



Message from the Alliance for Retired Americans Leaders

Federal Government Shutdown Looms as GOP House Members Disagree on Next Steps



Rich Fiasta,
Executive
Director, ARA

A federal government shutdown appears more and more likely ahead of Saturday's midnight

government funding deadline, as Republican House members continue to squabble amongst themselves.

Update

House passes (CR) Continuing Resolution

"It is certainly good news that the federal government will not shut down immediately and that

an unnecessary crisis has been averted," said **Richard Fiasta, Executive Director of the Alliance**. "However, GOP House members must get their act together. Extremism and chaos is not a suitable recipe for governing. Seniors and all Americans deserve stability and we need to know that we have funding for more than 45 days at a time."

Medicare Open Enrollment Starts October 15: What to Know about the Process and Coverage Options



Joseph Peters
ARA

The annual Medicare open enrollment period runs from October 15th to December 7th each year. During this time,

Medicare beneficiaries can review features of Medicare plans offered in their area and make changes to their coverage which goes into effect on January 1st of the following year. The changes may include switching from traditional Medicare to a Medicare Advantage plan (or vice versa), switching between Medicare Advantage plans, and electing or switching between Medicare Part D prescription drug plans.

"Open enrollment season can be confusing and overwhelming for many retirees," said **Joseph Peters, Jr., Secretary Treasurer of the**

Alliance. "But it's worth taking the time to review your health care coverage to make sure you're in the best plan for your current health care needs"

Beneficiaries can contact their State Health Insurance Assistance Program (SHIP) to get free, unbiased information about Medicare options in their state.

Find your local SHIP office [here](#).



SHIP

State Health Insurance
Assistance Program

Navigating Medicare

Social Security Overpayments Draw Scrutiny and Outrage From Members of Congress

Several members of Congress are calling on the Social Security Administration to answer for issuing billions of dollars of payments it says beneficiaries weren't entitled to receive — and then demanding the money back

Many of the recipients are elderly, poor, or disabled and have already spent the money. They have little or no way of repaying it.

"The government's got to fix this," said Sen. Sherrod Brown (D-Ohio), who chairs a Senate panel that oversees Social Security.

"It's a management problem, and people there should be held accountable," Brown added.

Rep. Mike Carey of Ohio, the No. 2 Republican on a House

panel that oversees Social Security, called for a congressional hearing on the subject.

"We need to have a hearing," he said. "The general sense from members is ... we do have a problem, we've got to address it, we've got to fix it," he added.

Sen. Rick Scott (R-Fla.), a member of the Committee on Aging, questioned how the volume of overpayments was allowed to grow to more than \$20 billion. "Is somebody going to be held accountable at the federal level for, you know, messing this up?"

Those lawmakers and others commented in the wake of an



investigation by KFF Health News and Cox Media Group (CMG) that

found many of the nation's poorest and most vulnerable, including people receiving disability benefits, have been called on to repay the government sums that can reach tens of thousands of dollars or more.

The Social Security Administration recovered \$4.7 billion of overpayments during the 2022 fiscal year but ended that year with **\$21.6 billion of overpayments** still uncollected, according to a November 2022 report by SSA's inspector general.

In many cases, the

overpayments were the result of errors by the government rather than the person receiving the money, the agency has stated.

For example, in a disclosure covering some of the programs involved — Old-Age, Survivors, and Disability Insurance, collectively known as OASDI — the agency reported issuing about \$2 billion of overpayments in the 2022 fiscal year, of which about \$1.5 billion was "within agency control."

"The beneficiary or third-party provided the information we requested, but we failed to use the data/information to validate accuracy prior to making a payment," the agency reported...[Read More](#)

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

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If you're in a Medicare Advantage plan, watch out! Your doctor or hospital might no longer be in-network

Health care providers across the country look to be dropping their Medicare Advantage plan contracts like flies. Sometimes, physicians or hospital systems cancel contracts with Humana, UnitedHealthcare, Aetna, Cigna and other health insurers because they deny too many prior authorization requests, causing patient safety concerns. Sometimes, these health insurers fail to pay physicians and hospitals what they owe them. Whatever the reason, if you're in a Medicare Advantage plan, watch out. Your doctors or hospital might no longer be in-network.

Over the last few years, Medicare Advantage plans have been found to inappropriately delay and deny care. The Office of the Inspector General has twice now reported **widespread and persistent inappropriate**

denials of care in some Medicare Advantage plans, with an average of 13 percent of claims wrongly denied. However, our government won't tell us which Medicare Advantage plans are the bad actors.

Data as basic as Medicare Advantage plan denial rates and disenrollment rates are not publicly available. Social Security Works has sent a Freedom of Information Act to the Centers for Medicare and Medicaid Services, requesting this information. But, so far, Social Security Works has not received a substantive response.

Instead, we are seeing several large hospital systems and physician groups end their contracts with corporate health insurers offering Medicare Advantage. Most recently, **MedPage Today** reports



that "two influential medical groups with San Diego-based Scripps Health are cancelling their Medicare Advantage contracts for 2024 because

of low reimbursement and prior authorization hassles, leaving 30,000 enrolled seniors to look for new doctors, or different coverage."

The problem is not going away but rather looks to be getting worse. As MedPage Today reports:

- ◆ Mayo Clinic in Arizona and Florida no longer contracts with most Medicare Advantage plans.
- ◆ Samaritan Health Services in Oregon terminated its contract with UnitedHealthcare.
- ◆ Regional Medical Center terminated contracts with Cigna's Medicare Advantage

plans and says it will end its Aetna and Humana MA plans in 2024.

- ◆ Stillwater Medical Center, a 117-bed hospital in Oklahoma ended contracts with all its MA plans. It said that MA plans denied 22 percent of prior authorization requests; traditional Medicare denied 1 percent.
- ◆ Brookings Health System, a 49-bed hospital in South Dakota ended its MA contracts effective 2024.
- ◆ St. Charles Health System in Oregon is still on the fence but told its patients to enroll in Traditional Medicare.
- ◆ Baptist Health Medical Group in Louisville, Kentucky ended its Medicare Advantage contract with Humana.

Important Final Rule Streamlines Enrollment Into Medicare Savings Programs

This week, the Centers for Medicare & Medicaid Services (CMS) finalized a long-awaited rule that will make it easier for people with Medicare to be and stay enrolled in a **Medicare Savings Program (MSP)**. **CMS estimates** that this rule will result in 860,000 more individuals participating in MSPs.

MSPs are a set of financial assistance programs that help pay Medicare costs for people with few resources, helping enrollees afford their health coverage and other basic needs. Despite their value, **an estimated** 40% of those who are eligible—2.5 million people—are not enrolled. This **may be due** to lack of information about the programs and how to sign up, or difficulty

navigating an enrollment process that is **notoriously complex**.

