Rhode Island Alliance for Retired Americans®

RI ARA

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"Fighting for the future of our members."
"NOW, more than ever!!!"

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Friday Alert Message from the Alliance *for* Retired Americans Leaders

Alliance Members Demand Action to Protec\ Social Security on its 90th Anniversary

Robert Roach, Jr
President, ARA

Alliance members continued to hold "Save Social Security" events with the American Federation of Government Employees (AFGE) and other labor allies this week to mark Social Security's 90th anniversary this Thursday.

"For 90 years, Social Security has allowed millions of Americans to retire with dignity. It's a sacred promise between them and their government," said **Robert Roach, Jr., President of the Alliance**. "We should be celebrating that legacy, but instead we have to worry about Social Security's future. This Administration has slashed the Social Security Administration (SSA) workforce, spread disinformation about earned benefits, and talks openly about doing things to privatize and weaken Social Security, including raising the retirement age."

Attendees urged lawmakers and SSA Commissioner Frank Bisignano to take action to address three key demands for keeping Social Security strong:

- Fully staff the Social Security Administration to reduce wait times and ensure high quality service delivered by professionals, not machines;
- \Protect Americans' private SSA data;
- Make the wealthy pay their fair share into Social Security so we can strengthen benefits for current and future generations.

The Texas Alliance kicked the week off with an event on Sunday in Corpus Christi, holding events later in the week in Houston, Beaumont, San Antonio, Dallas, and Austin. Rep. Jasmine Crockett (TX) received a "Retiree Hero" Award from members on Friday.

On Wednesday, Wisconsin Alliance members rallied in front of a recently closed SSA office in Racine. "We're standing out here today in front of this Social Security office that has permanently closed. This location was so easy for people to go to. Right on the bus route, they could come here, get off right across the street and walk over here," said Ross Winklbauer, President of the Wisconsin Alliance. "But unfortunately, because of the cuts that are going on in our government right now and the attacks on our Social Security and Social Security offices, we're making it harder and harder for our seniors to be able to go and apply and collect Social Security." right now and the attacks on our Social Security and Social Security offices, we're making it harder and harder for our seniors to be able to go and apply and collect Social Security."

The New Mexico Alliance commemorated Social Security's anniversary with cake deliveries at nine senior centers in Albuquerque. Alliance members were particularly active on Thursday, attending and hosting Social Security events in 18 states, including California, Connecticut, Florida, Illinois, Minnesota, Nebraska, Nevada, New York, and Ohio.

The Pennsylvania Alliance joined the American Federation of Government Employees (AFGE) and the AFL-CIO "It's Better in a Union" Bus to start the day with a special "Keep Social Security Strong" breakfast in Wilkes-Barre.

The bus then took AFGE President Everett Kelley and Pennsylvania Alliance leader Jody Weinreich to a rally outside an SSA facility to highlight how this Administration's changes and staff cuts are hurting workers and Social Security beneficiaries.

"Across the country, we are using our voice — as workers, as parents, as people who care about our communities — to demand that this administration and Congress do whatever it takes to protect Social Security," AFGE President Everett Kelley said. "The American people deserve nothing less."

"My benefits let me stay in my home, put food on the table, pay my bills, keep my car running, spend time with my loved ones, and volunteer in my community," said Weinreich. "What's happening at Social Security right now is a travesty. These are backdoor cuts to the benefits we earned. Let me be clear: Firing staff doesn't make Social Security more efficient. Making seniors wait longer for claims or answers doesn't prevent fraud. It just makes it harder for people to access their benefits."

The Arizona Alliance hosted "Silver Sit-ins," where they presented Rep. David Schweikert (AZ) and Rep. Juan Ciscomani (AZ) with "Retiree Zero" awards for their anti-retiree votes on key retirement security issues last year, while the Kentucky Alliance rewarded Rep. Morgan McGarvey's (KY) pro-retiree voting score with a "Retiree Hero" award. The Florida Alliance also drew attention to their congressional delegation's voting record, presenting Sen. Rick Scott (FL) and Rep. Neal Dunn (FL) with "Retiree Zero" certificates.

The week's actions ended with a Social Security anniversary rally hosted by the Pittsburgh Federation of Teachers. **Alliance Executive Director Richard Fiesta**, American Federation of Teachers (AFT) Secretary-Treasurer Fedrick Ingram, Rep. Chris DeLuzio (PA) and Rep. Summer Lee (PA) all spoke during the event.

There are also several anniversary events planned for the coming days, including a protest outside Rep. Tim Walberg's (MI) office in Niles, Michigan on Monday.

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Medicare Rights Experts Highlight the Value and Impact of Medicare Savings Programs

The Medicare Rights Center's New York Policy experts have **released a new paper** focused on helping people gain access to **Medicare Savings Programs (MSPs)**. The paper, supported by the West Health Policy Center, includes case studies and policy recommendations derived from the essential work our national helpline does to help people understand and enroll in Medicare benefits and assistance programs like MSPs.

MSPs are Lifelines for People with Low Incomes

MSPs were established in the Medicare Catastrophic Coverage Act of 1988 and subsequently expanded by the Omnibus Budget Reform Act (OBRA) of 1990, the Balanced Budget Act of 1997 (BBA), the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, and the Medicaid Access and CHIP Reauthorization Act in 2015.

The programs support Medicare enrollees by paying Medicare premiums and other Medicare costs for people with low incomes; automatically enrolling people into the federal Part D Low-Income Subsidy, also known as "Extra Help," which helps pay prescription drug costs; and helping individuals enroll in Medicare through a process called "buy-in." These benefits help people afford their care and reduce states' uncompensated care costs.

MSPs help people afford their care and reduce states' uncompensated care costs.

Barriers to MSP Enrollment

Standard MSP eligibility rules leave many people without access to the help they need. **The income and asset thresholds are extremely low in most states**, leaving many struggling people just outside of the eligibility range.

Even those who qualify face barriers. Millions of people within the strict income and asset thresholds are **still not enrolled.** This may be due to a lack of information about the programs and how to sign up, or people may have difficulty navigating an enrollment process that is **notoriously complex**. Taken together, an estimated 40% of those who are eligible are missing out on important MSP benefits.

An estimated 40% of those who are eligible are missing out on important MSP benefits. Unfortunately, Congress has curtailed some federal efforts to increase access to MSPs. The recently passed reconciliation bill halted **rules designed to streamline application processes**. The **Congressional Budget Office projects** nearly **1.4 million low-income people with Medicare**—more than 10% of the dually enrolled Medicare-Medicaid population—will lose their MSP coverage due to the rollback of these simplifications.

Opportunities Remain

Though the reconciliation bill halted the streamlining rules and made it harder for people to enroll, it did not prevent states from acting.

