AARP Bulletin

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SPECIAL REPORT

WHERE HAVE ALL THE DOCTORS GONE?

FINDING A PHYSICIAN IS HARDER THAN EVER. HERE'S HOW TO GET THE CARE YOU NEED

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> "Who came up with these rules?"
>
> *—Bill Gates*

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Author Talk
Percival Everett, author of the bestseller *James*, among other novels, will join AARP's *The Girlfriend* for an author talk on Facebook. The event will take place at 7:30 p.m. ET Feb. 18. For more information, visit thegirlfriend.com.

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MUNCHIES The easing of marijuana laws is having a health impact little discussed—expanded waistlines from pot-related cravings. Using NielsenIQ consumer data, researchers found states that decriminalized cannabis saw spending rise on snack foods (13 percent), cookies (17.5 percent) and candy (8.5 percent).

ALCOHOL DEATHS RISE FOR OLDER AMERICANS

An alarming new study shows that alcohol-related death rates more than doubled in the past two decades, with particularly high levels among older Americans.

"Alcohol is the leading avoidable cause of premature death and disability in the United States," says Charles H. Hennekens, M.D., an author of the study, which was published in the *American Journal of Medicine*.

The dramatic increase in alcohol-related deaths (such as from cirrhosis and alcohol poisoning) was especially high among 55- to 64-year-olds. That group had the highest level of mortality—with 39.3 deaths per 100,000 people. The numbers have worsened since 1999 for every age group, including rising from 15.9 to 27.1 deaths per 100,000 for 65- to 74-year-olds.

The troubling numbers for older Americans are driven by several factors, says Hennekens, a professor of medicine at Florida Atlantic University's Schmidt College of Medicine. Older adults can suffer from the cumulative effects of excessive drinking for many years. They don't process alcohol as well as when they were younger. And other ailments that are on the rise, such as obesity, can add to the impact of excessive drinking.

The effects of alcohol on medications commonly used by older Americans also can be risky, says Alison A. Moore, M.D., a geriatric medicine professor at the University of California, San Diego, and head of its Sam and Rose Stein Institute for Research on Aging and Center for Healthy Aging. Alcohol can negate some of the benefits of certain drugs, and exacerbate the side effects of others, such as lowering blood pressure too much.

Alcohol is a factor in many diseases, including high blood pressure, stroke, and breast and prostate cancers. And older adults have weaker immune systems, so stressing the system more with alcohol can leave people vulnerable to infection, Moore says.

APPOINTMENTS ONLY AT SOCIAL SECURITY

Social Security beneficiaries can no longer just drop in at a local or regional office to get an issue resolved. Beginning in January, those seeking a face-to-face meeting will be required to make an appointment at their local office, the Social Security Administration recently announced.

"In recent years, some Social Security offices have seen growing walk-in lines that have resulted in lower levels of service, including cut offs of lines before closing time," an SSA spokesperson wrote to the *Bulletin*. Turning to appointment-based services is expected to reduce wait times and improve customer experience.

Customers wanting personal service will have to call their local office or the SSA's national number (800-772-1213) to schedule an appointment, including for Social Security card requests. Many tasks can also be completed online at ssa.gov/onlineservices. Military personnel, people with terminal illnesses, and individuals requiring immediate attention can still walk in for service at field offices, the SSA spokesperson said.

Chronic Pain Surges Among Those 65-Plus

Chronic pain has reached alarming levels in the U.S., with nearly a quarter of Americans saying they had discomfort that had an impact on their daily life or work activities in 2023, and 8.5 percent reporting "high-impact" pain, defined as pain that can cause opioid misuse, anxiety and depression, according to the Centers for Disease Control and Prevention.

The number of people in pain has increased steadily from 2019, when 1 in 5 claimed chronic pain and 7.4 percent noted high-impact pain.

The statistics are even more striking for people 65 and older, with the CDC finding 36 percent experienced chronic pain in 2023. And 13.5 percent of older Americans reported high-impact chronic pain.

Women of all ages were slightly more likely to report both chronic pain and more severe pain in 2023—25.4 percent of women reported chronic pain and 9.6 percent described high-impact pain. That compared with 23.2 percent and 7.3 percent of men.

Spring COVID Booster Advised

Older Americans who recently got an updated coronavirus vaccine should plan to roll up their sleeves in the spring for another shot.

The Centers for Disease Control and Prevention late last year issued a recommendation that adults age 65 and older receive a second dose of the latest COVID-19 vaccine, after a panel of experts that advises the CDC reviewed the latest data on the durability and effectiveness of the vaccines in older adults.

COVID has settled into a more predictable pattern in the past few years, though the virus continues to spread throughout the year. Cases climb in the winter months, when flu, RSV and other respiratory illnesses spike. But they also tend to surge in the summer.

"If we want to provide maximum protection for those people at highest risk, they should get their vaccine in the fall in order to help get them through the winter," says William Schaffner, M.D., professor of preventive medicine at Vanderbilt University School of Medicine. "But by the time they get to May, their protection will have waned ... So let's give them two doses every year."

But with COVID, things can change. "Of course, if a substantially new variant crops up, then we'll have to reevaluate," Schaffner says.

The shots don't cost most people anything out of pocket.

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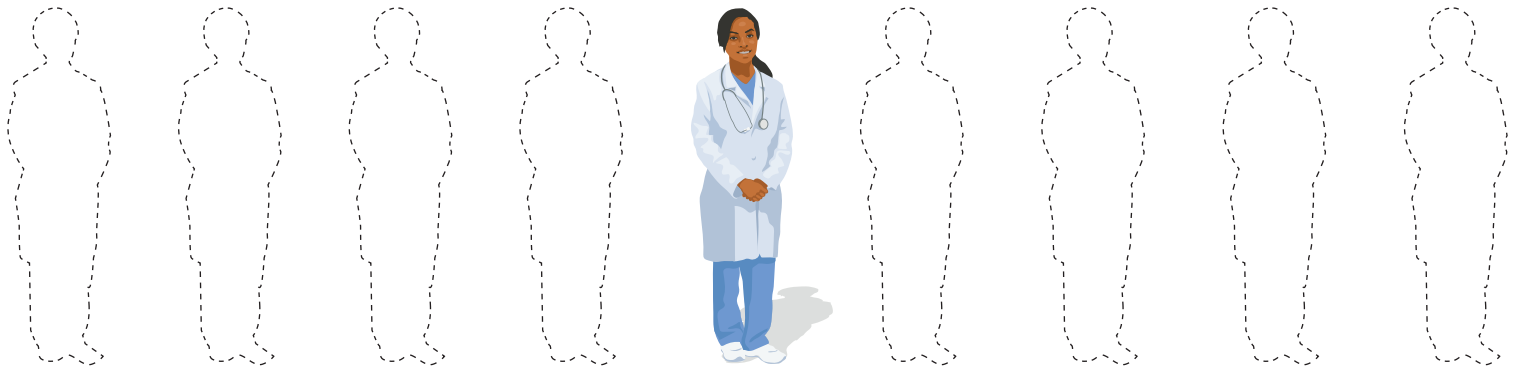
WHERE HAVE ALL THE DOCTORS GONE?



Physicans quitting medicine: It's a crisis that's shaking our health care system. Here's how you can protect yourself

BY HOWARD ZUCKER, M.D.

HOW CAN I find a doctor who can help me?"

As a physician, I get this question from friends and family all the time. And for most of my professional life, I was able to refer them to a medical colleague; a simple phone call was all it took to get someone an appointment within a reasonable amount of time.

But no longer.

The average wait for new patients to see a physician is 26 days, and that's for mostly healthy people. In a medical emergency, the situation can become even more frightening: Twenty-two percent of acutely ill patients 65 or older who sought medical attention had to wait six days or more for an appointment, according to a 2021 survey by the Commonwealth Fund.

This is a crisis. And it's a crisis that's getting worse, rapidly.

"The backbone of our health care system, private practice, is on the brink of collapse," warns Clarel Antoine, M.D., professor of obstetrics and gynecology at New York City's NYU Grossman School of Medicine. "As a result, the nearly 70 million Americans on Medicare, many with chronic conditions, can expect longer waiting times for medical care."

Due to an astonishing combination of professional missteps, failed policies and an aging population, America is facing an unprecedented shortage of physicians—one that is putting each of us at increased risk.

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ILLUSTRATION BY CHRIS LYONS

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Here's what older Americans need to know about protecting themselves and their loved ones—and how you can ensure you get the care you need.

HOW DID WE GET HERE?

Alli Phillips, 49, of Denver, developed swollen joints in her hands in April 2023, but when she called her physician's office, she was told the first available appointment wasn't until June. When the appointment finally came around, the doctor told Phillips that she suspected rheumatoid arthritis and referred her to a specialist. But the specialist had no appointments available until November.

In the meantime, Phillips's knees began to swell, and she struggled to walk down steps and turn doorknobs. When her appointment finally came, her visit with the rheumatologist lasted only about 15 minutes. She left with a prescription for prednisone, which made only mild improvements to her symptoms. After two more 15-minute visits to the rheumatologist, Phillips finally hired a concierge doctor for $3,500 per year—a fee not covered by insurance. The concierge doctor took time to discuss multiple treatment options and long-term care, and prescribed methotrexate, a chemotherapy and immunosuppressant drug, to get her condition under control.

Phillips was lucky, her new doctor told her: The delay in treatment could have caused further joint damage, and she was fortunate to be able to afford the out-of-pocket expense. But, as Phillips says today, "How do people without resources to get around the system find the care they need?"

Even being an established, well-connected doctor doesn't always help. One colleague of mine, working at a major medical center in the South, recently decided to move with his family to the Northeast. But as the process was underway, his wife was diagnosed with cancer. Even though she'd already received a diagnosis, and even though they were using the same insurance company, the insurer refused to cover her oncology treatment until she got a referral from a new primary care physician.

MEGHAN McCORMICK, 57, of Surprise, Arizona, has a rare heart condition that needs specialized care. On Medicare disability coverage, she has struggled to find timely care: "Six-month waits if you're a new patient. When you have cardiovascular disease you can't wait six months," she says. She ended up with a pacemaker she may not have needed.

> **"The backbone of our health care system, private practice, is on the brink of collapse. As a result, the nearly 70 million Americans on Medicare, many with chronic conditions, can expect longer waits for medical care."**
>
> **—Clarel Antoine, M.D.,**
> NYU Grossman School of Medicine

Despite being a prominent doctor himself, my colleague could not find a single physician willing to take his wife on as a new patient. The family was forced to go back to their previous state so his wife could receive care. Fortunately, she is doing well, but my colleague asks, "How do people do this without the connections we have?"

Too often, the answer is, they don't. Although there were some 835,000 practicing doctors in America in 2023, according to the U.S. Bureau of Labor Statistics, we are currently experiencing a shortage because demand exceeds supply.

"My 82-year-old father almost died because it took us months to find him a doctor," says Michelle*, 54, of New York City. One night in August 2023, Michelle's father, Marvin, a retired engineer, called her. He was slurring his speech and had developed a facial droop—both classic signs of a stroke. She immediately sent him to a hospital.