To help address these access problems, the final rule requires states to make use of existing eligibility information from the Social Security Administration (SSA). SSA oversees enrollment into the low-income subsidy (LIS)—also called "Extra Help"—a program that helps people with Medicare afford their prescription drugs and has similar application requirements as MSPs. In addition, the rule reduces the burden on applicants to produce certain types of documentation prior to enrollment, ensures more people have an earlier effective date for their MSP coverage, and



automatically enrolls Medicare-eligible people receiving Supplemental Security Income (SSI)

into the MSP known as the **Qualified Medicare Beneficiary (OMB)** program.

At Medicare Rights, we **strongly supported the proposed rule and submitted comments** to that effect. But the final rule does not go as far as the proposals. The draft rule also dealt with burdensome redetermination processes, important provisions that are not addressed in the final rule. This leaves people with both Medicare and Medicaid at risk of losing their Medicaid and MSP coverage because they have to fill out burdensome eligibility

paperwork multiple times a year. We will continue to urge CMS to address this issue.

The effective date for key provisions that will reduce burdens on applicants is also later than first proposed. Initially, the latest compliance date was to be 12 months after publication of the final rule. Now, the latest compliance date is April 2026 for some provisions. While this extension gives states more time to come into compliance, and many states may choose to act more quickly, it delays access to the streamlined processes for people in states that do not. We will continue to urge states to act sooner rather than later to ensure beneficiaries get the help they need.

Nursing Home Costs and How to Pay

Nursing home care is costly, but there are ways to manage without going broke.

Many people grow up with grandparents who lived for years in their homes and, despite various illnesses and conditions, never saw the inside of a nursing home.

That still may be true for some of today's older adults, a third of whom may never need **long-term care services** and support.

However, according to the U.S. Department of Health & Human Services' **Administration on Aging**, the average 65 year old has an almost 70% chance of needing some type of long-term care – like that at a nursing home – at some point, and 20% will need such care for more than five years.

With those odds, you'll need to account for how you'll pay for a



nursing home. In this simple and straightforward guide, we'll explore practical steps, government programs and financial options to ensure your loved ones get the care they need.

Nursing Homes vs. Assisted Living

There are many options out there for older adults who need care or assistance.

Nursing homes, for instance, offer both long-term, round-the-clock custodial, or nonmedical, care as well as **skilled nursing care**. Skilled care can include specialized therapy and services only licensed professionals can provide, such as catheter management. In many cases, a stay in a nursing home follows a period of hospitalization....**Read More**

Dear Marci: What do I need to do during Fall Open Enrollment?

Dear Marci,
I enrolled in Medicare earlier this year. My sister told me that Fall Open Enrollment for Medicare is coming up. What is Fall Open Enrollment, and what do I need to do during this time?
-Abigail (Redding, CA)

Dear Abigail,
Fall Open Enrollment runs from October 15 through December 7 each year. This period is also sometimes called the Annual Election Period. During this time, you can make changes to your health insurance coverage, including adding, dropping, or changing your Medicare coverage. Even if you're happy with your current health and drug coverage, Fall Open Enrollment is the time to review what you have, compare it with other options, and make sure that your current coverage still meets your needs for the coming year.

You can make as many changes as you need to your

Medicare coverage during Fall Open Enrollment. The changes you can make include:

1. Joining a new Medicare Advantage Plan
 2. Joining a new Part D prescription drug plan
 3. Switching from Original Medicare to a Medicare Advantage Plan
- ◆ Switching from a Medicare Advantage Plan to Original Medicare (with or without a Part D plan)
 - ◆ Regardless of how you receive your Medicare coverage, you should consider:
 - ◆ Your access to health care providers you want to see
 - ◆ Your access to preferred pharmacies
 - ◆ Your access to benefits and services you need
 - ◆ The total costs for insurance premiums, deductibles, and cost-sharing amounts



Dear Marci

◆ If you have Original Medicare, visit

www.medicare.gov or read the 2024 *Medicare & You* handbook to learn about Medicare's benefits for the upcoming year. You should review any increases to Original Medicare premiums, deductibles, and coinsurance charges.

If you have a Medicare Advantage Plan or a stand-alone Part D plan, read your plan's Annual Notice of Change (ANOC) and/or Evidence of Coverage (EOC). Review these notices for any changes in:

- The plan's costs
 - The plan's benefits and coverage rules
 - The plan's formulary (list of drugs your plan covers)
- Make sure that your drugs will still be covered next year and that your providers and pharmacies are still in the plan's network. If

you are unhappy with any of your plan's changes, you can enroll in a new plan. If you want assistance reviewing your options, contact your **State Health Insurance Assistance Program (SHIP)** for individualized counseling.

Even if you are happy with your current Medicare coverage, consider other Medicare health and drug plan options in your area. For example, even if you do not plan to change your Medicare Advantage or Part D plan, you should check to see if there's another plan in your area that will offer you better health and/or drug coverage at a more affordable price. Research shows that people with Medicare prescription drug coverage 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 and/or lower prices.

-Marci

Almost half of US adults plan to get new COVID-19 vaccine, survey finds

Nearly half of all adults in the United States plan to get the **newly recommended COVID-19 vaccine**, according to results from a survey released Wednesday.

The latest poll conducted by the KFF COVID-19 Vaccine Monitor found that 23% of U.S. adults say they will "definitely" get the updated booster, 23% say they will "probably" get it, while 19% say they will "probably not"

get it and 33% say they will "definitely not" get it.

The new shots from Pfizer-BioNTech and Moderna, which are formulated to target newer variants of COVID-19, are recommend for everyone 6 months and older, but the survey found that the majority of U.S. parents say they aren't planning to get it for their children.

Consistent with prior trends as earlier vaccines were being rolled



out during the COVID-19 pandemic, the poll found that Democrats and people at least 65 years old are most likely to say they would "definitely" or "probably" get the updated booster.

The share of the American public who intend to get the new vaccine is higher than those who have received previous shots, but not as much as initial vaccine uptake back in 2020, according to the survey.

The poll results came as COVID-19 hospitalizations in the U.S. **surpassed** 20,000 for the first time since mid-March. However, recent data has indicated that the updated boosters could offer additional protection against currently circulating variants and especially protect against severe disease and death, particularly for those who are elderly or immune compromised.

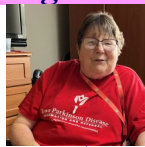
As Covid Infections Rise, Nursing Homes Are Still Waiting for Vaccines

"Covid is not pretty in a nursing home," said Deb Wityk, a 70-year-old retired massage therapist who lives in one called Spurgeon Manor, in rural Iowa. She twice contracted the disease and is eager to get the newly approved vaccine because she has chronic lymphocytic leukemia, which weakens her immune system.

