available on the plan's website and can be requested by calling the plan.

Also **next year**, several key Inflation Reduction Act (IRA) provisions will take effect. Everyone with Medicare Part D will have access to certain vaccines at no cost, including the shingles vaccine. And monthly insulin costs will be held to \$35 per prescription. The new insulin limit will not be reflected in Medicare Plan Finder this fall. To avoid inaccurate pricing when using the tool, our Helpline counselors **recommend** searching for a plan based on all other medications, then separately confirming one's preferred insulin is on the plan's formulary.

For assistance, contact your local **State Health Insurance Assistance Program (SHIP)** for unbiased, one-on-one counseling; contact Medicare online at <https://www.medicare.gov/> or by calling 1-800-MEDICARE; or call the Medicare Rights Center's national helpline at 800-333-4114.

[Read the KFF Fact Sheet.](#)

Social Security Is About to Do Something It's Only Done 3 Times Before

Although Social Security has been around for a really long time, the program tends to evolve from year to year. One change seniors have come to expect is their annual cost-of-living adjustment, or COLA.

The purpose of COLAs is to give seniors on **Social Security** the opportunity to maintain their buying power as living costs creep upward. Over time, the value of a dollar tends to erode, due to inflation. If benefits were to stay the same indefinitely, seniors who get the bulk of their retirement income from Social Security would no doubt struggle immensely, so COLAs are designed to prevent that. (Whether they actually do the trick is a different story.)

Meanwhile, in 2023, Social Security will be giving seniors a major boost to their benefits. In fact, next-year's COLA is the highest that Social Security

recipients will have received in decade

Seniors are getting a COLA above 8%

Prior to 1975, Social Security benefit increases were determined by legislation. But starting in 1975, the rules changed, and since then, Social Security benefits have been eligible for an automatic COLA that's pegged to the rate of inflation.

Because inflation has been rampant this year, the Social Security Administration just announced that seniors will be privy to an **8.7% COLA** that takes effect in 2023. And that's huge, because prior to this recent COLA, Social Security has only dished out a COLA above 8% three times before:

- ◆ In 1979, it announced a 9.9% COLA
- ◆ In 1980, it announced a 14.3% COLA



◆ In 1981, it announced an 11.2% COLA

All told, even though this recently announced 8.7% COLA isn't the largest Social Security has ever given, it's still pretty significant. While some seniors may be disappointed with that number (namely because some experts had initially been calling for an 11% COLA for 2023), it could end up being a very helpful boost.

How far will an 8.7% COLA go?

That's really the big question. For many years, seniors on Social Security have been losing buying power due to the inability of COLAs to keep up with inflation - even though they're supposed to be tied directly to it.

This-year's COLA is a prime example of that failing. At the start of 2022, seniors on Social

Security saw their benefits increase by 5.9%. And at the time, that read like a pretty significant raise.

But over the past 10 months, the rate of inflation has far exceeded 5.9%. As a result, seniors on Social Security once again lost buying power, even when their COLA was relatively generous.

As such, whether this newly announced 8.7% COLA actually holds up will hinge on inflation levels in the coming months. If inflation finally starts to cool, seniors might gain a modest amount of buying power -- something they desperately need. But if inflation continues to soar, seniors may not come out ahead financially in 2023 -- even with one of the most substantial COLAs Social Security has ever seen.

Working and Collecting Social Security? Big Changes May Be On the Way In 2023

Every year, during the second week of October, retirees around the U.S. wait on proverbial pins and needles for the biggest announcement of the year from the Social Security Administration (SSA): The **cost-of-living adjustment (COLA)**. COLA is the benefit boost Social Security's recipients receive most years that accounts for inflation.

On Oct. 13, 2022, the U.S. Bureau of Labor Statistics (BLS) provided the final inflation data point needed for COLA to be calculated for the upcoming year - and what a COLA it turned out to be! According to the SSA, the program's nearly 66 million beneficiaries will **receive an 8.7% cost-of-living adjustment**. In nominal-dollar terms, it'll be the biggest payout increase on record for recipients, with the average retired worker, disabled worker, and survivor beneficiary netting a greater than \$100 increase in their monthly payout next year.

Social Security isn't just for retirees

But what you might not realize about **Social Security** is that it's not just for retirees. Although the program was founded in the 1930s with the intent of providing financial protection to aged

Americans who could no longer work, an increasing number of seniors are remaining in the workforce for a variety of reasons.

Based on data provided by the BLS, the labor force participation rate for persons aged 65 to 74 has increased from less than 20% in 2001 to nearly 26% by 2021. Similarly, Americans aged 75 and older have seen their participation rate jump from 5.2% in 2001 to 8.6% in 2021. BLS projections for 2031 show participation rates for both groups continuing to rise.

Although these seniors can qualify for a retired worker benefit while remaining in the labor force, there are certain changes to Social Security announced each year that can apply to this group of workers. Here are two notable changes that could affect seniors who collect a Social Security benefit but remain in the labor force.

The retirement earnings test may come calling

Without question, the biggest Social Security change is one that could affect early filers. By "early filers," I mean eligible people aged 62 to 66 years and 11 months who chose to take their retired worker benefit prior to reaching **full retirement**



age (FRA) -- the age where beneficiaries can receive 100% of their monthly payout.