We urge all states to do more to increase MSP availability, including by raising income thresholds for eligibility and eliminating asset barriers that can make application processes overly burdensome. And some states are taking action: Medicare Rights has successfully advocated for streamlining MSP enrollment and **expanding MSP eligibility in New York and other states.**

We also encourage all states to make it easier for people to learn about and sign up for MSPs through increased outreach, streamlined applications, and automatic enrollment where income data are already available.

Our New Paper Illustrates Obstacles and Potential Solutions

The case studies in the new paper illustrate the obstacles beneficiaries commonly face when trying to enroll and stay enrolled in MSPs. They also highlight the vital role Medicare and MSPs play in real people's lives. The policy recommendations come directly from our experience helping people who are struggling to access these essential benefits. Common-sense changes can make significant improvements to people's ability to manage their health and finances.

The policy recommendations come directly from our experience helping people who are struggling to access these essential benefits.

At Medicare Rights, we remain committed to informing people about Medicare and assistance programs, helping them enroll into these programs, and tackling systemic inefficiencies that burden enrollees. Too many people struggle to pay for their health care and prescription drugs. We urge policymakers to prioritize the health, wellbeing, and financial security of the millions who rely on Medicare and MSPs and to embrace policies that tear down barriers to care.

New Social Security Garnishments Will Likely Start Soon: What To Know

New Social Security garnishments are set to kick in soon, and they could cause 15 percent of payments to be withheld for retired workers and Americans with disabilities.

The garnishment will apply to roughly 452,000 beneficiaries who are in default on their student loans.

Why It Matters

Americans hold roughly $1.75 trillion in student loan debt, with some of that carried by seniors and disabled workers who are in default on their loans.

The Trump administration has marked a departure from then-President Joe Biden's student loan forgiveness-friendly policies, and the shift has meant many student loan borrowers see higher payments and lose access to income-driven repayment plans like SAVE. Similarly, a percentage of Social Security payments will soon be withheld for those in default.

Roughly 22 million Americans were lifted out of poverty due to their Social Security benefits in 2023, according to the Center on Budget and Policy Priorities.

What To Know

The Department of Education (DOE) issued a pause in the restart of garnishments for these borrowers in early June, but the pause is expected to end soon.

"If you receive monthly federal benefit payments, such as Social Security benefit payments, and Railroad and Office of Personnel Management retirement benefits you may have received a letter from the Department of Treasury that listed a date when offsets to your payments was scheduled to begin. Please be aware that the Department of Education is delaying offsets of these monthly benefits for a couple of months and plans to resume sometime this summer," the DOE said.

It's not yet clear when the 15 percent garnishment rate will apply despite the DOE saying it would kick start "sometime this summer."

"These are mostly Parent PLUS loans from decades ago. Think about 70 year olds who co-signed for their kids' education in the 1990s and got buried by compound interest," Michael Ryan, a finance expert and the founder of MichaelRyanMoney.com, told *Newsweek*. "It's a family wealth transfer in reverse. Instead of leaving something behind, these seniors are having their final safety net shredded for loans they probably forgot they even had."

On July 24, Social Security garnishments were around 1 million beneficiaries who had been overpaid started, meaning 50 percent of Social Security income would be withheld until the overpayment was cleared out. During Biden's time in office, that overpayment recovery rate was just 10 percent.

A significant number of federal student loan borrowers are seniors today, according to the Consumer Financial Protection Bureau, which found borrowers aged 62 and older jumped by 59 percent, from 1.7 million to 2.7 million between 2017 and 2023…..**Read More**

Medicare Advantage Proliferation and the Cluttered Plan Landscape

In 2018, the average Medicare beneficiary had 21 **Medicare Advantage (MA)** plans from six insurers to choose from. By 2024, just six years later, **the number had doubled** to 43 plans from eight organizations. This steep increase in the number of plans is not due to a nationwide expansion in the breadth of services covered by MA, nor is it due to a diversification of the insurance companies offering MA plans. Rather, it is largely because of a 2019 rollback by the Centers for Medicare & Medicaid Services (CMS) of the "meaningful difference" rule, which required MA plans from the same insurer to be "substantially different… with respect to key plan characteristics such as premiums, cost sharing, or benefits." This rule elimination has led to the recent proliferation of MA plans and driven the accompanying surge in MA enrollment, which increased to 54% of Medicare beneficiaries in 2024.

Choice Overload

With the "meaningful difference" requirement no longer in place, many insurers have flooded the market with plans that vary only slightly in supplemental benefits or cost-sharing for certain services. Such plans may vary more significantly in their network directories, but Medicare Plan Finder doesn't allow users to filter by providers or even display provider directories to consumers comparing plans. This places the burden upon Medicare beneficiaries to individually consult each plan's directory or contact their providers to learn the details they need to make an informed enrollment decision.

This choice overload—making it difficult and time-consuming to even navigate the plan offerings—may be part of MA organizations' strategy to retain consumers. A greater number of plans, especially when they include "affinity plans" targeting certain populations, makes it more difficult to make an informed choice and more intimidating to switch plans, much less insurers. The overwhelm also often drives people with Medicare to seek help from brokers or agents, who may be financially incentivized by particular insurers to promote their plans.

A greater number of plans makes it more difficult to make an informed choice and more intimidating to switch plans, much less insurers.

Using this and other strategies like favorable selection, denials, and upcoding, MA reaps incredibly high profit margins through **overpayment.** In 2023, MA plans had gross margins over twice those of Medicaid managed care plans and group market plans. As MA plans raise their profit margins, beneficiaries suffer: Drawn in by MA's promises of supplemental benefits and pushed to enroll with inadequate information, they may find themselves locked into a plan that doesn't work for them and unable to afford or navigate a switch to another plan or to Original Medicare. and unable to afford or navigate a switch to another plan or to Original Medicare.

Needed Policy Reforms

MA proliferation can be addressed by policies that directly regulate MA plans, mitigate overpayment and other financial incentives for insurers and individual brokers, and strengthen counseling and educational resources for Medicare beneficiaries. Most directly, CMS could reinstate the "meaningful difference" requirement and standardize plans—as they have done for Medigap and certain Affordable Care Act Marketplace plans—to reduce confusion and advance equity. Closing loopholes that allow for upcoding and overpayment, as well as regulating broker payments, could reduce some of the financial incentives that motivate MA organizations to go to great lengths to retain consumers.

Greater access to information would empower Medicare beneficiaries to understand plan offerings and choose the ones that best fit their needs.

People with Medicare need better information and resources from CMS that directly address their primary decision-making considerations. Federal resources for Medicare beneficiaries, such as Medicare Plan Finder and **State Health Insurance Assistance Program (SHIP)** counselors need to be better publicized and funded. Medicare Plan Finder, though a valuable source of information, lacks critical search features like the ability to search by providers, and the expert enrollment counseling provided by SHIP counselors is hampered by federal underfunding. A policy emphasis on greater access to information would empower Medicare beneficiaries to understand plan offerings and choose the ones that best fit their needs.

