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May 20, 2018 E-Newsletter

Publication 2018 Issue 20
Published in house by the
RI ARA

Republicans Warming to $15 Billion Cuts Package

Dispute remains over whether proposal is protected from filibuster.

Republicans appear ready to advance the White House's $15.4 billion rescissions request through both chambers of Congress, after the administration dropped the idea — for now — of canceling funds provided in the fiscal 2018 omnibus spending bill enacted in March.

"If the House is able to pass the rescissions package, we'll take a look at it," Senate Majority Leader Mitch McConnell, R-Ky., said Tuesday, noting that the so-called special message "does not breach the bipartisan agreement we reached in the caps deal."

In February, lawmakers agreed to bolster defense and nondefense appropriations for fiscal 2018 by a combined $143 billion above the previous statutory caps, paving the way for a $1.3 trillion omnibus to become law in March

Democrats are displeased with proposed cuts, but the package's procedural protections mean that it could potentially pass the Senate without Democratic support — if every Republican votes in favor of passage. That's not yet set in stone, as GOP senators are just getting their first glimpse of the cuts sent to Congress officially on Tuesday morning.

Senate Transportation-HUD Appropriations Subcommittee Chairwoman Susan Collins said she is still reviewing the rescissions package.

"I don't know yet," said the Maine Republican, pointing out some $320 million in cuts from within her subcommittee's purview. "I would be concerned if money's taken out of the Highway Trust Fund," she said, since there is "not enough" money in the fund now. "But I just don't know."

The Trump administration maintains that eliminating budget authority provided for two Children's Health Insurance Program accounts, the Center for Medicare and Medicaid Innovation, the 2015 Ebola outbreak, watershed rehabilitation programs for Superstorm Sandy and a handful of other government programs will benefit the nation's fiscal standing.

"These proposals include rescissions of funding that is no longer needed for the purpose for which it was appropriated by the Congress; in many cases, these funds have been left unspent by agencies for years," Office of Management and Budget Director Mick Mulvaney said in a statement. "These proposals also include rescissions of low priority and unnecessary Federal spending."

The overall request, however, despite canceling $15.4 billion in budget authority would only reduce the deficit by about $3 billion, because many of the items included are unneeded or are inactive accounts, according to Mulvaney's letter accompanying the special message.

Democrats weren't holding back in their initial assessments of the cuts request.

"As far as I'm concerned, it's dead on arrival," said Sen. Robert Menendez, D-N.J. "It is outrageous for the administration to try to hide their deficits that they created through their tax bill, on the shoulders of children in the Children's Health Insurance Program, on the back of transit riders, on the back of so many people who depend upon so many of these critical programs."...**Read More**

Trump Vows (Again) To Lower Drug Prices But Skeptics Doubt Much Will Change

Administration's Prescription Drug Price Remedy Fails Seniors

Statement of Richard Fiesta, Executive Director of the Alliance for Retired Americans, following the release of President Trump's plan to reduce prescription drug prices:

"President Trump's prescription drug price proposal is anemic. By leaving out the most potent weapon to combat skyrocketing prices, allowing Medicare to negotiate prices with pharmaceutical corporations, he's broken his oft-stated campaign promise. We are outraged that he has chosen to side with the powerful multinational pharmaceutical corporations and against American retirees and consumers.

"Drug price negotiation works for the Veterans Administration and Medicaid, saving taxpayers millions each year. It makes no sense to continue to prevent Medicare from doing the same on behalf of its 55 million beneficiaries. Pharmaceutical corporations received a huge windfall in the 2018 tax bill, and this proposal ensures their profits will increase even further.

"The administration's approach consists largely of encouraging increased use of generic prescription drugs, increasing competition and creating nonspecific incentives for lower list prices. Medicare Part D's 20 most prescribed drugs have seen a 12% price increase, while another six saw hikes over 100%. We need strong actions that get to the root of the issue, not just rhetoric.

Rich Fiesta

"Most seniors will not see any changes in what they are charged for their medicines if this plan is enacted. They need relief now, including what was promised during the 2016 campaign."

Health Care Legislation Cropping Up in Unexpected Places

This week, several health care programs appeared in legislation that does not normally address health care. Two of the surprise provisions are embedded in draft Farm Bill legislation and in cuts, or rescissions, requested by the White House. While these measures may gain traction in the U.S. House of Representatives, they face a more uncertain future in the Senate.