The Centers for Disease Control and Prevention approved the latest vaccine on Sept. 12, and the new shots became available to the general public within the past week or so. But many nursing homes will not begin

inoculations until well into October or even November, though infections among this vulnerable population are rising steeply, to nearly 1%, or 9.7 per 1,000 residents, as of mid-September from a low of 2.2 per 1,000 residents in mid-June.

"The distribution of the new covid-19 vaccine is not going well," said Chad Worz, CEO of the American Society of Consultant Pharmacists. "Older adults in those settings are certainly the most vulnerable and should have been prioritized."



With the end of the formal public health emergency in May, the federal government stopped purchasing and distributing covid vaccines. That has added complications for operators of nursing homes who have encountered resistance throughout the pandemic in persuading employees and residents to get the shots.

The coronavirus decimated nursing homes during the first two years of the pandemic, killing more than 200,000 residents and staffers. Elizabeth Sobczyk, project director of

Moving Needles, a CDC-funded initiative to improve adult immunization rates in long-term care facilities, said without a government agreement to purchase the shots, vaccine manufacturers will make large quantities only once CDC experts have recommended approval.

"Then they need to be FDA inspected — we want safe vaccines — then there is contracting and rollout," Sobczyk said. "So, I completely understand the frustration, but also why the availability wasn't immediate." ...**Read More**

New study finds billions in overpayments to Medicare Advantage plans

If you're enrolled in a Medicare Advantage plan, you could be benefiting from billions of taxpayer dollars in overpayments to Medicare Advantage (MA) plans. More likely, you could be suffering from widespread and persistent **inappropriate delays and denials of care and ghost networks**, without doctors who are willing to take your insurance. One thing's for sure, there's little you can count on about your MA coverage.

In addition, notwithstanding the government's massive overpayments to Medicare Advantage plans, millions of people in Medicare Advantage plans **struggle to afford their care**. Between high copays, inappropriate denials and narrow

networks that keep people from seeing the health care providers they want to see, people in Medicare Advantage are at risk of not getting the care they need. The federal government does not name the bad Medicare Advantage actors, so people are left to choose blindly among MA plans.

Moreover, a new study in **Health Affairs** out of the Brown University School of Public Health finds that the way our federal government sets the benchmark for paying Medicare Advantage plans is seriously flawed. As a result, the researchers find that the federal government overpaid Medicare Advantage plans by an average of



\$9.3 billion a year in 2017, 2018, 2019 and 2020. What will the Congress and the Biden administration do about this huge payment defect?

To be clear, \$9.8 billion a year in Medicare Advantage overpayments from using a flawed benchmark is only a piece of the overpayment problem. Another study out of the **University of Southern California** found that the federal government is overpaying Medicare Advantage plans \$75 billion this year as a result of the fact that Medicare Advantage enrollees are healthier than enrollees in Traditional Medicare but the government pays MA plans as if their enrollees are less

healthy than enrollees in Traditional Medicare.

The Brown University researchers call for the government to change the way it adjusts for risk when it sets the benchmark rate in order to offset the \$9.8 billion in overpayments to Medicare Advantage plans. Truth be told, no one has come up with a good way to make the risk adjustment that leads to appropriate payment and provides an incentive for the MA plans to cover the care people need, without delay, from the best health care providers. It's time to end the defective capitated risk-adjusted payment system and pay the MA plans differently.

Older adults owe \$54 billion in medical debt

The **Consumer Financial Protection Bureau**, an arm of the federal government reports that almost four million older adults owe as much as \$54 billion in medical debt. Of those, 98 percent have either traditional Medicare or Medicare Advantage. What's truly shocking is that a lot of that debt is money they should not be paying.

Virtually all older adults have Medicare, and seven in 10 report having additional insurance, either Medicaid, retiree coverage from a former employer or supplemental insurance such as Medigap. Yet, between 2019 and 2020, there was a 20 percent increase in the amount of unpaid medical bills of older adults, from \$44.8 billion to \$53.8 billion. That's about 25 percent of all medical debt among adults at that time.

The average amount older adults owed in 2020 was 13,800, although half of them owed less

than \$1,500. In 2019, they owed an average of \$11,700, with half owing less than \$1,200. The jump is confounding since fewer people got medical care in 2020 than in 2019 as a result of Covid-19. The jump is also greater than the increase in Medicare premiums and overall health spending.

The Consumer Financial Protection Bureau found that a smaller percentage of people in Traditional Medicare with supplemental coverage, either Medigap or retiree coverage from a former employer, had unpaid medical bills than people in Medicare Advantage.

There is a substantial chance that a lot of these medical bills are erroneous. Physicians and other health care providers sometimes wrongly bill Medicare patients extra. You should never pay an unexpected bill from a physician without first checking with your local State Health Insurance Program (SHIP).

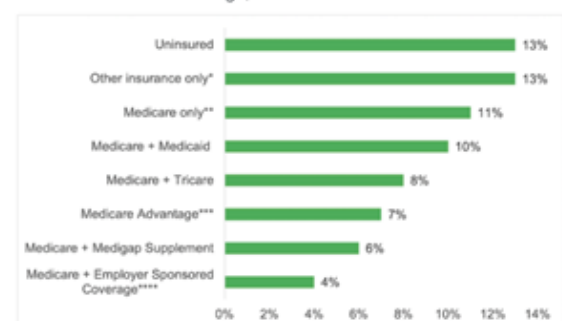
If you have both Medicare and Medicaid, you should have no or virtually no out-of-pocket costs for all Medicare-covered services. And, physicians and other health care providers are prohibited from charging you directly, except for a small copay in some states. Do not pay those bills. Call the doctors office and assert your rights; you might also want to file a complaint with Medicare.

If your health care provider sends an erroneous bill to a bill collector or credit reporting company, it could harm your credit. Call your local member of Congress and seek help correcting your credit report. If you are not able to get additional care because of your medical

debt, let your member of Congress know.

Congress allows bill collectors to go after people with Medicare with near impunity. The bill collectors should be penalized for going after people with Medicare without taking appropriate steps to ensure that bills are accurate. Meanwhile, people with Medicare, including people in Medicare Advantage plans, often pay these erroneous bills, deplete their savings and then **struggle to afford the care they need**.

Percentage of older adults reporting unpaid medical bills by selected sources of coverage, December 2020



Source: CFPB analysis of the Census Bureau, Survey of Income and Program Participation 2021, public use files.

Interpreting Emojis

Emojis are a crucial part of communication in texts and social media. You might even say they play a role in our social well-being. With thousands of individual characters, our messages to one another can now include hearts, rocket ships, or cups of coffee. But here's the problem: **Do we always**

understand the meaning of these emojis?

While a thumbs-up or middle finger emoji may be easy to decode, many characters often leave recipients guessing. In interviewing Americans over the age of 55 in South Florida and



conducting a similar online poll, we're

able to outline what people do or don't understand about the most popular emojis on the market. Curious to see what's being interpreted by older adults who live in **55+ communities** or who enjoy other **senior living**

options?