Early filers can be subjected to what's known as the retirement earnings test. If a Social Security recipient's earnings surpass predetermined thresholds, the SSA can withhold some or all of their benefits. Once a beneficiary reaches their FRA, the retirement earnings test is no longer applicable, regardless of when they began taking their benefits.

The SSA breaks down early filers into two categories: Those who won't reach their FRA in the upcoming year and those who will. The **retirement earnings test income thresholds** vary pretty significantly between these categories.

In 2023, early filers who won't reach their full retirement age can generate \$21,240 (\$1,770/month) in **earned income** without the SSA withholding a single dollar. But for every \$2 in wages and salary above this threshold, the SSA can withhold \$1 in benefits. Next year's \$21,240 income threshold is \$140/month higher than in 2022.

For early filers who *will* reach their FRA in 2023, the earnings threshold is a more robust

\$56,520 (\$4,710/month). Seniors who surpass this level prior to hitting their FRA next year will have \$1 in benefits withheld for every \$3 earned above it. For context, this \$4,710/month income threshold represents a \$380/month increase from this year.

For some working seniors, these increases mean they'll be able to double-dip and keep more of their total take-home pay (earned income plus Social Security income) in the upcoming year.

Additionally, keep in mind that withheld benefits are returned in the form of a higher monthly payout once an eligible beneficiary hits their full retirement age.

A higher payroll tax earnings cap could mean bad news for high earners

The other big Social Security change that could affect people working and collecting a Social Security benefit is the coming adjustment to the payroll tax earnings cap.

The 12.4% payroll tax on earned income is **what powers the Social Security program**. In 2021, payroll taxes brought in \$981 billion of the \$1.09 trillion in total revenue collected by Social Security.**Read More**

Family Caregivers Find Support on #dementia TikTok

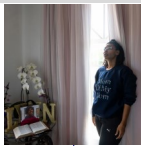
It all changed on a Saturday night in New York City in 2016. Jacquelyn Revere was 29 and headed out to attend a friend's comedy show. She was on the subway when her phone rang. It was a friend of her mom's, back in Los Angeles. That's weird, Revere thought. She never calls.

"And while I was on the subway, my mom's friend said, 'Something is wrong with your mom,'" Revere said. "We don't know what's going on, but your mom got lost driving home. What should have been a 15-minute drive ended up taking two hours."

Revere flew to L.A. At her mom's home in Inglewood, she found foreclosure notices, untreated termite damage on the porch, and expired food in the kitchen. Her mother, Lynn Hindmon, was a devout evangelical who worked for her church. A slim, regal self-

declared "health nut," Hindmon was now forgetting to pay bills and couldn't remember whom she was talking to on the phone.

Revere did not know it then, but that tough time would lead her to find — and help build — a community of caregivers who support one another on social media. TikTok has been an especially helpful platform. Content with the hashtag "dementia" has racked up more than **4 billion views on TikTok**, as younger generations, already accustomed to sharing their lives online, now find themselves caring for aging loved ones — often with little preparation and no idea how to do it. Over the past few years, Revere's account, [@MomofMyMom](#), has become wildly popular, with more than 650,000 followers.



Ardent fans have told her they feel like they personally know her and her mom.

It would take nearly a year to get the diagnosis that confirmed what Revere already suspected: Her mother — still in her 50s — had Alzheimer's disease. Barely 10 years since Revere left home, she found herself moving back in to become a full-time caregiver for her mom and her grandmother, diagnosed with Alzheimer's years earlier.

"That first year and a half, I was just filled with fear: What if I lose the house?" Revere said.

Because of the stress, she said, "I went through bouts of migraines. My hair, right in the middle, fell out completely."

"I had to figure out how to get control of all the banking, figure out the passwords, make sure the bills are paid, make sure

everything's taken care of."

In 2017, her grandmother died. Revere's grief and isolation felt overpowering. Her friends in their 20s either couldn't relate or thought she was "wallowing in pity," Revere said.

Trying to make them understand what her daily life was like now seemed impossible. "I just wanted to find people I didn't have to explain everything to," she said.

Revere tried a support group for caregivers, an hour's drive away. But the other attendees were decades older and had more financial resources. "[They] would say, 'And now I have to take equity out of our house,' or 'I'm thinking of reaching into our 401(k).' And then I would tell my story, and people would be looking at me like ... a charity case, or like my problem is unsolvable. ... I just felt worse." ... [Read More](#)

Study finds No link between Drug Costs and Research and Development Costs

Over the last several years drug companies and their trade groups have opposed many of the reforms proposed in Congress and supported by TSCL to lower drug prices by arguing that high drug prices are needed to recover research and development investments.

Most debates around drug price regulations have centered on how to strike the right balance between lower drug prices and greater incentives for innovation, yet no study had

investigated whether there is an association between how much drug companies invest in research and development to develop new drugs and how much they charge for these drugs. If high research and development costs justified high drug prices, then an association between these 2 measures would be expected.