"The doctors told him that he needed an MRI, but there was one problem—his pacemaker needed to be switched to an MRI-safe mode," Michelle says. "I called every hospital and doctor I could—neurologists, cardiologists, even primary care doctors—but no one was available to get that done and the MRI completed." Over the next several months Marvin experienced two more episodes. When he finally went back to the ER that November, he'd developed sepsis—from an infection in his heart—and tests revealed he'd suffered two more strokes. "Finally, he had open-heart surgery," Michelle says. "But it left us so angry and frustrated that he had to nearly die to get the care he needed."

To understand why doctors are in such short supply, it helps to think of the medical field as a bathtub. To keep the tub full, the faucet needs to be adding water at least as fast as the drain empties it. But that's not what's happening. The current shortage of physicians, combined with a number of other factors, has placed such an intense strain on doctors that many in the medical field are choosing to

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switch professions or simply retire early. And despite efforts by the Association of American Medical Colleges (AAMC) to graduate more doctors, those efforts to fill the tub simply can't keep up with the drain.

WHY DON'T WE HAVE ENOUGH DOCTORS?

In 1980, a U.S. government report concluded that American teaching hospitals were graduating too many medical students. It predicted a surplus of 70,000 physicians by 1990, an alarming statistic. In response, medical schools established what became a 25-year moratorium on increasing class size, enforced by the AAMC and the American Medical Association (AMA).

Yet there was a significant flaw to that initial report: It failed to account for the nation's rising population, which is now 110 million more than it was 45 years ago. By 2005, as the population grew and the potential for a severe physician shortage emerged, the AAMC and AMA reversed their recommendation, and in the past 20 years, more and more young people have trained to be doctors. Yet despite the more than 97,900 students in medical school, 38,000 in osteopathic school, and 162,000 doctors currently in residencies and fellowships, the AAMC predicts a shortage of up to 86,000 physicians by 2036. By then, it projects that the U.S. population will have risen 8.4 percent since 2021. The population of those over 65 will increase by 34 percent, while the number of people 75 and older will increase by 55 percent.

"Medical education is a long journey, and even though medical school enrollment has risen, we need more residency positions [where med school graduates get hands-on training], which requires increased government support," says David Skorton, M.D., president of the AAMC.

It's not just that we don't have enough doctors. Part of the problem may be that we don't have enough of the right kind of doctors.

Becoming a doctor is expensive: The average medical student emerges with roughly $235,000 in debt. Now consider that the average primary care physician (PCP) in internal medicine, geriatrics, pediatrics or family medicine makes about $250,000 to $275,000 a year. Becoming a PCP just isn't financially feasible for most recent graduates. Two-thirds of newly minted doctors are choosing to become specialists, which allows them to earn salaries upwards of twice what a primary care doctor can make.

PATIENT

LENORE TATE, 72, of Sacramento, California, has to drive three hours to get to her preferred specialist, who sees patients only one day a week. "If you miss an appointment, you're out of luck for about another six months," she says. "It's very distressing and anxiety-provoking."

"Primary care physicians are undervalued by government and insurance companies, and that is reflected in decreased compensation," says Isaac Opole, M.D., president of the American College of Physicians. "It makes the field unattractive to medical students."

Yet it is the PCP who provides the annual checkups that may detect problems early on, and who serves as the gatekeeper for referrals to specialists. Many people with private insurance, as well as those enrolled in Affordable Care Act plans, are required to see a PCP before they can access specialists in a majority of fields.

And while many med students are choosing to go into specialty care, others opt not to become physicians at all. Indeed, more than 50 percent of medical students and residents surveyed preferred to pursue careers that do not involve direct patient care, such as research or teaching, according to a 2023 report from Elsevier Health. One in 4 contemplate dropping out of medical school altogether, citing overwork, financial stress and mental health concerns. In a study published in 2019, parts of chromosomes that shorten with age eroded six times faster than average for doctors in their first year of training after medical school; researchers attributed the accelerated aging to the doctors' stress levels.

Even as we struggle to bring more physicians into the fold, another crisis has emerged: More and more frequently, doctors are cutting their hours, seeing fewer patients—or just quitting the medical field altogether. To go back to the bathtub analogy, we're opening the spigot, but there's too much water draining out from under the surface.

WHY YOUR DOCTOR DOESN'T HAVE TIME FOR YOU

Many doctors dreamed of medicine as a profession from early childhood. In past generations, it was common to see physicians practicing long past the age when they could retire. Yet a recent AMA survey found that 1 in 5 doctors were hoping to find a way out of medicine in the next two years. Among those 55 or older, that figure was 1 in 2. Why?

In reporting this story, I spoke with dozens of physicians, the vast majority of whom vented their frustrations with the current state of medicine. But just as tellingly, almost all of them also refused to talk to me on the record, fearing that speaking out could cost them their jobs.

Part of what's driving this is the growing trend of private equity firms and corporations, such as CVS Health and Amazon, purchasing hospitals and private practices. One major medical group, with about 90,000 doctors in some 2,000 locations across the country, has spent billions of dollars acquiring physician-owned practices, home health centers and surgical centers. This past April, the Physician Advocacy Institute reported that just shy of 80 percent of all doctors were employed by hospitals or corporations, up 200 percent in just over 10 years.

Typically, when for-profit firms acquire practices, they approach these acquisitions utilizing a profit-based strategy. What does that look like?

The doctors I spoke with off the record explained that corporate entities now govern their allotted time with patients, often allowing just 15 minutes per visit, a situation that isn't healthy for either the doctor or the patient. "They control every aspect of a doctor's professional life, and it's all about the money," one doctor told me. A 2024 *JAMA*

PRESTON GANNAWAY

Internal Medicine report said that 61 percent of doctors surveyed found private equity ownership unfavorable for health care.

And then there's the paperwork. For every hour seeing patients, the average doctor now spends two hours doing administrative tasks, according to the AMA. A primary driver of paperwork: the electronic health record, or EHR.

"The EHR is the bane of existence for every doctor in the country," says Opole. The EHR was designed to eliminate a paper-based tracking system and make patients' health records easier for various health professionals to access. But in practice, doctors say, its primary focus is documenting for regulators and billing for insurers. To handle rising administrative demands, doctors have begun cutting back on office hours, resulting in even less time available to see patients. A 2023 Mayo Clinic study noted that 40 percent of doctors it surveyed intended to reduce their work hours in the coming 12 months.

The study estimates that the slashing of work hours, in addition to the 26 percent of doctors who said they were thinking of quitting their practice in the following 24 months, would decrease the workforce by the equivalent of 20,234 physicians—a number that equals all medical school graduating classes combined.

"The doctor-patient relationship requires time to establish a trust, which comes with patients sharing stories of their life with you as it relates to their health," John Dooley, M.D., an internist in private practice in Washington, D.C., shared with me one evening while driving home at 9:30 p.m. from a grueling day of work. "That doesn't happen if you only give them 15 minutes."

WHERE ARE ALL THE DOCTORS GOING?

To a person, physicians told me they are burned out. Simply put, they are being asked by the business world that owns their practices to do medicine, at times, in ways they view as not in the patient's best interest. Meanwhile, those who cling to their independent practices are finding it impossible to hold on given the financial pressures on them.

Michael Hotchkiss, M.D., recently sent an email to his patients, explaining why, despite his love for treating people, he was closing his obstetrics and gynecology practice in Waldorf, Maryland, after 45 years:

"I am no longer able to continue practicing medicine in a manner that aligns with my convictions regarding the best interests of my patients."

In a follow-up interview with AARP, the

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Who's Treating You? YOUR GUIDE TO SOME OF THE PROFESSIONALS WORKING IN YOUR PHYSICIAN'S OFFICE

Medical practices around the country increasingly rely on nurse practitioners, physician assistants and other health care professionals to help with everything from monitoring vital signs to ordering tests, diagnosing illnesses and even assisting in surgery. These providers also play a critical role on the front lines of pain management and in educating patients on their medical conditions and how to better take care of their health. Many are trained in what's known as the holistic model of nursing—an approach that's highly patient-focused; that different perspective can make nurse practitioners and others an impactful asset in the clinical setting. Here are some of the professionals you may encounter in a doctor's office, who they are, and what they are trained to do.*

SHUTTERSTOCK

Registered Nurse (RN)

Registered nurses graduate from an approved nursing program and pass an exam to be licensed by a state board. They can administer medication prescribed by a physician or other health professional, monitor a patient's vital signs and help educate the patient. They can help coordinate care, draw blood, insert intravenous lines and collect lab work.

▶WHAT TO KNOW: RNs cannot perform some procedures without additional training and certification. They cannot prescribe medication.

Nurse Practitioner (NP)

Nurse practitioners have additional training to assess and address patient needs. NPs have a master's or doctoral degree and provide primary, acute and specialty health care. In the primary care setting, NPs take medical histories, assess, diagnose, order tests and X-rays, prescribe medications, and refer to specialists.

▶WHAT TO KNOW: NPs may work in specific subspecialties, including pediatrics, critical care, geriatrics, emergency care and other areas.

Physician Assistant/Associate (PA)

Licensed clinicians with a master's degree who practice medicine in an array of specialties. PAs take patient histories, assess and diagnose conditions, prescribe medications, and order tests. The main difference from nurse practitioners is that PAs are trained according to the medical model while NPs are trained in the holistic nursing model of care.

▶WHAT TO KNOW: PAs may work in a doctor's office, clinic or hospital setting under the supervision of a licensed doctor. They can also assist with surgery.

Certified Registered Nurse Anesthetist (CRNA)

Advanced practice registered nurses with specific training in anesthesiology, CRNAs have a master's or doctoral degree. CRNAs provide a full range of anesthesia and pain management services, the latter being particularly important for older adults who want to stay independent and active.

▶WHAT TO KNOW: CRNAs have specialized training focused on administering anesthetic agents.

Advanced Practice Registered Nurse (APRN)

This title is an umbrella term covering four approved roles, including NPs and CRNAs. They all earn a master's or doctoral degree in their specific area and they need to pass a certification examination. APRNs can provide medical care during emergency situations.

▶WHAT TO KNOW: APRNs are trained in designated specialties.

**Responsibilities may vary based on state law.*

CONTINUED FROM PAGE 11

doctor lamented, "If I were independently wealthy, I would keep doing it. I absolutely love what I do, but it has become unsustainable. Enough is enough." What haunts him further is that he's been unable to refer his patients—two-thirds of whom are 50 or older—to other nearby physicians: "We're sending people who need doctors to Northern Virginia or Annapolis, but they have to travel 45 minutes to see a doctor who is accepting new patients. I don't have anyplace closer to send them," says Hotchkiss. "It's horrible."

This dilemma has translated into yet another troubling trend: More than 300 doctors now die every year from suicide, a rate twice that of the general population.

"We take highly intelligent people with a calling, put them in a demanding and often hostile work environment without any reasonable labor protections, and they cannot even meet their basic needs," says Pam Wible, M.D., who runs suicide-prevention workshops for physicians. "They can find themselves on the path to taking their own life." The 2022 Dr. Lorna Breen Health Care Provider Protection Act, named for a physician who took her own life during the COVID-19 pandemic, provides funding to medical and other organizations to reduce and prevent physician suicide, and address the challenges they face today.

At a recent visit, my own primary care doctor, Paul Arias, M.D., shared that "the pandemic drove many doctors into retirement; others became ill and required disability and, sadly, some died. For those who remain, many fight daily with insurance companies to get approvals for a patient's labs or procedure. It's exhausting. Corporate America has taken over medicine."

