

## February 25, 2024 E-Newsletter



### Message from Alliance for Retired Americans Leaders

#### President Roach Joins Rep. Larson, Labor Leaders at Press Conference Opposing Benefit Slashing Fiscal Commission



Robert Roach, Jr.  
President, ARA

On Thursday Alliance President Robert Roach, Jr. joined Rep. John Larson (CT) and fellow labor leaders at a Capitol Hill press

advancement into law. For more on the details of the commission, see the [Alliance fact sheet](#).

"Republicans want to form a fast-track commission that would cut benefits for more than 67 million Americans who rely on Social Security behind closed doors," said Rep. Larson. "I stand against these attacks on earned benefits and will continue to oppose any and all attempts to

increase revenue are considered."

Other speakers at the Thursday event included American Federation of Government Employees (AFGE) President and Alliance Executive Board member Everett Kelley; American Federation of Teachers (AFT) Secretary-Treasurer Fredrick Ingram; American Federation of State, County and Municipal Employees (AFSCME) retiree Mary James-Cannon, and several other top AFL-CIO and labor officials. You can view the press conference video [here](#).

AFL-CIO President Liz Shuler issued a statement about the fiscal commission prior to the event on Thursday, saying, "The House Republican proposal for a fiscal commission is a terrible idea that would push older Americans into poverty, take away people's health care and end up costing the government more."

#### Federal Judge Dismisses PhRMA Lawsuit Challenging Medicare Drug Negotiations

A Texas federal judge [dismissed](#) a lawsuit challenging the Biden administration's Medicare drug price negotiations on Monday, marking the first time a court has outright dismissed a challenge to Medicare's new price



Rich Fiesta,  
Executive  
Director, ARA

negotiation authority. This lawsuit, filed by the pharmaceutical lobbying group PhRMA, is one of nine lawsuits challenging the constitutionality

of Medicare's negotiations for lower prescription drug prices.

The dismissal is an early legal success for the administration, providing a path for cost-saving negotiations to come. While other PhRMA lawsuits are expected to be bitterly fought well into the future, the drug industry cannot obstruct the process in the meantime — Medicare price negotiations have already begun, and finalized prices are expected in August. The lower prices will take effect in 2026.

The reason for the outright dismissal had more to do with the technicalities of how the lawsuit was filed rather than its main claim that negotiations violate drug companies' due process. PhRMA's lawsuit was joined by a trade association, the National Infusion Center Association (NICA). Judge David Alan Ezra in the Western District of Texas dismissed NICA from the suit because of the court's lack of jurisdiction. Without NICA, the case no longer had any plaintiff that resided in Texas, leading to the entire case being tossed.

"The decision is a win for seniors as the court rejected this unserious lawsuit," said **Richard Fiesta, Alliance Executive Director**. "Medicare drug price negotiations will benefit millions of retirees who struggle daily to afford essential prescription drugs. The Alliance has worked for twenty years for Medicare drug negotiations and we're at the brink of seeing it become a reality."



Left to right: Rep. Larson, President Roach (at podium) and Everett Kelley

conference to denounce House Republicans' Fiscal Commission Act (H.R. 5779), legislation promoted by Speaker Mike Johnson that [advanced](#) out of the House Budget Committee last month. The legislation creates a commission tasked with recommending cuts to programs like Social Security and Medicare with no amendments or proper debate. More than [100 organizations](#) have recognized the threat and signed up to oppose the bill's

slash Social Security...we should be acting to enhance benefits, not cut them."0

"History shows us that special 'commissions' can cause problems and injustices that last for Left to right: Rep. Larson, President Roach (at podium) and Everett Kelley decades," said President Roach. "If the commission's proponents were serious about the national debt and the solvency of Social Security and Medicare, they could ensure that measures to

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

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## Over a million boomers on Medicare could save big on prescription drugs next year