The Farm Bill is a large spending and policy package that must be renewed every five years or so. The majority of the bill's spending is on nutrition and food assistance programs like SNAP (previously known as "food stamps"). The bill also covers subsidies for farmers and other agricultural programs. In the current reauthorization, some lawmakers are seeking to expand the bill's scope. Tucked inside the House version of the bill is a little-noticed provision that, similar to recently proposed rules, seeks to expand access to health plans that are not compliant with the Affordable Care Act (ACA).

Specifically, the House's draft Farm Bill would provide $65 million in federal loans and grants for associations of ranchers, farmers, or other agribusiness owners to establish "association" type health plans through which they could offer their members health coverage. As Medicare Rights has **highlighted in the past**, Association Health Plans (AHPs) are formed by groups of businesses and self-employed individuals that pool together to buy health insurance plans that are exempt from many of the ACA's insurance protections. Without these protections, AHPs can exclude crucial health care coverage, like for cancer treatment, leading enrollees to find they have no coverage if they get a life-altering diagnosis.

These plans are likely to lead to higher premiums in the individual and small-group markets as people who feel they do not need comprehensive coverage switch to plans that appear to be a better bargain. But this means higher premiums for those who cannot afford to take these risks.

With this Farm Bill proposal, AHPs will not only be permitted to exist but would have direct federal funding and support. In combination with new, harsh work rules, that severely limit the availability of nutrition services for people who are approaching Medicare eligibility, the proposed Farm Bill puts the well-being of millions at risk.

In addition to the unusual health care component of the Farm Bill, Congress is contemplating taking back money that has already been allocated to a variety of programs, including the Children's Health Insurance Program (CHIP). The potential CHIP cuts are one of several rescission requests the White House transmitted to Congress earlier this week.

In late 2017 and early this year, lawmakers from both parties worked together to extend funding for CHIP for 10 years. This compromise was hard fought, with many starts and stops along the way. Now, the Administration has decided that Congress should rescind nearly $7 billion of the program's contingency funding, leading to a potential conflict between what the parties agreed to and what the White House wants.

The White House delivered its $15 billion rescissions package to Congress on Tuesday. Lawmakers have 45 days to act before the request expires. Largely seen as an effort to appease fiscal conservatives who balked at the recent budget deal and the FY18 omnibus, the rescissions package is not currently expected to take effect, but it does likely foreshadow future claw back requests from the Administration.

These proposed legislative actions show that health care policy can crop up in unexpected times and places. As always, Medicare Rights will stay alert for changes that affect how people with Medicare, and people approaching Medicare eligibility, gain access to high-quality, affordable health care.

Read more about the Farm Bill.

Read more about the rescissions package.

Big Pharma Owns the Trump Administration

SOCIAL SECURITY WORKS.

The following is a statement from **Alex Lawson**, Executive Director of **Social Security Works**, on Donald Trump's upcoming speech on drug pricing:

"Donald Trump works for the prescription drug industry, not the people. He talked a big game on the campaign trail and immediately after the election, but tough rhetoric means nothing if it is not matched by actions.

Trump's speech today will include yet more tough talk, but no one should be fooled. He promised that he would let Medicare negotiate lower prices, but now he has completely caved to the drug corporations and is blocking Medicare from doing so.

Far from taking on the prescription drug corporations, Trump has put them in charge and made the US government the industry's enforcer, bullying countries around the world into raising drug prices. Even knowing that pharma owns DC, this is a new low of industry control of government. I wonder if Donald Trump will get a new title and paycheck from big pharma to go along with all the work he is doing for it."

Related Article

Trump promised to bring pharma to justice. His speech sent drug stocks soaring

For months, President Trump promised to deliver a speech that would put to justice the pharma companies he claimed were gouging consumers. But his **long-awaited remarks**, delivered Friday, sent biopharma stocks skyward instead.

Trump did not call for Medicare to negotiate lower prescription drug prices, an idea the industry had feared, and he did not revisit the **caustic rhetoric** that marked his presidential campaign.

Instead, most of Trump's proposals disclosed during a White House Rose Garden event focused on the middlemen who negotiate drug costs on behalf of insurance companies, a group pharma would love to see slip into the White House's crosshairs.