DOCTOR

MICHAEL HOTCHKISS, M.D., 79, recently emailed his patients that he would have to close his clinic in Waldorf, Maryland, after 45 years. Hotchkiss says his malpractice insurance has risen to $96,000 a year and his revenue hasn't kept pace. "I absolutely love what I do, but it has become unsustainable. Enough is enough."

> **"[Former patients] who need doctors ... have to travel 45 minutes to see a doctor who is accepting new patients. I don't have anyplace closer to send them. It's horrible."**
>
> **—Michael Hotchkiss, M.D.,** is closing his practice due to financial constraints

To increase revenue, reduce paperwork and regain control of their lives, more and more doctors are choosing concierge medicine, a system in which patients pay a yearly out-of-pocket fee in exchange for longer visits and shorter wait times. Costs can range from $2,000 to $10,000 annually, though some practices have upfront prices that are markedly higher. And since most Americans don't have the financial resources to pay such high and nonreimbursable fees, this further drains the pool of doctors available, especially to older people on fixed incomes.

Nancy F.*, 67, of Los Angeles, found out her PCP was going concierge, so she and her husband each shelled out $1,800 to join the service. But the level of care doesn't feel "concierge."

"Most of the time I'm talking to a PA [physician assistant] or nurse practitioner," Nancy explains. "If I want to have the doctor more available to me, that's $10,000 a year." Nancy has also been struggling to find a neurologist to treat her migraines. "When I finally found one, I was told it would be a couple months before I could get in to see her—or I could pay $2,500 to join her practice and get an appointment sooner."

Doctors have also turned to shift work, a model in which they manage patients in a hospital during set hours, thereby protecting their time off. These hospitalists, as they are called, transfer care to the next doctor on call when their hours end. In 2000, there were only a few hundred hospitalists; today that number exceeds 60,000.

These doctors are well-equipped to handle day-to-day issues when you're hospitalized. But this trend further decreases the pool of physicians available for routine wellness visits. And, as in the case of Marvin, the stroke victim, a hospital visit may leave you with no one to follow up with after you're released.

THE SPECIAL DANGER TO OLDER AMERICANS

Despite an aging population, there are fewer than 7,000 geriatricians in the U.S. today. We face a projected shortage of more than 2,000 geriatricians by 2037, according to Health Resources & Services Administration (HRSA). Although there has been growth in available geriatric fellowship slots, a substantial number of positions remain unfilled.

"There is a perfect storm coming," says Bruce Scott, M.D., president of the AMA, "with increased patient complexity, de-

CONTINUED ON PAGE 14

STEPHEN VOSS

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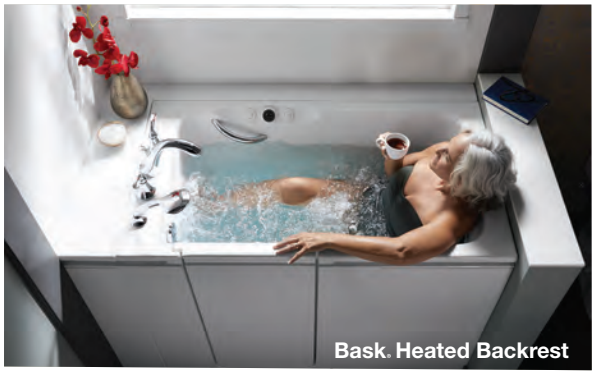

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CONTINUED FROM PAGE 12

creased reimbursements and increased demand for prior authorizations from the insurance company. The combination of these makes it increasingly difficult for physicians to accept new patients and, in some cases, even keep their doors open. We can't afford to lose even one more doctor."

With no influx of geriatricians on the horizon, one option is training primary care and specialty doctors on the specific changes that aging patients experience.

"To effectively meet the health needs of an aging population, we need to create an age-friendly workforce," says Nancy E. Lundebjerg, CEO of the American Geriatrics Society. "We need to create a well-defined curriculum not only in medical school but also in residency programs focused on the older adult. We believe there should be a requirement that all Medicare-supported training include a focus on older adults."

"We must create seamless care that is age-friendly. This includes home-based care, telehealth visits, hospitals, emergency rooms, office practices, clinics and nursing homes," says Terry Fulmer, president of the John A. Hartford Foundation, a nonprofit focused on improving care for older adults. A report from the National Academy of Medicine identified a multipronged approach, including boosting the skills of those caring for aging patients, developing new models of care, and increasing and retaining an elder-care workforce.

> **"To effectively meet the needs of an aging population, we need to create an age-friendly workforce. We believe there should be a requirement that all Medicare-supported training include a focus on older adults."**
>
> **—Nancy E. Lundebjerg,**
> **CEO, American Geriatrics Society**

HOW TO GET THE CARE YOU NEED

We turn to our doctors during times of vulnerability, and we want them to be available. Only about 1 in 3 Americans have a high level of confidence in the medical system, but two-thirds of us trust our doctors, according to 2023 Gallup polls.

So when we discover our doctor is retiring or simply has no time to see us, it can be unnerving, to say the least.

To ensure you get the care you need:

▶**Become friends with the nurses or schedulers in the doctor's office.** Learn their names and make sure they know yours. They can let you know if a cancellation has occurred and keep your name on a waiting list.

▶**Schedule your next appointment while you are at your current one.** That's your best shot at securing a spot on the calendar.

▶**Make sure to fill out all health forms online in advance of your visit.** You may have only the smallest of windows to talk with a provider, so make sure you've provided as much information as possible to maximize your time in the doctor's office.

▶**If the physician's practice cannot see you in the office, speak with the scheduler to see if a telehealth visit is possible.** In surveys, about 87 percent of doctors reported using telemedicine, but only 37 percent of adult patients had taken advantage of it within the previous 12 months, according to CDC data. Or ask if one of your doctor's colleagues or another provider in the practice can see you. (For a rundown on the different kinds of medical care providers found in a doctor's office, see "Who's Treating You?" Page 11.)

▶**Ask your doctor for a referral—and to reach out on your behalf.** If your doctor is retiring, moving or turning to concierge medicine, and following them is not an option, ask them for a referral. If they can recommend someone else in their group, even better—that comes with the advantage of your medical records being readily available. Either way, ask your doctor to personally contact that clinician on your behalf; you may have a better chance of being accepted as a new patient than if you just cold call with a referral. And always check to see if that new physician accepts your insurance, including Medicare.

▶**Ask your insurance company for a list of names of physicians.** If you are on Medicare,

go to Medicare.gov and click on the Providers & Services tab to find and compare doctors by location. You may want to consider a physician who is not geographically convenient to your home but who meets your other needs.

▶**Don't be shy about going to urgent care or the ER if necessary.** In many cases it's better to get someone to look at you today than to wait weeks for your regular doctor.

▶**Learn more about home care devices that can help to detect important changes in your health,** such as a blood glucose monitor, pulse oximeter (to measure oxygen levels), blood pressure monitor, or electrocardiogram (ECG) to track heart rhythms. Calling a doctor's office to report a change in a vital sign can speed up an appointment, give you some worthwhile reassurance—or urge you to get to an emergency room.

▶**And of course, use the internet wisely.** Physician reviews may not be particularly helpful, as they are not only subjective but often filled with complaints; satisfied customers are less likely to post reviews. What is useful, however, are a physician's board certification, specialty training, insurance plans and hospital affiliations. As with all relationships, there needs to be a good fit, founded on confidence, compassion and communication.

The health care system touches all of us: Millions of American workers are currently employed in health care in some capacity, many in government, for insurance companies, or in corporate oversight. But in the end, it is often doctors on the front lines, bearing the blame and anguish when diagnoses are wrong or treatments go badly. It's incumbent upon all of us to understand why our system is in crisis and to support efforts to make it work better for everyone. ■■

**Some names have been changed to protect patient privacy.*

***Howard Zucker** is board-certified in six medical specialties. He has served as U.S. deputy assistant secretary of health, New York State commissioner of health, assistant director-general of the World Health Organization, and as a deputy director at the Centers for Disease Control and Prevention.*

P. 18 STRENGTHEN YOUR IMMUNITY

EASY YOGA FOR STRONGER BONES

Research shows you can rebuild bone mass with these 5 simple moves

To see animations of each pose, scan this code or go to **aarp.org/yogaforbones**.

BY **ANDREW J. STILLMAN**

As we age, bone loss can become a serious threat—especially for postmenopausal women and men after age 70. And while exercise in general is a smart strategy for combating it, specific yoga poses can be especially effective.

That's because, unlike running, biking or even weight training, a yoga pose involves holding sustained pressure on the skeletal system, says Loren Fishman, M.D., medical director of Manhattan Physical Medicine and Rehabilitation in New York, who has conducted studies on yoga and bone mass.

His research has identified a series of yoga poses that significantly improve bone density in the spine and thigh bone and increase it in the hips; these three sites are among the most commonly fractured parts of the body.

First, if you're at risk for low bone density (osteopenia or osteoporosis), Fishman urges you to get a DEXA (dual-energy X-ray absorptiometry) scan, which measures your bone density levels with low-dose X-rays. Many radiology clinics offer them, and for people diagnosed with osteoporosis, they can be an excellent tool for tracking your progress.

You can do these poses daily; the whole routine should take only about 12 minutes to complete. And if you can't stay in a pose very long, don't worry: "You only need to exert 30 to 50 seconds of pressure on a bone to start forming new bone," Fishman says. "I recommend holding the poses for 40 to 60 seconds for optimal results."

Andrew J. Stillman is a yoga instructor and journalist who has written for Yoga Journal, The Advocate *and other magazines.*

1. WARRIOR 2

Start by sitting on a chair. Position your right leg parallel to the edge of the seat, with your right knee bent 90 degrees and your right foot flat on the mat, toes pointing to the right.

Extend your left leg out to the left and plant your left foot on the mat. Your left leg should be straight, with the arch of your left foot in line with the heel of your right.

PHOTOGRAPHS BY **ELI MEIR KAPLAN**

2. TREE POSE

Tree Pose is great for strengthening the bones of the lower body, and it can help improve your balance, reducing the danger of falls. Start with one or both hands on a wall or a chair for support. Ground your weight into your left foot and keep your left leg straight. Place the bottom of your right foot against your inner left ankle, calf or thigh (but avoid your left knee). Gently draw your right knee backward to open your hip. Maintain a long spine and relaxed shoulders. If you feel steady enough, try lifting one or both hands off the wall or chair. Repeat on the other side.

Extend both arms out to the sides at shoulder height, palms facing down. Your shoulders should be in line with your hips—just above them. You can bring your hands behind you on the back of the chair to align your shoulders, then return them to horizontal. Hold, then return to the seated position and repeat the pose with your left leg bent and your right leg straight.

3. TWISTED TRIANGLE

Stand in the middle of a mat, feet slightly wider than hip-width apart, and position a chair in front of your right leg with its seat toward you. Turn your right foot 90 degrees to the right, so your toes point toward the end of your mat. Angle your left foot 60 degrees to the left. The arch of your left foot should be in line with your right heel. Inhale and extend your arms in front of you at shoulder height, palms facing down. Lengthen your spine as you exhale, twist and lower your left hand to the chair. Now reach your right arm up over your head as you twist the left side of your torso to the right and look up at your right hand. Return to the starting position, then repeat on the other side.