For more on this topic, explore Part 2 on Medicare Advantage Proliferation from the Medicare Sustainability policy series available now at **www.medicarerights.org/policy-series/medicare-sustainability.**

How Ohio saved tens of millions by cutting the pharmacy middlemen out of Medicaid

The state of Ohio successfully demonstrated that taking for-profit drug middlemen out of Medicaid saves tens of millions of dollars a year. A new Ohio report shows that the state and its pharmacies benefited handsomely financially from the elimination of corporate pharmacy benefit managers (PBMs) in its Medicaid program and the establishment of one state PBM, reports Marty Schladen for **Ohio Capital Journal**.

Ohio pharmacies had been struggling to stay afloat because PBMs were not paying them adequately for their Medicaid patients. So, Ohio kicked the PBMs out of the Medicaid program. And, pharmacies saw 12-fold increases in their dispensing fees, $9 per prescription v. $0.73. Moreover, almost every Ohio pharmacy agreed to fill prescriptions for people with Medicaid.

Ohio also gave people with Medicaid coverage from specialized compounding pharmacies, mail-order pharmacies, home delivery pharmacies, and specialty pharmacies.

Without corporate PBMs in Medicaid, Ohio saved $333 million through the elimination of duplicative administrative costs. Administrative costs fell, while accountability and transparency grew. Net savings in Ohio were $140 million

because the state increased dispensing fees to pharmacies. Milliman conducted the **study**. The **biggest PBMs**– ExpressScripts, OptumRx and CVS Caremark– represent almost 80 percent of the business in the US. They are each owned by a big insurer and work for those insurers, as well as many others. Their job is to negotiate drug prices with manufacturers, design the insurers' list of covered drugs (formulary), establish the pharmacy networks, and reimburse the pharmacies their established rates for the drugs.

A Columbus Dispatch investigation in Ohio had shown that the PBMs charged the state a lot more for drugs in Medicaid than the PBMs paid the pharmacies dispensing them. A separate state-commissioned study showed that the state paid $224 million more for drugs than the pharmacies received for dispensing them. Consequently, Ohio's Medicaid department created its own PBM.

Several state and federal lawsuits against the PBMs have followed. Now, 38 state attorneys general are urging Congress to forbid health care giants to own PBMs and pharmacies. They say that the PBMs give priority to their own pharmacies, harming competitors.

Trump asks drug companies to lower prices for Medicaid drugs, or else what?

.In a **letter** to CEOs at 17 large pharmaceutical companies, President Trump asked them to lower their prices for Medicaid drugs to match what their companies charge other wealthy countries. If they do not do so voluntarily by the end of September, Trump threatened to use his authority to make them do it. Even if honored, Trump's request is not likely to lower drug prices for anyone in the US, including people with Medicaid, who already pay low drug prices.

To be clear, Congress had authority to require drug companies to reduce drug prices for all government programs in the reconciliation bill that Trump signed into law on July 4. It would have saved hundreds of billions of dollars. But, Trump did not ask Republicans in Congress to use this authority. It's not evident that Trump has the authority to make them do anything to lower drug prices without Congressional action.

This letter to Pharma CEOs suggests that President Trump is willing to let pharmaceutical companies charge Americans high drug prices. He appears no longer to want all Americans to enjoy the same low prescription drug prices that people in other wealthy countries enjoy. His request to Pharma CEOs applies only to drugs on the market that Medicaid patients take. He added that everyone should benefit from lower prices that peer countries pay for "all new drugs."

The President uses strong language: "If you refuse to step up, we will deploy every tool in our arsenal to protect American families from continued abusive drug pricing practices." But, what tools does he have? Why would the pharmaceutical companies blink?

The President also asked pharmaceutical companies to sell some of their biggest-selling drugs to all Americans directly (presumably without pharmacy benefit managers acting as middlemen and without insurance coverage) at the same low price they charge other wealthy nations. Trump does not specify how many or what types of drugs. He then says that the cost should be the same as what these companies charge "third-party payers," presumably Pharmacy Benefit Managers. But, it's not at all clear that PBMs get the same low prices as other wealthy nations.

It's hard to believe Trump's letter to Pharma CEOs will bring down Medicaid drug costs. Trump's May **executive order** calling on pharmaceutical companies to reduce the prices of their drugs failed to reduce drug prices, which are only going up. Even President Trump called their response to his executive order inadequate. His new request comes at the same time that he is imposing 15 percent tariffs on the EU, which will eat into the profits of many pharmaceutical companies and lead them to raise drug prices further.

Understanding the Different Eldercare Options

There are many options for senior care, but the key is to start researching sooner rather than later.

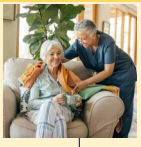
Understanding the Different Types of Eldercare: Custodial vs. Skilled Nursing Care

There are many options for care for your aging loved one.

Find the best assisted living near you

Search by state, city or ZIP code to find the right assisted living community for you. Before understanding the **types of long-term care facilities,** however, it's important to establish how coverage options like **Medicare and Medicaid** categorize the types of senior care:

Custodial care. Custodial care, or long-term care, is any type of care that can be performed by nonmedical or unlicensed assistive personnel. This kind of care may involve assisting older adults **with activities of daily living,** such as bathing, dressing or eating, for instance. Or, it could be helping an older person with grocery shopping and bills. Custodial care is a primary offering at assisted living and nursing homes and is generally not covered by **Medicare.** Some seniors may qualify for custodial care through **Medicaid,** depending on their state's availability and eligibility requirements.



Skilled nursing care. **Skilled nursing** care requires trained or licensed personnel to perform a task, such as IV therapy, wound care or medication administration. Medicare Part A, which covers inpatient care, offers some coverage of skilled nursing after a qualifying hospital stay. Medicaid may provide some coverage for those who meet specific eligibility requirements.

Home-Based Senior Care

Many older adults prefer to **age in place** at home as long as possible. In fact, "99% of the people I meet say they want to stay at home," says Howard S. Krooks, an elder law attorney with Cozen O'Connor who practices in Florida, New York and Pennsylvania. Krooks is also a past president of the National Academy of Elder Law Attorneys.

In some cases, a senior may receive home-based care through informal **caregiving** from a friend or relative. However, not all seniors have adult children or other friends and relatives to help full-time with shopping, cleaning, driving and other activities of daily living. When they don't, they need to enlist services provided by a home care agency or hire an eldercare aide.

Home health eldercare

Home health care may refer to an umbrella of services, including:

- Personal care, such as assistance with a morning routine or cooking meals
- Skilled nursing care, such as catheter changes
- Therapy, such as speech, **physical or occupational therapy**

Home care is only covered under Medicare Part A for skilled services, not for custodial care. Krooks also says there are issues in the home care industry that make it challenging for seniors to receive care at home**….**Read More

When is the Right Time to Adopt a Pet?

