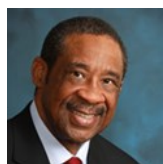


November 12, 2023 E-Newsletter



Message from the Alliance for Retired Americans Leaders

Biden Administration Announces Plan to Retirees Seeking Financial Advice



Robert Roach, Jr.
President, ARA



On Tuesday, Alliance President Robert Roach, Jr. and Executive Director Richard Fiesta joined President Biden at the White House for the **announcement**

of a new standard to close investment advice loopholes

that can increase costs for retirees.

The rule **revises** the definition of an "investment advice fiduciary" under the Employee Retirement Income Security Act (ERISA) pension law so that it covers a wider array of financial advisers.

Currently, investment professionals like brokers and insurance agents are not required to comply with regulations protecting retirement investors, even if they provide advice on 401(k) savings. Categorizing these individuals as investment

advice fiduciaries under ERISA will require them to adhere to more rigorous standards which protect investors from "junk fees" and conflicts of interest.

"Older Americans worked hard to retire with dignity, and they deserve to have access to investment professionals who will protect their retirement savings instead of trying to make a quick buck," said **Robert Roach, Jr., President of the Alliance**. "This rule will protect consumers and help ensure that all financial advisers are acting in their client's best interest."

Senate Finance Committee Considers Nomination for Commissioner of the Social Security Administration



Rich Fiesta,
Executive
Director, ARA

The Senate Finance Committee **held a confirmation hearing** this week on the nomination of former Maryland

Governor Martin O'Malley for Commissioner of the Social Security Administration (SSA).

O'Malley's opening remarks stressed the intergenerational impact of Social Security and

how vital it is for Americans, stating: "Social Security is the most far-reaching and important act of social and economic justice that the people of the United States have ever enacted for one another."

He pledged to uphold the legacy of Social Security as an insurance and retirement security program for Americans. O'Malley then outlined the challenges facing the SSA, including addressing long wait times for beneficiaries who need help or information or decisions on applications for disability benefits that stem from underfunding the agency. He promised to make customer service and efficiency his top priorities as Commissioner.

"Governor O'Malley is an exceptional nominee to serve as Commissioner of the Social Security Administration (SSA) at a critical time in its history," said **Richard Fiesta, Executive Director of the Alliance**, in a **statement** urging the committee to advance O'Malley's nomination swiftly.

Medicare Expands Mental Health Coverage Options



Joseph Peters
ARA
Sec.-Trea.

Starting in January, Medicare **will cover** services provided by mental health counselors and marriage and family therapists, who account for more than 40 percent

of the mental health workforce. The need for mental health care for older patients is acute. One in four Medicare beneficiaries report that they have a mental health condition, but only about half of those patients have received treatment. Even if they do seek treatment, older patients have trouble finding care due to a shortage of mental health professionals that Medicare would pay for. Older patients also face other unique barriers, including needs that require more time-consuming and complex care. "This is a common sense move that should help more older Americans get the health care they need," said **Joseph Peters, Jr., Secretary-Treasurer of the Alliance**. "No one should have to go without the health care they need."



**VETERANS
DAY** * THANK
* YOU

HONORING ALL WHO SERVED



ADD
YOUR
NAME

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

Rhode Island Alliance for Retired Americans, Inc. • 94 Cleveland Street • North Providence, RI • 02904-3525 • 401-480-8381

riarajap@hotmail.com • <http://www.facebook.com/groups/354516807278/>

Anatomy of a two-week Skilled Nursing Facility (SNF) stay by John A. Pernorio, President, Rhode Island Alliance for Retired Americans



John A. Pernorio
RIARA
President

On October 12, 2023, I was taken by North Providence Rescue to the Fatima Hospital ER. After some blood work, it was found that I had

a bad blood infection, Cellulitis. I was admitted and treated for seven days.

On October 19th I was transferred to a (SNF) Heritage Hills Rehabilitation & Healthcare Center in Smithfield, Rhode Island. I arrived there at 4 p.m. and was put into a room with another person who was dropped off at 1:30 that afternoon. At six o'clock neither of us was attended to. We had no bed control or call button. I happened to catch the attention of a CNA walking by the room and asked if anyone was going to help us. This CNA, Shannon, was surprised that no one came in to help us. She jumped into action to help us

with food, a call button, and bed control and alerted the nurse about us.

The next day I was transferred to a different room that had a long-term patient in it. From that day and the next 14 days, it was hell there.

Let me start off by saying that the staff, CNAs Shannon, Alex, Eli, and Nurses Claudia and Lauren were great. Most nurses just passed out meds.

Here are my complaints;

1. Staffing in SKF is inhumane. One CNA for 12 patients. Especially in the long-term wing.
2. I was on multiple occasions, left for up to 5.25 hours in feces and urine-soiled briefs. Multiple times I had to call the phone number of the Facility to tell them that I had been waiting for help for over an hour. Nurses would come in turn off the call light and walk back out.

Ten to fifteen minutes later, I would have to press the call button again.

3. Call buttons took anywhere from 30 to 60 minutes to be answered by CNAs. All the call buttons do is light a light outside the room. If your CNA is at the other end of the wing, no one will help you because you are not their patient.
4. Every shift of the 4 CNAs on my wing, a CNA would call out of work leaving three to take care of all the patients. If an agency was called for a Per diem replacement, they would not show up.
5. There is a very small therapy room. The therapy I was sent there for, PT & OT to do transfers from my wheelchair did not emulate any of the conditions that I have in my home and most of the sessions were a waste of time.

6. I missed 4 therapy sessions because I wasn't cleaned, dressed, and transferred to my wheelchair on time.
7. A patient could suffer a stroke, or heart attack, or be choking and die by the time someone came to help.
8. I give the SNF one star only because some staff really do care but are hampered by the lack of staffing. I was told by many staffers about the high turnover of CNAs because of the wages and working conditions. As I was told, who wants to clean soiled patients for \$15 an hour when they could flip burgers at McDonalds for \$20 an hour?

To sum up, if you have someone in an SNF, please be very vigilant about their care.

I would not under any circumstance recommend this SNF to anyone.

Curtailing Executive Overcompensation (CEO) Act



From Senator Whitehouse, (D-RI)
FOR IMMEDIATE RELEASE

November 2, 2023

Contact: Meaghan McCabe (Whitehouse), (202) 224-2921

Sean M. Ryan (Lee), (202) 713-7385

Lauren Hitt (Ocasio-Cortez),
aoc.press@mail.house.gov

Whitehouse, Lee, Ocasio-Cortez Introduce Legislation to Increase Worker Pay, Rein in Runaway CEO Compensation

CEOs made 308 times what the average worker earned last year
Washington, DC – As

executive pay soars, U.S. Senator Sheldon Whitehouse (D-RI) and

Representatives Barbara Lee (D-CA) and Alexandria Ocasio-Cortez (D-NY) have introduced the Curtailing Executive Overcompensation (CEO) Act, which would apply an excise tax on public and private companies that have at least a 50 to one CEO-to-median-worker pay disparity. In 2022, the CEO Act would have raised over \$10.1 billion from the top 100 US companies alone.