4. STANDING TWIST 2

Place the side of a chair against a wall. Stand in front of the chair with the right side of your body against the wall, feet hip-width apart. Step your right foot onto the chair with your right thigh flush with the wall. Inhale to lengthen your spine, then exhale and twist to the right. Place both hands on the wall for support at about shoulder height. With each inhale, roll your right shoulder back and lengthen your spine. With each exhale, move your left chest forward to deepen the twist. Return to the starting position, then turn the chair around and repeat in the opposite direction, with the wall to your left.

5. HAND-TO-FOOT 1

Sit in a chair. Keep your butt and back pressed against the back of the chair throughout the pose. Dangle the loop of a belt on the floor and step on it with your right foot. Keeping your back flat and a slight bend in your right knee, lift the strap to straighten your right leg. Pull your shoulders back and down as if you were rowing a boat. Hold the position, then slowly rebend your knee to release your foot. Repeat on left leg.

Should You Get a DEXA Scan?
Learn more about bone health in an exclusive video by Dr. Adam Rosenbluth. Scan this code or go to **aarp.org/dexascan**.

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ASK DR. ADAM

A top internist and cardiologist answers your questions with surprising doctor-tested tips

"How can I boost my immune system?"

Dr. Adam: You're right to want to boost your immune system, especially around this time of year. Several steps can help you make it happen. But before we look into them, let's talk about what your immune system is and how it helps your body fight illness.

The immune system is your defense against infections caused by bacteria, viruses and parasites. It also protects your healthy cells from cancer by identifying and then destroying abnormal cells.

Our immune system is active 24 hours a day, all year long. But as we age, it's not as strong as it was when we were younger. Not only do we have fewer immune cells as we get older, but the ones we have don't communicate as well with each other. It's the reason the immune system takes longer to react to germs and why we're slower to heal.

Certain conditions, including cancer, diabetes and obesity, can weaken an immune system, as can some fairly common medications such as steroids, some medications that treat inflammatory conditions, and others that suppress the immune system. No matter how old you are, or what may be depleting your immune system, you can boost your defenses by choosing healthy behaviors.

What are they? Well, you've probably read it before—eating a healthy diet with plenty of fresh fruits and vegetables, whole grains and lean protein, not smoking, getting between seven and eight hours of sleep a night, avoiding alcohol, reducing stress, maintaining a healthy weight and exercising regularly.

In general, my older patients who stay active have a stronger immune system and get sick less often. On the other hand, I have some patients who tell me "Oh, I'm not going to go out because I'm too afraid of catching something."

Since our bodies are designed to interact with the environment, isolation is not necessarily a good way to protect yourself. Even if you mostly stay on the couch, you can still develop pneumonia. An analysis of 10 different studies showed that regular physical activity is linked to a lower risk of getting pneumonia.

Another thing I hear from patients is that when winter rolls around, they increase their vitamin C intake. OK, but if you're still smoking or staying awake until 3 in the morning, more vitamin C won't do much to protect you.

What else? Vaccines. The idea that vaccines diminish the immune system is not true. Many vaccines are made of very small amounts of weak or dead germs. Although a vaccine won't make you sick, it does trigger your immune response. So, if your body is exposed to that germ again, it recognizes it and goes on the attack. Some of the COVID-19 vaccines work in a slightly different way. They deliver instructions to your cells to help them build protection against the virus.

One of my favorite protective measures against contagious diseases like the flu, or even COVID, is to avoid touching your face. I read an Australian study reporting that most of us touch our faces 23 times an hour; almost half of those touches involve the mouth, nose or eyes. These are all easy places for viruses and bacteria that catch a ride on our hands to enter our bodies.

Not touching your face takes some practice. Washing your hands with scented soap acts as a good reminder. When you raise your hand to your face, the scent will give you the clue to put your hand down.

Some people just have stronger immune systems. But for most of us, it's in our hands to build up our defense system. ■

Adam B. Rosenbluth, M.D., practices and teaches in New York City. Each Monday online, he answers your questions about how to make your body work better for you.

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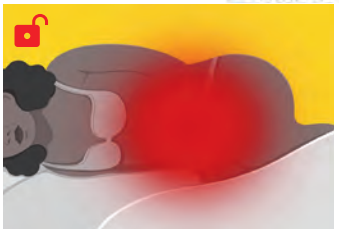

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THE RISING COSTS OF USING A CREDIT CARD

Even if you aren't carrying a balance, you might pay more

BY **KELLY DILWORTH**

No, you're not imagining it. Increasingly so, you're paying more up front when you pull out a credit card.

Sixty-nine percent of Americans surveyed by LendingTree in 2023 reported they'd paid an extra fee when using a credit card for a purchase. A smaller, more recent survey by WalletHub put that figure at 79 percent, with 85 percent of respondents saying that credit card surcharges made them feel "nickel-and-dimed." And the size of those charges is on the rise: The typical credit card surcharge in 2019 added 1 to 2 percent to a purchase price, but climbed to 3 to 4 percent by 2022, according to the market research firm Ipsos.

As more people of all ages turn to plastic instead of checks and cash, merchants up and down Main Street—dentists, veterinarians, restaurateurs and florists—are turning to credit card surcharges and similar policies, such as cash discounts, to help recoup their costs. Ten percent of card-accepting small businesses charge a fee for using a credit card, up from only 2 percent in 2019, estimates the payment consulting group TSG. Among new merchants, as many as 20 percent have a surcharge policy, say TSG.

Here's what to know about these charges and when it's best to avoid them.

▶Businesses aren't fond of fees either. Most businesses don't like charging extra for paying with a credit card, says Doug Kantor, general counsel for the National Association of Convenience Stores: "Customers get upset with them." Credit card surcharges may also reduce revenue, reports Ipsos, which estimates they can cause debit and credit card sales to decline by as much as 10 percent.

But some businesses see these surcharges as one of the few tools they have to cut costs, Kantor says. Facing rising labor costs and thinning profit margins, restaurants face a choice, says financial planner Shinobu Hindert. They can either raise menu prices or be transparent about their card fees: "This is how much it costs. We're passing on this surcharge to you."

▶Processing fees can be steep. As retailers fight card networks over the fees merchants pay to accept credit and debit cards, known as "swipe fees," the size of their burden on merchants' bottom lines is a matter of debate.

Credit card interchange rates—the part of the fee that goes to the bank issuing a card—have been flat for eight years, according to Nick Simpson of the Electronic Payments Coalition (EPC), a consortium of card issuers and payment networks. Data from the Federal Reserve Bank of Kansas City shows a similar trend, although fees for some credit types have climbed more than others.

But data from the Nilson Report also shows that total card-acceptance costs, including fees paid to other behind-the-scene parties, have soared. And a 2024 analysis by consulting firm CMSPI found that U.S. merchants pay the highest credit card acceptance fees in the world, with the average fee at just under 3 percent.

On the other hand, speaking for card issuers and networks, the EPC's Simpson notes that many merchants benefit from credit card payments because they're popular with customers and are more efficient to process.

▶Rewards and convenience add to the expense. Merchants' costs are also climbing because the way people like to pay has changed, says CMSPI chief economist Callum Godwin.

CHRIS GASH

The mix is moving away from cheaper-to-accept payment methods like cash, he says, to more expensive methods such as credit cards and buy-now, pay-later agreements.

While younger adults are especially likely to ditch cash in favor of credit, people 55 and up are also using credit and debit more often.

Credit card users who are focused on collecting rewards points or cash-back benefits drive up merchants' expenses as well, since rewards cards are more costly to process, says payments consultant Richard Crone. The growth of rewards collecting gives retailers more incentive to add a surcharge, especially because some rewards enthusiasts will gladly pay it. "They'll go through all kinds of weird gyrations in order to earn these points," Crone says.

▶ **Rewards and surcharges don't mix well.** It rarely makes sense, though, to pay a surcharge to rack up rewards points. A new Visa rule, for example, caps surcharges at 3 percent. So unless you're using a 5 percent cash back card—and most no-annual-fee rewards cards offer only 1 to 2 percent back—your points won't cancel out a fee that high. "You're in the hole every time," Crone says. (Even if there is no surcharge, you'll also lose money carrying a balance month to month while chasing points.)

If you visit an establishment with a surcharge below 2 percent, then some credit cards, such as a 2 to 3 percent cash back card, could recoup the fee. When dining out, you might want cash or a debit card on hand in case a credit card surcharge is too much. That said, for big retail purchases, paying with a credit card offers you greater consumer protection.

▶ **Not all plastic is the same.** Although debit cards tied to a bank account may look like credit cards, these cost less for merchants to process. Card networks forbid collecting a surcharge on debit card transactions, even if they're handled by a retailer just like a credit card. The same rule applies to prepaid stored-value cards.

Merchants can pay a hefty penalty for charging to use a debit card, but mistakes happen, says TSG senior associate Jeff Fortney, who himself has had to deal with a wayward debit card surcharge. If you're charged extra for using your debit card, Fortney advises keeping your receipt and contacting your bank to request that the fee be reversed.

▶ **Rules vary by state.** The legality of surcharges, their size limits and their disclosure rules depend on where you are. A new California law, for example, requires any credit card surcharges, if they are imposed, to be included in the up-front advertised price—except in restaurants, where any surcharges to be added to the bill can be disclosed on the menu. Technically, only two states, Massachusetts and Connecticut, completely ban credit card surcharges. In contrast, discounts for using cash or other favored payment methods—a price break, as opposed to a surcharge's price increase—are allowed everywhere.

In general, all merchants are supposed to disclose surcharges before you pay. Check your state laws to learn what's allowed, Hindert advises. If a merchant breaks the rules, you can complain to the office of your state's attorney general. ■

***Kelly Dilworth** has written for* CreditCards.com, Yahoo Finance, LendingTree *and other news outlets.*

Your Money
Live Well for Less

BY **LISA LEE FREEMAN**

FOOD LABELS DECODED

Use those mysterious little symbols to shop smarter

I'm one of those annoying shoppers who stand in supermarket aisles squinting at labels. A can of soup, a box of cereal—to me, every package is a good read.

As I hunt for nutritious food, I see official-looking symbols on many labels. They look reassuring, but that might just be the "health halo" effect, says Eva Greenthal, a scientist at the Center for Science in the Public Interest (CSPI): A stamp or a seal can make foods seem like good choices even if they're loaded with added sugars, sodium and saturated fats.

The federal government is developing a new symbol to help shoppers identify healthy foods, but for now, you're on your own. These common icons will get you started.

SMARTLABEL

Use your smartphone to scan the QR code next to this logo to get detailed product info. When I scanned a box of cake mix, I found an easy-to-read list of ingredients, nutrition facts, allergens and a disclosure that the product contains bioengineered ingredients, also known as genetically modified organisms (GMOs).

WHOLE GRAIN

The logo of the Whole Grains Council, a nonprofit supported by food companies, appears on grain-based foods like breads and cereals. The stamp comes in different varieties that confusingly look the same. The "100%" stamp means that all grain ingredients are whole grain, with a minimum of 16 grams per serving—for example, one slice of bread. The "50%" stamp signifies that at least half of grain ingredients are whole grain. The basic stamp requires 8 grams of whole grains per serving; the catch is that the bread may contain more refined grains than whole grains.

CERTIFIED GLUTEN-FREE

The National Celiac Association says that foods with these labels are safe to eat for anyone with celiac disease, an immune disorder. Foods not labeled gluten-free may also be OK; go to the NCA's website (nationalceliac.org) for advice.