However, it was reported last week in the Journal of the American Medical Association



Network Open, researchers found no association between a drug's list price and research and

development costs. The study looked at 60 drugs approved by the Food and Drug Administration between 2009 and 2018.

"Drug companies should make further data available to support their claims that high drug prices are needed to recover research and development investments if

they are to continue to use this argument to justify high prices," the authors said.

With some Republican Senators already proposed new legislation to repeal the new drug price reduction law just passed by Congress, TSCL hopes this new study becomes a major factor in the debate about any attempt to repeal the new drug price reduction law.

Blind to Problems: How VA's Electronic Record System Shuts Out Visually Impaired Patients

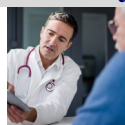
Sarah Sheffield, a nurse practitioner at a [Veterans Affairs clinic in Eugene, Oregon](#), had a problem. Her patients — mostly in their 70s and beyond — couldn't read computer screens. It's not an unusual problem for older people, which is why you might think [Oracle Cerner](#), the developers of the agency's new digital health record system, would have anticipated it.

But they didn't.

Federal law requires government resources to be accessible to patients with disabilities. But patients can't

easily enlarge the text. "They all learned to get strong reading glasses and magnifying glasses," said Sheffield, who retired in early October.

The difficulties are everyday reminders of a dire reality for patients in the VA system. More than a million patients are blind or have low vision. They rely on software to access prescriptions or send messages to their doctors. But often the technology fails them. Either the screens don't allow users to zoom in on the text, or screen-reader software that translates text to speech isn't



compatible.

"None of the systems are accessible" to these patients, said [Donald Overton](#), executive director of the [Blinded Veterans Association](#).

Patients often struggle even to log into websites or enter basic information needed to check in for hospital visits, Overton said: "We find our community stops trying, checks out, and disengages. They become dependent on other individuals; they give up independence."

Now, the developing VA medical record system, already

bloated by outsize costs, has been [delayed](#) until June 2023. So far, the project has threatened to exacerbate those issues.

While users in general have been affected by numerous incidents of downtime, delayed care, and missing information, barriers to access are particularly acute for blind and low-vision users — whether patients or workers within the health system. At least one Oregon-based employee has been offered aid — a helper assigned to read and click buttons — to navigate the system. ... [Read More](#)

Here are the biggest changes to Medicare next year

Next year, seniors will see three key changes to Medicare that could save them money.

Premiums and deductibles on Medicare Part B are going down, while co-sharing costs for adult vaccines are going away. Insulin copays will also be capped starting in 2023.

These changes could affect if seniors choose to switch their coverage options during the annual open enrollment window that runs from October 15 to December 7.

"The most important change in 2023 will help people with diabetes," Mark Miller, author of the forthcoming book *Retirement Reboot: Commonsense Financial Strategies for Getting Back on Track*, told Yahoo Money. "Another important change in 2023: vaccines covered under Part D will come with no copays or deductibles. That will help with expensive vaccinations, such as the shingles vaccine."

Here's what to know.

Although some choose injections with stem cells and

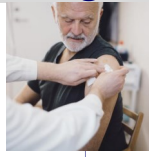
platelet-rich plasma, referred to as "**regenerative medicine**," they are experimental without firm evidence that they work, he said.

"In the past, older people just accepted joint pain," Sanchez-Sotelo said in a Mayo Clinic news release. "Now people are living longer and want to remain active as they age. We are not all destined for **joint replacement**. There are some people in their 80s and 90s who have great joints."

Medicare Part B

Medicare premiums will be cheaper. The standard monthly premium for Medicare Part B, which covers physician services, outpatient hospital services, certain home health services, durable medical equipment, and certain other medical and health services not covered by Medicare Part A, will be \$164.90 for 2023, a decrease of \$5.20 from \$170.10 in 2022.

The annual deductible for all Medicare Part B beneficiaries is



\$226 in 2023, a decrease of \$7 from the annual deductible of \$233 in 2022. Medicare beneficiaries can add that \$5.20 monthly refund to the sizable 8.7% Social Security COLA for 2023. Part B premiums typically are deducted from monthly Social Security benefits, so that boost will be welcome as retirees still grapple with rising costs.

Adult vaccines

Starting in 2023, seniors will no longer have to pay for cost sharing for adult vaccines covered under Medicare Part D and under Medicaid that are recommended for adults by the Advisory Committee on Immunization Practices (ACIP).

Coverage of vaccines ranging from the flu to pneumonia to shingles for adults has been optional, with about half of states providing coverage and some charging cost-sharing, according to KFF data.

Inflation Reduction Act

Next year, thanks to provisions in the Inflation Reduction Act,

3.3 million Medicare Part D beneficiaries with diabetes will benefit from a guarantee that copays for insulin will be capped at \$35 for a month's supply. However, if you're comparing Part D plans using the Medicare Plan Finder, the insulin copay cap will not show up in online descriptions of plan costs.

That's because the law is new. The Medicare Rights Center experts advise choosing a plan by the cost of all the prescriptions you take and separately confirm that your insulin prescription is listed in the plan's covered drugs, or the formulary. You can then add the \$35 co-pay to your estimated costs.