Some Medicare recipients could save thousands of dollars on **out-of-pocket drug costs** next year as even more boomers reach their spending threshold. Under Medicare **Part D** — an outpatient drug benefit that was expanded in **President Joe Biden's 2022 Inflation Reduction Act** — beneficiaries are not required to pay more than \$2,000 for out-of-pocket prescription drugs a year. This includes high-cost medications for **cancer**, rheumatoid arthritis, **diabetes**, and other serious health conditions. Largely, qualifying recipients are over 65 years old. A **recent analysis by KFF** (formerly known as the Kaiser Family Foundation), suggests that over a million more Medicare beneficiaries could see relief from the cap in 2025. This comes ahead of the 2024 presidential election, where the cost of medication is **expected to be a top issue for voters**. According to the nonprofit and nonpartisan **Progressive Change Institute**, 91% of voters support **lowering prescription drug costs**, 83% of voters support capping out-of-pocket insulin prices, and about 90% of voters support protecting **Medicare** and **Social**

### Security funding.

**KFF health tracking polls** also reported that inflation, healthcare affordability, and Medicare/Medicaid funding are among the "most important" considerations for over 75% of voters.

In 2023, 50.5 million Medicare beneficiaries were enrolled in Part D plans. About 65 million people in total are enrolled in Medicare, according to the **Centers for Medicare & Medicaid Services**.

The drug benefit program was initially created around **2007**, but millions of boomers still paid over \$2,000 a year in out-of-pocket medicine costs prior to Biden's cap.

If the national cost cap had been in place in 2021, **KFF estimates** that 1.5 million Medicare beneficiaries would have seen relief. For example, 122,000 California Medicare enrollees paid over \$2,000 in drug costs that year.

Older adults in California, Florida, Texas, New York, and Pennsylvania — states where more than 75,000 beneficiaries were paying over \$2,000 in out-of-pocket costs — are expected to see the most benefit from the cap, according to **KFF** and



### Medicare claim data.

Experts predict that the cap will continue to provide relief for more boomers over time as they reach the \$2,000 payment threshold.

This is because the cost cap applies to beneficiaries who have persistently high drug costs over multiple years, as well as those who have high costs in one year but not over time. Individuals who have chronic health conditions will see especially significant benefits, KFF experts said.

There is a risk that more Medicare enrollees using the \$2,000 out-of-pocket cap could raise plan premiums, but the Inflation Reduction Act includes a **stabilization provision** designed to keep plans affordable over time. And, drug companies are now **legally required to pay**

### rebates or offer partial

**refunds** to the Centers for Medicare and Medicaid Services on any drug prices hiked beyond the rate of inflation.

Changes to Medicare in past years have also included the implementation of a **\$35 cap on insulin prices** and negotiation on the **sale price of several other drugs**



Joseph Peters, Jr.  
Secretary-Treasurer ARA

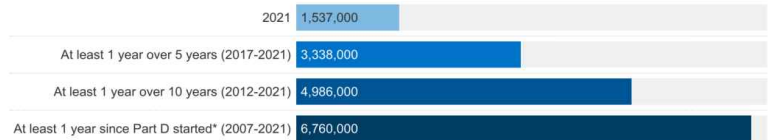
"There is already a \$3,200 out-of-pocket cap in place under Part D this year," said **Joseph Peters, Jr., Secretary-Treasurer of the Alliance**. "The \$2,000 cap in 2025

will bring seniors and their families even more relief." **Read More**

Figure 1

Five Million Medicare Part D Enrollees Spent \$2,000 or More Out of Pocket on Prescription Drugs in at Least One Year Between 2012 and 2021

Number of Medicare Part D enrollees with out-of-pocket drug spending of \$2,000 or more in:



NOTE: Estimates exclude Part D enrollees receiving Low-Income Subsidies. Estimates rounded to the nearest thousand. \*2007 was the first full year of Part D coverage.

SOURCE: KFF analysis of 2007-2021 Medicare Part D claims from the CMS Chronic Conditions Data Warehouse.

KFF

## Patients See First Savings From Biden's Drug Price Push, as Pharma Lines Up Its Lawyers

Last year alone, David Mitchell paid \$16,525 for 12 little bottles of Pomalyst, one of the pricey medications that treat his multiple myeloma, a blood cancer he was diagnosed with in 2010.

The drugs have kept his cancer at bay. But their rapidly increasing costs so infuriated Mitchell that he was inspired to create an advocacy movement.