KOSHER

Kosher icons can easily flag certain foods if, say, you are lactose-intolerant or allergic to shellfish. Kosher means food was processed using Jewish religious standards, which ban many animal products, including pork and shellfish, as well as foods combining meat and dairy ingredients. To find foods without meat or dairy, look for the letter U with a circle around it; or the letter K or a K inside a circle logo, adjacent to the word "Parve" or "Pareve." While these foods have no dairy or meat ingredients, they might include fish or eggs. If the product has the OU or OK symbol and the letter D, M or F, that means it's a kosher dairy, meat or fish product.

NON-GMO PROJECT VERIFIED

The Non-GMO Project's seal means that the product was made without genetically engineered organisms that have been altered in a lab, and that it meets the group's standards, including undergoing inspections. Another way to avoid GMOs is to buy organic, according to CSPI. Like many seals, this one can be misleading: Some orange juices are labeled Non-GMO, implying they're special. But they aren't, Greenthal says: "There are no GMO oranges." ■

Lisa Lee Freeman, *a journalist specializing in shopping and saving strategies, was editor in chief of* ShopSmart *magazine from Consumer Reports.*

99 GREAT WAYS TO SAVE: HOME FIX-IT PROJECTS

BY **BETH BRAVERMAN**

Get creative with your contractors. Some may be more willing to negotiate during the winter months, which are typically a slower season for them, says Courtney Klosterman, home insights specialist with Hippo Home Insurance. In exchange for a discount, offer to do some of the prep work or purchase the materials yourself.

Go straight with countertops. Replacing your countertop can be a budget-friendly way to give a facelift to an older kitchen. In addition to going with lower-cost materials (think slate or quartz), opt for eased edges rather than more labor-intensive designs, such as bevel or bullnose, which can cost twice as much per linear foot of counter.

Small tasks with big impact. Painting an accent color on the back of a built-in bookcase, retiling a fireplace and painting the mantle, or replacing a light fixture are relatively small lifts that can make an outsize design difference. "Those kinds of things don't seem like a big deal, but they really are," says Lisa Cini, founder of Mosaic Design Studio in Columbus, Ohio.

Paper your powder room. Wallpaper is a major home decor trend now, especially in a small space such as a bathroom or laundry room. It's also a project you can do on your own.

Use pre-owned materials. From appliances to countertops and cabinets, you can purchase materials salvaged from construction sites or retail floor models for a fraction of the cost of purchasing such items new. Sites to check include TheReusePeople.org, AuroraCirc.com, and Habitat.org/restores.

Look for closeouts. For materials like flooring, tiles and lighting, watch for closeout sales. As long as you know exactly how much you need, you can save up to 90 percent. "They can be of incredible quality; it's just that they're discontinuing the line," Cini says.

PORTRAIT ILLUSTRATION BY MICHAEL HOEWELER; BEN MOUNSEY-WOOD; LIAM EISENBERG

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Female Rates

Issue Age	$10,000	$25,000	$50,000
45–49	$10	$15	$23
50–54	11	18	29
55–59	13	22	38
60–64	17	32	58
65–69	21	44	81
70–74	33	74	141

Male Rates

Issue Age	$10,000	$25,000	$50,000
45–49	$12	$21	$36
50–54	14	26	45
55–59	18	36	65
60–64	24	50	94
65–69	31	67	128
70–74	42	95	184

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HELP! MY DATA'S BEEN HACKED

The personal info of hundreds of millions of Americans has been exposed. Do you know how to stay safe?

BY **SARI HARRAR**

Your personal information is under attack like never before.

A record-setting 1.3 billion American consumer records—including Social Security, driver's license, credit card and health-related account numbers—were stolen in data breaches in the first nine months of 2024, according to the Identity Theft Resource Center (ITRC).

And personal info, including medical records from 1 in 3 Americans, was swiped in the massive Change Healthcare data breach made public in 2024.

The resulting losses are staggering. Criminals stole nearly $23 billion from consumers last year in traditional identity fraud, often info filched in part from data breaches, according to a report cosponsored by AARP and Javelin Strategy & Research. "Your data is valuable. Bad guys find ways to make money with it," says James E. Lee, the ITRC's chief operating officer.

More than 80 percent of Americans have

received at least one data-breach notification in the past year, Lee says. But more than half of them don't know what to do next. "People are afraid," says Amy Nofziger, director of fraud victim support for the AARP Fraud Watch Network. "They're worried about what it means when you get a notification. They're unsure about what steps to take. We want people to feel empowered and not to panic."

Recent callers to AARP's Fraud Watch Network Helpline have plenty of questions about data breaches, Nofziger says. They include Joyce, a Michigan resident, who's frightened after getting a data-breach letter in the mail. Eugene, from Montana, got a similar letter regarding the Change Healthcare breach. It exposed his Social Security and driver's license numbers. Rebecca, from Maryland, received documents to sign after a health care system data breach but doesn't know if it's safe to share her Social Security number.

Data breaches target customer information kept online by companies, organizations, health care systems, schools and government agencies. Banks, drug store chains, ticket agencies, health insurers, hotel chains and even auto parts stores have been in the crosshairs recently.

Criminals break into databases—often by sending a fake email to an employee. They download your data, then sell it on the internet's dark web or use it to access consumers' bank accounts and credit cards, open financial accounts in consumers' names, even file fraudulent tax returns and pocket the refund. What they want most may surprise you.

"Social Security numbers are important to protect, but in fact they've been compromised for years," Lee says. "What is more valuable is your login and your password. And your driver's license is extraordinarily valuable because people can use it to open new accounts in your name. On the dark web, driver's license information sells for $150 to $250."

The total number of data breaches in the U.S. hit a record high of 3,203 in 2023, but the number of affected consumers soared in 2024 with the rise of "mega breaches" affecting more than 100 million individuals. Laws in all 50 states as well as Washington, D.C., Puerto Rico and the Virgin Islands, require companies to notify consumers of a breach involving personal information, according to the Federal Trade Commission.

But don't wait for a notification letter to protect yourself, says Lisa Plaggemier, executive director of the National Cybersecurity Alliance. "Breaches can occur without companies even realizing it right away, so it's crucial to establish good security habits that you maintain regularly," Plaggemier says. "Assume your data may already be out there and focus on improving your security habits." She recommends freezing your credit reports, using unique long passwords for online accounts, setting up multi-factor authentication and monitoring your financial accounts regularly. "This way, you'll gain more peace of mind without the constant worry of chasing down every potential data breach." ■

HAVE QUESTIONS RELATED TO SCAMS?

Call the AARP Fraud Watch Network Helpline toll-free at 877-908-3360. For the latest fraud news and tips, go to aarp.org/fraudwatch network.

WHAT DO I DO NOW?

Receiving a data-breach notification is a "wake-up call," says Matthew Klaus, vice president of information security at AARP. Follow these expert-endorsed steps when a notification letter arrives in your mailbox.

- Read the letter carefully and opt in to free credit-monitoring and identity-recovery services.
- Sign up for free credit-protection offers in the letter.
- Freeze your credit. Putting a free security freeze on your credit reports will stop criminals from opening new accounts in your name because creditors won't be able to run a credit check.
- Change passwords and user names. Create new passwords that are long and easy to remember.
- Set up MFA. Using multi-factor authentication adds an extra layer of security to important accounts. Not sure which of your online accounts use MFA? Go to 2fa.directory/us.

Sari Harrar is a contributing editor to AARP The Magazine *and frequently writes on health and fraud for the* Bulletin.

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MEET THE UNSUNG NURSING HOME HERO

One advocate's work shines a light on a little-known national program

BY **JAMIE McGEE**

> "Every time I feel like I just can't do it anymore, I'll have a resident say, 'You are my guardian angel.'"
> —Melinda Lunday

DIANA KING

At a nursing home northeast of Nashville, across from a cornfield in a rural stretch of middle Tennessee, Melinda Lunday walks by a resident's room. A man in a wheelchair at the doorway is watching television as he struggles with a heavy cough. In a raspy voice, he tells her he needs more medical help and is ready to throw punches over the matter.

"I quit telling my nurse anything. It doesn't do no good," he says, spitting into a trash can. He taps his hand to his chest. "It feels just like a sharp knife. Right here, I'm hurting right here," he says.

"You don't need to pop your fist off at anybody," responds Lunday. "Let me go see what I can do to get you some help."

With his permission, Lunday shares his complaint with the home's administrator. By the time she leaves, the man is approved to resume his medications.

This is the third long-term care facility Lunday has visited today. She has two more to go.

Lunday is one of more than 1,500 long-term care ombudsmen across the country; their paid work is supported by a network of nearly 3,500 volunteers. Under a federal program established in the 1970s, ombudsmen advocate on behalf of older residents and those with disabilities living in nursing homes, assisted living facilities and other residential care homes. As resident advocates, they seek to ensure residents' rights are protected and that quality care is provided.

'THERE ARE FAR TOO FEW OF US'

Ombudsmen respond when call lights are ignored, when medications are given incorrectly, when pressure ulcers form from not enough movement, when toenails go untrimmed, when teeth go unbrushed and when soiled briefs are left unchanged. They provide information on available supports and services, answer questions, and investigate and resolve complaints. When a nursing home shuts down, ombudsmen help ensure that residents have another place to live. When a facility threatens to eject a resident, they help the person find a way to stay or suggest alternative arrangements.

Yet the valuable services that ombudsmen perform are increasingly hard to provide. One reason: Partly because of COVID restrictions and concerns, the pool of volunteers who can serve as representatives supervised by paid ombudsmen such as Lunday has shrunk by 40 percent over the past five years. "There are far too few of us in Tennessee and across the country to do really excellent work," says Teresa Teeple, Tennessee's state ombudsman.

Meanwhile, the number of complaints lodged with ombudsmen about long-term care have been climbing rapidly over the past few years, returning to pre-COVID levels of more than 202,000 in 2023. Speaking about Tennessee, Teeple says, "Almost, in every single case, regardless of how we code it, there is an element of there being too few staff or staff not trained well enough to provide care to residents in the way that they need it."

Better oversight would require more money. Annual federal funding for the nationwide ombudsman program was $22 million in 2023 and 2024, and some states have temporarily bolstered staff with COVID-related funding sources. But funding falls below recommended ombudsmen-per-bed ratios in nearly half of the states, according to data provided by the National Association of State Long-Term Care Ombudsman Programs (NASOP).

"I haven't seen this kind of crisis before," says Patricia Hunter, NASOP president, long-term care ombuds for the state of Washington and a 30-year veteran of this field of work. "People are not getting their needs met," Hunter says. "The funding is just not adequate."

Ombudsmen also face challenges due to limitations on their authority. They can advocate for residents but have no regulatory power to

CONTINUED ON PAGE 28

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GET HELP To find a long-term care ombudsman in your state, or to learn how you can volunteer, visit **aarp.org/ombudsman**.

CONTINUED FROM PAGE 26

fine or decertify a facility. For serious matters, or when a facility fails to remedy an issue, ombudsmen can bring in state regulators partnering with the Centers for Medicaid & Medicare Services, or they will work with state or federal law enforcement. To push for any kind of reform at the state or federal level, ombudsmen make recommendations to lawmakers and lobbyists, another part of their job.