“Year after year, superrich CEOs extract massive pay raises

INEQUALITY.ORG

for themselves while many of the workers who keep their companies growing scrimp to make ends meet,” said Whitehouse. “There’s no justification for a CEO making hundreds of times what the average worker at their company is earning. It’s a sign of illness in society and a drag on our economy. Congress has to step in and correct the wretched excess of CEO self-dealing.”

“Right now, the average CEO makes in one day what the average worker makes in ten months,” said Lee. “After decades of this extreme,

corrosive economic inequality, workers across corporate America are standing up and using their power to fight for greater equity. It’s only fair that we in Congress fight just as hard as those on the ground. I am proud to introduce this critical bill with Senator Whitehouse and Rep. Ocasio Cortez, and urge my colleagues to support it and stand in solidarity with workers.” A summary of the bill is available [here](#); bill text is available [here](#).

Visit Inequality.org

Essential Questions to Ask When Choosing a Nursing Home

Choosing a nursing home for your loved one? Make sure to ask questions in these nine important areas to ensure they get quality care at the right facility for them.

Finding the right nursing home for a loved one can be a challenging proposition. The options are many, but the industry can seem completely opaque. That's why visiting a home – and asking a lot of

questions – before you move a loved one there is a critical part of the process.

The following nine categories, each with recommended questions, can help you determine whether a specific nursing home is a good fit for your loved one:

Basic information.
Living space details.



Safety track record.
Staffing specifics.
Care approach.
Memory and dementia care approach.
Abuse prevention

strategies.
Quality of life concerns.
Financial details.

Basic Information
Ideally
Other People to Talk With

While many of the questions you'll have can be adequately answered by the nursing home's administrator or sales team, it's also important to spend some time chatting with other folks at the facility to get a more comprehensive view....**Read More**

P.S. I did not have time to do my due diligence on the facility I chose.

Dear Marci: How do I choose a Part D plan?

Dear Marci,

My Part D premium is increasing a lot in 2024, so I want to use Fall Open Enrollment to sign up for a different Part D plan. How should I choose a new Part D plan?

-Louise (Fort Lauderdale, FL)

Dear Louise,

I'm glad to hear you're comparing your Medicare coverage options this fall! Research shows that many people with Part D could lower their costs by shopping among plans each year. There could be another Part D plan in your area that covers the drugs you take with fewer restrictions or with lower costs, so it's great that you are trying to compare plans.

I would recommend using **Plan Finder** to compare Part D plans. Medicare Plan Finder is an online tool at www.medicare.gov that can be used to compare stand-

alone Part D plans or Medicare Advantage Plans. Plan Finder provides information about costs, drug coverage, and the **star rating** of the plan.

To use Plan Finder, follow these steps:

Go to www.medicare.gov and click on the button that says, "Find Plans Now."

- ◆ You can do a general search on the right side of the page, under the title "Continue without logging in." If you wish to save your drugs and pharmacy information, you can log into or create your Medicare account on the left side of the page.
- ◆ Next, put in your zip code and then choose what kind of plan you are looking for—a Medicare Advantage Plan, a Medicare drug plan, or a



Dear Marci

Medigap policy.

- ◆ Then you can enter the drugs you take, choose the pharmacies you use, and indicate whether you are interested in a mail order option.

Plan Finder will display results for plans in your area. Note that a plan may not cover all the drugs you take, but it may cover alternatives. Speak to your provider about whether these alternatives would be appropriate for you. Plan Finder also tells you if the plan has a deductible and how much the monthly premium is. Initially, the plans will be sorted by "lowest drug + premium costs." This is the closest estimate to what you may pay out of pocket for your Part D coverage for the year. You can select "Plan Details" to find out more specifics about coverage,

including any **coverage restrictions** that might apply to your drugs. Before enrolling, it is a good idea to call the plan directly to confirm any information you read on Plan Finder, as information may not be completely up to date. **Here is a list of questions you can ask when calling a company about their prescription drug coverage.** You can enroll in a plan online, by calling 1-800-MEDICARE (633-4227), or by calling the plan directly.

You can make as many changes as you want between October 15 and December 7, but only the last change you make will take effect on January 1.

Good luck choosing the best Part D plan for your needs!

-Marci

Younger Medicare Enrollees Experience High Rates of Access and Affordability Challenges

Younger adults **can qualify for Medicare** due to having a long-term disability, End-Stage Renal Disease (ESRD), or Amyotrophic Lateral Sclerosis (ALS). A recent KFF **survey and analysis** confirm **previous research** on the unique **challenges facing** this population. Compared to older beneficiaries, they are more likely to have low incomes, poor health, and severe chronic conditions, as well as problems with Medicare enrollment, access, and affordability. In 2022, 12% of all beneficiaries—nearly **8 million** people—were under 65.

Using data from the **2023 KFF survey** of health insurance consumers, the new brief focuses on the experiences of younger Medicare enrollees with long-term disabilities, including the barriers they often face. Key findings include:

- ◆ People with Medicare are **more satisfied** with their health coverage than adults with other types of insurance. But younger Medicare enrollees were less satisfied overall than those 65 or older (79% and 90%, respectively). Similarly, 78% of younger enrollees were satisfied with provider quality and 74% with

provider availability compared to 91% and 89% of older enrollees.

- ◆ The younger Medicare beneficiaries were also more likely to have difficulty enrolling in Medicare (26% vs. 10%) and obtaining financial assistance (30% vs. 11%). These challenges likely reflect well-documented complexities with Medicare and complementary program enrollment systems. Navigating Medicare enrollment—from adhering to confusing rules and intricate timelines, to choosing between Original Medicare (OM) and Medicare Advantage (MA), to evaluating seemingly endless private plan options—is a high stakes and confusing endeavor. Similarly, people often do not know they are eligible for low income supports like Medicaid, the Medicare Savings Programs, and the Part D Low-Income Subsidy or how, when, and where to sign up.
- ◆ Younger enrollees also experienced disproportionate coverage problems (70% vs. 49%). They reported higher rates of care delays (27% vs.



9%), of being charged for services they thought were covered (24% vs. 8%), and of being unable to receive recommended treatment (24% vs. 6%).