When is the Right Time to Adopt a Pet?

Adopting a pet is a heartwarming decision. November—a month dedicated to helping senior pets find forever homes—is a perfect time to consider adding a furry companion to your family. While playful kittens and energetic puppies often steal the spotlight, senior pets deserve equal love and attention. They bring just as much loyalty, affection, and companionship.

Why Choose a Senior Pet?

Being fully grown, senior pets offer a level of predictability that younger animals cannot. You'll know their personality, energy levels, and grooming requirements upfront, making finding the perfect match for your household easier. Older pets are also calmer and often quicker to adapt to training. Many already understand basic commands, making them ideal for families who prefer a pet with established behaviors.

Young pets require significant energy and commitment, which can be overwhelming for some. On the other hand, senior pets move at a more manageable pace and are less demanding. Their relaxed demeanor makes them well-suited for various living situations, including apartments. Most senior pets are housetrained, saving you from the challenges of teaching essential bathroom habits….**Read More**

Some states make it harder for private equity firms to buy health care companies

Private equity firms are buying up our health care system piece by piece–**hospitals**, nursing homes, hospice agencies, **emergency rooms**, **specialty practices** and more. Health care costs are rising, patient care is in jeopardy, and the federal government is doing nothing to stop private equity firms. Glenn Daigon reports for the **Progressive Magazine** that states are making it harder for private equity firms to buy health care companies.

As of June 2025, at least **15 states had passed laws to rein in private equity purchases of health care companies**, including some red states. The states require that their attorneys general have the ability to review any private equity purchase of a health care group before the purchase can move forward. The attorneys general can then decide whether the purchase will promote the public good and, presumably, block the sale, when appropriate.

Indiana, Oregon and Maine are three of the states that have passed laws reining in private equity. Oregon's law prevents private equity firms from having ultimate control over hospital hiring, staffing, work schedules and other management activities. Maine has **temporarily stopped** private equity purchases of hospitals.

Other states have not been successful in controlling private equity firms in the health care space. California's legislature put forward legislation requiring more transparency and oversight of private equity purchases of health care companies. But, Governor Newsom vetoed the legislation.

When a private equity firm buys a health care company, it tends to act swiftly to take as much money out of the company as possible. Private equity might: force a hospital to cut the number of ER doctors; do little to prevent hospital-acquired infections; stint on protective supplies like masks and cleaning services. Private equity's goal is to spend less on care and draw out more in profits before selling.

At the same time, private equity raises health care costs for patients. Not surprisingly, the **National Institutes of Health** reported poor health outcomes for patients and staff in private-equity owned hospitals. After private equity firms bought hospitals, patient **falls, infections and other adverse events increased.**...**Read More**

Experts Say Rural Emergency Rooms Are Increasingly Run Without Doctors

Dahl Memorial's three-bed emergency department — a two-hour drive from the closest hospital with more advanced services — instead depends on physician assistants and nurse practitioners.

Physician assistant Carla Dowdy realized the patient needed treatment beyond what the ER could provide, even if it had had a doctor. So, she made a call for a medical plane to fly the patient to treatment at Montana's most advanced hospital. Dowdy also called out medications and doses needed to stabilize the patient as a paramedic and nurses administered the drugs, inserted IV lines, and measured vital signs.

Emergency medicine researchers and providers believe ERs, especially in rural areas, increasingly operate with few or no physicians amid a nationwide shortage of doctors.

A **recent study** found that in 2022, at least 7.4% of emergency departments across the U.S. did not have an attending physician on-site 24/7. Like Dahl Memorial, more than 90% were in low-volume or critical access hospitals — a federal designation for small, rural hospitals.

The results come from the 82% of hospitals that responded to a survey sent to all emergency departments in the country, except those operated by the federal government. The study is the first of its kind so there isn't proof that such staffing arrangements are increasing, said Carlos Camargo, the lead author and a professor of emergency medicine at Harvard Medical School. But Camargo and other experts suspect ERs running without doctors present are becoming more common.

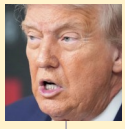
Placing ERs in the hands of nondoctors isn't without controversy. Some doctors and their professional associations say physicians' extensive training leads to better care, and that some hospitals are just trying to save money by not employing them. The **American Medical Association**, open to all medical students and physicians, and the **American College of Emergency Physicians** both support state and federal laws or regulations that would require ERs to staff a doctor around the clock. Indiana, Virginia, and South Carolina recently passed such legislation….**Read More**

Trump's tax law will mostly benefit the rich, while leaving poorer Americans with less, CBO says

President **Donald Trump'stax and spending law** will result in less income for the poorest Americans while sending money to the richest, the nonpartisan **Congressional Budget Office** reported Monday.

The CBO estimates that the 10% of poorest Americans will lose roughly $1,200 a year as they experience restrictions on government programs like Medicaid and food assistance, while the richest 10% of Americans will see their income increase by $13,600 from tax cuts. Overall, American households will see more income from the tax cuts in the legislation, including middle income households, but the largest benefit will go to the top 10% of earners.

The CBO's report comes as lawmakers are away from **Washington,** many taking their messages about the bill to voters. Republicans muscled the legislation — deemed "the big, beautiful bill" by Trump — through Congress in July. Democrats all vehemently opposed the legislation, warning that its tax cuts and spending priorities would come at the expense of vital government aid programs and a **ballooning national debt**. "This really is a big, beautiful bill for billionaires, but for the poor and the working class in this country, you are actually poorer," said Rep. Brendan Boyle, the top Democrat on the House Budget Committee, in an MSNBC interview on Monday.



"This really is a big, beautiful bill for billionaires, but for the poor and the working class in this country, you are actually poorer," said Rep. Brendan Boyle, the top Democrat on the House Budget Committee, in an MSNBC interview on Monday.

Following release of the report, Rep. Jason Smith, the Republican chair of the House Ways and Means Committee, said he took issue with CBO's methodology, repeating criticism he has made in the past.

"CBO has a troubled track record of getting its estimates incorrect and, like Democrats, is biased in favor of more federal spending and higher taxes," Smith said on social media. "Don't buy it."

Republicans have been eager to sell the upsides of the legislation — arguing that the tax cuts will spur economic growth — while they are on a monthlong summer break from Washington. But those who have held townhalls in their home districts have often been greeted by an earful from voters and activists.

"Tax the rich," the **crowd in Lincoln, Neb. chanted last week** as Republican Rep. Michael Flood attempted to defend the bill.

Still, Trump has been undeterred.

"President Trump's One Big Beautiful Bill is putting America First like never before, delivering huge savings for hardworking families, boosting our economy, and securing our borders," said White House deputy press secretary Abigail Jackson in a statement last week.

