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August 12, 2018 E-Newsletter

Publication 2018 Issue 32
Published in house by the
RI ARA

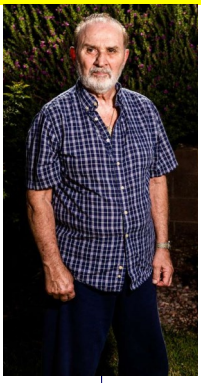
'Too Little Too Late': Bankruptcy Booms Among Older Americans

For a rapidly growing share of older Americans, traditional ideas about life in retirement are being upended by a dismal reality: bankruptcy.

The signs of potential trouble — vanishing pensions, soaring medical expenses, inadequate savings — have been building for years. Now, new research sheds light on the scope of the problem: The rate of people 65 and older filing for bankruptcy is three times what it was in 1991, the study found, and the same group accounts for a far greater share of all filers.

Driving the surge, the study suggests, is a three-decade shift of financial risk from government and employers to individuals, who are bearing an ever-greater responsibility for their own financial well-being as the social safety net shrinks.

The transfer has come in the form of, among other things, longer waits for full Social Security benefits, the replacement of employer-provided pensions with 401(k) savings plans and **more out-of-pocket spending** on health care. Declining incomes, whether in retirement or leading up to it, compound the challenge.



Cheryl Mcleod of Las Vegas filed for bankruptcy in January after struggling to keep up with her mortgage payments and other expenses. "I am 70, and I am working for less money than I ever did in my life," she said. "This life stuff happens."

As **the study**, from the Consumer Bankruptcy Project, explains, older people whose finances are precarious have few places to turn. "When the costs of aging are off-loaded onto a population that simply does not have access to adequate resources, something has to give," the study says, "and older Americans turn to what little is left of the social safety net — bankruptcy court."

"You can manage O.K. until there is a little stumble," said Deborah Thorne, an associate professor of sociology at the University of Idaho and an author of the study. "It doesn't even take a big thing."

The forces at work affect many Americans, but older people are often less able to weather them, according to Professor Thorne and her colleagues in the study. Finding, and keeping, one job is hard enough for an older person. Taking on another to pay unexpected bills is almost unfathomable.

Bankruptcy can offer a fresh start for people who need one, but for older Americans, it "is too little too late," the study says. "By the time they file, their wealth has vanished and they simply do not have enough years to get back on their feet."

The data gathered by the researchers is stark. From February 2013 to November 2016, there were 3.6 bankruptcy filers per 1,000 people 65 to 74; in 1991, there were 1.2.

Not only are older people seeking relief through bankruptcy, but they also represent a widening slice of all filers: 12.2 percent of filers are now 65 or older, up from 2.1 percent in 1991.

The jump is so pronounced, the study says, that the aging of the baby boom generation cannot explain it….**Read More**

Senate Majority Leader Mitch McConnell and his fellow Republicans are feverishly trying to confirm President Trump's Supreme Court nominee, Judge Brett Kavanaugh, before midterm elections start. They have already cut the U.S. Senate recess short and plan to steamroll past the National Archives, after learning it would take too long to secure certain documents, according to *POLITICO*.

The documents were requested by Democrats in order to assess Kavanaugh's work for the George W. Bush administration. But his record already speaks for itself. As the *New York Times* has reported, Judge Kavanaugh has consistently ruled against workers and threatened Americans' access to health care, even going so far as questioning the validity of the Affordable Care Act.

If confirmed, Kavanaugh would have a chance to dismantle the ACA very soon after reaching the bench. The Supreme Court is set to hear a case that would rip coverage away from those with pre-existing conditions, which affect more than half of all Americans, including 75 percent of people ages 45 to 54 and 84 percent of people between the ages of 55 to 64, according to the Center for American Progress.

With our health care at stake, we can't afford to remain silent.

Dial 1-866-828-4162 and urge your Senator to vote NO on Kavanaugh's nomination. You can let us know how the call went **here.**

Please call your Senator at 1-866-828-4162 and say,

"Reject Judge Kavanaugh's nomination."

Trump Administration Expands "Short-Term" Health Plans, Jeopardizing Coverage for Millions

This week, the Trump Administration issued a final rule expanding the availability of "short-term" health plans that do not have to comply with the Affordable Care Act's (ACA) consumer protections and coverage requirements.