The relatively poor self-reported health status of younger enrollees (52% vs. 19%) may be a contributing factor, leading to more encounters with the health care system and more room for error. The survey does not classify respondents according to OM and MA enrollment, but KFF notes beneficiary coverage pathway may also play a role, since common MA features like narrow provider networks and **prior authorization** can significantly limit timely access to care.

- ◆ Medicare affordability is an issue for enrollees of all ages; approximately 30% of all Medicare beneficiary survey participants reported problems paying for prescription drugs and covering monthly premiums. However, larger shares of those under 65 said they struggled to afford medical bills (35% vs. 9%) and delayed or skipped care due to cost, including dental

(42% vs. 24%) and vision services (25% vs. 13%) not covered by Medicare, prescription drugs (18% vs. 10%) and doctor visits (14% vs. 4%). These variances are likely tied to the cohorts' income differences: 77% of those under 65 with disabilities lived on **less than \$29,160** a year (\$39,440 for couples), compared to 44% of older enrollees.

At Medicare Rights, we know that beneficiary problems with understanding and using their coverage can be difficult to resolve quickly and independently, especially in time-sensitive and stressful situations. This can lead to harmful care delays, higher costs, and worse outcomes. To ensure Medicare works well for everyone, including younger enrollees, we support policy and program changes to simplify enrollment and plan comparisons, empower informed beneficiary decision-making, enhance coverage and benefits, strengthen consumer and cost protections, and ease access to Medicare's financial assistance programs.

Medicare Beneficiaries Are Not Exempt From Cost-Based Barriers to Care

A recent Commonwealth Fund [survey report](#) shows that a third of Medicare beneficiaries, including more than half of those under 65, have found it difficult to afford health care costs this year. More than one in five beneficiaries reported delaying or skipping needed health care because of the cost, including more than four in 10 under age 65. Over half of these respondents reported worsening health problems as a result. More than one in five beneficiaries also said health care costs made it harder for them to afford food and utility bills. This was even

more pronounced among younger beneficiaries—over 40% had such experiences. In more concrete terms, nearly one in four beneficiaries under age 65 and more than one in seven older beneficiaries reported that health care costs consumed more than 25% of their monthly budget. Contrary to common assumptions about wealthy older adults enjoying [lavish benefits](#), many people with Medicare, both over and under age 65, struggle to pay their health care related out of pocket costs. These individuals, many of whom have complex



health care needs and live on fixed incomes, experience cost-based barriers to care and face health care costs that impact their ability to afford other essentials.

Health care costs are a problem for all Americans—even those with Medicare. We urge policymakers to act swiftly and thoughtfully to reduce systemic and beneficiary costs. As [related Commonwealth Fund survey](#) analysis notes, "...many Americans, regardless of where their insurance comes from, have inadequate coverage that's led to

delayed or forgone care, significant medical debt, and worsening health problems. While having health insurance is always better than not having it, [these] findings challenge the implicit assumption that health insurance in the United States buys affordable access to care. Difficulties affording care are experienced by people in employer, marketplace, and individual-market plans as well as people enrolled in Medicaid and Medicare."

The cost of weight-loss drugs is driving up our insurance premiums

Gina Kolata reports for [The New York Times](#) that the cost of weight-loss drugs is not what it seems. People must take them throughout their lives, and weight-loss drugs have list prices of as much as \$1,300 every four weeks. Ozempic, Wegovy and drugs like them could literally mean a huge increase in people's health insurance premiums.

One epidemiologist projects that if prices for these weight-loss drugs are not controlled, they could increase health care spending by 50 percent! What's interesting is that it is not only the drug manufacturers that are

raking in the profits from these drugs. The health insurance companies and pharmacy benefit managers are profiting wildly from them as well.

The weight-loss drug manufacturers pump up the list price of the drug so that they can then give a major rebate to the pharmacy benefit managers and insurers as a financial incentive to promote and cover them. The insurers and PBMs pocket these rebates or most of the rebates rather than pass them along to consumers.



Net prices for the weight-loss drugs are, according to the conservative [American Enterprise Institute](#),

AEI, much less than the list prices. The AEI believes that the net price for Ozempic is just \$300, \$650 less than its list price. Similarly, AEI believes the net price for Wegovy is \$700 or \$650 less than its list price.

The weight-loss drugs are unaffordable to many Americans because they cannot afford the copays even with insurance, they have no health insurance, or their insurance does not cover

them. [Medicare does not cover weight-loss drugs for weight-loss](#). However, it does cover the drugs for people with diabetes. Medicaid rarely covers the drugs.

Novo Nordisk, a Danish company, expects to generate \$11 billion in revenue this year from Ozempic and another \$4 billion from Wegovy. Some might argue that the price for these drugs is fair because treating obesity, with its risk of diabetes, kidney failure, heart attacks and strokes, can be very expensive. No other wealthy country pays prices anywhere near as high as Americans.

'MAGA Mike Johnson' wants commission to cut Social Security formed 'immediately'

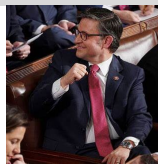
When Republicans in the U.S. House of Representatives elected Louisiana Congressman Mike Johnson as speaker last week, critics quickly [sounded](#) the alarm about his previous calls to cut trillions of dollars from Social Security, Medicare, and Medicaid—and the GOP leader triggered a fresh wave of fears on Thursday with related comments to a Capitol Hill journalist.

[NBC News'](#) Sahil Kapur [reported](#) on social media that Johnson "says he pitched a debt commission to Senate Republicans yesterday and 'the idea was met with great enthusiasm.' He says it will be bipartisan and bicameral. He says he wants 'very thoughtful people' in both parties to lead it. He wants this 'immediately.'" In response to Johnson's remarks—which [echoed](#) his first

speech as speaker—the Alliance for Retired Americans [wrote](#), "Translation: They're eager to begin gutting Social Security behind closed doors."

Rep. Matt Gaetz (R-Fla)—who led the ouster of ex-Speaker Kevin McCarthy (R-Calif.)—celebrated Johnson's rise as a win for the far-right. He [declared](#) last week that "MAGA is ascendant," referring to the "Make America Great Again" campaign slogan of former President Donald Trump, who is the GOP front-runner for 2024.

Critics of the new speaker have similarly framed his election as a display of the far-right's hold on the Republican Party, and are even calling him "MAGA Mike," including in response to his comments Thursday.



"A week into his tenure, MAGA Mike Johnson is ALREADY calling for closed-door cuts to the Social Security and Medicare benefits

American workers have earned through decades of hard work," [warned](#) Democrats on the House Ways and Means Committee.

[Social Security Works](#) said that "MAGA Mike Johnson's NUMBER ONE priority is to cut our earned benefits behind closed doors."