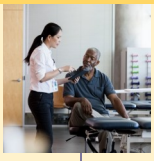
Does Medicare Require Prior Authorization?

Learn about when and why prior authorizations are needed, which services require them and how they are used differently between original Medicare and Medicare Advantage.

Whether you're filling a **prescription** or scheduling a procedure, chances are you've been asked whether you have prior authorization.

Prior authorization is approval from a health plan before a service, prescription or other benefit is covered by a patient's insurance to ensure that health care services are medically necessary. When a provider orders a service, such as a diagnostic test, routine procedure or prescription drug, that may require a prior authorization, your doctor sends a request for approval.

This requirement has been widely adopted by the insurance industry to control **health care costs**.



"While prior authorization has long been used as a tool to contain spending and prevent people from receiving unnecessary or low-value services, there are some concerns that current prior authorization requirements and processes may create barriers and delays to receiving necessary care, as well as exacerbate complexity for patients and their providers," explains Jeannie Fuglesten Biniek, an associate director for the Program on Medicare Policy at KFF.

Medicare and Prior Authorization

Currently, original **Medicare (Part A** and **Part B**) rarely requires prior authorizations. However, to contain costs, the Centers for Medicare & Medicaid Services (CMS) has authorized Medicare to require prior authorizations for certain hospital outpatient procedures, durable medical equipment and pre-approval for inpatient rehabilitation and **home health services**.

Common procedures or equipment that require prior authorization include:

Durable medical equipment

- Infusion pump systems
- Leg braces

Prosthesis

Wheelchairs and accessories

Hospital outpatient services

Body contouring surgery to **remove excess skin and fat**

Botulinum toxin injections

- ♦ Cervical fusion with disc removal
- ♦ Eyelid surgery
- ♦ Facet joint interventions to treat chronic pain in the neck or **lower back**
- ♦ Implanted spinal neurostimulators
- ♦ Nose reconstruction
- ♦ Vein ablation
- ♦ To see the full list, visit the **CMS website.**

Beginning in 2026, the CMS has announced it will implement prior authorization requirements for certain services in six states – Arizona, New Jersey, Ohio, Oklahoma, Texas and Washington. According to the **CMS**, a new cost-effective model will be examined in these states to see if advanced technologies, including artificial intelligence (AI), can speed up the prior authorization process for certain services that are especially prone to fraud, waste, abuse or inappropriate use….**Read More**

What is the difference between Original Medicare and Medicare Advantage?

Dear Marci

I turn 65 soon. I can't decide whether to sign up for Original Medicare or Medicare Advantage. What's the difference?

– Henry (Hartford, CT)

Dear Henry,

Great question! Choosing between Original Medicare and Medicare Advantage is an important step in planning your healthcare coverage. I'd like to help you make an informed choice. Here's a clear breakdown of both options and the key differences between them. It should help you decide which option best fits your needs.

Original Medicare is the traditional program offered directly through the federal government. **Medicare Advantage** plans are private plans that contract with the federal government to provide Medicare benefits.

Key differences between Original Medicare and Medicare Advantage:

Costs

- ♦ **Original Medicare**
  - o You will owe Part A and Part B costs, including the monthly Part B premium.
  - o You will owe a 20% coinsurance for Medicare-covered services if you see a participating provider and after meeting your deductible.
- ♦ **Medicare Advantage**
  - o Your cost-sharing will vary depending on plan.
  - o You will usually pay a copayment for **in-network** care.
  - o Plans might charge a monthly premium in addition to the Part B premium.

Supplemental insurance

- ♦ **Original Medicare**
  - o You have the choice to pay an extra premium for a **Medigap policy** to cover Medicare cost-sharing.
- ♦ **Medicare Advantage**
  - o You can't purchase a Medigap policy.

Provider access

- o **Original Medicare**

You can see any provider and use any facility that accepts Medicare (participating and non-participating).

- ♦ **Medicare Advantage**
  - o You typically can only see in-network providers.

Referrals

- ♦ **Original Medicare**
  - o You don't need referrals for specialists.

Medicare Advantage

- o You typically need referrals for specialists.

Drug coverage

- ♦ **Original Medicare**
  - o You have to sign up for a stand-alone **prescription drug plan**.
- ♦ **Medicare Advantage**
  - o In most cases, your plan will provide prescription drug coverage. You may be required to pay a higher premium.

Other benefits

- ♦ **Original Medicare**
  - o Does not cover vision, hearing, or dental services.
- ♦ **Medicare Advantage**
  - o May cover additional services, including vision, hearing, and/or dental. Additional benefits may increase your premium and/or other out-of-pocket costs.

Out-of-pocket limit

- ♦ **Original Medicare**
  - o No out-of-pocket limit.
- ♦ **Medicare Advantage**
  - o Annual out-of-pocket limit. Your plan will pay the full cost of your care after you reach the limit.

You might sign up for Original Medicare and later decide you would like to try a Medicare Advantage Plan–or vice versa. Be aware that there are only certain **enrollment periods** when you are allowed to make changes.

Keep in mind that different areas have different Medicare Advantage Plans. A particular plan may not be available where you live. Call 1-800-MEDICARE (633-4227) or your **State Health Insurance Assistance Program (SHIP)** to find out about plans available in your area.

Hope this helps!

-Marci

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

Please Note: All Articles In This Section Are For Information Only And Not Medical Advice

Improved Calculator Predicts Stroke Risk For A-Fib Patients

A newly refined test can help detect which people with abnormal heart rhythms need treatment for an increased risk of **stroke,** researchers report.

Adding blood tests to an existing risk calculator can help doctors suss out which patients with **atrial fibrillation** would most benefit from blood thinners, according to findings published Aug. 6 in the ***Journal of Thrombosis and Hemostasis***.

"This could be a game-changer for stroke prevention," said senior researcher **Dr. Mary Cushman**, a professor of medicine and pathology and laboratory medicine at the University of Vermont.

"We're giving physicians a sharper tool to provide a personalized approach to anticoagulation for patients who need it most, while sparing others from unnecessary risk," she said in a news release.

People with atrial fibrillation (A-Fib) have a fivefold increased risk of stroke, due to blood pooling and potentially clotting in the quivering upper chambers of their hearts, researchers said in background notes.

Doctors counter this risk by prescribing blood thinners, but the drugs themselves pose the risk of dangerous or uncontrolled bleeding, researchers said.

An existing risk calculator called the CHA2DS2-VASc helps doctors calculate stroke odds for A-Fib patients before prescribing blood thinners, but researchers said the score has limited capability and doesn't account for important risk factors.

To improve the calculator's usefulness, researchers evaluated nine blood tests to see whether they could predict stroke in 2,400 A-Fib patients.

Results showed that two blood tests for proteins associated with heart function and inflammation increased the CHA2DS2-VASc calculator's ability to predict stroke, researchers said.

The research team has posted the improved calculator, now dubbed CHA2DS2-VASc-Biomarkers, online for doctors to use.