Continue reading to find out.

- ◆ **Lost in Translation**
- ◆ **Fact: You're Using Emojis**
- ◆ **A Literal Translation**
- ◆ **Misunderstood Emojis**
- ◆ **Sexy Veg**
- ◆ **Peach, Butt, Or Peachy Butts**

People in Medicare Advantage struggle to afford their care

Medicare offers very good coverage of inpatient and outpatient medical services, but it comes with significant out-of-pocket costs. A new report from **The Commonwealth Fund** lays out how these additional costs affect access to care for older adults and people with disabilities. In sum, people in Medicare Advantage are as likely to struggle to afford their care as people in Traditional Medicare.

Unless they qualify for Medicaid or a Medicare Savings Program, people with Medicare generally pay monthly Medicare Part B premiums, deductibles, coinsurance and copays. They also generally pay all or most of the cost of dental, hearing, vision and long-term care services.

Nearly 20 percent of people with Medicare face burdensome out-of-pocket costs—they are underinsured—based on their income. Whether they are in Traditional Medicare or Medicare Advantage, particularly people whose income is under twice the federal poverty level (\$27, 180

for an individual and \$36,620 for a couple in 2022) but who do not qualify for Medicaid, struggle to pay for their care. About 21 million people with Medicare have incomes under 200 percent of the federal poverty level.

The Commonwealth Fund survey found that 38 percent of people with Medicare reported one or more problems accessing care during the year. As a result, they might have not filled a prescription or gone to the doctor or dentist. People in Traditional Medicare and Medicare Advantage experienced access to care problems at the same rate. It should go without saying that people with annual incomes above \$55,000 experienced fewer problems accessing care.

Medicare Part B premiums alone are substantial. And, 23 percent of people with Medicare reported that it is a challenge to pay these premiums. Nearly four in ten people with incomes under 200 percent of the federal poverty level reported a challenge paying these premiums.

If you're in a Medicare

Advantage plan, out-of-pocket medical and inpatient costs can be as high as **\$8,300 a year in 2023** for in-network services alone, depending upon the Medicare Advantage plan you're enrolled in. If you're in traditional Medicare, these costs are very limited if you have Medicare supplemental coverage or Medigap, retiree coverage from a former employer or Medicaid. But, if you do not have this extra coverage, your costs are uncapped.

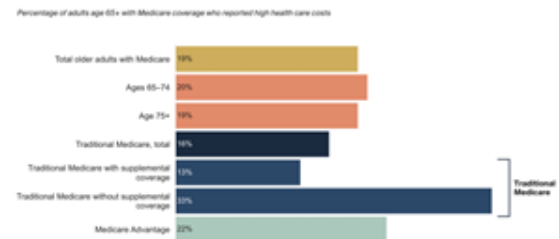
And, while people often join a Medicare Advantage plan believing they will get help with the cost of dental care, often that help appears better than it is. The data show that 30 percent of people in Medicare Advantage plans do not get dental care because of the cost as compared with 24 percent of people in traditional Medicare. More people in

Medicare Advantage plans have incomes under 200 percent of the federal poverty level than people in traditional Medicare.

Medical debt is another challenge facing older adults. One in six people with Medicare said they struggled with a medical bill or medical debt. People enrolled in Medicare Advantage plans faced significantly more medical bill and medical debt problems than people in Traditional Medicare, particularly people with incomes between 200 and 400 percent of the federal poverty level.

Twenty-eight percent of people facing medical debts and bills reported depleting their savings.

About one in five older adults with Medicare coverage reported high health care costs in the past year that make them underinsured.



Want a Healthy Old Age? Get Your Finances in Order Now

Planning for your long-term financial future doesn't just make good economic sense — it could also save your life.

People in both the United States and the United Kingdom have a higher risk of dying prematurely if they aren't engaged in long-term financial planning, according to a report published online Sept. 27 in **PLOS One**.

In fact, the researchers found that the shorter a person's financial planning horizon, the greater their risk of dying.

"The people who live the longest are the ones who are looking years into the future," lead researcher **Joe Gladstone**, an assistant professor of marketing at the University of Colorado Boulder, said in a university Q&A.

"It's very scary how many people are living week to week, month to month, paycheck to paycheck," Gladstone added. "The majority of people are only looking financially out no more than a month ahead."

The study further revealed that

long-term financial planning is most important to the health of those with the fewest means.

Increases in financial planning were significantly associated with better health among households making less than \$80,000 a year and with overall wealth lower than \$450,000, the results showed.

"Planning benefits health for financially disadvantaged people more than the advantaged, because those with greater wealth and income have a financial buffer to income or expenditure shocks, insulating them from experiencing financial hardship," the authors explained in their paper.

"These results are consistent with the idea that planning ahead represents an important resource for those with few financial resources, possibly as they do not have the buffer to cope with shocks," the researchers concluded...

For the study, the investigators tapped into two large pools of data, one in the United States and



the other in the United Kingdom. The U.S. data tracked nearly 11,500 people over a 22-year period, between 1992 and 2014, while the U.K. data covered about 11,300 people for a decade spanning 2002 to 2012.

Short-term planners in the U.S. study had about a 20% higher relative risk of early death compared to long-term planners, the results showed.

The results were even more stark in the United Kingdom, with short-term financial planning associated with an almost 50% higher relative risk of early death compared to long-term planning.

"I think this really shows the importance of what we like to say — your health is your wealth and your wealth is your health," said **Genevieve Waterman**, director of economic and financial security with the National Council on Aging.

The stress caused by financial uncertainty is probably the main culprit behind this increased risk of premature death, said **David**

John, a senior policy advisor with the AARP's Public Policy Institute.

"We know that stress hurts health and stress can kill, and having a longer-term financial plan is one way that people can reduce that stress," John said.

"When people are asked what are some of the great stressors in life — and AARP does research in some of this — one that always comes up is having enough money in retirement or having enough money so that I can pay my bills," John added. "It just makes sense that having longer-term financial planning as part of your life is going to reduce the risk."

The researchers also posited that people with a long-term plan also can better afford the sort of preventive care that can head off chronic health problems.

However, John noted that this was an observational study that cannot rule out other factors that might influence the relationship between health and financial planning... **Read More**

Focus Groups of Older Adults and People with Disabilities Say Medicare Advantage Marketing is Confusing and Overwhelming

Last week, we covered new **KFF research** on Medicare Advantage (MA) television advertisements that aired during the Fall of 2022, as people were making coverage choices for the current calendar year. In a complementary report, **What Do People with Medicare Think About the Role of Marketing, Shopping for Medicare Options, and Their Coverage?**, KFF reveals findings from a series of Medicare beneficiary focus groups conducted during the same time frame, which capture enrollee experiences with coverage choices and plan marketing.