"The White House has rightfully called this type of commission a 'death panel' for Social Security and Medicare," the group noted. "HANDS OFF!" Back in February, long before

McCarthy struck a deal with President Joe Biden to suspend the country's [debt ceiling](#), Republicans in Congress and Sen. [Joe Manchin](#) (D-W.Va.) were floating the idea of a commission, and White House spokesperson Andrew Bates [said](#) that "the American people want more jobs and lower costs, not a death panel for Medicare and Social Security."

As Republican lawmakers have continued to pursue the idea, others have [embraced](#) the "death panel" description.

After Johnson's mention of the commission in his speech last week, *Los Angeles Times* columnist Michael Hiltzik [wrote](#):....[Read More](#)

People under 65 with Medicare less satisfied than people over 65

People under 65 with disabilities are less satisfied with Medicare than adults over 65, reports **Kaiser Family Foundation**. The reason is likely that people with disabilities need a lot more health care than older adults and face obstacles to care that people who are relatively healthy do not face. Still, people under 65 with Medicare are more satisfied with their health care coverage than people who have Medicaid, employer coverage or coverage through a state health insurance exchange.

Medicare covers about 66 million people. Nearly eight million (12 percent) of them are under 65 and enrolled in Medicare because of long-term disabilities, including End-Stage Renal Disease and ALS. People with disabilities on Medicare are more likely to be people of color, people with lower incomes and lower education levels; they also tend to be people in worse health than people over 65 in Medicare. No matter how you qualify for Medicare, you are supposed to get the same Medicare benefits. But, people under 65 are not

guaranteed the right to **Medicare supplemental insurance or Medigap**—coverage that generally picks up most or almost all of people's out-of-pocket costs—from a commercial insurer. So, unless people qualify for **Medicaid or a Medicare Savings Program**, they could have large out-of-pocket costs in Traditional Medicare and in Medicare Advantage. Not surprisingly, people with disabilities on Medicare report greater struggles getting and paying for care as well as less satisfaction with Medicare than people over 65.

Overall satisfaction with Medicare jumps from 79 percent for people with disabilities to 92 percent for people over 65. Much of the concern among people with disabilities is around their ability to get care from good quality physicians and hospitals. Seven in ten of them reported having a problem with Medicare in the last year, whereas far fewer people over 65 (five in ten) say they experienced a problem with Medicare.



It's important to keep in mind that it's a lot easier for people who do not use the health care system much or at all to be satisfied with their Medicare coverage than people who have complex conditions, as many people with disabilities under 65 do. About half of people with disabilities say they are in fair or poor physical health. Just 19 percent of people over 65 report that they are in fair or poor physical health. In fact, about half of people with Medicare use little or no health care in any given year.

About 30 percent of people with disabilities say they have fair or poor mental health, as compared with just nine percent of people over 65. Twenty seven percent of them struggled to get mental health treatment they needed but was not covered, as compared with seven percent of people over 65. Eighteen percent said that they could not get medicines they thought they needed, as compared with five percent of people over 65.

Nearly three in ten people with disabilities report having a hard

time getting their Medicare plan to approve critical care, as compared with nine percent of people over 65. While the Kaiser Family Foundation does not distinguish those in Medicare Advantage plans from those in Traditional Medicare, only Medicare Advantage plans require prior approval before getting critical care.

Twenty-four percent of people with disabilities reported not having their insurance pay for their care that they thought was covered, as compared to eight percent of people over 65. More than one in three people under 65 said they struggled to pay a medical bill as compared to nine percent of older adults.

People under 65 experienced more difficulty getting care than older adults. They were more likely to **skip or delay getting dental care, prescription drugs and medical care because of the cost** than people over 65. People under 65 also reported greater difficulty enrolling and understanding their options relative to people over 65.

Social Security: When Can Your Benefits Be Garnished Due to Unpaid Deb

Because **Social Security income** is intended as a financial safety net for **retirees** and other qualified Americans, most benefits are exempt from garnishment, levies, attachments and other legal processes. However, there are a few exceptions. According to the Social Security Administration's **Social Security Handbook**, if you have any unpaid federal taxes, the IRS can levy your Social Security

benefits. Your benefits can also be garnished to collect unpaid child support and/or alimony. In addition, Social Security benefits can be garnished in response to Court Ordered Victims Restitution.

Your benefits might also be reduced or offset to collect delinquent debts owed to other federal agencies, such as **student loans** owed to the U.S. Department of Education. Garnishments apply to



retirement, **spousal and survivor benefits**, and Social Security Disability Insurance (SSDI)

payments. Supplemental Security Income (SSI) payments can't be garnished or levied.

One thing to keep in mind is that there are limits on how much of your Social Security payment can be garnished. If you're behind on your federal income taxes, for example, the IRS can take no more than 15% of

your **monthly Social Security benefit**.

In terms of court-ordered child support or alimony: The Consumer Credit Protection Act (CCPA) allows garnishment of up to 50% of your benefits if you are supporting a spouse or child apart from the subject of the court order, and up to 60% if you are not. An additional 5% can be garnished if you are 12 or more weeks in arrears.....**Read More**

Medicare Open Enrollment Period Has Begun

In case you haven't heard, the Medicare open enrollment period has started, and it runs through Dec. 7. This is when Medicare enrollees can make changes to their coverage effective for the 2024 plan year, including changes to their Medicare prescription drug coverage.

It is important that you pay attention to the open enrollment period by:

- ◆ Opening and studying the Annual Notice of Changes. You

should have received it by now. If not, contact your plan.

- ◆ Focusing on Section 1, Changes to Benefits and Costs for Next Year, especially the prescription drug cost changes in Section 1.3.
- ◆ Determining the impact on your costs and coverage.
- ◆ If a new plan will work better or save money, enroll in it by the end of November. Although



you technically have until the open enrollment period ends on Dec. 7, experience indicates that

those who wait until the very end frequently have some sort of problem.

Some new features regarding Medicare Part D drug coverage for 2024 include:

- ◆ Insulin: All insulins covered under Part D, whether injected or administered by pump, are capped at \$35. To get an idea of

the savings, 3.3 million beneficiaries with Part D coverage in 2020 spent \$1 billion out of pocket on insulin.

- ◆ Part D vaccines: There is no copayment for vaccinations, such as shingles (known as Shingrix), hepatitis B administered to non-high-risk individuals, DTaP (diphtheria, tetanus, pertussis), RSV (respiratory syncytial virus) and others.

Medicare cuts doctor and hospital payments

Medicare administrators served doctors and hospitals a pair of big payment cuts late Thursday.

The big picture: Doctors will see a 3.4% decrease to a key factor determining their base Medicare pay next year, officials announced in a final rule. That's virtually unchanged from what administrators **proposed this summer**.