"This will help doctors better select patients for anticoagulation, potentially saving lives and reducing health care costs," lead researcher **Dr. Samuel Short**, a hematology fellow at the University of North Carolina at Chapel Hill, said in a news release.

What You Should Know About Spinal Muscular Atrophy (SMA)

While existing SMA therapies have transformed the treatment landscape, researchers and clinicians continue to push the field forward with a focus on improving outcomes across the lifespan. Several promising avenues are now being explored: Improving drug delivery and access: Efforts are underway to make the most of how current treatments are administered, minimizing invasiveness, lowering how often they are taken, improving their durability and expanding access around the world. For example, **Biogen's DEVOTE study** evaluates the impact of higher dose nusinersen to potentially make it more effective and longer-lasting.Meanwhile, the **NURTURE study** assesses the benefits of initiating nusinersen in presymptomatic individuals, highlighting the importance of early intervention to preserve motor function before symptoms emerge.

Regenerative and restorative approaches: Scientists are investigating ways to repair or regenerate motor neurons and muscle tissue already lost to SMA. This includes stem cell therapies, as well as use of neuroprotective agents and muscle-directed treatments, as reviewed recently in ***Trends in Molecular Medicine***, aimed at strengthening muscle function and restoring mobility in individuals who begin treatment later in life. For instance, **Scholar Rock's apitegromab**, a treatment designed to boost muscle strength by blocking a protein called myostatin is under FDA review, with a decision expected by the end of the year….**Read More**

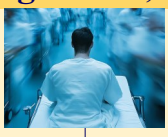
More ER Patients Waiting Hours, Days For A Hospital Bed

An increasing number of Americans are languishing in ERs for hours or even days, waiting for a hospital bed to open for them, a new study says.

More than 25% of ER patients who require admission for hospital treatment wind up "boarded" – biding four or more hours in spare rooms or busy hallways until a bed becomes available, researchers reported recently in the journal ***Health Affairs***.

That number increases to 35% during the winter months, when infectious diseases lead to more emergency hospitalizations, researchers said.

Worse, nearly 5% of patients admitted during the peak winter months waited a full day for a bed, and nearly 3% waited that long during off-peak months, results showed.



"This growth in long boarding times for admitted patients is the most important driver of crowded conditions and long wait times in emergency departments," said lead researcher **Dr. Alex Janke**, an emergency physician at the University of Michigan.

"Long boarding times increase patient safety risks, and delay needed care, while making it difficult for emergency departments to see new patients as they arrive," Janke added in a news release. "Sustained high levels of boarding, as we have seen over the past three years, suggest the health system is at risk of collapse in the event of another pandemic."

For the study, researchers analyzed health records of 1,500 hospitals in all 50 states from 2017 through September 2024.

They found that boarding had started to increase prior to the COVID-19 pandemic, but its rise accelerated starting in mid-2020 and has remained high ever since.

The practice hit its peak in January 2022, when 40% of patients boarded in an ER for more than four hours and 6% for 24 hours or more.

By 2024, the average percentage of patients waiting four or more hours for a bed was higher than it had been during the worst times of year in 2017 to 2019.

Nowadays, the number of patients waiting more than 12 hours for a bed rarely drops below 5%, even though that was a rare occurrence prior to the pandemic, researchers said.

Boarding has grown nationwide and in all patient groups, but the Northeast has the highest rate of boarding for 24 hours or more, researchers found.

"Our work highlights the need both to prepare for winter peaks and to address years-long mismatches between acute care demands and available resources," the researchers concluded.

New Vaccine May Help Stop Deadly Pancreatic Cancers From Coming Back

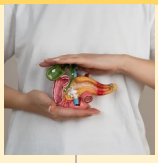
A new vaccine aimed at a common cancer gene mutation could help stop aggressive pancreatic cancers from coming back, a small clinical trial suggests.

Pancreatic cancer is one of the most lethal cancers, with a five-year survival rate of about 13%, according to the **American Cancer Society**.

Further, up to 80% of cases return after treatment, the **National Institutes of Health** says.

"If you were to ask me what disease most needs something to prevent recurrences, I'd say this one," **Dr. Zev Wainberg**, a leader of the trial, told *NBC News*. He's co-director of the University of California, Los Angeles, gastrointestinal oncology program.

The experimental vaccine targets KRAS gene mutations, which are found in about 25% of all cancers, the **University of Texas MD Anderson Cancer Center** says. This includes up to **90% of pancreatic cancers** and roughly **40% of colon cancers**.



While these mutations have long been considered impossible to treat with drugs, researchers are finding new ways to target them.

The vaccine, called ELI-002 2P, uses small chains of amino acids called peptides to train the immune system to spot and destroy cells with KRAS mutations.

Unlike many cancer vaccines that are custom-made for each patient, this one is designed to be off the shelf, meaning it doesn't require the tumor to be sequenced before it's used, *NBC News* reported.

The Phase 1 study — reported Aug. 12 in ***Nature Medicine*** — included 20 people with pancreatic cancer and five with colon cancer. All had KRAS mutations and had already undergone surgery and **chemotherapy**.

Blood tests after surgery showed microscopic evidence of residual disease — cancer cells too small to see on scans. These leftover cells can cause the cancer to spread and return.

Post-surgery, participants received up to six priming doses of the vaccine, with 13 also getting booster shots. In all, the process took six months. Here's what the results showed: 85% (21 of 25 participants) had an immune response to the KRAS mutations.

- About two-thirds of those had a strong enough response to help clear lingering cancer cells.
- Nearly 70% developed immunity to other tumor targets not included in the vaccine.
- A few "super-responders" had exceptionally strong immune reactions and the best outcomes.

In the pancreatic cancer group, patients survived for an average of 29 months, staying recurrence-free for more than 15 months after vaccination.

"That far exceeds the rates with resectable [surgically removable] cancers," Wainberg said.

Cancer vaccines have been difficult to create because cancer cells share many proteins with healthy cells, making safe targets hard to find. Advances in mRNA technology and faster gene sequencing are now making more effective cancer vaccines possible.

The peptides in this vaccine also have a unique "tail" that helps them stay in lymph nodes, where immune cells are activated — a feature past peptide vaccines didn't have, said Stephanie Dougan, an associate professor at Dana-Farber Cancer Institute in Boston, who was not involved in the study.

More research is needed to confirm the findings, and a Phase 2 trial is now underway to compare the vaccine with standard care.

"The fact that the long-term survival really correlated with T-cell response suggests that the vaccine caused this," Dougan said, referring to the specific immune cells activated by the vaccine. "The idea that you can target KRAS is really exciting."

A Small Change In Your Stride Can Ease Knee Arthritis Pain

Slightly altering your stride while walking could considerably ease pain caused by **wear-and-tear knee arthritis**, a new study says.