In particular, short-term plans are free from the ACA's insurance regulations–including the mandate to cover essential health benefits like maternity care, prescription drugs, and mental health treatment—as well as from the health law's consumer protections that prevent insurers from charging sick people more than healthy people, excluding coverage of pre-existing conditions, and denying coverage based on medical history.

Under the final rule, these policies will now last up to 12 months, and consumers will be able to renew them for a maximum of 36 months. Previously, the plans were limited to three months and were not renewable.

Since they can cover fewer services and deny coverage for serious medical needs, these bare-bones plans are typically cheaper than traditional insurance. As a result, they are likely to attract younger, healthier consumers who do not think they need the ACA's more robust coverage. As these consumers exit the individual market, they will leave behind an older, sicker risk pool. Insurers will likely raise premiums and decrease plan choices in response—endangering the health and economic security of millions of Americans, including those nearing Medicare eligibility.

According to recent estimates, broadening access to short-term plans could increase individual market premiums by **18.3% in 2019**. For a 60-year-old buying mid-level coverage, this could mean a **$4,000 monthly premium hike.**

Throughout the rulemaking process, the Administration has contended that expanding access to short-term insurance that bypasses key ACA requirements will "**increase insurance options for individuals unable or unwilling to purchase [ACA]-compliant plans**." However, as we outlined in **our comments** in response to the proposed rule, increasing the availability of short-term plans will not create a meaningful new health insurance option for those who need coverage. These plans circumvent many ACA protections and are therefore not a realistic option for people with pre-existing conditions, who would likely either have services for those conditions excluded from coverage or be denied coverage altogether. Consumers who could qualify for and afford short-term coverage would also be at risk, as these plans are unlikely to protect those who buy them.

While our comments were largely ignored in the final rule, we remain concerned that increasing access to these plans will re-introduce discrimination into the health care system, lead to consumer confusion, and destabilize the individual market. Older adults and people with disabilities in particular will face additional barriers to care, including higher costs and fewer coverage options. This could force some people approaching Medicare eligibility to go without the care they need–ultimately resulting in worse health outcomes and higher costs in the Medicare program.

Looking ahead, Medicare Rights will continue to oppose policies that increase costs or threaten access to care for older adults and people with disabilities.

Importantly, this final rule was not issued in a vacuum. Previously, we discussed how an estimated **4 million people have lost coverage** since 2016. This rule will add to those losses, especially in conjunction with the recent expansion of non-ACA compliant coverage for small businesses and associations. The Administration also drastically cut funding for the federal program that helps people enroll in ACA plans and other health coverage. To top it off, the Justice Department is **legally challenging**—and seeking to eliminate—the ACA's coverage protections for people with pre-existing conditions.

All of these changes are likely to lead to more erosion of recent coverage gains for millions of people.

Read our comments on short-term plans

Average Medicare Part D Premiums Inch Lower but Drug Affordability Still a Problem

This week, the Centers for Medicare & Medicaid Services (CMS)—the agency that oversees the Medicare program—announced that premiums for Medicare Part D, an optional benefit that provides prescription drug coverage, will be slightly lower for 2019. The average 2018 premium for basic coverage is $33.59, and the projected average for 2019 will be $32.50.

CMS suggests that increased competition and changes in cost sharing are the main reasons for the reduction. However, the drop may more likely reflect changes that Congress made earlier this year that shifted some of the costs for medications in the "donut hole"—a coverage gap in the program where costs for beneficiaries historically increased sharply—away from drug plans and onto manufacturers.

This decline in premiums is good news for people with Medicare, but careful selection of a Part D plan during fall open enrollment—the time of year when people with Medicare can make changes to their coverage– is just as important as ever. Beneficiaries should find a plan that meets their needs and shop every year to ensure they are in the right plan.

The premium reduction also does not fix the problem of affordability for many in the Medicare program. The underlying problem of high drug prices continues to drive up costs for everyone. A report from the Office of the Inspector General (OIG) in June showed that costs for brand-name medications were increasing six times faster than inflation between 2011 and 2015, leading to "greater overall Medicare Part D spending and higher beneficiary out-of-pocket costs for these drugs." The average out-of-pocket costs for brand-name drugs increased 40% from 2011 to 2015 for people with Medicare Part D, and "the percentage of beneficiaries who had at least $2,000 per year in out-of-pocket costs for brand-name drugs nearly doubled from 3.7% in 2011 to 7.3% in 2...**Read More**

Celebrate Medicare's birthday by covering everyone

By F. Douglas Stephenson, L.C.S.W., B.C.D.