- ◆ Medicare will also cut payment for many hospital outpatient services starting in 2026 in order to **reimburse** safety-net hospitals that were hit by earlier cuts to a discount drug purchasing program that the Supreme Court deemed illegal.
- ◆ The hospital pay cuts will amount to \$7.8 billion over an estimated 16 years, officials said. Hospitals affected by the

cuts to the drug discount program will get one-time lump sum payments totaling \$9 billion.

What they're

saying: The hospital repayment policy "erodes the ability of hospitals to deliver lifesaving services that patients depend on, especially in rural areas where many hospitals are already struggling to survive," Chip Kahn, CEO of the Federation for American Hospitals, wrote in a statement.

- ◆ Doctors are equally upset with their lot. The American Medical Association called the final physician payment plan "a recipe for financial instability." The Medical Group Management Association accused it of "dangerously impeding beneficiary access to care."



◆ Providers lobbied against both policies for months, saying the cuts would wreak havoc on a health care system already facing high inflation and labor costs.

Yes, but: Providers did get some wins in the finalized policies.

- ◆ Medicare will start hospital payment cuts a year later than originally proposed in response to stakeholder comments, officials said in a **fact sheet**. Medicare will also **extend** several telehealth provisions for doctors.
 - ◆ Additionally, family physicians say they'll gain from the full implementation of a **new billing code** that will increase payment for complex patient office visits.
- What's next:** Providers could still get a reprieve if Congress

steps in to delay or ease scheduled payment cuts before the end of the year.

◆ Professional associations didn't waste any time asking for help after the final rule came out. "Congress has to act to stop these cuts," American Medical Group Association CEO Jerry Penso said in a news release sent immediately after the payment rule dropped.

◆ FAH's Kahn also hinted that hospitals may take legal action against the safety-net hospital repayment plan, calling it a "decision to brush aside the Medicare statute."

Worth noting: In a **separate rule** also released Thursday, Medicare finalized a 3.1% increase to hospital outpatient and ambulatory surgical center rates for 2024.

Nursing Home Red Flags You Should Watch Out For

When comparing nursing homes for a loved one, diligence is key. Be on the lookout for the telltale signs of a poor nursing home facility.

The importance of visiting nursing homes

Overwhelmed with choosing **the right nursing home** for yourself or a loved one? With an abundance of options, as well as startling stories about senior living conditions, this can be a challenge. You want a facility where the residents aren't merely surviving but are also socializing and **thriving, even in their advanced age**.

To avoid nursing home red

flags, get started on comparing facilities:

- ◆ **Rely on nursing home ratings from federal and state agencies.** Using websites like **Care Compare**, you can search by region and view different metrics for nursing homes, long-term care hospitals, in-patient rehabilitation centers and other facilities. You can also try **Medicare's Nursing Home Lookup**.
- ◆ **Research state agencies for similar resources.** For instance, the California Department of Public Health provides the California Health



Facilities Information Database.

◆ **Check out U.S. News ratings.** U.S. News assessed more than 15,000 **nursing homes** this past year and rated most of them on short-term rehabilitation and long-term care. You can also search for nursing homes by **city or state**.

- ◆ **Look up online reviews.** If you notice multiple negative reviews, consider steering clear of that facility. Nursing homes cited for abuse will have an icon showing a white hand within a red circle next to their name on Medicare.gov.

Even after sufficient online research, consider visiting a few nursing homes in person. Dr. Tanya Gure, section chief of geriatrics and clinical professor of internal medicine at the **Ohio State University Wexner Medical Center** in Columbus, says that ratings can lag behind recent updates or improvements a facility has made. On the other hand, the facility could have since taken a turn for the worse.

But once you take a tour, what should you look for? Here are nine signs a nursing home isn't right for you or your loved one: ...**Read More**

Medical Debt Is Disappearing From Americans' Credit Reports, Lifting Scores

The share of American consumers with medical debt on their credit reports has declined dramatically over the past year as major credit rating agencies removed small unpaid bills and debts that were less than a year old, according to a **new analysis** from the nonprofit Urban Institute.

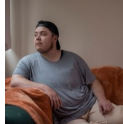
At the same time, millions of Americans have seen their credit scores improve, making it easier for many to get a job, rent an apartment, or get a car.

"This is a very significant

change," said Breno Braga, an economist at the Urban Institute and a co-author of the study. "It affects a lot of people."

The analysis found that, as of August, just 5% of adults with a credit report had a medical debt on their report, down from almost 14% two years earlier.

Urban Institute researchers also found that Americans with a medical debt on their credit report in August 2022 saw their VantageScore credit score improve over the next year from



an average of 585 to an average of 615.

That moved many consumers out of the subprime category.

Subprime borrowers typically pay higher interest rates on loans and credit cards, if they can borrow at all.

Consumers' improved scores don't mean the medical debts have been eliminated. Hospitals, collectors, and other medical providers still pursue patients for unpaid bills. And many continue to sue patients, place liens on

their homes, or sell their debts.

But the credit reporting changes appear to be mitigating one of the more pernicious effects of medical debt that for years has undermined the financial security of tens of millions of patients and their families.

Credit scores depressed by medical debt, for example, can threaten people's **access to housing** and fuel homelessness....**Read More**

2024: Access to Medicare mental health services is expanding

Even with Medicare, it can be hard to see mental health providers. Tens of thousands of mental health providers will not take Medicare because of its low payment rates and, on top of that, for people in Medicare Advantage plans, a lot of administrative burdens. But, beginning in January 2024, Medicare will cover mental health care from marriage and family therapists, mental health counselors, and drug addiction specialists, increasing the pool of mental health providers available for people with Medicare to see, reports Judith Graham for [The Washington Post](#).

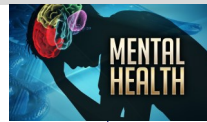
To date, Medicare has only covered care from psychiatrists, psychologists, psychiatric nurses and licensed clinical social workers. They are a small group, and nearly half of psychiatrists and more than half of psychologists, 124,000 mental health providers, have opted out of Medicare. In addition, many Medicare Advantage plans do not contract with adequate numbers of mental health providers, according to a recent [report from the Kaiser Family](#)

[Foundation](#) and a recent [Senate Finance Committee survey](#).

People in Medicare Advantage plans can struggle to access mental health services as well as a wide range of other services, particularly costly ones such as rehab therapy and nursing home care. Even if they can find a mental health provider who will see them in network, Medicare Advantage enrollees generally need approval from their Medicare Advantage plans before their mental health care will be covered. And, that approval can be hard to come by.

Inability to get Medicare-covered mental health care has been a huge issue for the more than 15 million people with Medicare who have a mental health condition. As many as 7,500 of them do not receive mental health treatment today. The wait for a therapist who accepts Medicare can be six months.