Finally, while the Inflation Reduction Act delivered the most significant changes to Medicare in almost two decades, most of the provisions, including lower prescription drug prices and out-of-pocket costs, won't kick in for several years. Patience.

Biden administration vows tougher oversight of poor-performing nursing homes with safety issues

The Biden administration announced plans Friday to toughen oversight of the nation's poorest-performing nursing homes with escalating fines and terminating federal funding for the homes that fail to improve.

The administration will

overhaul the Centers for Medicare and Medicaid Services "special focus facility" program of **homes with poor safety records**. Homes in the program that fail to improve will be fined escalating penalties for violations. Those facilities



with safety violations that generate at least two "immediate jeopardy" warnings could be terminated from Medicare or Medicaid funding – a potential death blow for homes that rely on federal funding to sustain operations.

The agency that oversees Medicare and Medicaid will also advise states to consider a **facility's staffing level** when deciding whether to assign homes to the special focus program....[Read More](#)

Record Spending by Big Drug Companies to Fight Drug Price Reduction

The pharmaceutical industry has spent more than \$100 million on lobbying so far in 2022. According to *OpenSecrets*, the pharmaceutical industry has spent \$101 million lobbying on behalf of 483 clients in 2022, fighting Democratic efforts to rein in prescription drug costs. That is *double* the amount of the next largest industry.

In addition, a new report by the House of Representatives targets 14 pharmaceutical companies for spending more on stock buybacks and dividends than they did on research and development over a five-year period. The 14 companies spent a combined \$31 million in the first quarter of 2021 on lobbying.

The House report said numerous drug companies were spending a significant percentage of their research and development to suppress generic and biosimilar competition instead of on innovative research, while still raising the prices of their drugs.

According to an analysis released last week by the Kaiser Family Foundation drug companies raised prices faster than inflation for about half of all drugs covered by Medicare between July 2019 and July 2020. The median price increase was 5.6% for drugs covered by Medicare Part D and 5.4% for drugs covered by Part B, compared with a 1% inflation



rate over the period. According to the Campaign for Sustainable Rx Pricing, leading drug companies also reported massive profits in the fourth quarter of 2021.

Drug Prices Went Up Again Although President Biden's new drug price reduction law was passed this year, the law will not take effect immediately.

The need for the new law, however, was underscored by the release of a study showing that drug price increases for over 1,200 drugs exceeded inflation between July 2021 and July 2022, including many drugs used to treat cancer and other chronic conditions, according to a new

report from the Department of Health and Human Services (HHS).

The increases in these drugs averaged 31.6%. Beginning in 2023, the Inflation Reduction Act requires drug manufacturers to pay rebates to Medicare if they enact price increases greater than inflation. The law also requires the federal government to negotiate prices for certain Medicare drugs with high spending.

Between 2016 and 2021, drug spending growth was largely due to an increase in spending per prescription and a 43% increase in the cost of specialty drugs, according to another new HHS report.



Common A-Fib Treatment May Be Riskier for Women

While a common non-drug treatment called ablation exists for the heart rhythm disorder atrial fibrillation (a-fib), the procedure can be more problematic for women than for men.

A-fib, a chaotic electrical pattern in the upper chambers of the heart, affects up to 20% of Americans during their lifetimes. It can be dangerous, raising the odds for a stroke.

A **new study** looked to better understand differences in treating men and women for a-fib, and its authors called for further research to improve quality of life for female patients.

"This study is a call to arms to continue efforts to mitigate the risk of these procedures and continue to try to improve the safety profile for women," said Dr. James Freeman, associate professor of medicine (cardiology) at Yale University in New Haven, Conn.

For the study, Freeman's team followed nearly 59,000 patients in an American College of Cardiology registry. The patients were seen at one of 150 U.S. sites between January 2016 and September 2020. The researchers' intent was to analyze

sex-based differences in complications of catheter ablation.

Catheter ablation uses radiofrequency energy burning or freezing technology to inhibit the electrical signals triggering the condition in pulmonary veins.

Over the past decade, as cardiologists have gained more understanding of anatomical differences in women (such as size), safety of the procedure has improved.

For example, many medical centers now use ultrasound rather than just feeling for a pulse to more accurately place catheters.

To prevent heart perforation, the catheters also are now designed to allow cardiologists to feel how much force is being used in the ablation. Doctors are also now more aware about sex-based differences in appropriate doses of **blood thinners** for women at the time of the procedure.

In analyzing patients' overall adverse event rates, major adverse event rates and extended hospitalizations, the investigators found that men tended to experience persistent a-fib.

Women, however, tended to



go in and out of atrial fibrillation, while also having more symptoms such as heart palpitations, chest pain, fatigue and dizziness.

Women tended to be older when they had the procedure and had experienced a significantly lower quality of life.

"This suggests that there may be an opportunity for cardiologists to treat women earlier in the course of their disease than we are," Freeman said in a Yale news release. Women were also more likely to experience a range of complications after the ablation, including **pericardial effusion**, which happens when the heart is perforated and blood builds up around it. It can be life-threatening. They were also more likely to experience **slow heart rates** that required a permanent pacemaker.