Foot positioning while walking can reduce stress on a person's knee joint, researchers reported Aug. 12 in ***The Lancet Rheumatology***.

People trained to angle their feet slightly inward or outward from their natural alignment experienced slower degeneration of the cartilage cushion inside their aching knees, results show.

They also reported greater reductions in knee pain and better knee function after a year, researchers said.

"Altogether, our findings suggest that helping patients find their best foot angle to reduce stress on their knees may offer an easy and fairly inexpensive way to address early-stage osteoarthritis," said co-lead researcher **Valentina Mazzoli**, an assistant professor of radiology at NYU Grossman School of Medicine in New York City.

10.2

68 people with knee osteoarthritis and recorded their gait while walking on a treadmill. A computer program simulated their walking patterns and calculated the maximum stress they were placing on their knees.

The research team also generated computer models of four new foot positions angled inward or outward by 5 or 10 degrees and estimated which would best reduce stress on each person's knees….**Read More**

AI Uses Voice To Detect Throat Cancer

A person's own voice might soon be a means of detecting whether they're suffering throat cancer, a new study says.

Men with cancer of the larynx, or voice box, have distinct differences in their voices that could be detected with trained artificial intelligence (AI), researchers reported Aug. 12 in the journal ***Frontiers in Digital Health***.

These differences are caused by potentially cancerous lesions that have cropped up in a person's vocal folds – the two bands of muscle tissue in the larynx that produce sound, also known as vocal cords.

"We could use vocal biomarkers to distinguish voices from patients with vocal fold lesions from those without such lesions," lead researcher **Dr. Phillip Jenkins**, a postdoctoral fellow in clinical informatics at Oregon Health & Science University in Portland, said in a news release.

Catching voice box cancer early can be a matter of life or death.

There were an estimated 1.1 million cases of laryngeal cancer worldwide in 2021, and about 100,000 people died from it, researchers said in background notes. Risk factors include smoking, drinking and HPV infection.

A person's odds of five-year survival can be as high as 78% if their throat cancer is caught at an early stage, or as low as 35% if it's caught late, researchers said.

For the study, researchers analyzed more than 12,500 voice recordings from 306 people across North America. These included a handful of people with either laryngeal cancer, benign vocal cord lesions or other vocal disorders.

Researchers discovered that the voices of men with laryngeal cancer exhibited marked differences in harmonic-to-noise ratio, which judges the amount of noise in a person's speech….**Read More**

Phone App Reduces Suicide Among High-Risk Patients

A mobile smartphone app can help reduce the risk of death among people at high risk for suicide, a new study says.

The app, called OTX-202, reduced suicide attempts by 58% among a large group of recently discharged psychiatric patients who had previously attempted suicide, researchers reported Aug. 8 in ***JAMA Network Open***.

App users also experienced sustained reductions in their suicidal thoughts for close to six months after their psychiatric hospitalization, researchers said.

The app could potentially help fill the gap left by a shortage of therapists available to help troubled individuals manage suicidal thoughts, researchers said.

This is particularly important during the high-risk period after a psychiatric patient has been discharged from the hospital, said co-lead researcher **Craig Bryan**, director of the Suicide Prevention Program at Ohio State University in Columbus.

"Although suicide-specific therapy is highly effective for reducing suicidal thoughts and urges, finding therapists who know how to do this life-saving therapy after leaving the hospital can be challenging," Bryan said in a news release. "OTX-202 provides a possible solution to that problem."

OTX-202 offers a series of 12 lessons each 10 to 15 minutes long providing specific cognitive-behavioral therapy for suicide prevention.

For example, the first lesson teaches how to restrict access to potentially lethal means of suicide and how to identify suicidal thoughts and behaviors, the study says. Later lessons teach better ways to regulate emotions and reconsider thoughts of self-harm….**Read More**

AMA, AAP, IDSA Among Organizations Disinvited From CDC Vaccine Workgroups

U.S. health officials have informed more than half a dozen leading medical organizations that they will no longer be invited to participate in developing vaccination recommendations.

Last Thursday, the American Medical Association, the American Academy of Pediatrics, the Infectious Diseases Society of America, and other medical organizations were notified via email that their experts are being removed from the U.S. Centers for Disease Control and Prevention Advisory Committee on Immunization Practices (ACIP) workgroups, the *Associated Press* reported.

One email said the organizations are "special interest groups and therefore are expected to have a 'bias' based on their constituency and/or population that they represent."

The move is the latest in an ongoing dispute involving ACIP. Since 1964, ACIP has guided how U.S. Food and Drug Administration-approved vaccines should be used, with CDC directors typically endorsing its recommendations. These decisions shape medical practice and enable insurance coverage for vaccines.

U.S. Health Secretary Robert F. Kennedy Jr. **abruptly dismissed** the entire ACIP in June, alleging it was too aligned with manufacturers. He then replaced its members with a group that included several vaccine skeptics.

William Schaffner, M.D., a Vanderbilt University vaccine expert who for decades has been involved with ACIP and its workgroups, told the *AP* that input from professional groups ensured ACIP recommendations were practical for doctors and bolstered public trust by securing support from respected medical organizations. Workgroup members were vetted for conflicts of interest to prevent financial or other ties to the vaccines under review.

Additional organizations disinvited from the groups include the American College of Physicians, American Geriatrics Society, American Osteopathic Association, National Medical Association, and National Foundation for Infectious Diseases.

"To remove our deep medical expertise from this vital and once transparent process is irresponsible, dangerous to our nation's health, and will further undermine public and clinician trust in vaccines," the AMA and several of the other organizations said in a **joint statement**. "We strongly urge the administration to reconsider excluding our organizations from participating in the ACIP vaccine review process."

How to Prepare Seniors for Surgery: Anesthesia Risks and More

Learn more about the risks, things to consider and questions to ask your doctor before undergoing a procedure. Modern technology has advanced the effectiveness and safety of many surgeries. But surgeries still aren't risk-free. Particularly for vulnerable older adults who may have **compromised immune systems**, physical and cognitive declines or **frailty**, surgery can pose health dangers and raise **anxieties**.

"As people age – especially over 65 – their bodies may have less physiological reserve to handle stress, including the stress of surgery," says Dr. Ryan Jamison, a board-certified anesthesiologist and medical director of the Department of Anesthesia at **MemorialCare Orange Coast Medical Center** in Fountain Valley, California.

Jamison adds that "While there's no hard cutoff, we begin to see increased vulnerability typically around age 65, and even more so after 75."

Risks of Surgery as an Older Adult

If you're an older adult, you may be vulnerable to risks related to surgeries, such as:

- Cognitive impacts from anesthesia
- Prolonged recovery
- Respiratory complications
- Difficulty metabolizing certain medications

"Patients age 65 and over are more likely to exhibit characteristics of frailty and multiple co-morbidities as well as **polypharmacy**, which present unique aspects of surgical care in seniors," says Dr. Tracey Childs, a board-certified general and colorectal surgeon and chief of surgery at Providence Saint John's Health Center and Adjunct Associate Professor of Surgery at Saint John's Cancer Institute in Santa Monica, California.