This month marks Medicare's 53rd birthday. In July 1965, Congress enacted Medicare to provide health insurance to people ages 65 and older, regardless of income or medical history.

In the years since, Medicare has become proof that public, universal health coverage is superior to private insurance in every way. Medicare is more efficient than private health insurance and is administered at a cost of 3 percent to 4 percent, as opposed to private, for-profit health insurance, which has administrative costs above 15 percent.

Medicare's costs have risen more slowly than those of private health insurance. Medicare provides better access to care, better financial protection and higher patient satisfaction.

Although many have negative feelings toward government, and examples of government inefficiency and incompetence abound, the record of private health insurers is far worse. Dozens of financial profiteering scandals have wracked private insurers and HMOs in recent years.

To continue our progress, it's time to upgrade Medicare by establishing a 21st century "Medicare for All" health insurance system that covers all age groups, cradle to grave. Newborns will leave the hospital with their new Medicare card, and drop it off years later at life's end.

A bill now filed in Congress, H.R. 676, covers all medically necessary services, including primary care, medically approved diet and nutrition services, inpatient care, outpatient care, emergency care, prescription drugs, long-term care, palliative care, mental health services, dentistry, eye care and substance abuse treatment. Patients have their choice of physicians and other providers, hospitals and clinics.

Co-pays and deductibles paid at health professionals' offices are ended because payment for health insurance is fully prepaid directly into Medicare, much like Social Security, and covered at first dollar amounts. This means the obsolete 80 percent/20 percent payment split between private health insurance companies and Medicare is eliminated, with Medicare for All covering 100 percent.

All citizens are guaranteed access to decent health care while achieving significant overall savings compared to our existing system by lowering administrative costs, controlling the prices of prescription drugs and fees for physicians and other health-care professionals and hospitals, reducing unnecessary treatments and expanding preventive care.

Good health care would be established as a basic human right, as in almost all other advanced countries. Nobody would have to forego needed treatments because they didn't have insurance or they couldn't afford high insurance premiums and co-pays.

Nobody would have to fear a financial disaster because they faced a health care crisis in their family. Virtually all families would end up financially better off and most businesses would also experience cost savings compared to what they pay now to cover their employees.

We finance our new Medicare for All by eliminating profiteering by the private health insurance industry and slashing the system-wide administrative waste they generate, with a single streamlined, nonprofit public payer health insurance system. Such savings, estimated in 2017 to be about $500 billion annually, would be redirected to patient care.

Existing tax revenue would fund much of the system. According to a 2016 study in the American Journal of Public Health, tax-funded expenditures already account for about two-thirds of U.S. health spending. That revenue would be retained and supplemented by modest progressive taxes based on ability to pay, taxes that would typically be fully offset by ending today's very high premiums paid to the for-profit private insurance industry and out-of-pocket expenses for care.

The vast majority of U.S. households — one study says 95 percent —would come out financially ahead. The system would reap savings by dealing with drug and medical supply companies for lower prices.

More than two dozen independent analyses of federal and state single-payer legislation by agencies such as the Congressional Budget Office, the General Accountability Office, the Lewin Group and Mathematica Policy Research Group have found that the administrative savings and other efficiencies of a single-payer program would provide more than enough resources to provide first-dollar coverage to everyone in the country with no increase in overall U.S. health spending.

A majority of Americans support Medicare and expansion of this program to provide health insurance for all. Write to your senators and representatives and let them know how you feel about expanding Medicare. Ask them to improve and strengthen Medicare with Medicare for All, H.R. 676.

By making health insurance available to all age groups, we can enjoy and celebrate Medicare's 53rd birthday with the assurance that this life-saving health insurance program will continue.

F. Douglas Stephenson is a retired clinical social work psychotherapist.

Action Alert #102 – The Perfect Time to Express Our Outrage!

Social Security Fairness
Repeal the Government Pension Offset and the Windfall Elimination Provision

The House of Representatives is out of session for all of August and the Senate will be out at least part of that time. Lots of campaigning is going on back in home districts.

Needed Action: Pick your favorite Outrage/s from the list below, and stand up at rallies, buttonhole your representatives and senators as they are shaking hands, or meet them in their offices. Share your story with them, even if they have signed onto the current bills: HR 1205 in the House has 187 signatures, including 58 Republicans; S915 in the Senate has 25 signatures, 4 Republicans.

We need everyone to understand our plight!