"We're very much eliminating the middlemen," Trump said. "The middlemen became very, very rich. … They won't be so rich anymore."...**Read More**

Hearing on the Medicare Advantage Program Highlights Need for Improved Beneficiary Outreach and Educatio

This week, the U.S House of Representatives Committee on Ways and Means Health Subcommittee held a hearing on the Medicare Advantage (MA) program. MA allows people with Medicare to choose a private insurance option instead of traditional Medicare. Witnesses included representatives from two MA plans—Andrew Toy of Clover Health and Daphne Klauser of Independence Blue Cross—who spoke to their experience administering MA plans, as well as Dr. Karoline Mortensen, Associate Professor of the Department of Health Sector Management and Policy at the University of Miami Business School, who discussed quality measures in MA plans. Dr. Jack Hoadley, Research Professor Emeritus at Georgetown University's McCourt School of Public Policy and former Commissioner on the Medicare Payment Advisory Commission (MedPAC) also testified, speaking for himself and not on behalf of Georgetown or MedPAC.

Throughout the hearing, various witnesses and members of Congress emphasized the importance of robust beneficiary education tools and resources. Dr. Hoadley, in particular, **testified** about the need to modernize and improve the Medicare Plan Finder tool, citing recommendations in the recently released "**Modernizing Medicare Plan Finder**" report from Clear Choices and the National Council on Aging (NCOA).

As Medicare Rights has **discussed** in recent weeks, the changes coming to MA next year that increase plan flexibility will make the adequacy and accessibility of resources like Plan Finder more important than ever. We recognize that these changes could allow some people with MA to have better access to needed services, but we are concerned they could also increase consumer confusion across the Medicare program, and that their restriction to MA could disadvantage people with traditional Medicare.

The witnesses addressed these potential outcomes, with Mr. Toy and Ms. Klausner voicing strong support for the new flexibilities. Dr. Hoadley expressed concern that these changes may make beneficiary decision-making more complex, and recommended balancing innovation with standardization so that people with Medicare can evaluate their options and make optimal choices. Dr. Mortensen urged that these new flexibilities must be reflected in quality measures, and he expressed the need to ensure that people in traditional Medicare not be left out of any comprehensive improvements.

Medicare Rights appreciates the importance of empowering people with Medicare to make informed and timely choices about their coverage, through MA or traditional Medicare. Accordingly, we welcome the attention and bipartisan support the hearing brought to opportunities to improve existing counseling, assistance, and communication pathways.

We look forward to working with Congress and Administration to build on these areas of shared importance and promote informed choices, strengthen beneficiary decision-making, and expand benefits and care innovations across the Medicare program.

Read the submitted testimony.

Social Security Still Financial Bedrock for Retirees

♦ Nearly six in 10 retirees rely on Social Security as major income source

♦ Pensions rank distant second with 35% relying on them

♦ Nonretirees put somewhat more emphasis on 401(k) type plans

WASHINGTON, D.C. -- Retired U.S. adults are relying on a number of income sources in their golden years, although Social Security is the only one a majority (57%) calls a "major source." Work-sponsored pensions and 401(k) or other personal retirement savings accounts rank a distant second and third. Fewer than one in five rely on any of several other sources, including home equity, regular savings accounts and part-time work….**Read More**

	Major source	Minor source	Total source	Not a source
	%	%	%	%
Social Security	57	33	90	10
A work-sponsored pension plan	35	22	57	42
A 401(k), IRA, Keogh or other retirement savings account	27	34	61	38
The equity you have built up in your home	19	29	48	52
Other savings such as a regular savings account or CDs	17	42	59	40
Individual stock or stock mutual fund investments	15	30	45	54
Annuities or insurance plans	9	20	29	71
Money from an inheritance	7	15	22	78
Part-time work	3	15	18	82
Rent and royalties	3	15	18	81

Novartis shelled out $1.2 million to Trump lawyer Michael Cohen

President Donald Trump didn't mention Novartis or other drugmakers by name last year when he said the industry is "getting away with murder."

Yet executives at the Switzerland-based pharmaceutical giant shelled out $1.2 million to Trump lawyer Michael Cohen to "**advise**" its executives on health policy and what was happening in the Trump White House.

Novartis paid more money to Cohen than did any of his clients revealed thus far.

The company said it quickly determined he was unable to deliver the help but paid the full amount owed in his contract. "We made a mistake" in hiring him, CEO Vasant Narasimhan **told Novartis employees** on Thursday.

Hiring the president's personal attorney matches a history of aggressively courting government officials by a corporation with much to lose in the debate over high drug prices.

Novartis has nine blockbuster drugs generating around $1 billion or more in annual sales and priced so high in some cases that patients have trouble affording them even with insurance. Another nine drugs produce more than $500 million in sales.