Medicare's expansion of mental health services to marriage and family therapists and mental health counselors should mean that people will



have less trouble finding a mental health provider who takes Medicare, at least if they are enrolled in

Traditional Medicare. An additional 400,000 mental health providers are eligible to see patients with Medicare. In particular, people with Medicare in rural areas should have better access to mental health services.

However, a lot turns on the payment rates Medicare sets for these providers. If Medicare's approved rate is not fair, these providers may refuse to see Medicare patients. And, if Medicare Advantage plans engage in [inappropriate denials and delays of care](#) or refuse to pay mental health provider bills, as they too often do, these mental health providers will refuse to contract with them. Often older adults needing mental health services also have multiple chronic conditions. Providing treatment for them is not as simple as caring for younger adults.

Medicare will also cover as much as 19 hours a week of outpatient mental health care for

people most in need of outpatient mental health services—people with severe mental illness and people in need of substance use disorder care. Medicare will also enable some people to get mental health treatment in their homes through an expansion of mobile crisis services.

Since the Covid pandemic began, people with Medicare can receive mental health services through [telehealth](#), on the phone or through a computer. Medicare pays providers the same rates for telehealth services as for in-office appointments.

Graham raises the question of whether Medicare will ever have mental health parity as is required for private insurance plans. Given so many other issues with Medicare mental health coverage, it's not clear how much difference it would make, beyond an important symbolic one. But, at least it would eliminate Medicare's 190-day lifetime limit on psychiatric hospital care. Medicare has no lifetime coverage limit on hospital care.

False-Positive Mammogram Result Raises Odds for Breast Cancer Later

Women who have a false-positive result on a screening mammogram may have an increased risk of breast cancer for up to 20 years, a large new study finds.

False-positives occur when a screening mammogram seems to show something abnormal that, with follow-up testing, is declared non-cancerous.

The [new study](#) — published online Nov. 2 in *JAMA Oncology* — suggests those screening results can be more than a false alarm. For some women, they may signal a relatively heightened risk of breast cancer in coming years.

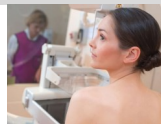
The link between false-positives and future breast cancer was strongest among older women (age 60 and up) and women with low breast density, which means the breasts have more fat tissue than fibrous and

glandular tissue.

Experts said the findings underscore the importance of continuing to get regular breast cancer screenings after a false-positive result — even though that experience might make some women hesitant.

"It's important for these women to maintain long-term awareness of breast cancer," said study leader [Xinhe Mao](#), a researcher at the Karolinska Institute in Stockholm, Sweden. "They should continue attending regular mammography screenings and remain vigilant about breast symptoms and changes in breast appearance."

The findings are based on nearly 500,000 Swedish women who underwent mammography screening between 1991 and 2017. The group included more than 45,000 women who had



received a false-positive result.

Over 20 years, 11% of women in that false-positive group later developed breast cancer, versus 7% of women without a false-positive.

When Mao's team dug deeper, they found that age and breast density were important factors. Among women aged 60 to 75, those with a false-positive had double the risk of later developing breast cancer compared to those with no history of a false-positive. The risk linked to false-positives was less among younger women.

Meanwhile, breast density was even more important. Among women with low breast density, those with a false-positive mammogram were nearly five times more likely to eventually be diagnosed with breast cancer.

In contrast, there was no strong link between false-positives and later breast cancer risk among women with dense breasts.

That finding is "novel," Mao said, but it's not surprising.

False-positive results are more common among women with dense breasts because that non-fatty tissue makes mammograms harder to read. So those women, Mao said, are often called back for follow-up testing simply because it was hard to distinguish normal from abnormal tissue on the initial mammogram.

, versus 20% of their European counterparts.

According to Mao, that may be due in part to more-frequent screening. But U.S. providers may also be more likely to flag mammograms as abnormal....[Read More](#)

The American Cancer Society says more people should get screened for lung cancer

Lung cancer is the country's most lethal cancer, with over 127,000 people dying of the disease every year. The American Cancer Society on Wednesday updated its [lung cancer screening recommendations](#), expanding the pool of current and former smokers who should be screened for it every year, starting at age 50.

The ACS's Chief Scientific Officer [Dr. William Dahut](#) says catching lung cancer early matters more than ever.

"There are so many new treatments out now for lung cancer, so many new targeted therapies, that the chances for survival is so much better if one

is diagnosed earlier on," Dahut says.

The new recommendations expand the age range for testing, to between 50 and 80.

Previously, the age range had been 55 to 74. The group is also getting rid of a barrier to screening for former smokers. The previous guidelines said if you quit smoking more than 15 years ago, you didn't necessarily need to be screened. Now even someone who quit 40 years ago might be eligible to be screened.

Screenings are reserved for current smokers and people who smoked heavily in the past in that age range. This is defined as at least a pack a day for 20 years.



However, the American Cancer Society has a "pack year" measurement to quantify very heavy smoking. For example, someone who smoked two packs a day for 10 years is equivalent to 20 "pack years" and should be screened yearly starting at age 50 under the new guidelines.

ACS estimates an additional 5 million Americans should be scanned under the new guidelines. The screening test is a [low-dose computed tomography](#) scan (also called a low-dose CT scan, or LDCT).

In 2023, ACS researchers estimate 238,340 new cases of lung cancer (117,550 in men and

120,790 in women) will be diagnosed. By the time people are symptomatic, treatment options can be limited, so screening offers a better chance for new treatments to succeed.

Anyone at any age can get lung cancer. However, lung cancer mainly occurs in older people, as most people diagnosed with the disease are aged 65 or older, ACS says.

The guidelines for screening were last updated in 2013.

The expanded screening recommendations "could make a real difference in saving lives," says Dr. Robert Smith, who leads early cancer detection science at ACS and is the lead author of the screening guideline report.

Stress Can Damage Your Heart Health in Many Ways, Studies Show

A person's mental state can have a tremendous impact on heart health, two new studies report.

Depression and anxiety accelerate the development of heart risk factors like elevated blood pressure, high cholesterol or type 2 diabetes, one study found.

And the second study found that chronic stress was associated with the development of heart disease and clogged arteries.

"There are clear associations between psychological health and cardiovascular disease risk. These studies add to a growing body of data we have on how negative psychological health can increase the risk of heart and brain disease," said [Dr. Glenn](#)

[Levine](#) in an American Heart Association (AHA) news release. Levine chaired the

writing of the association's 2021 scientific statement on psychological health, well-being, and the mind-heart-body connection.

Researchers are scheduled to present both studies at the association's annual meeting Nov. 11-13, in Philadelphia and online. Research presented at meetings is typically considered preliminary until published in a peer-reviewed journal.

For the first study on mood and heart health, researchers analyzed data on more than 71,000 adults gathered from 2010 to 2020.