Check on the names with these links:

H.R.1205 – Social Security Fairness Act of 2017
S.915 – Social Security Fairness Act of 2017

….Read More

Once Its Greatest Foes, Doctors Are Embracing Single-Payer

When the American Medical Association — one of the nation's most powerful health care groups — met in Chicago this June, its medical student caucus seized an opportunity for change.

Though they had tried for years to advance a resolution calling on the organization to drop its decades-long opposition to single-payer health care, this was the first time it got a full hearing. The debate grew heated — older physicians warned their pay would decrease, calling younger advocates naïve to single-payer's consequences. But this time, by the meeting's end, the AMA's older members had agreed to at least study the possibility of changing its stance.

"We believe health care is a human right, maybe more so than past generations," said Dr. Brad Zehr, a 29-year-old pathology resident at Ohio State University, who was part of the debate. "There's a generational shift happening, where we see universal health care as a requirement."

The ins and outs of the AMA's policymaking may sound like inside baseball. But this year's youth uprising at the nexus of the medical establishment speaks to a cultural shift in the medical profession, and one with big political implications.

Amid Republican attacks on the Affordable Care Act, an increasing number of Democrats — ranging from candidates to established Congress members — are putting forth proposals that would vastly increase the government's role in running the health system. These include single-payer, Medicare-for-all or an option for anyone to buy in to the Medicare program. At least **70 House Democrats** have signed on to the new "Medicare-for-all" caucus.

Organized medicine, and previous generations of doctors, had for the most part staunchly opposed to any such plan. The AMA has thwarted public health insurance proposals since the 1930s and long been considered one of the policy's most powerful opponents.

But the battle lines are shifting as younger doctors flip their views, a change that will likely assume greater significance as the next generation of physicians takes on leadership roles. The AMA did not make anyone available for comment.

Many younger physicians are "accepting of single-payer," said Dr. Christian Pean, 30, a third-year orthopedic surgery resident at New York University.

In prior generations, "intelligent, motivated, quantitative" students pursued medicine, both for the income and because of the workplace independence — running practices with minimal government interference, said Dr. Steven Schroeder, 79, a longtime medical professor at the University of California-San Francisco.

In his 50 years of teaching, students' attitudes have changed: "The 'Oh, keep government out of my work' feeling is not as strong as it was with maybe older cohorts," said Schroeder. "Students come in saying, 'We want to make a difference through social justice. That's why we're here.'"

Though "single-payer" health care was long dismissed as a left-wing pipe dream, polling **suggests** a slim majority of Americans now support the idea — though it is not clear people know what the term means…**Read More**

We Need to Talk: The Difficult Driving Conversation

When — and how — to talk about turning over the car keys

Whether it's the driving of a spouse, a parent or another loved one, there may come a time in your life when you begin to question whether a loved one is still safe to drive. But how do you know when it's time for your loved one to limit or stop driving?

Although there are natural changes that may occur in our brains and to our bodies as we age, the question of when it is time to limit or stop driving is not about age. It's about the ability of the driver. To this end, observing the driving of the loved one about whom you are concerned and looking for warning signs of unsafe driving is a great first step in determining whether it's time to talk to them about hanging up the keys.

As we all know, driving ability goes beyond the simple ability to physically operate a vehicle. Safely driving a vehicle requires physical and cognitive capabilities, driving skills and good driving behavior.

Here are only a few warning signs of unsafe driving:

- Delayed response to unexpected situations
- Becoming easily **distracted while driving**
- Decrease in confidence while driving
- Having difficulty moving into or maintaining the correct lane of traffic
- Hitting curbs when making right turns or backing up
- Getting scrapes or dents on car, garage or mailbox
- Having frequent close calls
- Driving too fast or too slow for road conditions

If you've noticed that your loved one shows some of these warning signs, it means it is time to talk with them. But how are you supposed to sensitively broach the topic of stopping or limiting driving and have a productive conversation?

First, it's important to remember that limiting or stopping driving is a complex and emotionally charged discussion. Older drivers have a lifetime of driving experience behind them and deeply value the independence and mobility that driving provides.

Preparing for the conversation with **We Need to Talk,** a free online seminar developed jointly with the Hartford and MIT AgeLab, can help guide you through what steps to take. Beyond providing you with tools to begin a casual conversation about driving and tips on engaging an older driver in self-evaluation, We Need to Talk can also help you with possible solutions for your loved one's transportation needs — helping your loved one maintain their independence and relieving some of the pressure on you as the caregiver.