High costs and copayments for Novartis' Gleevec, which treats a form of leukemia, are associated with patients delaying or skipping doses, said researcher Stacie Dusetzina of Vanderbilt University.

Gleevec often must be taken for life and costs $148,000 a year — three times more than when it came out, according to Connecture, which provides technology to help people save money on prescriptions.

Novartis also makes drugs for psoriasis and multiple sclerosis that cost more than $100,000 a year. The price tag for Kymriah, a Novartis leukemia treatment approved last year, **is $475,000**.

The company earned $7.7 billion in profits last year on worldwide sales of $49 billion.

Novartis' political action committee has been a sizable contributor on Capitol Hill, **donating $204,500** last year to candidates for federal office and other political causes.

The company **spent $8.8 million** lobbying U.S. lawmakers in 2017, its highest amount ever, according to the Center for Responsive Politics. That doesn't count the previously undisclosed payments to Cohen, which the company said were for consulting, not lobbying.

One issue that especially interests the company: the importation of drugs from Canada and other countries, which would undercut its high U.S. prices and badly hurt profits. Novartis sells its drugs for a fraction of U.S. prices in other developed countries. In 2015, Gleevec sold **for $38,000 a year** in Canada while a generic version of the same drug sold for only $8,800.

Importation was one of Novartis' **most lobbied issues** last year.

A few of Novartis' blockbusters:

Drug	Disease	Annual Cost	% 5 Yr. Price Increase	Annual Sales
Cosentyx	Psoriasis	$101,788	38%*	$2.1 billion
Gilenya	Multiple sclerosis	$114,712	58%	$3.2 billion
Gleevec	Leukemia	$147,788	58%	$1.9 billion
Tasigna	Leukemia	$199,202	59%	$1.9 billion

Cutting Meals On Wheels Hurts Elderly And Low Income Americans

The Trump Administration's planned budget cuts could decimate the program, which serves more than 2.4 million seniors every year

The Trump Administration's proposed budget cuts advise eliminating community development block grants, which many of our country's Meals on Wheels programs rely on for support, placing our country's most vulnerable citizens at great risk.

Meals On Wheels has provided a crucial service to Americans since it was initiated by a small group of compassionate Philadelphians in 1954. The program not only provides nutritious meals to the elderly and impoverished, as well as their animals, it helps them maintain the social connections that add safety and human comfort to their lives.

Meals On Wheels attempts to feed the 10 million elderly Americans—that's one in six—who struggle with hunger in this country daily, as well as the 15.2 million living in isolation, and 18.4 million in or near poverty. The population of elderly citizens in the U.S. is expected to grow from around 60 million to over 112 million by 2050, making demand for Meals on Wheels services even greater.

More than 2.4 million homebound seniors from 60 years old to over 100 are served by Meals on Wheels every year, and a large number will be left hungry and alone if the program is defunded.

There are currently around 5,000 Meals on Wheels programs operating in the U.S., some which offer added benefits like pet food delivery, senior center meal programs, home repair services, and transportation. Younger generations may take those services for granted, but they lend a clinically proven lifeline to those who need it most. In a randomized test for Meals on Wheels America, a scientist from Brown University concluded that seniors gain mental and physical benefit from regular visits, possibly even keeping them out of the nursing home.

"It's not just a meal, but a wellness check," Sandra Noe, executive director of Meals on Wheels of Northwest Indiana told USA Today. "That volunteer, that driver is able to tune into whether that person's health is failing, or if they've fallen or can't get out of their chair. And we're delivering relief from isolation, and were delivering relief to their family as well."

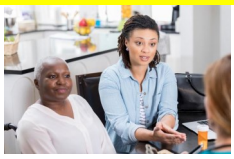
The elimination of community block grants by way of a 16 percent cut to the Health and Human Services budget would not only burden communities already trying to fight poverty, it would make it impossible for some Meals on Wheels programs to continue operation.

This myopic attempt at trimming the budget hurts those who need the most help of all.

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

What to Look for in a Geriatric Care Manager



WHEN OLDER ADULTS CAN no longer care for themselves, it's usually up to their family members to take over the responsibility. But it's hard to know where to begin managing the care of someone who has chronic health conditions, requires frequent doctor visits and needs assistance at home – which may be in another town. "Families are often overwhelmed and ask, 'What do we do? How do we handle this?'" says Nancy Avitabile, president of the board of directors of the Aging Life Care Association.