In addition, women's **phrenic nerve** was more likely to be injured. This can paralyze the diaphragm, causing breathing difficulties.

Women were also more likely to have vascular injury and bleeding in the adjacent groin area that required surgery, as well. They had more fluid

buildup in the lungs, which can cause shortness of breath or heart failure. Treating it requires medication to remove the fluid and extends their hospital stay.

"One of the greatest advantages of our study compared with prior studies is that we were able to look at a lot of specific adverse events that had not been previously well-studied," Freeman said.

"There is a real opportunity to minimize health resource utilization," he added. "If a significant number of women are having to stay in the hospital for an extra day, that's not insubstantial."

Freeman hopes the findings will help cardiologists make the procedure even safer for women. He plans to continue studying these differences over time to monitor progress.

"Despite awareness around the complications of ablation, we're still seeing persistent complications," he said. "Time and time again, these procedures are improving patients' quality of life and symptom burden. But we must continue our efforts to mitigate the risk."

The findings were recently published in **Heart**.

Surgery Holds Danger for Seniors. Who's Most at Risk?

Surgery can be a daunting prospect at any age. Now, researchers say they've spotted two key factors upping the odds of a poor surgical outcome in seniors.

Older adults who are either frail or suffering from dementia have high rates of death in the year following a major procedure, a new U.S. study finds.

Researchers found that among Americans aged 65 and older who underwent major surgery between 2011 and 2017, 13% died in the following year. And some seniors were at particular risk: One-year death rates were 28% among older adults who were frail, and nearly 33% among those with probable dementia.

The extent to which the surgery, itself, precipitated those deaths is unclear.

"Over a year, it's harder to make a direct linkage to the surgery," said lead researcher Dr. Thomas Gill, a professor of geriatric medicine at Yale School of Medicine.

But, he added, it is likely the procedures often played an important role in those older adults' deteriorating health.

Gill said the overall death rate in the study group, at 13% over one year, is substantially higher than would be expected for Americans that age.

Does that mean many older people were having operations that should not have been done?

That might be true in some cases, said Gill. But he thinks the



bigger issue is that the most vulnerable seniors need better care both before and after surgery.

To start, Gill said, geriatric patients should be assessed for frailty or early dementia (which is often undiagnosed, he noted) ahead of an elective surgery.

Those with signs of frailty -- such as low weight, slow movement or fatigue -- might benefit from therapy to improve their fitness, for example. And anesthesiologists, Gill said, might make different decisions on the type of anesthesia used during the procedure, based on information from those pre-surgery assessments. (**Click here** for more on geriatric anesthesia).

For patients with probable dementia, he said, it's particularly

important to **prevent and treat delirium**. That's a common post-surgery complication for older adults, but it can be especially serious and long-lasting in those with dementia.

Those pre-surgery assessments are critical, agreed Dr. Daniel Anaya, chief of gastrointestinal surgery at Moffitt Cancer Center in Tampa, Fla. All patients need to be evaluated ahead of surgery, he noted, but geriatric patients have unique concerns.

Anaya, who wrote "This study brings to light how important that process is," said Anaya, who wrote an **editorial** published with the findings Oct. 19 in **JAMA Surgery** ... **Read More**

Black Americans Less Likely to Get Lifesaving Heart Treatments

A person with advanced **heart failure** may often need a heart transplant or a mechanical heart pump to survive.

But white patients are twice as likely as Black patients to get this critically important care, a new study finds, and racial bias may be the reason why.

The findings come from an observational two-year study supported by the U.S. National Institutes of Health (NIH).

"The lives disabled or lost are simply too many," said study author Wendy Taddei-Peters, a clinical trials project official within the Division of Cardiovascular Sciences at the National Heart, Lung, and Blood Institute (NHLBI).

"An immediate step could be to require implicit bias training, particularly for transplant and VAD [mechanical heart pump] team members," Taddei-Peters said in an NIH news release.

In this part of the study, the researchers looked to further analyze disparities in heart failure care.

To do this, they followed the

cases of 377 patients who received treatment at one of 21 centers in the United States.

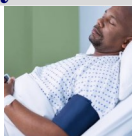
They found that 62 of 277 white adults, or 22%, received a heart transplant or **ventricular assist device** (VAD).

Yet, only 11 of 100 Black adults, or 11%, received the same therapies to extend and improve their quality of life with end-stage heart failure.

"The totality of the evidence suggests that we as heart failure providers are perpetuating current inequities," said study first author Dr. Thomas Cascino, a clinical instructor in the Division of Cardiovascular Disease at the University of Michigan.

"However, recognizing disparities isn't enough," he said in the release. "As physicians and health care providers, we must find ways to create equitable change."

After controlling for multiple factors ranging from disease severity to several social determinants of health,



researchers did not find associations between patient race and death rates. About 18% of Black adults and 13% of white adults died during the study.

While treatment preferences between the two groups were similar, Black patients had a 55% reduced rate for receiving VAD therapy or a heart transplant.

That's a key point because the research showed patient treatment preferences did not drive the inequities.

There was a notable disparity in treatment that could not be explained through any other measures except unconscious bias and even overt racism and discrimination among health care providers and within the health care system, the researchers said.