They found that people diagnosed with anxiety or depression developed a new heart health risk factor about six months earlier on average than people without a mood disorder.

Depression and anxiety increased the risk of a heart attack, stroke or other major event by about 35%.

Further, the accelerated development of heart risk factors explained about 40% of the link between mood disorders and major heart events.

The researchers also found that those who were genetically predisposed to stress tended to develop their first heart health risk factor about a year and a half

earlier on average than those without higher genetic risk.

"Developing cardiovascular risk factors more than six months earlier over an average of five years is a lot," lead author [Dr. Giovanni Civeri](#), a research fellow at the Cardiovascular Imaging Research Center at Massachusetts General Hospital and Harvard Medical School, said in the release. "The fact that genetic analysis supported the clinical findings was intriguing and provided further confidence in our results."

The second study looked at nearly 2,700 adults without existing heart disease taking part in a Dallas heart study, who were followed an average of 12 years....[Read More](#)

Most Who Get Heart Valve Replacement Don't Get Follow-Up Rehab

A majority of people who have a minimally invasive heart valve replacement procedure are not getting the recommended cardiac rehab after their surgeries, researchers say.

A new study finds that just under 31% of patients who have transcatheter aortic valve replacement (TAVR) are receiving this service within 90 days of the procedure.

This could be explained by TAVR patients being more frail or having medically complex conditions, the study authors noted.

It may also be that patients are not receiving the appropriate education about the importance of rehabilitation.

"Cardiac rehabilitation has been shown to improve the quality of life for so many patients after cardiovascular procedures," said first study author [Dr. Devraj Sukul](#). He is an interventional cardiologist at the University of Michigan Health's Frankel Cardiovascular Center.

"We found that the differences in participation between hospitals



may be related to differences in the process each hospital takes after a patient undergoes

TAVR. It is critical that we identify best practices to promote cardiac rehab participation to improve post-operative outcomes," Sukul said in a news release from Michigan Medicine.

To study this, the researchers used clinical registry and health care claims data from more than 3,300 patients who underwent TAVR in Michigan across 24 hospitals between 2016 and mid-2020.

The investigators found that patients who were older, frailer, smoked or had a history of common heart rhythm issues, such as atrial fibrillation, were less likely to enter cardiac rehab. Participation varied substantially across the 24 hospitals, ranging from 5% to 60%, and this variation persisted even with patient differences.

The study authors noted that cardiac rehab participation after TAVR was significantly lower than that for patients who had open-heart surgeries.

Health misinformation and lack of confidence in vaccines continue to grow, years after the Covid-19 pandemic, survey shows

Vaccine misinformation, which first began spiraling during the Covid-19 pandemic, has grown in the United States in the years since, according to a [new survey](#) from the Annenberg Public Policy Center of the University of Pennsylvania.

More than 1,500 adults responded to the survey between October 5 – 12 and according to the results, the share of people who viewed vaccines as less safe and effective has increased since April 2021, when the group was first included on a panel for the survey.

Americans are less likely to consider it safe to get the measles, mumps and rubella (MMR), pneumonia and Covid-19 vaccines than they were in April 2021.

While still a small group, people with views about the vaccines causing autism, cancer and illnesses such as the flu or Covid-19 also ticked up.

The percentage of Americans who believe that vaccines are approved for use in the US are safe dropped 6 percentage points since April 2021 to 71%, while the share of adults who don't think the approved



vaccines are safe nearly doubled in the same time frame – increasing from 9% to 16%.

“There are warning signs in these data that we ignore at our peril,” said Kathleen Hall Jamieson, director of the Annenberg Public Policy Center and director of the survey, in a [news release](#). “Growing numbers now distrust health-protecting, life-saving vaccines.”

Jamieson told CNN in an email that she was surprised by the data.

“Instead of plateauing, levels of misinformation increased as

the pandemic was winding down,” she said, noting that, “For a worrisome part of the population, the rhetoric surrounding COVID vaccination increased acceptance of misinformation and decreased confidence in vaccines.”

“Health misinformation is a serious threat to public health. It can cause confusion, sow mistrust, harm people's health, and undermine public health efforts. Limiting the spread of health misinformation is a moral and civic imperative that will require a whole-of-society effort,” he said...[Read More](#)

Critics Slam Updated Infection Control Recommendations for Hospitals

Advisors to the U.S. Centers for Disease Control and Prevention are expected to approve new draft guidelines for hospital infection control this week, the first update since 2007.

But healthcare workers worry whether the guidelines, which suggest that surgical masks are as good as N-95 masks at preventing the spread of respiratory infections during routine care, are protecting a hospital's bottom line rather than worker health, *CNN* reported.

The [Healthcare Infection](#)

Control Practices

Advisory

Committee plans to conclude a two-day meeting on the proposed updates on Friday.

The new guidelines aren't mandatory, but they're often used and agencies like the Occupational Safety and Health Administration tend to base worker safety standards on them.

“What they are working on ... it's going to impact patients and health care workers in so many different places. It's going to



determine whether some of them live or die, quite honestly,” [Jane Thomason](#), lead industrial hygienist for

National Nurses United, told *CNN*.

Thomason's concerns include that the guidelines will reduce protections for healthcare workers, despite lessons learned during the pandemic.

More than 4,500 physicians died between early 2020 and December 2021, which was 600 more than would have been

expected, according to a recent [study](#) from researchers at Stanford and the University of Southern California at Los Angeles.

“This is going backward,” [Dr. David Michaels](#), an epidemiologist and professor at the George Washington University School of Public Health told *CNN*, noting the guidelines could have benefited from knowledge gained during the pandemic about transmission of respiratory infections....[Read More](#)

Experimental Pacemaker Can Recharge Its Own Battery

It's a pacemaker that's a bit like the Energizer bunny – it will keep ticking and ticking and ticking.

An experimental pacemaker is able to partially recharge its own battery by using heartbeats to generate fresh electrical energy, researchers report.

The device can recoup about 10% of the energy needed to stimulate another heartbeat, which would extend the 6- to 15-year life of a typical pacemaker battery, results show.

These findings will be presented at the American Heart Association's annual meeting, to be held from Nov. 11-13, in Philadelphia and online.

“Mechanical and electrical energy are linked and can be exchanged back and forth,” explained lead researcher [Dr. Babak Nazer](#), an associate

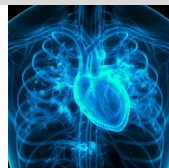
professor of medicine at the University of Washington in Seattle.

“Just like ultrasound converts electrical voltage into pressure or sound, we can engineer similar materials onto implantable medical devices to convert the heart's natural oscillating pressures ‘backward’ into voltage to prolong battery life,” Nazer said in a meeting news release.