Avitabile is an aging life care manager (also known as a geriatric care manager), a type of elder care professional trained to jump into these challenging situations and offer solutions, guidance and hands-on management.

"It's not uncommon for adult children to involve a geriatric care manager when things are getting complicated with a new diagnosis or a change in function or cognition, especially when the family lives far away and they need guidance on which options are available," says Dr. Christine Ritchie, a geriatrician, palliative care physician and professor at the University of California—San Francisco School of Medicine.

What Do Geriatric Care Managers Do?

Think of a geriatric care manager like a corporate consultant hired to stabilize a struggling company. The job typically involves a thorough evaluation of a family's situation and then the creation of a plan to get an older adult's care back on track. "When I meet with a family, I'm assessing the person's condition and lifestyle, looking at the available resources and coming up with recommendations most suitable to that family," Avitabile explains.

Sometimes a geriatric care manager's role is short term, limited to developing the care plan, coaching the family on how to implement the plan and suggesting agencies or services (like private duty care, food services, transportation or adult day care facilities) that the geriatric care manager knows to be reliable. (The geriatric care manager should not receive a referral fee for such services, Avitabile points out.)

In other cases, the relationship is long term, with a family asking the geriatric care manager to carry out and manage the plan. That may involve vetting and arranging all services and overseeing all care of the older adult. "They may ask that we visit weekly, monitor home care, assist with social activities, coordinate doctor appointments and then provide necessary follow up," Avitabile says.

Geriatric care managers may also accompany older adults to doctor appointments and serve as a liaison between the family, patient and health care team. "What's wonderful is that they have the savvy to translate the medical terms to the family," Ritchie says. "Most health providers are appreciative of that."...**Read More**

Better Life for People with Dementia Found in Key Factors

"... vital that we understand how we can optimize quality of life for the 50 million people worldwide who have dementia"

Good relationships, social engagement, better daily functioning, good physical and mental health, and high-quality care were all linked to better quality of life for people with dementia by a study published in *Psychological Medicine*.

"This research supports the identification of national priorities for supporting people to live as well as possible with dementia, according to Professor Linda Clare, at the University of Exeter that led the study.

"While many investigations focus on prevention and better treatments, it's equally vital that we understand how we can optimize quality of life for the 50 million people worldwide who have dementia. We now need to develop ways to put these findings into action to make a difference to people's lives by supporting relationships, social engagement and everyday functioning, addressing poor physical and mental health, and ensuring high-quality care."

The research was supported jointly by the Economic and Social Research Council (ESRC) and the National for Health Research (NIHR). It involved collaboration with the London School of Economics, the universities of Sussex, Bangor, Cardiff, Brunel and New South Wales in Australia, and Kings College London.

The team carried out a systematic review and meta-analysis to examine all available evidence about the factors that are associated with quality of life for people with dementia. They included 198 studies, which incorporated data from more than 37,000 people.

The study found that demographic factors such as gender, education marital status, income or age were not associated with quality of life in people with dementia. Neither was the type of dementia.

Factors that are linked with poor quality of life include poor mental or physical health, difficulties such as agitation or apathy, and unmet needs.

Factors that are linked with better QoL include having good relationships with family and friends, being included and involved in social activities, being able to manage everyday activities, and having religious beliefs.

Many other factors showed small but statistically significant associations with quality of life. This suggests that the way in which people evaluate their quality of life is related to many aspects of their lives, each of which have a modest influence. It is likely that to some extent the aspects that are most important may be different for each person.

Evidence from longitudinal studies about what predicts whether or not someone will experience a good quality of life at later stages was limited. The best indicator was the person's initial rating of quality of life. This again highlights the importance of optimising quality of life from the earliest stages of living with dementia .**Read More**

Deadly Falls On the Rise Among U.S. Senior

The number of seniors dying from falls has increased dramatically over the past decade, U.S. health officials reported Friday.

Across the nation, the rate of deaths from falls among those 65 and older increased 31 percent from 2007 to 2016 -- from about 18,000 to nearly 30,000, researchers found.

"If deaths from falls continue to increase at the same rate, the U.S. can expect 59,000 older adults will die because of a fall in 2030," said lead researcher Elizabeth Burns. She's a health scientist at the National Center for Injury Prevention and Control, which is part of the U.S. Centers for Disease Control and Prevention.

Falls are the leading cause of both fatal and nonfatal injuries among adults aged 65 and older, she added.