One solution is training to help health care professionals become aware of their biases.

Finding ways to standardize advanced heart failure therapy would also help. This could begin by determining where the disparities in clinical care begin.

To support uniformity in doctor

assessments, medical centers could partner with "disparity experts," the researchers suggested.

"Disparity experts can identify these biases and barriers in real time, provide learning opportunities, and promote equity," Taddei-Peters said. "This can be especially valuable for centers where the demographics of health care providers may not reflect the patients they serve."

About 6.2 million Americans have heart failure, **according** to the U.S. Centers for Disease Control and Prevention. That includes 600,000 who have end-stage heart failure. Black adults have a greater risk for the condition and are twice as likely to die from it, according to past research.

Symptoms of heart failure include shortness of breath, swelling in the lower body such as the legs and ankles, and feeling tired. Diabetes is an underlying risk factor.

The findings were published Oct. 19 in the **Circulation: Heart Failure**.

Feds Make Big Funding Push for More Mental Health Clinics

The federal government is pumping millions more dollars into an effort to expand the United States' network of community mental health centers. Up to 15 states now can apply for \$1 million grants to help plan new **Certified Community Behavioral Health Clinics** (CCBHC) in their region, the U.S. Department of Health and Human Services (HHS) announced Tuesday. Funding for the grants was included in the **Bipartisan Safer Communities Act**, passed earlier this year.

These crisis centers are available around the clock to help anyone with mental health or substance abuse problems, regardless of their ability to pay.

The \$15 million in additional planning funds is in addition to nearly \$300 million awarded in September for new and existing CCBHCs, the agency said.

"Today we're talking about providing to Americans 24/7 support for crisis care," HHS Secretary Xavier Becerra said during a media briefing. "That's

something that's only been available to some. Depending on your income and your ZIP code, you could be totally out of luck. That's going to start to change."

The strategy is to provide enough funding that at least 10 more states will be able to open their own local CCBHCs every two years, gradually expanding a network of crisis centers across the nation, said Sen. Roy Blunt, R-Mo., a leader of the bipartisan **2014 Excellence in Mental Health and Addiction Treatment Act** that created CCBHCs.

Ten states – Michigan, Missouri, Kentucky, Minnesota, Nevada, New Jersey, New York, Oklahoma, Oregon and Pennsylvania – are operating CCBHCs as part of a demonstration program created by the 2014 law.

Early next year, federal officials expect to name up to 15 states that will receive \$1 million one-year planning grants. From that group, 10 states will be



selected in 2024 to join the demonstration project.

"Step by step, we are going to take this nationwide," said the law's other major sponsor, Sen. Debbie Stabenow, D-Mich.

Statistics from the 10 states now in the program show how the effort is "changing people's lives already," Stabenow said.

"People who receive services at CCBHCs show a 72% reduction in hospitalization; 69% reduction in emergency room visits; 41% decrease in homelessness; and they spent 60% less time in jails," she said.

CCBHCs are reimbursed through Medicaid for the full cost of services they provide at higher, more competitive rates than community mental health centers now receive, the HHS said.

However, they are also subject to exacting quality standards and are required to get people into care more quickly. A CCBHC must provide routine outpatient care within 10 business days after an initial contact, to keep people from languishing on waiting lists,

the agency said.

Expansion of the CCBHC program is part of the Biden administration's effort to tackle America's mental health crisis, joining the launch of the **988 crisis line** in July, Becerra said.

The 988 line is "the 911 for those who are about to do something they should not do with their own life," Becerra said. "988 becomes a place where you get help, and if we do it right, when you call that three-digit number you will get the support you need – and you will get the support you need because we now will be establishing nationwide Certified Community Behavioral Health Clinics."

Sgt. Chad Matthews, supervisor of the Crisis Response Support Section with the Montgomery County Police Department in Maryland, said these crisis centers are helping take pressure off police officers, who are often the first responders in a mental health crisis. **Read More**

It Doesn't Take Much Weight Gain to Raise Odds for Knee Trouble

A person doesn't have to pack on very many extra pounds before their risk of needing a knee replacement increases substantially, a new evidence review has found.

Weight gain of just 11 pounds increases a woman's odds of needing **total knee replacement** surgery by one-third, and a man's by one-quarter, researchers reported Tuesday at the International Congress on Obesity in Melbourne, Australia.

Knee pain and stiffness also increased with this weight gain, while people's overall quality of life and ability to use their knee decreased, the researchers said.

Osteoarthritis occurs when the cartilage that cushions the joints wears away over time, allowing the ends of bones to rub against each other, causing pain,

swelling and stiffness.

Losing 10% or more of total body weight has been found to improve knee arthritis, but if it gets too bad patients might need an artificial joint to replace the ruined one.

For this study, researchers reviewed 20 prior studies that examined the relationship between weight gain and osteoarthritis.

The studies found that weight gain had significant detrimental effects on the knee joint, including damage visible on X-rays.

"In other words, osteoarthritis was more likely to develop with weight gain and to progress more quickly," said lead researcher Dr. Anita Wluka of the Monash University School of Public



Health and Preventive Medicine, in Melbourne. Combining results from two large studies involving more than a quarter of a million people, Wluka and her colleagues found that an 11-pound **increase in weight made total knee replacement** surgery 35% more likely for women and 25% more likely for men.