For this study, researchers engineered three prototype pacemakers designed to recover some of their electricity through the beating of a heart.

Leadless pacemakers are all-in-one devices placed inside the heart's right ventricle.

The battery cannot be easily replaced because the device can't be easily removed from inside the



heart. It is sometimes necessary to implant new pacemakers alongside previous ones that have lost their battery charge, researchers noted.

The team placed the prototypes into a special cardiac pressure simulator, which was designed to replicate the heart's natural pressures at a rate of 60 beats per second.

The best of the three prototypes harvested about 10% of the energy needed to pace the “next beat,” based on average pacemaker output.

“Our next step is to optimize materials and fabrication to improve energy-harvesting efficiency, and then show we can do so consistently in long-term studies,” Nazer said. “When we can improve upon our 10%

harvesting efficiency, we hope to partner with one of the major pacemaker companies to incorporate our design and housing into an existing leadless pacemaker.

“We hope to prolong battery life further and expand access of this product to younger patients, who would hopefully require fewer implants over their lifetime,” Nazer added.

This experiment “provides valuable information on harvesting energy from the heart to recharge pacemaker batteries,” [Dr. Kenneth Ellenbogen](#), a professor of cardiology at Virginia Commonwealth University's School of Medicine, said in the release....[Read More](#)

Too Much Salt Could Raise Your Odds for Diabetes

Put down the saltshaker — especially if you're at risk of type 2 diabetes.

While the condition brings to mind the need to avoid sugar, a new study links it to frequent salt consumption.

"We already know that limiting salt can reduce the risk of cardiovascular diseases and hypertension, but this study shows for the first time that taking the saltshaker off the table

can help prevent type 2 diabetes as well," said lead study author **Dr. Lu Qi**. He is chair and professor at the Tulane University School of Public Health and Tropical Medicine in New Orleans.

"It's not a difficult change to make, but it could have a tremendous impact on your health," Qi said in a university news release.

To better understand the link,



the researchers surveyed more than 400,000 adults registered in the UK Biobank about their salt intake.

Over almost 12 years on average, the research team saw more than 13,000 cases of type 2 diabetes develop.

Compared to those who "never" or "rarely" used salt, participants who "sometimes," "usually" or "always" added salt

had a respective 13%, 20% and 39% higher risk of developing type 2 diabetes, according to the study.

Why high salt intake would have this impact is not fully understood.

Qi thinks salt encourages people to eat larger portions, which then increases the chances of developing risk factors such as obesity and inflammation...[Read More](#)

Managing Your Heart Health Through Menopause

Women can help protect their heart health as they go through menopause.

The American Heart Association (AHA) offers some tips for protecting that most critical organ while hormone levels and body composition change.

"More women in the U.S. are living longer, and a significant portion of them will spend up to 40% of their lives postmenopausal," said **Brooke Aggarwal**, an assistant professor in cardiology at Columbia University Medical Center in New York City.

"Navigating through menopause isn't one-size-fits-all, and neither is the journey to good heart health," added Aggarwal, a volunteer for AHA's Go Red for

Women movement.

"This makes it even more important to focus on heart and brain health at all stages of life," she said in an AHA news release.

The best defense against menopause-related changes is working with your doctor, according to the AHA.

It's important that key health numbers are in a healthy range.

Blood pressure, blood sugar and body mass index -- a measure of body fat based on height and weight -- should be monitored yearly. If your numbers are out of range, they should be monitored even more often.

Cholesterol level is also important. Healthy numbers are



more individualized based on your other risk factors, which your doctor can help you figure out. Your overall pattern of eating is also important.

Both the DASH and Mediterranean types of eating plans have the most heart-healthy elements. They are high in vegetables, fruit, whole grains, healthy fat and lean protein. They're also low in salt, sugar, alcohol and processed foods.

Exercise is also important. Strength and resistance training, endurance, balance and flexibility make for a well-rounded routine.

Strength and resistance have the added benefit of increasing bone strength and muscle mass, according to the heart association.

As women enter menopause, their bone density is affected. Body composition tends to shift to lower muscle mass. Strength training at least twice a week can help both bones and muscles.

It's also important to prioritize sleep.

In menopause, many symptoms can affect a good night's sleep. These include night sweats, insomnia and getting up to go to the bathroom. But if you manage to get enough rest, you'll have a stronger immune system, better mood, more energy, clearer thinking and lower risk of chronic diseases.

Setting an alarm to remind you it's time to wind down can help. Shut down all electronic devices at that time. Call your doctor if you're still having trouble.

Cardiac Arrest? Drones Might Someday Come to the Rescue

Drones might prove a feasible way to deliver lifesaving defibrillators to cardiac arrests in remote areas, a new research simulation suggests.

Delivering automated external defibrillators (AEDs) by drone could dramatically improve emergency response times in both urban and rural areas, according to findings to be presented Saturday and Sunday at an American Heart Association meeting, in Philadelphia.

The five-minute response time for AED arrival at a cardiac arrest improved from 24% to 77% for urban areas and 10% to 23% for rural areas, a computer simulation revealed.

"We were a bit surprised that the improvements appeared greater in the urban areas," said lead researcher **Jamal Chu**, a

doctoral student at the University of Toronto.

"There's an historical inequity in EMS response times in rural versus urban areas, so we anticipated that drones could provide a bigger improvement in response times in rural areas and, thus, reduce that inequity," he said in a meeting news release.

More than 350,000 cardiac arrests occur outside of a hospital each year, and the survival rate for these events is only about 10%, the American Heart Association says.

Shocking the heart back to beating with a defibrillator could save some of those lives.

The AHA estimates that a person's chances of survival can as much as triple if they receive immediate CPR, including the



use of an automated external defibrillator (AED) if needed. But the number of out-of-hospital cardiac

arrest victims who have an AED applied by a bystander remains low, researchers say. Timely access to an AED is a major barrier, particularly in rural areas.

For this study, scheduled for presentation Sunday, Chu's team developed a simulation model that evaluated how quickly a network of drones could deliver AEDs to the scene of a cardiac arrest in 19 counties in North Carolina, compared to the response times of local first responders.

The analysis included nearly 9,000 out-of-hospital cardiac arrests that occurred in those counties between 2013 and 2019

-- more than 5,700 in urban areas and around 3,200 in rural areas.

Historically, average response times in the counties were about 7 minutes in urban areas and more than 9 minutes in rural areas.

On average, estimated response times would be reduced by 42% to 4 minutes in urban areas and by 24% to 7 minutes in rural areas, if drones were used to maximize delivery of AEDs, the simulation suggests.

Overall, a drone network would cause a significant improvement in response times in all 19 counties, for both urban and rural populations, researchers concluded...[Read More](#)