Some facilities do an excellent job providing care, Teeple says, and at many, ombudsmen are viewed as partners. Staff at other facilities see the program as adversarial and at times use code words to announce an ombudsman's arrival.

'I THOUGHT I HAD SEEN THE WORST'

Lunday, 54, is a Nashville native with a gentle Southern accent. She draws inspiration, she says, from her parents, now in their 80s. Her mother was a determined advocate for her younger brother with special needs during the 1970s, when inclusion efforts were rare. "I saw how she was able to network, to interact and to talk to other people," Lunday says. "Mom was my hero."

She is a recognized face to several residents at her assigned facilities and if she's not, she shares flyers to explain her role. She moves briskly down hallways in short black heels but is careful to not rush conversations with residents.

Some facilities can consume half of Lunday's day, increasingly so as complaints become more egregious and complex. To help get an authentic view of operations, she may start her visits early in the morning or delay them to late evening. She eats a packed lunch in a facility parking lot most days, as texts and calls from residents, their family members and her colleagues roll in. Along with two other paid ombudsmen, Lunday covers about 175 long-term care facilities in 13 counties.

With a background investigating child sexual and fatal abuse, Lunday assumed she had seen most forms of mistreatment. "I thought I had seen the worst in human beings," she says. "I have not seen it all."

In one facility, after she reported understaffing, an unsupervised resident died after mistaking cleaning chemicals for juice. Another resident hadn't had a shower in a year until Lunday intervened. Residents complain to her about waiting hours or even overnight in discomfort in soaked or soiled briefs. She has also dealt with reports of physical abuse and rape. "There are some days, you sit there and go, *How can people be this way to other human beings?*" she says.

'TREAT THEM WITH DIGNITY AND RESPECT'

On an August morning visit to an assisted-living and memory-care facility, Lunday walks through the halls, chatting easily with a group of residents about the eggs, bacon and hash browns on their plates.

"This is the ladies' table, I can tell," she says, greeting four women. "Coffee is the best part, isn't it?" She adds, "Coffee is my favorite part of the day."

At another table she comments on a woman's dog-themed pajamas, providing an excuse to show the group a picture of her brown Yorkshire terrier, Louie.

As she engages the residents in the dining room and hallways, she takes mental notes typical of her visits: How do the hallways smell? Are used briefs on beds or are they thrown away? What kind of activities are available to the residents? How accessible is the dinner menu, and are snacks and water available? How many caregivers are on duty? How long did it take for someone to respond to the call light?

Pushing open a laundry room door left ajar, she points out a container of laundry detergent. In memory-care units, residents should not be left around toxic chemicals or have access to rooms they could trap themselves in, she explains. She asks a staff member to close the door. When she sees a room of nearly a dozen unsupervised memory-care residents waiting for a caregiver to wheel in someone else, she pulls out her notepad.

"When you get that many people together, it's always good to have a caregiver there," she says. A resident might be aggressive or another might be unstable on his feet, she says. "There could be so many 'what-ifs' that come up."

Patricia Augustus, 55, who has been recovering from heart surgery at a Nashville rehab facility and has a worn-out knee, is one of the people who have Lunday on speed dial. In April, Augustus became faint with low hemoglobin and pulled a cord in the bathroom for help. It took several hours for someone to respond and take her to a local hospital's critical-care unit. There, a concerned case worker called Lunday, who began investigating the length of time Augustus had to wait for care, Augustus says. When, at a later date, Augustus was at the hospital after an injury to her toes, Lunday checked in with her by phone.

Augustus describes Lunday as both an advocate and a friend. "She has had to tell them what they can and what they can't do," Augustus says. "If it wasn't for Melinda being around and you didn't have anyone to stand up for you, the facility could get by with whatever they want."

The facility sought to discharge Augustus in June, she says, which would have rendered her homeless. But Lunday came to the facility and pointed out the statutes preventing discharge when Medicaid applications are pending; that secured Augustus more time to find an alternative group or assisted-living home. Augustus, who also has lupus, fears staying in a shelter could impede the health progress she has made in the past year. "[Lunday] said, 'Look, that's what I'm here for. You relax. You have a heart condition,'" says Augustus. "She keeps on telling me that. 'Let me handle the hard part.'"

Seeing her impact with clients such as Augustus, says Lunday, gives her the fuel she needs for her more challenging cases. Prayer helps, too, along with encouragement from her colleagues.

"Every time I feel like I just can't do it anymore, I'll have a resident say, 'You are my guardian angel,'" Lunday says. "These are people who have laid the foundation for our generation to build upon," she says. "You have to treat them with dignity and respect and also give them a good quality of life. They deserve it." ■

MORE COMPLAINTS, FEWER PEOPLE ABLE TO HELP

	Long-term care facility complaints	Ombudsmen staff and volunteer representatives
2020	153,324	6,533
2021	164,299	5,727
2022	182,864	5,524
2023	202,894	5,014

SOURCE: National Association of State Long-Term Care Ombudsman Programs

__Jamie McGee__ is a Nashville-based reporter who has written for The New York Times, USA Today *and* Bloomberg News.

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I FLEW TO PORTUGAL. MY MEDICAL DEVICE FLEW TO CANADA

One simple step would have prevented restless nights

BY **HANNELE RUBIN**

I unzipped my bag and screamed. "What's wrong?" my husband yelled from across our vacation rental in Lisbon, Portugal. "This isn't my machine," I cried. "The trip is ruined!"

Here we were on a family vacation, and I had someone else's CPAP, or continuous positive air pressure machine. These devices are prescribed to treat sleep apnea, a breathing disorder. An estimated 8 million Americans use one, and settings are customized for each patient. Without my device, I was facing two weeks of restless nights instead of a relaxing excursion. How did this happen? Looking back, it was an accident waiting to happen.

A CASE OF CONFUSION

Airline passengers are advised to bring portable medical devices as carry-ons, rather than in checked baggage, where they may be damaged or lost. By law, qualifying devices—such as CPAPs, portable oxygen concentrators and dialysis machines—don't count against a passenger's carry-on allowance.

But on our crowded first flight, from Texas to Newark, New Jersey, the bins above my seat were full. So my husband wedged my gray CPAP case into a bin a few rows in front of us. Curiously, after landing at this layover, it was in a bin several rows behind us. "That's strange," I said. "Maybe the flight attendants moved things around." My husband grabbed it, and we caught the flight to Lisbon.

WHERE'S MY MACHINE?

Upon realizing the mix-up—another passenger must have taken my machine—I became a student of lost-luggage policies. Unlike checked bags, airlines don't give claim tickets for carry-ons, and they aren't responsible for such items, if damaged or lost.

I turned in the mystery traveler's device (no contact info on or in the case) to the Lisbon airport's lost and found and filed my own missing carry-on reports.

That same day, I received an email from the airline saying the mystery traveler had returned my CPAP to the airport ... in Ottawa, Canada. A cabin crew would take it to Dulles International Airport near Washington, D.C., then pass it to another crew bound for Lisbon.

That night was torturous. Without my CPAP, my airways narrow or close as I sleep. I may snore or stop breathing. This can happen a few times every hour. My body rouses itself enough to gasp for air and start breathing again. But it was only one night. I thought.

The next morning, the CPAP didn't arrive. I began contacting customer service multiple times a day. This meant hours talking on the phone, waiting on hold, leaving voicemails or sending emails or texts. I eventually got to someone who located my CPAP at the lost and found at Dulles. I was given three options: pick it up in D.C., pay to have it shipped to my home in Texas, or pay (a prohibitive amount) to have it sent to Portugal. "But it wasn't my fault," I said. "It's a medical device. I need it!"

I CAN BREATHE AGAIN

I considered scrapping the rest of my trip, but instead I made one last-ditch attempt to get it to Portugal: I googled my airline's corporate officers and sent my sad story to every executive for whom I could find an email address.

Two days later—a week into my vacation—my CPAP arrived in Lisbon. It was a "goodwill gesture," an airline representative later said.

Back in Texas, I took a simple step to prevent future mix-ups—placing my contact information inside and using markers to doodle sparkly stars, squiggles and swirls on the case. No one will mistake it for theirs. I hope. ■

__Hannele Rubin,__ an avid traveler, has written for the New York Post *and several corporate publications. She taught journalism at Texas A&M University.*

RYAN JOHNSON

Tips for Traveling With a Medical Device

Some ways to avoid damage or loss:

- Take a photo of your device and its travel bag, says Christopher Elliott, a Seattle-based travel expert and consumer advocate. If it gets lost, you can show airline officials what it looks like.
- Ask the airline several days before departure about any special requirements. Your device must be Federal Aviation Administration-approved, and if you need to use it in flight, most airlines want you to let them know about it 48 hours in advance.
- Don't put the device in checked baggage, Elliott says. It's safer with you.
- Place your prescription inside the case, advises the Transportation Security Administration. You may need it to prove the device is exempt from carry-on limits.
- Attach your contact information, and personalize your travel case.

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"ALL THE GOOD THINGS YOU HEAR ABOUT AI, AND THE THINGS TO WORRY ABOUT, ARE ABSOLUTELY CORRECT."

— **BILL GATES, 69,** TALKS ABOUT HIS JOURNEY FROM REBELLIOUS KID TO MICROSOFT COFOUNDER, AND HOW AI WILL CHANGE OUR LIVES

ROY ROCHLIN/GETTY IMAGES

What motivated you to write your memoir, *Source Code* (the first of three volumes), now?
Microsoft's now 50 years old, and still going strong, amazingly. So I've been thinking back, how did Microsoft happen? I think I owe a lot to the time I was born, having the parents I had.... It's kind of a fun story: Growing up in the place I did [Seattle] and at the time I did was pretty fantastic.

Sounds like you were a challenge for your parents as a kid.
I was pretty much questioning rules as kind of arbitrary. Who came up with these rules, you know? It was mostly when I was 10 to 12, when I would challenge my parents' thinking—even though, in retrospect, they were quite amazing parents. My dad actually wrote a book called *Showing Up for Life*. And his values, his approach, were pretty amazing. And my mom was ambitious for me, which both bothered me and helped me. I didn't want to do things just to vindicate her. But then I kind of did. So she and I had some tension. Even when I was starting Microsoft, she was still sort of acting like I was living at home.

Do you think you might have been diagnosed as being on the spectrum if you were a kid today?
My social skills, particularly with peers, were a little slower to develop, and I did kind of get obsessed with things. But I probably would have been diagnosed with ADHD, just because of my intensity and energy. I remember in grade school, there was one teacher who said I should skip a grade, and then another teacher told me I should be held back a grade.

But as a teen you were sneaking out in the middle of the night to do computer coding, right?
That was less about being rebellious [than] about how darn interesting it was. Software was

kind of this magical thing, because the microprocessor was going to take software from something that's just an afterthought—because hardware was everything, then—to something even more important.

There's lots of talk about how artificial intelligence is going to change the world. How do you view AI?

What AI means—and this will sound weird, but it's the best way to think of it—is that intelligence almost becomes free. For example, if you were in a meeting with a doctor, and they said complicated things, the idea is that the AI sits in that doctor-patient meeting, and then it's available to talk with you. It can explain your medical bill, it can explain that MRI outcome. It's almost like getting free white-collar workers. It's still not totally reliable, but that's being worked on, and people shouldn't assume that that won't get fixed. We also have to think about how do we deal with somebody who's got ill intent, who's using this tool for a cyberattack, or somebody who's trying to defraud. Some of these scams, which are bad enough without AI, become even more effective if you have AI tools.... So all the good things you hear about AI and most of the things to worry about are absolutely correct.