"This is particularly concerning," Wluka said in a news release from the International Congress on Obesity. "Knee replacements are costly and one in five people are dissatisfied with the results and remain in pain after surgery. Those who remain in pain are more likely to require a second surgery, which is more costly and less likely to control their pain."

People at risk for osteoarthritis

should be counseled on ways to manage their weight, Wluka concluded.

"Weight maintenance in middle age would reduce the risk of knee osteoarthritis occurring and, in those with osteoarthritis, it would reduce worsening of pain, loss of function and the need for costly joint replacement," she said. "We know that people tend to put on nearly 1 kilogram (2.2 pounds) a year as they get older, but the good news is that there is evidence from previous studies that it is possible to prevent weight gain."

Research presented at medical meetings should be viewed as preliminary until published in a peer-reviewed journal.

There's a Push to Expand Medicare's Coverage of Dental Issues

Dental coverage under Medicare could soon start expanding for seniors under a new **proposal** from the U.S. Centers for Medicare and Medicaid Services (CMS).

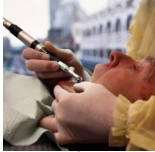
Still, the proposed rules would not provide full coverage for regular dental care, which has been explicitly excluded from Medicare since the program's founding in 1965.

"Traditional Medicare doesn't cover routine preventive dental services, such as exams, cleanings, X-rays, nor more expensive services such as fillings, crowns or dentures," said Meredith Freed, a Medicare expert with the Kaiser Family Foundation.

However, the new proposal would effectively open the door to Medicare potentially covering a wider array of dental services if medical science can demonstrate that **oral health** substantially improves the outcomes of different diseases and treatments.

Under the proposal, rule makers and bureaucrats would have greater flexibility to approve whole new areas of dental coverage as well as to pay for specific procedures on a case-by-case basis, experts say.

Currently, nearly half of all Medicare beneficiaries — about 24 million people — don't have dental insurance, even though



two-thirds suffer from periodontal disease, according to a **letter** from U.S. Senators urging the CMS to expand coverage. Rotting teeth and inflamed

gums can have a tremendous impact on a person's overall health, contributing to **heart disease, diabetes, pneumonia** and a host of other illnesses, research has shown.

Despite this, existing law allows Medicare to cover dental procedures only under very narrow circumstances, if dentistry can be proven "an integral part of a covered procedure," Freed explained.

For example, Medicare will pay dentists to help reconstruct a

jaw following a traumatic injury, or to perform an oral exam prior to a kidney transplant, said Wey-Wey Kwok, senior attorney for the Center for Medicare Advocacy.

But if the dentist finds a decayed tooth that needs to be pulled, Medicare won't cover the cost of the extraction, Kwok added.

The new CMS proposal would require Medicare to pay outright for dental exams and all procedures necessary to eradicate oral infections prior to any organ transplant surgery or **cardiac valve procedure**, Kwok and Freed said....**Read More**

Use of Hair Straighteners Tied to Doubling of Risk for Uterine Cancer

Women who regularly use chemical hair straighteners may be more prone to developing **uterine cancer**, a new large government study suggests.

The study, which followed nearly 34,000 U.S. women over a decade, found that those who frequently used hair straighteners were 2.5 times more likely to develop uterine cancer, versus non-users. "Frequent" was defined as more than four times in the past year.

Experts cautioned that the

findings do not prove cause and effect. And given that uterine cancer is relatively uncommon, even the increased risk linked to hair straighteners is small.

Frequent users had a 4% chance of developing the cancer by age 70, versus a 1.6% chance among non-users, the investigators found.

"The overall risk is not large, and chemical hair products are just one of many factors that may influence a woman's chances of



getting uterine cancer," said senior researcher Alexandra White, of the U.S. National Institute of Environmental Health Sciences.

Dr. Eva Chalas is a gynecologic oncologist at NYU Langone Health Perlmutter Cancer Center—Long Island. She said the researchers did a "thorough analysis," and the large number of study participants and long follow-up are strengths.

"I think this is real," Chalas

said of the relationship between **hair straighteners** and uterine cancer.

Should women avoid the products? White said that "more research is needed before firm recommendations can be made."

But she also noted that women who used hair straighteners less frequently did not have an elevated risk of uterine cancer. So women could consider cutting down on the treatments....**Read More**

Certain Class of Diabetes Meds Could Cut Dementia Risk

An older class of type 2 diabetes drugs known as thiazolidinediones, or TZDs, may protect you from dementia down the road, according to new research.

Thiazolidinediones, also known as glitazones, cut dementia risk by 22% among folks at high risk who also had mild or moderate type 2 diabetes when they took these medications for at least one year.

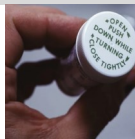
Exactly how these diabetes drugs lower risk for dementia is not fully understood, and **the study** wasn't designed to answer that question.

Diabetes is a **known risk factor** for dementia, and glucose or blood sugar is the brain's main fuel for important functions, including thinking,

understanding, and problem-solving, said study author Roberta Diaz Brinton. She directs the Center for Innovation in Brain Science at the University of Arizona Health Sciences.