Patients for Affordable Drugs, which he founded in 2016, was instrumental in getting drug price reforms into the 2022 Inflation Reduction Act. Those changes are kicking in now, and Mitchell, 73, is an early beneficiary.

In January, he plunked down \$3,308 for a Pomalyst refill "and that's it," he said. Under the law, he has no further responsibility for his drug costs this year — a savings of more than \$13,000.

The law caps out-of-pocket

spending on brand-name drugs for Medicare beneficiaries at about \$3,500 in 2024. The patient cap for all drugs drops to \$2,000 next year.

"From a selfish perspective, I feel great about it," he said. But the payment cap will be "truly life-changing" for hundreds of thousands of other Medicare patients, Mitchell said.

President Joe Biden's battle against high drug prices is mostly embodied in the IRA, as the law is known — a grab bag of measures intended to give Medicare patients immediate relief and, in the long term, to impose government controls on what pharmaceutical companies charge for their products. The law represents the most significant overhaul for the U.S. drug marketplace in decades.



With Election Day on the horizon, the president is trying to make sure voters know who was responsible. This month, the White House **began a campaign** to get the word out to seniors.

"The days where Americans pay two to three times what they pay for prescription drugs in other countries are ending," Biden said in a Feb. 1 statement.

KFF polling indicates Biden **has work to do**. Just a quarter of adults were aware that the IRA includes provisions on drug prices in July, nearly a year after the president signed it. He isn't helped by the name of the law, the "Inflation Reduction Act," which says nothing about health care or drug costs.

Biden's own estimate of drug price inflation is quite

conservative: U.S. patients sometimes pay more than 10 times as much for their drugs compared with people in other countries. The popular weight loss drug Wegovy lists for \$936 a month in the U.S., for example — and \$83 in France.

Additional sections of the law provide free vaccines and \$35-a-month insulin and **federal subsidies** to patients earning up to 150% of the federal poverty level, and require drugmakers to pay the government rebates for medicines whose prices rise faster than inflation. But the most controversial provision enables Medicare to negotiate prices for certain expensive drugs that have been on the market for at least nine years. It's key to Biden's attempt to weaken the drug industry's grip.... **Read More**



## Action Still Needed to Protect Critical Medicare Outreach!

We wrote **last month** and **late last year** about the crisis facing programs that support assistance for low-income Medicare beneficiaries. Unfortunately, the problem has not yet been resolved. Authorization and funding for programs that support outreach and enrollment into benefits that help with health care costs was dropped from the current short-term federal spending bill, or Continuing Resolution (CR), at the last minute. With work on the next CR underway, it's critical that lawmakers hear from you today about this important program. Established in 2008 by the Medicare Improvements for

Patients and Providers Act (MIPPA), this funding helps community-based organizations like **State Health Insurance Assistance Programs (SHIPs)**, Area Agencies on Aging (AAAs), and Aging and Disability Resource Centers (ADRCs) identify Medicare beneficiaries who need financial assistance and help them enroll in programs that can make their health care and prescription drugs more affordable, like the **Medicare Savings Programs (MSPs)** and Part D Low Income Subsidy (**LIS/Extra Help**). These programs can make a

## MEDICARE RIGHTS CENTER

Getting Medicare right

significant difference in the health and budget of older adults and people with disabilities. But they have **notoriously burdensome application processes** and **many who may qualify are unaware of their existence**, leading to **underenrollment**. Medicare Rights **often hears** from beneficiaries who haven't ever been told about this assistance or are caught in administrative **red tape**, and who are facing health and economic hardships as a result.

### Act Now!

Ask your Members of Congress to include funding for MIPPA's

low-income Medicare beneficiary outreach and enrollment activities in the next 2024 spending bill. Explain that you are a constituent, that this program has a footprint in your state and/or community, a long history of success and bipartisanship, and must be extended without delay.

### To Weigh In:

Look up your elected officials (**House, Senate**). Most have information on their websites. You can also connect by calling the U.S. Capitol Switchboard at **(202) 224-3121** and by sending an email through NCOA's **advocacy portal**.