Many of the key takeaways reinforce KFF's marketing analysis and Medicare Rights' experience around misleading and aggressive plan practices.

- ◆ Focus group participants said they were **inundated by Medicare marketing**, including unsolicited phone calls and TV ads, and believed the ads were often misleading and deceptive.
- ◆ Many participants reported receiving unwelcome and unsolicited phone calls from brokers and plan representatives, though it was not always obvious to the participants who was calling. Similarly, nearly all had seen MA TV ads and often found those sponsorships—whether

it was the government or a private company behind the ad—to be unclear.

- ◆ In general, many thought the private plan TV ads were misleading. They did not find celebrity endorsements particularly compelling and were skeptical of many of the ads, particularly those promising an array of “free” benefits.

The participants echoed what we often hear from beneficiaries about the challenges of enrolling in Medicare initially and the complexity of re-evaluating one's coverage every year.

- ◆ Participants found **selecting Medicare coverage overwhelming**. Many were also confused about how Medicare works, including the different parts of the program and what is included in an MA plan vs. supplemental coverage.
- ◆ As a result, participants often looked to brokers for help. Beneficiaries were not bothered by broker commissions “as long as they felt they were getting good recommendations on their plan options.” However, there is no guarantee they were.
- ◆ While few used official Medicare resources, such as the Medicare Handbook or 1-800



Medicare, those who did find them helpful. Most had not heard of or used **State Health Insurance Assistance Programs (SHIPs)**, which are uniquely well positioned to provide unbiased, independent Medicare counseling and assistance.

- ◆ They **highlighted a number of factors** that were important when first choosing their Medicare coverage, including premiums and out-of-pocket costs, access to specific doctors, availability of extra benefits, and coverage of prescription drugs.
- ◆ Most participants with MA did not review their coverage options every year, and even fewer switched plans. Most said selecting a new plan would be too much work, and they felt they would **not be better off with a different option** anyway. However, many wished they had had more information before initially enrolling.
- ◆ Most focus group participants said they were relieved to have Medicare and **satisfied with their coverage**. But some, primarily MA enrollees and individuals dually eligible for Medicare and Medicaid, reported problems specific to their coverage type.
- ◆ Participants dually eligible

for **both Medicare and Medicaid** had varying experiences signing up for Medicaid, with some choosing their coverage and others being assigned a plan. Some participants were worried about losing their Medicaid coverage in general, and during the redetermination process in particular.

- ◆ Some MA enrollees with serious medical conditions encountered high medical bills when using certain services—such as needed care that was not covered and higher than anticipated co-pays.
- ◆ MA participants, including some dually eligible individuals, also reported problematic care delays due to their plan's use of utilization management tools like prior authorization.
- ◆ MA enrollees were generally aware of the importance of having their doctors in-network, but many nevertheless encountered situations when the doctor they wanted to see was out of network. Some dually eligible MA enrollees reported difficulty finding providers who were in-network and accepted both their MA and Medicaid coverage..**Read More**

Part D and Medicare Advantage Plans Stable for 2024

In advance of the upcoming Medicare Fall Open Enrollment period, beginning October 15, the Biden-Harris **administration announced** that Medicare Advantage (MA) and Part D plans for 2024 will be largely stable from 2023 offerings, with slight or no premium changes for most plans.

Standalone Part D plans are how people with original Medicare get prescription drug coverage. According to the announcement, the average Part D plan's premium will decrease slightly, from \$56.49 in 2023 to an expected \$55.50 in 2024.

MA plans cover original Medicare benefits, usually

bundled with a Part D plan. MA plan premiums are expected to go up slightly in 2024, from \$17.86 to \$18.50. The announcement also estimates that 73% of MA enrollees will not see an MA premium increase. These stabilized prices come as the Inflation Reduction Act (IRA) makes additional important changes to prescription drug coverage. Already, the IRA has lowered **insulin and vaccine costs**, and **penalizes companies for raising prices faster than inflation**. Starting in 2024, there is an \$8000 out-of-pocket cap for people with high Part D costs. This cap will lower



to \$2000 from 2025 onward.

In addition, the IRA **extends eligibility for the low-income subsidy (LIS)**, also called “Extra Help.” LIS helps people afford prescription medications and many people are eligible but not enrolled. The administration predicts that more people will join MA plans this year, pushing MA enrollment over 50% of all Medicare beneficiaries, and that they will have more plan choices available. At Medicare Rights, we are concerned that the rise of MA is putting **Medicare's financial footing at risk** and that there

are **too many plans** for people to tell them apart. We will continue to advocate for ways to curtail MA overpayment and to standardize plan offerings to make it easier for beneficiaries to choose the right coverage for their circumstances. Importantly, the separate Medicare Part B premium has not been announced yet. People in both original Medicare and in MA have the Part B premium. If you cannot afford your Part B premium, you may be eligible for a **Medicare Savings Program** that can help cover your costs. As with LIS, **many people are eligible but not enrolled**.

It's once again time to get your flu shot!

It's important to get the flu shot every year, no matter how old you are. It's particularly important for older adults. And, it is all the more important with Covid-19 surging. With summer at an end, it's time to get your flu shot!

Talk to your doctor about getting the flu shot and about whether you should get a **special vaccine** available for people over 65. The good news: **Medicare covers the full cost of a flu shot.**

You do not need to go to the doctor's office for your flu shot. You can likely get the flu shot at your local pharmacy or your local supermarket. More pharmacies are offering drive-through and curbside flu shots, in addition to in-store vaccines.

Why get the flu shot now? That's how you best protect yourself, the people you love and your community. The flu, like Covid-19, can be lethal. It kills thousands of people each year. Because people have been taking precautions against Covid-19 though, in 2021-22, **the CDC** found a significant drop in hospitalizations and deaths from the flu. Ten thousand people in the US were hospitalized from the flu and 5,000 people died. **Older adults are more likely to die from the flu** than younger people.

The flu vaccine takes between two and four weeks to become effective. So, even if you get it now, it might not protect you



from the flu until the end of October. It will not protect you from Covid-19, though the symptoms can be quite similar—a cough, a cold, sore throat, fever. You should also talk to your doctor about getting the **Covid-19 booster shot**, now available; also ask **whether you should get the new RSV vaccine.**

Unfortunately, sometimes the flu shot will not keep you from getting the flu. However, even if you get the flu, the flu shot reduces the odds that it will be a severe case. The flu shot may keep you from being hospitalized for the flu or, worse still, from being in the intensive care unit of

the hospital. It also reduces your risk of death.

You shouldn't wait to get the flu shot. No one knows whether the flu season will begin this month or next. You want to protect yourself as soon as possible.

You need the flu shot even if you have not gotten the flu before. (There is one exception: People who are allergic to the flu vaccine.) There is only benefit from getting the flu shot. The flu shot cannot give you the flu.