"Falls are a common, serious and growing public health problem," Burns said. "Falls often result in substantial medical expenditures to treat fall-related injuries."

As the U.S. population ages, the number of seniors injured and dying from falls is expected to keep rising, the researchers noted.

"Falls may be increasing because older adults are living longer with chronic conditions," Burns suggested.

"The chance of falling increases with age, and risk is higher with certain chronic diseases, such as a history of stroke, arthritis, diabetes, dementia and Parkinson's disease," she explained.

Other risk factors include muscle weakness, difficulty walking, and using medications -- especially those for anxiety, depression, or difficulty sleeping, which can cause dizziness or confusion. Poor vision and environmental hazards also contribute to an increased risk of falling.

"Falls are preventable. While the rate of deaths from falls is increasing, older adults can take steps to prevent falls, including talking to their doctor and staying active," Burns advised.

While there are many effective fall-prevention measures one can take, an important strategy is to encourage health care providers to discuss falls with their patients, she said. Doctors should screen for fall risk, and assess medication problems with walking and balance.

"Falls are not an inevitable part of aging," Burns stressed.

Dr. Gisele Wolf-Klein is director of geriatric education at Northwell Health in Great Neck, N.Y. She pointed out that, in many cases, "seniors are reluctant to admit they have fallen, because they fear it will limit their independence."

Wolf-Klein said seniors can sometimes prevent falls by being aware of the dangers, and taking steps to mitigate them.

These can include installing grab bars in bathrooms and tubs, removing throw rugs, and making sure slippers and shoes have nonslip soles.

In addition, some may need to avoid stairs, and have their bedroom and bath on one floor, Wolf-Klein said.

Also, seniors need to keep active, which is a great way to prevent falling, she said.

"It's important to tell your doctor if you've fallen," Wolf-Klein said. "Because if you've fallen, it's likely you will fall again, and falls can cause major problems."

The new report covered deaths from falls in 30 states and the District of Columbia between 2007 and 2016. It included both men and women, along with people of all races and ethnic groups.

People aged 85 and older were the most likely to suffer a fatal fall. Among these folks, the rate of deadly falls increased nearly 4 percent each year, the investigators found.

Wisconsin had the highest rate of fatal falls, at nearly 143 per 100,000 people aged 65 and older, while Alabama had the lowest, at 24 per 100,000, the findings showed.

Poor Seniors May Be More Vulnerable to Dementia

Being poor later in life may boost the risk of dementia by 50 percent, new research suggests.

"Our study confirms that the risk of dementia is reduced among well-off older people compared with those who have fewer economic resources," said lead researcher Dorina Cadar.

"Public health strategies for dementia prevention should target socioeconomic gaps to reduce health disparities and protect those who are particularly disadvantaged," Cadar added.

She's a research associate at University College London's department of behavioral science and health.

Many factors could be involved in the findings, including differences in lifestyle and overall health. Also, affluent people have greater social and cultural opportunities that allow them to remain actively engaged with the world, Cadar explained.

And the study did not prove that poverty directly causes dementia risk to rise, just that there's an association.

Dr. Sam Gandy, director of the Mount Sinai Center for Cognitive Health and NFL Neurological Care in New York City, said it's possible that one sign of dementia is losing control over your finances.

"Poor financial management may be an early sign of dementia, such that financial resources are depleted late in life," he suggested.

"This may also be a manifestation of executive thinking dysfunction, such as paying bills multiple times, or poor judgment and vulnerability to scam artists," Gandy said.

But Gandy also agreed that financial status may be a stand-in for a poorly managed diet and lifestyle, both of which are linked to the risk for dementia.

Cadar said that in "an English, nationally representative sample, the incidence of dementia appeared to be socioeconomically patterned, primarily by the level of wealth."

In the study, she and her colleagues collected data on more than 6,200 men and women aged 65 and older.

Seven percent developed dementia in the 12 years between 2002-2003 and 2014-2015.

The risk of dementia was 50 percent higher among the poorest, compared with the richest people, the researchers found.

This finding was independent of level of education, amount of deprivation and overall health factors.

Rebecca Edelmayer is director of scientific engagement at the Alzheimer's Association. She said, "This paper adds credence to the growing list of evidence suggesting that access to good health care and the ability to make healthy lifestyle decisions can really impact our risk of developing dementia."

The report was published online May 16 in the journal *JAMA Psychiatry*.

More information

Visit the **Alzheimer's Association** for more on dementia.