## Medicare Advantage cannot rely exclusively on AI to deny coverage

For some time now, UnitedHealth and other health insurance companies are reported to have been using artificial intelligence tools to broadly deny coverage in certain instances for people enrolled in Medicare Advantage plans. Insurers claim that the tools simply help them determine whether to deny a service. Use of these tools appears to have led to large numbers of inappropriate denials of care for Medicare Advantage enrollees, and the Biden administration is now stepping in reports **SkilledNursingNews**.

The Centers for Medicare & Medicaid Services (CMS), which oversees Medicare, is restricting

insurers' ability to use AI tools to deny claims for Medicare Advantage enrollees. It issued an **FAQ** to insurers offering Medicare Advantage plans to ensure insurers understand that Medicare Advantage plans cannot deny care without considering individual patient's needs.

The FAQ explains how insurers can use algorithms and AI in Medicare Advantage. And, it clarifies coverage requirements for post-acute care to help ensure patients aren't wrongly denied critical care. Insurers can use prior authorization, but not in an emergency or urgently needed



care situations or for out-of-network services they cover.

While insurers can use AI in determining whether to cover a service, they are responsible for making sure that the AI complies with the Medicare coverage rules. And, they can't rely exclusively on AI. Insurers offering MA must consider each individual enrollee's situation, including the enrollee's medical history and treating physician's recommendation, in deciding whether care is medically necessary. And, before an insurer ends services for MA enrollees, their individual conditions must

be reevaluated.

Furthermore, insurers must publicly release their coverage criteria on a website and cannot change it as they please, according to CMS. And, if your doctor says you need post-acute care in a rehab facility, your health insurer cannot second-guess that decision so long as you meet Medicare coverage criteria for such care.

If an insurer still denies coverage, it bears the burden of proof on appeal that care is not medically necessary through a detailed explanation. And, a provider with expertise in that care must issue the denial.

## Medicare fraud: Traditional Medicare v. Medicare Advantage

What makes news is often confounding. Report after report comes out revealing as much as **\$140 billion in overpayments** each year to insurers offering Medicare Advantage plans, eating into the Medicare Trust Fund and driving up Medicare premiums. Still, the **New York Times** focuses on \$2 billion in fraudulent claims for catheters in Traditional Medicare without placing it in the context of a projected \$1.56 billion in waste and fraud in Medicare Advantage through 2033. Of course, \$2 billion isn't chump change, and catheter fraud is a new and perhaps more colorful story.

No question there's Medicare

fraud. The only question is how and when it is detected and addressed. It seems that when the Centers for Medicare and Medicaid Services (CMS), which oversees Medicare, is dealing with relatively small durable medical equipment companies in Traditional Medicare, it is better able to address a fraud than when it is dealing with gigantic health insurers in Medicare Advantage. In other words, watch out for bad actors in Medicare Advantage that could keep you from getting critical care because the government isn't watching out for you.

What's particularly striking



about the catheter story is that it does not focus on the Medicare carrier that processes Medicare claims. How could the Medicare carrier possibly have paid out \$12,000 for 2,000 urinary catheters to one Medicare enrollee? Why wasn't there a red flag in its computer system?

The catheter story also doesn't highlight that the reason we know about this fraud is that the data is accessible for analysis, unlike Medicare Advantage data, which tends to be incomplete, inaccurate, if available at all, and untimely.

What happened in the case of the catheter fraud? Seven

suppliers of these catheters billed the Medicare accounts of 450,000 people enrolled in Traditional Medicare \$2 billion for urinary catheters in 2022-2023. Not one of these 450,000 people received these catheters. It turns out that six of the seven companies did not have a working phone number.

What is CMS doing about these fraudulent bills? Curiously, it has the ability to withhold payments to companies suspected of fraud until it determines whether the bills are legitimate or not. Of note, CMS is either unable to use this authority with insurers offering Medicare Advantage plans when they are suspected of fraud or unwilling to.