Here's some good news: Everything you are doing to protect yourself from Covid-19—social distancing, wearing a mask and regular hand washing—should also minimize your chance of getting the flu!

Fast-Acting Nasal Spray May Ease Rapid Heartbeat

Up to 2 million people in the U.S. experience rapid-fire heartbeats from time to time, and many end up in the hospital for treatment.

But an investigational nasal spray may help folks with paroxysmal supraventricular tachycardia (PSVT) safely and quickly slow their heart rate on their own.

"Currently, PSVT is treated with intravenous medication administered in the emergency room or by paramedics when vagal maneuvers are not effective, which is the majority of

cases," said study leader **Dr. James Ip**, an associate professor of clinical medicine at Weill Cornell Medical Center in New York City.

Vagal maneuvers are physical actions such as bearing down that make the vagus nerve slow your heart down.

At 160 to 250 heartbeats a minute, Ip said PSVT can be scary, but it isn't usually life-threatening.

When self-administered as a nasal spray, etipamil can slow heart rate in 30 minutes,



according to a clinical trial funded by its maker, Milestone Pharma.

Etipamil is a calcium channel blocker, a class of drugs known to slow down heart rates.

No medications are currently approved to treat PSVT without direct medical supervision, researchers said in background notes.

"This is a game changer because patients can now treat their own PSVT episode by themselves and avoid calling an ambulance or going to the emergency room," Ip said.

The study was published Sept. 27 in the *Journal of the American Heart Association*.

Milestone Pharma plans to submit a new drug application to the U.S. Food and Drug Administration in October.

The new research is an extension of a previous trial of the nasal spray. Folks were 58 years old, on average, and had experienced 9.7 PSVT episodes in the previous year. Most were taking long-acting medications to prevent rapid heartbeats....**Read More**

Mammograms: An Expert Overview on Why They're So Important

Mammograms have long offered early detection of breast cancer, which is why getting them regularly is crucial to women's health, one expert says.

"There are several risk factors associated with breast cancer. As with many other diseases, risk of developing breast cancer increases as you get older," said **Dr. Mridula George**, associate program director of breast medical oncology at Rutgers Cancer Institute of New Jersey.

Breast cancer is the second-most common cancer for women after skin cancer, according to the

American Cancer Society.

A woman whose mother or sister developed breast or ovarian cancer may be at high risk for the disease. So, too, might someone who has multiple family members who developed breast, ovarian or prostate cancer.

In the early stages of breast cancer, it may not be possible to find signs through breast self-exam. Early disease also doesn't cause pain, George noted in a Rutgers news release.

Later, symptoms can include a lump or thickening in or near the



breast or in the underarm area. It may be seen as a change in the size or shape of the breast or felt as tenderness.

A woman may also experience nipple discharge or the nipple pulled back into the breast, or a change in the way the skin of the breast, areola or nipple looks or feels, such as being warm, swollen, red or scaly, George added.

Mammography uses low-dose X-rays to show abnormal areas or tissues in the breast before a woman has noticeable symptoms.

The breasts are each placed in a

special machine between two plates. The plates move together to compress the breast tissue, so it's easier for the X-ray to obtain a clear image.

The images are stored on a computer where they can be viewed and analyzed by the radiologist and a woman's doctor.

When a breast cancer is detected early and hasn't spread, the five-year relative survival rate is 99%, George said. Those found during screening exams are more likely to be smaller and less likely to have spread outside the breast....**Read More**

Biden Administration Gives Funding Boost to Help Curb Suicides

The Biden administration is allocating \$232.2 million in grants to help stem suicides and improve behavioral health care for at-risk groups.

Suicide is happening at an "alarming" rate, according to the U.S. Department of Health and Human Services (HHS).

Last year alone, nearly 50,000 Americans died by suicide, up 2.6% from 2021, according to the U.S. Centers for Disease Control and Prevention.

"September is National Suicide Prevention Awareness Month. During this month, we are reminded that suicide is preventable, and no one should go through a suicide-related crisis alone," HHS Secretary **Xavier Becerra** said

Wednesday, emphasizing that the Biden administration "is deeply committed to tackling the mental health challenges facing America, and particularly focused on addressing the alarming rates of suicide."

About \$200 million of the grant will be used to build local capacity for the 988 Suicide & Crisis Lifeline and related crisis services. The national suicide hotline was revamped last year with a three-digit number to make it easier to recall in a crisis.

The new lifeline received nearly 5 million calls in its first year, almost 2 million more for similar timeframes on the previous hotline, according to



HHS. Still, about 82% of respondents to a National Alliance on Mental Illness poll released in July were unaware that they could call or text those three digits for mental health help.

With more than 200 centers with volunteers and paid employees answering calls for people in crisis, calls are routed to a center in a caller's geographic area. Many local call centers have said they need more licensed counselors to answer phones, texts and chats, according to *CNN*.

In all, \$177 million is targeted to improvements in technology and security, as well as hiring and training crisis counselors.

Another \$18.3 million will be used to improve response to 988 contacts from American Indian or Alaska Native populations, including what HHS described as "culturally competent" support. An additional \$5 million is targeted for follow-up with those who have called for help.

Other funds are earmarked to foster improved coordination between call center staffers and emergency services operators, with an aim to reducing the burden on police. Funding for suicide-prevention efforts aimed at college-age people, older adults and those who live in rural areas is also included. Those in rural areas often have more access to guns....[Read More](#)

Over a Third of Adults With Type 1 Diabetes Weren't Diagnosed Until After 30

Type 1 diabetes has long been viewed as a childhood disease, but a new study suggests it might be time to revise that thinking.

Investigators concluded that nearly 4 in 10 Americans with type 1 diabetes aren't diagnosed with the blood sugar condition until they're at least 30.

"Our research adds to a growing body of studies showing that adult-onset type 1 diabetes may be as common as childhood-onset type 1 diabetes," said study author **Michael Fang**, an assistant professor in the Department of Epidemiology at the Johns Hopkins Bloomberg School of Public Health in Baltimore.

"Nonetheless," added Fang, "I think this finding may come as a surprise to many clinicians and people in the general population."

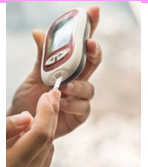
The U.S. Centers for Disease Control and Prevention explains

that only about 5% to 10% of all diabetes patients have type 1 diabetes, which is believed to be a result of the body essentially attacking itself, due to an immune system running amok.

That distinguishes it from the much more common type 2 version of diabetes, which is more often attributed to lifestyle factors. Such factors include being overweight or obese, which can trigger insulin resistance, ultimately leading to dangerously high blood sugar levels.

Identifying clear risk factors for type 1 is tricky, the CDC cautions, though having a family history of the disease is a big warning sign.