Why Take the AARP Smart Driver Course?

Because driving has changed since you first got your license and doing so could save you money.

Click here to access the Smart Driving Course

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

Dementia: Both too much and too little alcohol may raise risk

Some studies have suggested that drinking alcohol in moderation lowers the risk of dementia, but the evidence may have been prone to certain biases. A new study follows more than 9,000 people over a 23-year period to draw robust conclusions on the link between alcohol consumption and dementia risk.

As the world population grows increasingly older, more and more people are at risk of developing **dementia**.

In fact, according to recent estimates, almost **50 million** people worldwide are currently living with dementia, and this number is expected to double every 2 decades, reaching over 130 million by 2050.

In the United States, **5.7 million** Americans are thought to have **Alzheimer's disease**, and experts estimate that by 2050, this number will have reached 14 million.

In this context, research into the risk factors for developing dementia is vital. From a lack of **physical activity** to **high blood pressure** and even **sleep troubles**, the range of dementia risk factors that are being uncovered by the latest studies is varied.

But what about alcohol? Some **studies** have suggested that moderate alcohol intake may have protective effects on the brain, whereas excessive consumption is thought to raise the risk of dementia.

However, most of these studies have looked only at alcohol intake in later life, without accounting for the lifetime consumption. Such an approach may have skewed the results.

So, a team of researchers from Inserm — the French National Institute of Health and Medical Research in Paris, France — in collaboration with scientists from University College London (UCL) in the United Kingdom set out to rectify this by looking at patterns of alcohol consumption from mid-life into old age.

The first author of the paper is Séverine Sabia, a researcher affiliated with both of the above institutions, and the **findings** were published in *The BMJ*.

Studying alcohol intake and dementia risk

Sabia and colleagues examined 9,087 study participants who were aged between 35 and 55 at the beginning of the study….**Read More**

Agitation in dementia: Are drugs the best treatment?

A common symptom among people with dementia is agitation, which can affect their and their carers' well-being. Dementia experts conducted a new study and found the most effective means of addressing agitation.

In a **paper** that is now published in the journal *International Psychogeriatrics*, experts from several research institutions — including the University of Michigan in Ann Arbor, and Johns Hopkins University in Baltimore, MD — express their consensus on the best approaches to manage dementia-related behavioral and psychological symptoms.

More specifically, they speak of how to address states of agitation and psychosis in people with **Alzheimer's disease**.

This paper — which is based on evidence presented by **dementia** experts across the globe — ranks the best methods of addressing agitation in Alzheimer's, and nondrug-based approaches come first. ***This research advocates a significant shift from current practice, recommending that nonpharmacological treatments are a first-line approach for agitation in dementia."***

Person-centered care to be prioritized

In the new study, the first four treatments that the researchers advise healthcare professionals and other caregivers to prioritize are all nonpharmacological, focusing on behavioral approaches instead.

The specialists advise, first and foremost, the assessment and management of underlying causes for agitation and other behavioral and psychological symptoms.

They also encourage providing appropriate education to caregivers and adapting the environment that people with Alzheimer's inhabit to suit their needs as closely as possible...**Read More**

Antianxiety drugs — often more deadly than opioids — are fueling the next drug crisis in US

- Today more than 40 million adults in the United States suffer from anxiety, and it is the most common mental illness in the United States.
- Overdose deaths involving benzodiazepines — such as Xanax, Librium, Valium and Ativan, drugs commonly used to treat anxiety, phobias, panic attacks, seizures and insomnia — have quadrupled between 2002 and 2015, according to the National Institute on Drug Abuse.

- The trend is being fueled by a 67 percent rise in prescriptions.
- The market for benzos, as they are called, is expected to reach $3.8 billion in the U.S. by 2020, reports Zion Market Research.

It is little wonder that stress levels today are higher than ever across the United States. Overloaded work schedules, juggling family and a career and making ends meet financially can all lead to anxiety and can affect nearly everyone from time to time.

Today more than **40 million adults in America suffer from anxiety**, and it is the **most common mental illness** in the United States. But even more of a crisis than the number of those diagnosed with anxiety is the number of people who are addicted to the drugs that treat it — and the rising number of people dying from overdoses….**Read More**

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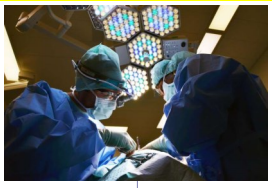
Women Survive Heart Attacks Better With Female Doctors

Among female patients who suffered heart attacks, researchers found a better chance of survival in people treated by female physicians in the ER when compared to those treated by male physicians.