"With type 2 diabetes, the mechanism for driving glucose out of the blood and into the cells is less functional and this can affect cognition, which is one of the most energy-demanding functions," Brinton said.

For the study, researchers compared risk for dementia in older veterans with type 2 diabetes who were treated with either a **sulfonylurea** or a thiazolidinedione drug for diabetes to those treated with metformin alone between 2000 and 2019 in the U.S. Veterans



Affairs Healthcare System. These diabetes drugs all work differently. Thiazolidinediones help your body better use insulin

to allow blood sugar to enter your body's cells where it can be used for energy. Sulfonylureas boost insulin production and help your body use this hormone.

Metformin makes your body more sensitive to insulin and decreases the amount of glucose secreted by your liver.

People aged 60 and older who were given a first prescription of metformin, a sulfonylurea or a thiazolidinedione between January 2001 and December 2017 were followed for about eight years. Those who took thiazolidinedione had an 11% lower risk of **Alzheimer's**

disease and a 57% lower risk of vascular dementia, the study showed. **Vascular dementia** is typically caused by multiple strokes.

The risk of dementia from any cause was 12% higher among folks who used a sulfonylurea drug alone for their diabetes, the study showed.

Folks under age 75 saw more benefits from a thiazolidinedione than older people, and these drugs seemed to be more protective in people who were overweight or obese.

"Thiazolidinediones were the most effective in reducing the chances of developing Alzheimer's disease later in life," Brinton said....[Read More](#)

Tips on Keeping Joints Limber, Healthy as You Age

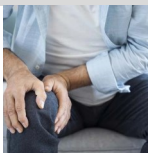
For many people, it is possible to slow the loss of **joint cartilage** as they age and avoid surgery to boot.

Certain steps can help with that, said one orthopedic surgeon from the Mayo Clinic in Rochester, Minn., who offered tips for maintaining joint health and also for managing pain in those who are already experiencing **osteoarthritis**.

Dr. Joaquin Sanchez-Sotelo said cartilage, that shock-absorbing, slippery tissue at the ends of bones, degenerates for various reasons.

Those reasons include being born with abnormally shaped bones or a tendency toward weaker cartilage. Obesity, overuse and injuries from accidents also can damage joints and cartilage.

"When cartilage degenerates, the body forms **bone spurs**," Sanchez-Sotelo said. "This is a reaction to the main underlying problem, cartilage degeneration. Bone spurs can hit each other and become painful. Many patients get obsessed with bone spurs, but just taking them out won't cure



the problem, except in very rare circumstances." Osteoarthritis can cause symptoms such as achy and painful joints, stiffness and loss of movement.

Sanchez-Sotelo often sees patients with osteoarthritis when they reach their 60s.

In the years before that, people can protect their joints by building strong muscle, which can take some of the pressure off joints. But those muscles should be built without intense exercise such as football or bodybuilding because those sports come with

higher risks of developing arthritis.

"You have to exercise within reason," Sanchez-Sotelo said. "Find that point where your muscles are healthy, flexible, strong and will protect the joints, but don't overdo it."

Sanchez-Sotelo also suggests maintaining a healthy weight. He's not so sure about **glucosamine and chondroitin**, which are popular supplements for joint pain, because of a lack of evidence that they actually work....[Read More](#)

Had a Stroke? Get These Professionals on Your Rehab Team

When someone has a stroke, many professionals come together to help the patient recover.

The **rehabilitation** plan varies depending on which parts of the body were affected by the **stroke** and the type and severity of damage.

Patients will have a team of physicians to guide and coordinate their long-term care. It often includes a **physiatrist** who specializes in physical medicine and rehabilitation; a neurologist; internist; family practice physician; and a geriatrician who specializes in working with seniors.

In addition, a variety of professionals help patients to

restore lost skills, according to the U.S. **National Institute of Neurological Disorders and Stroke**.

For example, a rehabilitation nurse can help a **stroke** patient relearn the skills they need for basic activities of daily living. This nurse also provides information about routine health care, including how to manage bladder and bowel issues, caring for the skin, following a medication schedule, moving from bed to wheelchair and back, as well as special needs for those with diabetes.

Physical therapists help patients with disabilities related to motor and sensory



impairments. This can include doing exercises that strengthen muscles and improve coordination.

Patients can work to regain a range of motion. One activity may be **constraint-induced therapy**, in which an unaffected limb is immobilized so the patient can work on regaining function in limbs affected by the stroke.

An occupational therapist will help the patient relearn personal grooming skills, house cleaning and preparing meals, while a therapeutic recreation specialist can help those recovering regain some of their leisure activities.

Because stroke can affect language abilities, a speech-

language pathologist is part of the team. This professional helps patients learn to use language again or develop different ways of communicating, as well as improving the ability to swallow.

Some patients also have a vocational therapist to help those who need to work identify strengths, develop resumes, and assist with job searches and referrals.

A social worker will help with other needs, including assisting with financial decisions, choices about living situations, while a psychologist can work with the patient on mental health, as well as in assessing thinking skills.