Until recently, the consensus has been that while type 1 diabetes can develop at any age it typically strikes children, teens



and young adults. However, that presumption may be incorrect, with the study team pointing to recent research that suggests that more than half of all type 1 diabetes cases (about 62%) develop after the age of 20.

To gain more insight into how old type 1 diabetes patients actually are when diagnosed, investigators examined data concerning nearly 950 adults (18 and up). All had previously been confirmed as having the disease. Patient information had been gathered by the U.S. National Health Interview Survey every year between 2016 and 2022, with the exception of 2018. The pool was almost equally divided between men and women, with an average age of 49 at enrollment. About three-quarters were white. The overall median age at

diagnosis was pegged as 24, meaning that half of the patients were diagnosed at a younger age, while the other half was diagnosed when older. Men were more likely to be diagnosed later in life than women, at 27. Among women, the median age was 22. Racial and ethnic minorities also tended to get diagnosed significantly later in life, the team found, with a median diagnostic age ranging from 26 to 30. That compared with 21 among white patients.

Fifty-seven percent of patients did not find out that they had type 1 diabetes until they were 20 or older, while 37% of the patients didn't find out until they were 30 or older. Another 22% were not diagnosed until they were at least 40.

What does this all mean?[Read More](#)

FDA Adds Warning to Ozempic Label About Risk for Blocked Intestines

Ozempic, a type 2 diabetes drug that has increasingly been used to help with weight loss, will now be labeled as having the potential to block intestines.

The U.S. Food and Drug Administration recently made the **label update** for the drug made by Novo Nordisk, without directly citing Ozempic as the cause for this condition.

"Because these reactions are

reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure," the label reads.

The side effect, known by the medical term "ileus," is also listed on labels for the weight-loss drug **Wegovy**, also made by



Novo Nordisk, and in the diabetes medication **Mounjaro**, made by Eli Lilly, *CBS News* reported.

Both Ozempic and Wegovy are known generically as semaglutide. Among more than 8,500 reports of gastrointestinal disorders after using semaglutide medications through June 30, ileus is mentioned in 33 cases,

including two deaths, *CBS News* reported.

The two pharmaceutical companies that make these medications are both being sued for claims that the drugs can cause a similar health issue known as gastroparesis, or stomach paralysis, *CBS News* reported.

In Mice, Gene Therapy Helps Restore Movement After Spinal Cord Injury

Gene therapy has restored mobility in mice with completely severed spinal cords, researchers report.

The mice regained the ability to walk, with gait patterns resembling those of mice that resumed walking naturally after only partial cord injuries, the investigators found.

This happened because the new gene therapy used techniques to not only repair spinal cord tissue, but also to direct the repairs in a way that would restore mobility, the study authors said.

"Five years ago, we demonstrated that nerve fibers can be regenerated across anatomically complete spinal cord injuries [when the spinal cord is completely severed]," said senior researcher **Mark Anderson**. He is director of Central Nervous System Regeneration at the Swiss

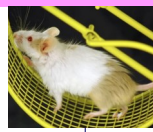
research and treatment center NeuroRestore.

"But we also realized this wasn't enough to restore motor function, as the new fibers failed to connect to the right places on the other side of the lesion," Anderson said in a Swiss Federal Institute of Technology news release.

Partial damage of human and mouse spinal cords can cause initial paralysis, but spontaneous recovery of motor function most often follows.

This is not true of a complete spinal cord injury. Natural repair doesn't occur, and the patient remains paralyzed, the study authors explained.

Recovery after severe spinal cord injuries requires strategies that promote the regeneration of nerve fibers, but researchers have struggled to find the right



combination to promote successful regrowth.

This group of scientists ran in-depth analyses to identify the specific type of neuron involved in the natural repair that occurs after a partial spinal cord injury.

The analysis revealed that specific axons — thin fibers that connect neurons — not only must regenerate, but must reconnect to their natural targets to restore motor function.

Based on this discovery, the researchers developed a multipronged gene therapy.

The team activated the growth of those identified neurons in mice to regenerate their nerve fibers, as well as promoting specific proteins to support the neurons' growth through scar tissue.

The researchers also used

guidance molecules to attract the regenerating nerve fibers to their natural targets below the injury.

The findings were published Sept. 21 in the journal **Science**. Research in animals doesn't always pan out in humans.

"We expect that our gene therapy will act synergistically with our other procedures involving electrical stimulation of the spinal cord," said senior researcher **Grégoire Courtine**, co-head of NeuroRestore. "We believe a complete solution for treating spinal cord injury will require both approaches — gene therapy to regrow relevant nerve fibers, and spinal stimulation to maximize the ability of both these fibers and the spinal cord below the injury to produce movement."

Stem Cell Treatment Halts MS for Some Patient

A new study is strengthening the evidence that stem cell transplants can be highly effective for some people with multiple sclerosis -- sending the disease into remission for years, and sometimes reversing disability.

Researchers found that of 174 MS patients who underwent stem cell transplants -- with cells from their own blood -- two-thirds had no evidence of "disease activity" over 10 years.

That meant no symptom relapses, no worsening disability and no signs of new damage in their brain tissue.

In fact, of patients who'd already developed disabilities before the procedure, more than half saw improvements afterward.

The findings were published Sept. 25 in the **Journal of Neurology, Neurosurgery & Psychiatry**.

Experts said the study bolsters evidence that stem cell transplantation is a good option for some people with MS.

"We do know that this treatment works and it can be performed safely," said co-author **Dr. Joachim Burman**, a neurologist at Uppsala University



Hospital in Sweden.

However, stem cell transplants are not for everyone.

From a safety standpoint, relatively younger patients are likely to fare better, Burman said. And people with "highly active" MS -- including flare-ups despite medication -- stand to benefit most.

MS is a neurological disorder caused by a misguided immune system attack on nerve fibers in the spine and brain. That leads to symptoms like vision problems, muscle weakness, numbness and difficulty with balance and

coordination.

The vast majority of people with MS initially have what's called the relapsing-remitting form, which means symptoms flare for a time and then ease. Most people, though, eventually transition to a progressive form of the disease, and their disability worsens over time.

Why treat MS with a stem cell transplant? The basic idea is to "reboot" the faulty immune system, said **Bruce Bebo**, executive vice president of research programs for the National Multiple Sclerosis Society....**Read More**

Arthritic Hands: What Works (and Doesn't) to Ease the Pain?

Millions of people who live with the pain and stiffness of arthritis in their hands get steroid or hyaluronic acid injections directly into their finger joints in the hopes of feeling better.

Now, a new review shows that even though these injections are widely recommended in treatment guidelines, they don't really work.

Joint injections to relieve the symptoms of hand osteoarthritis were no better than dummy (placebo) injections, the study found.

That's not all current treatment recommendations for hand arthritis seem to get wrong, either.