Is this the best time in history to be 50 or older?

Oh, certainly, by a long shot. You know, 20 years from now will be even better. I've met with Alzheimer's researchers, and these new medicines—particularly if we figure out how to use them early on—are very promising. I saw my dad face Alzheimer's, and it affected his last years a lot. I hope that there'll be fewer people having to go through that.

You'll be 70 in October. How are you changing with age?

I have to say, I'm enjoying these years as much as even those incredible years in my early life: The Microsoft years were incredible. And now, these older years, where my work is mostly foundation focused, are pretty incredible. I would not have guessed when I was young that this part of my life would be as fun or engaging. I take a lot more time off than I did in my 20s and 30s—I was pretty monomaniacal—but I still work pretty long hours. With the kinds of things the foundation does, we can save millions of lives if we do it the right way.

What about staying physically fit?

I'm lucky enough to be healthy, but you need to invest in that, which I never did until I was 60. Fortunately, I enjoy playing tennis and pickleball quite a bit, so I get about half of my exercise in a form that's purely fun. It's exercise I would do even if it didn't benefit me.

Are you optimistic about the future?

Overall, yes, I'm very optimistic, because I get to be involved in incredible innovation, whether it's reducing the damage of Alzheimer's or even preventing Alzheimer's, or ways we'll deal with cancer or the various diseases that are worse in poor countries or climate change or education. This pace at which we're going to improve our health and be able to have what's like a personal tutor, those are really good things. But, you know, it's not like it happens automatically. We have to figure out how to trust each other and work together in order to reap the benefits of these innovations. I hope we will. I believe we will.

—Interview by Christina Ianzito

SERVING THOSE WHO SERVED

AARP helps veterans and military families

Frank Lavender, 84, a Vietnam War veteran, was looking to make some home improvements. "I had these grandiose ideas about wanting to improve my bathroom because of health reasons," he says. But those changes could be pricey. What he didn't know is that he was eligible for help—if he knew where to look.

After meeting AARP representatives at a local fair, Lavender learned about resources dedicated to veterans, including grants to help him pay to remodel his house. "I didn't know that there was actually a way that you could go and get some of these services," he says.

The Department of Veterans Affairs (VA) delivered $187 billion in benefits to former service members and survivors in 2024. But many still don't know these grant programs exist—or that they could be eligible. AARP Veterans and Military Families was created in 2018 to address this challenge and make sure veterans take full advantage of the opportunities they earned through service.

"We try to be connectors of information and resources for these veterans who are so deserving of [these] benefits," explains Juanita Jiménez-Soto, AARP's national Veterans and Military Families manager.

To do so, AARP provides key resources to veterans and their families:

Online toolkits. AARP publishes guides summarizing health benefits and other grants veterans can claim. Recently, the Veterans and Military Families team worked on the "Home Modifications Benefits Guide," highlighting several grants, the largest of which could provide eligible vets with up to $117,000 to adapt their houses to their mobility needs.

Job center. The team also provides ways to connect former service members and their families with work opportunities, as well as classes designed to guide and counsel them as they explore new career paths. Go to aarp.org/vetsjobcenter.

Fraud center. Veterans and active-duty service members are 40 percent more likely to lose money to scams and fraud than civilians, a 2021 AARP survey found. Veterans who believe they are targeted by scammers can visit the AARP Veterans Fraud Center to learn more about the most common scams or contact the AARP Fraud Watch Network Helpline (877-908-3360).

Caregiver support. Those who served our country can face unique caregiving challenges. On average, veterans deal with more health problems than the general population. Their caregivers often have to step into the role at a younger age, Jiménez-Soto says, requiring more time and money to provide care. Caregivers of veterans spend 1.5 times more on out-of-pocket costs each year than other family caregivers. Military caregivers looking for help can call 877-333-5885.

You don't have to be an AARP member to access any of these resources. But if an AARP membership is of interest to you, veterans are eligible for up to 43 percent off.

Lavender is now an AARP volunteer who helps to connect other veterans with the resources they need. "Veterans served us," Jiménez-Soto says. "It's now time for us to serve them." ■

For more information about the work of AARP Veterans and Military Families, visit aarp.org/veterans or look for #AARPSalutesVets on social media.

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Your AARP
Where We Stand

BY **DR. MYECHIA MINTER-JORDAN, CEO**

MEETING THE MOMENT

AARP will rise to new challenges

I was honored to be asked to become AARP's new CEO, and am excited to begin my tenure at this pivotal moment for both the association and the nation.

We enter a new year facing immense change and uncertainty. People are deeply concerned about their futures, and those of their children and grandchildren, as physical, mental and financial health prospects are worsening for many in our country.

We have a new administration and Congress in Washington, and new leadership in some state capitals across the country at a time when many people continue to struggle economically.

As more people become caregivers, they face the mounting emotional, physical and financial stress of caring for a family member or loved one. And as technology advances at an ever-increasing pace, people are searching to understand how it will affect their day-to-day lives.

Despite these challenges, I feel optimistic. Thanks to the leadership of my predecessor, Jo Ann Jenkins, AARP is better prepared than ever to lead during this time of uncertainty as a wise friend and fierce defender of the needs and interests of people 50-plus.

I am determined to meet this moment. In many ways, I feel like my life and career have prepared me for it. For as long as I can remember, my parents have instilled in me the importance of giving back through service to others, especially those less fortunate. That is what led me to become a physician and to leave academic clinical medicine at Johns Hopkins to lead the Dimock Center in Boston, which serves many of the city's poorest and most vulnerable residents. During my time at Dimock and later at the CareQuest Institute for Oral Health, I learned the incredible power of community engagement to transform health care.

It's also what led me to pursue my MBA at Johns Hopkins. I loved helping my patients, and I realized I could have much broader impact by finding innovative ways to improve and transform health systems to deliver better care and reach more people, incorporating all aspects of physical and mental health.

As we shape this future together, we will strive to have a positive impact on people's health, wealth and wellness as we *make aging better for everyone.*

—AARP's new CEO, **Dr. Myechia Minter-Jordan**

AARP has a distinguished history of changing lives of individuals for the better and improving the programs that help them as they age, such as Social Security, Medicare and Medicaid. There is still more to do to build on that legacy.

As I lead AARP into this new year and beyond, I assure you that we will use the power of our collective voice and the strength of our numbers to provide you with valuable information and resources, advocate for your needs and interests, and drive market-changing products and services that empower you to live better as you age.

AARP founder Dr. Ethel Percy Andrus wrote, "Whatever many may say about the future, it is ours, not only that it may happen to us, but it is in part made by us." As we shape this future, we will strive to have a positive impact on people's health, wealth and wellness as we make aging better for everyone.

I look forward to our journey together. ■

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Readers Respond

THE CHALLENGES OF LIVING LONGER

Great article ["The Future of Aging," Cover Story, November] and, yes, most people would entertain living longer conditional on being healthy. As I'm reading the article, one issue comes to mind, and that is how will people pay for it? We hear that Social Security may be insolvent within the next decade. My wife and I planned back in our 40s with life expectancy in our 80s. So what happens when the money runs out and we live to 100? We can't expect the government to foot the bill. Someone should write part two of this article: Are you financially ready to live to 100?

CLAUDE BEAUDRY
WOODSTOCK, GEORGIA

Your November cover story about aging had lots of good information. As an almost 81-year-old, I did get a little chuckle out of the "My Longevity Secrets" sections, however. While almost all of their "secrets" were interesting, I did note that the providers of their personal "longevity secrets" ranged in age from a mere 60 to 69 years old.

MATTHEW SCULLY
SAHUARITA, ARIZONA

150? You betcha! In 1995, when my 5-year-old had her first concerns about mortality, after her goldfish passed, I assured her that that was a long way off since lifespans will keep extending with each generation and I was going to live to at least 150 and she would live until at least 250. At 71, I'm closing in on the new "middle age"!

CAMILLE GAON
RANCHO MIRAGE, CALIFORNIA

A RELATABLE CHEF

I read with interest the Q&A with Ina Garten. She said, "I surround myself with people who are happy and positive and smart and funny." Oh how that reminds me of my late mother (who lived to be almost 90)! My mom would always say, "Laugh and the world laughs with you." No wonder I like Ina Garten so much!

ANNE FORCELLA SKALITZA
SPRING LAKE, NEW JERSEY

JO ANN JENKINS' LEGACY

I want to thank Ms. Jenkins for her 10 years of leadership with AARP ["A Decade of Achievements for AARP's Leader"]. She accomplished a lot and left a big pair of shoes to fill by her successor. Good luck with your next project, Ms. Jenkins.

PETER ANDERSON
CHARLESTON, WEST VIRGINIA

FLIPPING THROUGH

I just received my November copy of the *AARP Bulletin*. The information is helpful as I age. However, at 85 years of age, I find the paper it is printed on is extremely difficult to page through. The pages stick together. Sometimes in my frustration, I don't read all the articles if I can't separate the pages. Maybe an e-edition would be appropriate.

CHET PEACHEY
GOSHEN, INDIANA

Editor's note: *AARP members can find current and back issues of the* Bulletin *at* ***aarp.org/bulletin*** *and on the* **AARP Now** *app; scan this code with your device's camera.*

We appreciate hearing from you. Write to: *Bulletin* Editor, Dept. RF, 601 E St. NW, Washington, DC 20049, or email **bulletin@aarp.org.** Please include your address and phone number.

Medicare Made Easy

BY **ANN KAYRISH**

Why was a copay charged at my annual physical? I thought Medicare covers that.

Medicare covers annual wellness visits but does not cover routine physicals. The AWV is available to all Medicare enrollees after their first 12 months of coverage and then once every year. The AWV includes a review of your health history, risk assessments and a plan to prevent future illness, but it doesn't involve the kind of "physical" exam where the doctor touches you, obtains blood work or runs diagnostic tests. Since the AWV focuses on prevention, copays and deductibles do not apply. However, some doctors may combine the AWV with diagnostic services that address specific health concerns. These are not part of the AWV and are subject to the Part B deductible and copays.

At my last doctor's appointment, I asked for additional blood tests and the office had me sign a form called an Advance Beneficiary Notice. Can you explain what this form is and what I may have agreed to?
An ABN is a form that a health professional gives you to read and sign before a treatment or service is provided because they believe Medicare might not cover the prescribed or requested service. By signing the ABN, you are agreeing to pay for the service yourself if Medicare doesn't cover it. The notice describes the service, an estimate of how much it will cost, and why your doctor thinks Medicare won't pay for it. You can still ask your doctor to send a bill to Medicare, even after signing an ABN, to see if Medicare will pay. If the claim is denied, you can appeal. ABNs are only for people in original Medicare. Medicare Advantage plans handle coverage decisions through their own process.

MEDICARE HOTLINE: 800-Medicare (800-633-4227)
MEDICARE ONLINE: medicare.gov

I am retired and have both Medicare A and B and am also covered by my spouse's work policy. Which plan pays first?
Your primary insurance pays first. If your spouse's employer has 20 or more employees, the job-based plan will be your primary coverage. If the employer plan has fewer than 20 employees, Medicare will be your primary payer and the work insurance will pay second. If you are unsure of the insurance plans connected to your Medicare account, log in to your medicare.gov account and check under the Profile symbol to see all the insurance plans linked to your Medicare number, or call the Benefits Coordination & Recovery Center at 855-798-2627.