The study titled "Patient-Physician Gender Concordance and Increased Mortality Among Female Heart Attack Patients" will be published in the Proceedings of the National Academy of Sciences. The research team examined nearly 582,000 heart attack cases admitted to hospital emergency departments in Florida. The admissions took place over a span of 19 years, between 1991 and 2010.



When treated by a female doctor, 11.8 percent of male patients and 12 percent of female patients died. But when treated by a male doctor, 12.6 percent of male patients died compared to 13.3 percent of female patients. With access to health data, the team could measure factors like age, race, medical history, and hospital quality. But even after accounting for them, the gender differences in survival rates were the highest under male physicians.

But the influence of female health professionals did not end there. Women also seemed to have a better survival rate when treated by male doctors who had a lot of female colleagues in the ER. Though, the best outcomes were still linked to being a female doctor.

"These results suggest a reason why gender inequality in heart attack mortality persists," the authors wrote. "Most physicians are male, and male physicians appear to have trouble treating female patients."

Recently, a **report** from Canada shed light on how more women die from heart failure than men. It was suggested that female patients are more likely to receive a misdiagnosis or delayed diagnosis, which can affect survival.

Researchers of the new study were interested in performing more detailed studies to uncover the exact mechanism behind the gender difference in outcomes.

While this was not included in the study, one variable they considered is how female physicians may perform better than their male counterparts when it comes to certain ailments. Indeed, studies from the past have also suggested that **women make better surgeons and may have better outcomes when treating elderly patients**….**Read More**

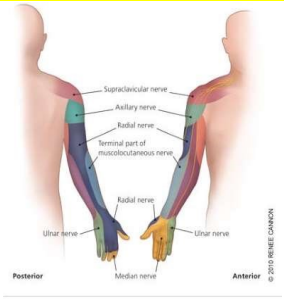
Ever wake up to a numb, dead arm? Here's what's happening.

Waking up in the middle of the night to discover one of your arms has lost all feeling is frightening.

At first, the limb is limp and flops around like a useless bag of bone before coming back to life with a flood of "pins and needles" sensations.

When this happened to me as a kid, I panicked, thinking I'd done something horrible to my body, anxious that I'd never be able to move my arm again. But the feeling in my arm always came back.

This phenomenon is really common, says **James Dyck**, a neurology researcher with the Mayo Clinic. And it's actually a cool example of how the body can protect itself even during the paralysis of sleep.



Dyck explained there's a common misconception that pins and needles and numbness are caused by a lack of blood flow to the nerves. "The more likely thing is nerve compression — nerves are being pushed on and squashed, and that causes these symptoms," he says.

You have several nerves in your arm. Each serves a vital function.

The axillary nerve lifts the arm at the shoulder.

The musculocutaneous nerve bends the elbow.

The radial nerve straightens out the arm and lifts your wrist and fingers.

The ulnar nerve spreads your fingers.

Although Dyck says the exact physiology isn't completely understood, the effect of compressing any of these nerves in sleep — when you sleep on top of your arm or pin it underneath a partner — is like stepping on a garden hose. The information that flows from your extremities back to your brain is temporarily disrupted….**Read More**

Why Seniors Can Struggle With Swallowing

If you have developed swallowing problems as you age, a new study may explain why.

A loss of muscle mass and function in the throat helps explain why 15 percent of seniors have difficulty swallowing (dysphagia), researchers have found.

"Dysphagia has serious consequences for health and quality of life," said study author Sonja Molfenter. She is an assistant professor of communicative sciences and disorders at New York University in New York City.

"This research establishes the need for exercise programs for older adults that target throat muscles, just like those that target the muscles of the arms, legs and other parts of the human body," Molfenter said in a university news release.

Swallowing problems can also lead to health issues such as malnutrition, dehydration and pneumonia from food and drink that end up in the lungs instead of going down the throat.

Research has also shown that when patients with dysphagia are admitted to the hospital, they're in the hospital an average of 40 percent longer than those without dysphagia. That adds up to an estimated cost of $547 million a year, the study authors said.

Dysphagia in older adults is concerning as the proportion of seniors in the United States is expected to top 20 percent by 2030, the researchers noted.

The findings were published recently in the journal *Dysphagia*.

More information

The U.S. National Institute on Deafness and Other Communication Disorders has more about **dysphagia.**