Most also call for topical pain relievers as the first -line therapy for hand osteoarthritis, but the evidence on those is iffy, said study author **Dr. Anna Døssing**, a rheumatology resident at the Parker Institute in Copenhagen, Denmark.

So, what does relieve the pain of hand arthritis?

"Oral nonsteroidal anti-inflammatory drugs [NSAIDs] and oral glucocorticoids effectively reduce pain in people with hand osteoarthritis," Døssing said. Of these, glucocorticoids (steroid) pills were most effective,



the study showed.

Oral NSAIDs also improved function and grip strength, and oral steroids improved function and people's health-related quality of life, a measure that encompasses physical and mental health status. People who took either of these medications reported improvements in hand symptoms and their overall health.

For the study, Døssing and her colleagues reviewed 65 studies of close to 5,250 people with hand osteoarthritis. The studies looked at 29 types of treatment for the condition.

Injections were found to be ineffective, but most people in the study received injections for osteoarthritis in the base of their thumb. Hydroxychloroquine, an arthritis medication that affects the immune system, was also found to be ineffective for hand arthritis, and the effectiveness of topical creams and gels for pain wasn't clear, the study showed.

The findings were published Sept. 28 in the journal **RMD Open**....**Read More**

More Women Using Cannabis to Help Ease Menopause Symptoms

Women over 50 are turning to weed in droves, and menopause symptoms may be one big reason why, new research suggests.

These women may not necessarily be getting the results they're looking for, however. That's according to menopause experts who say it's not clear from limited research whether the drug helps ease symptoms or exacerbates them.

"People are desperate. They want to sleep. They want to feel better. And it's been pretty normalized at this point that cannabis is something that works

for those issues. I want to be clear that we don't actually know if it works," said study author **Carolyn Gibson**,

a health services researcher at the University of California, San Francisco.

"The evidence is really mixed whether it's helping or hurting or maintaining or exacerbating sleep challenges and anxiety," Gibson noted.

It may be both easing and exacerbating symptoms, Gibson said.

It "also might be keeping folks



from engaging in evidence-based treatments that might be more effective," she added.

Gibson had been increasingly seeing cannabis advertising targeted at women dealing with menopause. A psychologist, she had also observed that more patients were self-medicating for issues like pain and anxiety.

To study this, her team included data from more than 5,100 mid-life women. More than 40% said they had ever used cannabis for recreational or

therapeutic reasons. About 28% said it was to treat chronic pain. Sleep problems and stress were the reasons why for 22%.

More than 10% of the study participants had used cannabis in the past 30 days. Most of those were smoking the drug, at 56%. About 52% were ingesting edible products, while 39% said they were using more than one form.

Among those who used cannabis in the past 30 days, 31% smoked it on a daily or near-daily basis. About 19% said they used edible cannabis on a daily or near-daily basis....[Read More](#)

Blood Tests for Long COVID Could Lead to Better Treatments

People who develop long COVID have distinct abnormalities in their immune and hormonal function that can be picked up with blood tests, researchers have found.

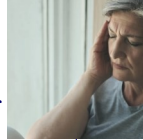
In a new study of 268 patients with and without long COVID, those with the condition showed a number of biological "markers" in their blood samples.

People with long COVID often showed signs of compromised immune function, including abnormal T cell activity and a reactivation of "sleeping" viruses that their immune system had

previously kept in check -- including Epstein-Barr and other herpesviruses.

They also had markers of hormonal dysfunction, like reduced morning-time levels of cortisol. That hormone, which normally peaks in the morning, plays an essential role in many bodily functions -- from the sleep/wake cycle and metabolism to controlling inflammation and responding to stress.

Researchers hope the discovery will lead to a deeper understanding of what causes long COVID, and ultimately,



ways to treat it.

"This study does start to give us some clues," said study author David

Putrino, a physical therapist and professor at Mount Sinai in New York City. "We're seeing signs of an immune system in trouble, a reactivation of viruses you'd conquered, evidence of hormonal dysfunction."

More immediately, the findings offer yet more proof that long COVID is real.

"Hopefully, we can move away from the narratives that long

COVID is a psychosocial condition," Putrino said. "There should be no more questions about that."

Nearly four years since the start of the pandemic, long COVID remains a puzzle. Its symptoms are complex and wide-ranging -- including chronic fatigue, breathing problems, heart palpitations, neurological issues like headaches, dizziness and "brain fog," digestive problems, muscle and joint pain, and more.

....[Read More](#)

Take These Steps to 'Fall-Proof' Your Home

The risk of falls increases in older age, and along with it, the risk for serious physical or psychological damage, but there are steps people can take to help prevent these accidents.

Each year, about 27% of adults 65 and older fall and about 10% of those are injured.

"If you've experienced a fall or have a fear of falling, you are at a higher risk of falling. Once an older adult falls, they can develop post-fall anxiety syndrome," said **Dr. Angela Catic**, associate professor at Baylor College of Medicine's Center on Aging, in Houston.

"It's important for older populations to remain as independent as possible in their own homes. You can help support this by making sure common falling hazards are not in their homes," Catic added in a college news release.

◆ She offered some tips for improved safety:

- ◆ Stay active but avoid exercises and equipment where seniors cannot be in complete control of their environment. This includes treadmills or other heavy machinery.
- ◆ Work with a physical therapist to determine what kind of exercise is best suited to the individual.
- ◆ Be aware of medications that can cause cognitive impairment.
- ◆ Give up slippers and flipflops in favor of shoes with traction.
- ◆ Make sure lighting is adequate both in and outside the house.
- ◆ Make sure paths inside the home and to bedrooms and living spaces are clutter-free, especially if your loved one uses a cane or walker. Remove rugs, which increase the risk of slipping even with fasteners



such as Velcro or tape.

◆ Do not keep extension cords in the walking path. Tuck them around or under furniture.

◆ Make sure carpeted rooms have no loose or uneven patches, which also can increase the risk of tripping. Even decorating and storage choices can make a big difference. Catic suggests coloring steps in contrasting shades to help older adults see where the step lands, especially if they have a visual impairment.

In the kitchen and bathroom:

◆ Make everything accessible and at eye level. Move items from high shelves to a lower shelf. If a step stool is needed, it should be one with a bar attached for stability. "Some older adults are prone to falling after standing for long periods of time, and this can

happen while cooking," Catic said. "Using a high stool that lets them sit can be helpful."

- ◆ Install grab bars near the shower or tub and by the toilet to help an older person navigate around the space. Note: Towel racks are not substitutes for grab bars because they are not designed to hold a significant amount of weight.
- ◆ Place slip-resistant aids in the bathtub or shower. If the tub requires an individual to step over the lip to get in, consider purchasing a sliding tub transfer bench. These benches can also be useful for seated showers if an older adult cannot stand for long periods of time.
- ◆ Consider buying raised toilet seats with attached arms if your or your loved one has mobility issues.... [Read More](#)