I heard that Medicare drug plans now have a $2,000 cap. Is this also true for Medicare Advantage plans?
Yes, if you're enrolled in either a Medicare Part D drug plan or a Medicare Advantage plan with drug coverage you won't have to pay more than $2,000 out-of-pocket for covered prescription drugs in 2025. Only the costs of covered drugs (drugs listed on your plan's formulary) count toward the $2,000 cap. Monthly plan premiums, over-the-counter drugs and the cost of drugs not covered by your plan do not count toward the limit. Some drugs, such as those given in a doctor's office or outpatient center (cancer treatments or injectables), are covered by Medicare Part B and their costs won't count toward the Part D drug cap. ■

__Ann Kayrish__ has worked as a Medicare counselor with the State Health Insurance Assistance Program and as the Medicare expert at the National Center for Benefits Outreach and Enrollment at the National Council on Aging. Send your questions about Medicare to __medicare@aarp.org__.

PORTRAIT ILLUSTRATION BY MICHAEL HOEWELER

SPOTLIGHT **MARYLAND**

CONNECTING WITH BLACK VETERANS

Former state Rep. Clarence "Tiger" Davis, 82, of Baltimore, sees a direct link between AARP Maryland's agenda and that of Black veterans in the state.

"One of the things we want to do in the Black veterans' movement is move America towards a more perfect union," which includes protecting older adults to make society better for all, he says. In addition to his stint in the state legislature, Davis served for six years as AARP Maryland's volunteer state president.

He used that time in part to strengthen the organization's work with veterans across the state—particularly with the National Association for Black Veterans. That relationship will be in the spotlight in February with AARP's sponsorship of a major fundraiser for NABVETS.

The Buffalo Soldiers Memorial Banquet—to be held on Saturday, Feb. 15, at Morgan State University—celebrates the contributions of Black soldiers to America's history. This year marks the 25th anniversary of the event—and the 80th anniversary of the end of World War II—so the program will focus on the stories of Black veterans who served in that conflict.

AARP Maryland has worked with NABVETS on a range of issues and events—from teaming up to push key bills in the General Assembly to sharing information at community events. About 31 percent of Maryland's 345,000-plus veterans are African American, state data shows.

The banquet is an opportunity to celebrate Black veterans and connect them with AARP's resources, says Hank Greenberg, AARP Maryland's state director.

"We have a great debt to those who have served our country, and the thing we can do at AARP is to be sure that they have all the opportunities to age with dignity," Greenberg says.

Find AARP veterans' resources at aarp.org/veterans.

—Michelle Cerulli McAdams

PENNSYLVANIA

Help with heat With colder temperatures here, AARP Pennsylvania is working to ensure residents know about financial assistance to help with heating bills.

The federal Low-Income Home Energy Assistance Program, known as LIHEAP, provides a cash grant to help eligible households cover their heating bill. The money goes directly to the recipient's utility provider.

The grants range from $200 to $1,000 and are based on factors like household size, income and the type of fuel used. They are available to both homeowners and renters. This year's application period is open now through Friday, April 4.

To view eligibility requirements or apply, visit pa.gov/en/agencies/dhs/resources/liheap.

DELAWARE

Online resources Learn about the latest AARP Delaware news and events on its YouTube page.

The site includes videos on everything from gift card scams to AARP's partnership with the YMCA. Find it at youtube.com/@aarpdelaware3389.

NEW JERSEY

Utility aid Rising utility bills are a challenge for many across the Garden State, especially those on fixed incomes. To help older New Jersey residents and their families lower their utility bills, AARP New Jersey has an online list of payment assistance programs.

Among other tips and resources, the site includes information on several financial assistance programs, including New Jersey's Public Utilities Universal Service Fund, which provides a credit for eligible households' energy bills, and the federal Low-Income Home Energy Assistance Program, known as LIHEAP, which offers assistance on utility bills to lower-income households.

Find details on those initiatives and other assistance at aarp.org/NJResources. *—MCM*

AARP RESOURCES

TAX HELP

AARP Foundation Tax-Aide can help prepare your returns for free. Key details include:

- ▶The program is open to all but focuses on people 50 or older with low-to-moderate incomes.
- ▶Tax-Aide volunteers are certified by the IRS.
- ▶Most sites are open from Feb. 1 through April 15.
- ▶Those seeking assistance must bring key tax documents.

More at aarpfoundation.org/taxhelp.

EVENTS & ACTIVITIES

AROUND THE REGION

For more information: **local.aarp.org.**

DISTRICT OF COLUMBIA
Learn how **AARP Community Challenge** grants can help make your community more livable, at **aarp.org/communitychallenge.**

DELAWARE
Put your **camera skills** to work. AARP is looking for volunteers to take photos and videos at events around the state. See **aarp.org/iwanttovolunteer** for details.

MARYLAND
With the **legislative session** underway this month, AARP is seeking volunteers to advocate for support for family caregivers and other key issues. Email **md@aarp.org** for more.

NEW JERSEY
Getting ready to **file your taxes?** Find information on income tax brackets, breaks for older New Jerseyans and other details at **aarp.org/NJtaxguide.**

WEST VIRGINIA
When the **legislative session** begins on Feb. 12, AARP will advocate on issues that affect older West Virginians. Learn about the 2025 agenda at **aarp.org/wv.**

JAMES OLSTEIN

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[1]**In Texas, the Auto Program is underwritten by Redpoint County Mutual Insurance Company through Hartford of the Southeast General Agency, Inc. Hartford Fire Insurance Company and its affiliates are not financially responsible for insurance products underwritten and issued by Redpoint County Mutual Insurance Company.**

[2]Average annual savings are derived from 6-month policy terms and based on information reported by customers who switched to The Hartford's newest rate plan between 9/1/22 and 8/31/23. Your savings may vary. [3]Terms and conditions apply. [4]Gift is a limited time offer and not available in all states. Email address required in most states. Allow 4-7 weeks for delivery. Bottle not included.

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- AARP Long-Term Care Options from New York Life
- AARP® Vision Plans from VSP

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- AARP® Medicare Advantage from UnitedHealthcare®
- AARP Medicare Enrollment℠ Guide
- AARP Medicare Resource Center
- AARP® Medicare Rx Plans from UnitedHealthcare®
- AARP® Medicare Supplement from UnitedHealthcare®
- Oak Street Health Primary Care

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- AARP Fitness Center
- AARP® Health Savings Account offered by Optum Financial®
- AARP Hearing Center
- AARP® Hearing Solutions™ provided by UnitedHealthcare® Hearing
- AARP® Personalized Nutrition
- AARP® Physical Therapy At Home™ by Luna
- AARP® Prescription Discounts provided by Optum Rx®
- AARP® Staying Sharp®
- BMI Calculator
- Calm Sleep, Meditation & Relaxation App
- Hero® Smart Pill Dispenser
- LensCrafters
- Target Optical
- The National Hearing Test

TECHNOLOGY & WIRELESS

- AARP Perks™ Browser Extension
- AARP Personal Technology Resource Center
- AARP Tech Guides
- AT&T
- Consumer Cellular
- GrandPad, Powered by Consumer Cellular
- In-Person and Online Technology Classes
- LifeLock™ by Norton
- Norton™ 360
- Norton Ultimate Help Desk

GAS & AUTO SERVICES

- AARP Driver Safety: AARP Smart Driver™ Course, CarFit℠, Smart DriverTEK℠, We Need to Talk
- AARP SafeTrip™ App
- Allstate Roadside
- Exxon™ Mobil™
- Valvoline

ADVOCACY

- Government Advocacy
- Legal Advocacy

TRAVEL

TRAVEL PLANNING

- AARP Travel Center Powered by Expedia
- AARP Travel Site
- Medjet Travel Protection
- RushMyPassport

CAR RENTALS

- Avis
- Budget
- Payless® Car Rental
- Zipcar Car Sharing

FLIGHTS, CRUISES, RAIL & TOURS

- British Airways
- Collette
- Collette Spotlights
- Explorations by Collette
- Grand European Travel
- Holland America Line
- HX: Hurtigruten Expeditions
- Vacations By Rail

HOTELS & RESORTS

- All Resort Store
- Best Western Hotels & Resorts
- Choice Hotels
- Extra Holidays
- Hilton Hotels & Resorts
- Karisma Hotels & Resorts
- Motel 6 and Studio 6
- Preferred Hotels & Resorts
- Radisson by Choice
- Red Roof
- Wyndham Hotels & Resorts

MAGAZINES & RESOURCES

- AARP Bookstore
- *AARP Bulletin*
- AARP Members Edition™
- AARP Rewards
- *AARP The Magazine*

FAMILY CAREGIVING

- AARP Family Caregiving
- AARP Family Caregiving Guides
- AARP Care to Talk?™ Conversation Cards
- CareLinx In-Home Care
- IRIS Ally Medical Alert Device from Consumer Cellular NEW
- Lifeline Medical Alert Service

COMMUNITY

EVENTS

- In-Person and Online Learning through AARP Programs
- AARP Near You

VOLUNTEERING

- AARP Driver Safety
- AARP Foundation
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- AARP Foundation Tax-Aide
- AARP State Offices
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- AARP® Auto Insurance Program from The Hartford
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- Boat & Personal Watercraft Insurance from The Hartford
- Collectible Vehicle Insurance from The Hartford
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LIFE INSURANCE

- AARP Guaranteed Acceptance Life Insurance from New York Life
- AARP Life Insurance Options from New York Life
- AARP Permanent Life Insurance from New York Life
- AARP Term Life Insurance from New York Life

PET INSURANCE

- Fetch Pet Insurance

PROPERTY INSURANCE

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- AARP® Mobile Home Insurance Program from Foremost®
- Renters Insurance from The Hartford

WORK & FINANCES

BANKING & INVESTMENTS

- AARP® Essential Rewards Mastercard® from Barclays
- AARP® Travel Rewards Mastercard® from Barclays

FINANCIAL PLANNING

- AARP Interview an Advisor™ Tool
- Online Money Tools
- Savi Student Loan Repayment Tool
- Trust & Will Estate Planning

WORK & JOBS

- AARP Skills Builder for Work℠
- On-Demand Webinars

FRAUD PREVENTION

- AARP Fraud Watch Network™
- AARP Fraud Watch Network™ Helpline
- AARP Fraud Watch Network™ Scam-Tracking Map
- Fraud Resource Center

RETIREMENT

- AARP Retirement Calculator
- AARP Social Security Resource Center
- Retirement Resources
- Social Security Calculator

HOME & REAL ESTATE

- AARP Foundation Local Assistance Directory
- AARP® Real Estate Benefits by Anywhere
- American Home Shield
- ADT™ Home Security
- Budget Truck Rental
- Home Resource Center

ENTERTAINMENT

- AARP Theater
- AARP Virtual Community Center
- Ancestry
- Free Online Games
- Movies for Grownups
- Paramount+
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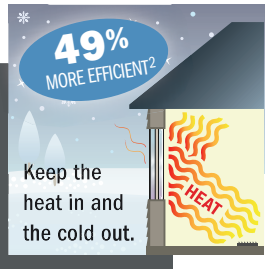

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