## How can Pharma defend drug prices in US?

The Biden administration and Congress are concerned about drug prices, they claim. Really? It would be so easy to lower drug prices quickly, simply by opening our borders to drugs from verified pharmacies abroad. Instead, for the first time, the US is negotiating drug prices for ten drugs, and those prices will only be available to Medicare. **Noah Weiland and Rebecca Robbins** report for **The New York Times** on a recent Senate HELP Committee hearing.

The Senate HELP Committee held a hearing on drug prices last week. The heads of three pharmaceutical companies had to defend their prices at the hearing. There was lots of talk and little action about why every other wealthy nation pays less for their prescription drugs than we do.

CEOs at Johnson & Johnson, Merck and Bristol Myers Squibb admitted that we pay more for our drugs in the US than people in other wealthy countries. In exchange, they claim that we get new drugs sooner. Clearly some spin doctor advised that they praise this "patient choice" in the US. What was left unsaid is that "choice" is only available to the wealthy. Countless Americans cannot afford their drugs even with health insurance because the copays are so high.

Senator Bernie Sanders, for reasons that I have never understood, is constantly comparing drug prices in the US with those in Canada and sometimes arguing that Americans should be able to



import drugs from Canada. Canada has the second highest drug prices in the world. Why not France and England, which have far lower prices?

Sanders was looking for the CEOs to voluntarily agree to lowering their prices to the same level as Canada. How could they possibly agree to reduce their revenue and profits voluntarily? In fact, they have filed lawsuits against the federal government (which they are so far losing), claiming that negotiated prices for ten drugs through the Inflation Reduction Act is unconstitutional!

Republicans on the HELP Committee appear to believe that the pharmaceutical market is working. In fact, Congress affords pharmaceutical

companies lengthy patent rights and ways to extend them. The pharmaceutical market is fixed to give pharmaceutical companies monopoly pricing power for lengthy periods.

Senator Romney would like you to believe that the pharmaceutical market works like the automobile market. Not at all. With cars, there's competition based on lots of known information, including the costs and benefits of the automobile. With drugs, people often don't know their value. Moreover, the price is rigged by the manufacturers, the pharmacy benefit managers and the health insurers.

We are paying about **three times more than people in other countries for our drugs**. Shame on Congress.

## The most expensive state for nursing home care in America—plus, see how your state compares

The most expensive states for nursing home care

Most Americans over the age of 65 will require some sort of long-term care in their later lives. About **1 in 3** will require the costliest kind of care—that of a skilled nursing home facility. **OMedic** analyzed data from long-term care insurance firm **Genworth** to illustrate how the cost of nursing home care has grown in recent years and where it stands around the country.

The average cost for one year of care at a skilled nursing home facility was \$108,405 in 2021, according to the latest estimates available from Genworth. It's a figure that's grown more than 3% since 2017 and doesn't include the impact of **record inflation** since then.

In-home care, demand for which has boomed over the past decade, and assisted living facilities provide long-term care options for older adults at a lower cost on average compared to nursing home care. The national average cost of in-home care for a year of services from a home health aide runs around \$62,000, according to Genworth. A private bedroom in an assisted living facility costs around \$54,000 on average.

But for older adults, an injury from a fall or worsening cognitive issues can be the catalyst for needing more care from professionals. Nursing homes, while pricey, can help with around-the-clock services, including daily hygiene, mobility, and eating. People who

develop Alzheimer's disease and other forms of dementia also require the kind of intensive care nursing homes can provide.

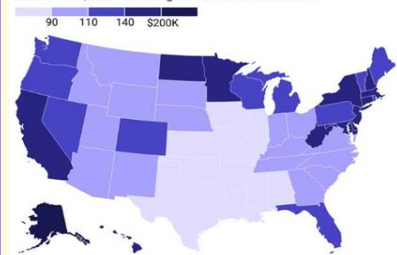
It's impossible for someone to know whether they'll need to pay for an extended stay in a nursing home. Medicaid **often doesn't cover the full cost** of long-term care. In some states, the cost of any significant stay in a nursing home can be **financially unfeasible** for many older middle-income adults.