Anesthesia Risks for Seniors

Anesthesia can be used safely and effectively during surgery. However, it can also be dangerous. For older adults in particular, anesthesia may increase risks for post-operative side effects.

Some potential anesthesia side effects on older adults may impact:

- Brain functioning
- **Blood pressure** stability
- Breathing
- **Kidney function**

Anesthesia may also increase risks for cognitive side effects in some older adults, including:

- **Postoperative cognitive dysfunction (POCD).** This condition is a delay in cognitive functioning or memory impairments that can occur after an operation. In the first 30 days after a surgery, POCD is referred to as "delayed neurocognitive recovery." If it is present within a year after a survey, it is referred to as "postoperative neurocognitive disorder."
- **Postoperative delirium.** This condition is a sudden change in mental status that can occur rapidly after an operation. Postoperative delirium can start as soon as ten minutes after a procedure, or appear before a patient is discharged from the hospital...**Read More**

Implant Protects Against Vision-Destroying Eye Disease

A newly approved implant appears to slow vision loss from a rare and previously untreatable eye disease, researchers report.

The eye implant, called ENCELTO, gradually releases proteins that protect light-sensing nerve cells against macular telangiectasia (MacTel) type 2, researchers recently reported in the journal ***NEJM Evidence***.

The capsule-sized implant slowed the progression of MacTel in two phase 3 clinical trials involving more than 200 people, researchers said.

"This is the first time we've seen a therapy meaningfully alter the course of MacTel," senior researcher **Dr. Martin Friedlander**, a professor of molecular and cellular biology at the Scripps Research Institute in La Jolla, Calif., said in a news release.

Based on clinical trial results, the U.S. Food and Drug Administration (FDA) in March **approved** ENCELTO as the first authorized treatment for MacTel, researchers said.

"This is a step toward redefining how we think about vision loss," Friedlander said. "Instead of waiting for cells to die, we're learning how to protect and preserve them."

MacTel occurs due to problems in the tiny blood vessels under and around the retina, the layer of nerve cells at the back of the eye that detect light and convert it into electrical signals that are sent to the brain, according to the **American Academy of Ophthalmology**.

The blood vessels leak fluid, causing the nerve cells of the retina to begin to die off. As the cells die, a person gradually loses their central vision, although MacTel usually does not cause total blindness, the AAO says.

MacTel affects about 0.1% of the world's population, researchers said in background notes.

Implanted in the back of the eye, the ENCELTO device releases ciliary neurotrophic factor (CNTF), a naturally occurring protein known to protect neurons in the retina.

For the two trials, researchers randomly selected half of a group of 228 MacTel patients to receive ENCELTO. All of the participants were followed for two years.

The device caused a 55% reduction in the rate of retinal cell degeneration in one trial and a nearly 31% reduction in the other, when compared to MacTel patients not provided the treatment.

Other tests also showed a significant slowing in loss of visual function, researchers said.

However, results regarding reading speed were mixed – one trial showed improvement and the other didn't.

"These differences highlight just how complex it is to measure functional vision loss in a slow-progressing disease like MacTel," Friedlander said. "If you look at certain functional outcomes from just one of the trials, they're not statistically significant. But when you pool data from both trials — which were conducted the same way — then you see statistically significant results, so we'll continue to investigate what's driving that."

The implant proved effective regardless of how far MacTel had progressed in a patient, suggesting that earlier treatment might be able to prevent more functional vision loss, researchers said.

ENCELTO also caused minimal side effects in patients, researchers said. The most common ones were pinpoint pupils and delayed adaptation to dark surroundings, which occurred in about 17% of trial participants. ...Read More

FDA Approves First Drug for Chronic Lung Condition Bronchiectasis

For the first time, people with bronchiectasis will have a treatment option.

The U.S. Food and Drug Administration (FDA) has approved Insmed's daily pill brensocatib, which will be sold under the brand name **Brinsupri**.

The drug is designed to treat non-cystic fibrosis bronchiectasis (NCFB), a chronic condition that damages the lungs and makes it harder to clear mucus, the company said in a statement.

The approval comes after the medication succeeded in one of last year's most closely watched Phase 3 clinical trials. The company says Brinsupri could become a blockbuster, estimating peak sales at $5 billion a year, *STAT News* reported.

"The FDA approval of the first-ever treatment for non-cystic fibrosis bronchiectasis is a historic milestone for patients and for Insmed," the company's chief medical officer, **Dr. Martina Flammer**, said in a statement.

The American Lung Association estimates that bronchiectasis affects between 350,000 and 500,000 adults in the United States.

It happens when the airways in the lungs become widened,

thickened and scarred — often after an infection or other damage. This makes it difficult to clear mucus, allowing germs and particles to build up and cause repeated lung infections.

Brinsupri works by blocking an enzyme called DPP1. Insmed bought the drug from AstraZeneca for $30 million and is also testing it for other conditions, such as chronic rhinosinusitis, *STAT News* reported.

The company plans to sell the drug in the U.S. at an annual list price of $88,000. It has also filed for approval in Europe and the United Kingdom, and it plans to do so in Japan.

"For the first time, we have a treatment that directly targets neutrophilic inflammation and addresses a root cause of bronchiectasis exacerbations. Based on the strength of the data and the impact we've seen in patients, I believe this could become the new standard in non-cystic fibrosis bronchiectasis care." **Dr. Doreen Addrizzo-Harris,** a pulmonary and critical care physician and director of the NYU Langone Health Bronchiectasis and NTM Program in New York City, said in a news release.

Early to bed means a more active lifestyle

New research out of Monash University in Australia finds that people who go to bed earlier tend to have a more active lifestyle, reports **MedXpress**. The research, which looked at the amount of sleep people got and when they got it, as it relates to activity the next day, was just published in *Proceedings of the National Academy of Sciences.*,

The researchers looked at data from 20,000 people who wore a WHOOP for one year. They found that physical activity tended to be greater among the people who went to sleep at 9pm than the people who went to sleep at 1am. Indeed, the early-to-bedders engaged in about a half hour more of moderate to vigorous physical activity the following day.

As compared to the folks who went to sleep at 11pm, those who went to sleep at 9pm engaged in about 15 minutes more moderate to vigorous physical activity the following day.

The thinking is that people who go to sleep later tend to be sleepier the following day. As a result, their sleep quality might not be as good as those who go to sleep earlier; they are less willing and have less time to engage in physical activity the following day.

People who go to sleep later can actually improve their sleep regimen. All they need do is go to sleep earlier than they tend to and sleep as much as they generally do. They then tend to have high levels of physical activity the following day.