Costs for nursing home care can run into six figures depending on where you live

Alaska ranks on the extreme end for the costs of providing a year's worth of nursing home care for someone over 65. The state's rural topography, small population, and labor force,

coupled with its isolation, mean that care can be incredibly expensive, a problem that has **plagued the state** for years. The island state of Hawaii is experiencing lengthening wait list times for its long-term care facilities as it faces a similar **shortage of care professionals**....**Read More**

Annual cost of a private room at a nursing home  
At \$378,000, Alaska is nearly \$200,000 more expensive than Connecticut, the second-highest state for cost of care.



Note: Costs represent statewide averages in 2021.  
Data source: Genworth  
By Dom DiFurio

## 2025 COLA Could Be 1.75%

The January CPI-W (Consumer Price Index for Urban Wage Earners and Clerical Workers) came in at 2.9%. That's higher than the inflation trends indicated last month based on December CPI-W data. Based on this trend, The Senior Citizens League (TSCL) is adjusting the long-term forecast COLA to 1.75% in 2025.

According to TSCL's 2024 Senior Survey, 73% said their

household costs rose by more than 3.2% in 2023, and 38% worry that their 2024 COLA will fall short of inflation this year.

TSCL COLA estimates tend to CHANGE month to month based on the most recent CPI data. This is the forecast based on data through January 2024 that was released today, and the final COLA for 2025 is likely to be different from the estimates because the COLA is calculated



on the average rate of inflation during the 3rd quarter (JUL, AUG, and SEP) which is compared against the 3rd quarter a year ago. In other words, there are another eight months of data to come in, and a lot could change.

How does our estimate compare with others?

The Congressional Budget Office recently released the annual Budget and Economic Outlook for 2024 to 2034.

The URL below links to the CBO's estimate of the 2025 COLA. Look for Key Assumptions. Then, see the column for 2024. The estimate is 2.5% (see footnote b. COLA payable in January of the following calendar year).

The CBO uses a different methodology than TSCL's, but clearly, inflation rates are expected to fall from 2023 levels, and the COLA for 2025 will also be lower.



## Plan ahead: Who will pay your bills if you cannot

If you're like most people, you are going through life doing your best to manage your bills, without thinking about who will pay them on your behalf if you are not able to. But, the last thing you want on top of the medical bills you'll accrue if you are hospitalized or need rehab care is a collection agency coming after you. So, it's wise to plan ahead, get your affairs in order, and appoint someone you trust to pay those bills through a durable power of attorney.

A durable power of attorney is a legal document that allows you to name someone to help with your financial affairs whenever you would like, including if you become unable to handle them yourself. The person you name should be someone you trust with your finances, someone who could make decisions about your finances if need be. That person also could be your **health care proxy or health care buddy**.

**Why should you give someone a durable power of attorney?** Giving someone you trust a durable power of attorney should give you peace of mind that your affairs will be taken care as you would like, if you

cannot take care of them. Without a durable power of attorney, the person you would want to handle your financial affairs would have to go through an expensive and lengthy court proceeding to make these decisions. Moreover, without the durable power of attorney, a judge might appoint someone you do not trust to handle your affairs.

**How long does a durable power of attorney last?** The durable power of attorney lasts until you die or until you change it.

**What is the difference between a durable power of attorney and a power of attorney?** If you give someone a power of attorney rather than a durable power of attorney, then the person you designate only has authority over whatever financial matters you specify until you become mentally incompetent. But, if you choose, you can make the power of attorney document a durable power of attorney. You need only include language in the power of attorney that specifies that the person you designate has authority if you become mentally incompetent. Unless you make the power of attorney a durable



power of attorney, the person you designate cannot handle your financial affairs if you become mentally incompetent.

**Who should have a copy of your durable power of attorney?** You should give a copy of the durable power of attorney to all financial institutions at which you have accounts. And, you should give a copy to the person you name to have your durable power of attorney or, at the very least, let that person know he or she has that authority and where to find the document if needed.

**If I give someone a durable power of attorney, will that person be able to take money from my bank accounts?** Yes. The person you name as having durable power of attorney, your financial agent, will be able to take care of your financial affairs using your bank accounts if you give the person that authority. But, this agent does not own the money in your accounts and may not take money from your accounts for himself or herself.

**What should I discuss with the person I name as having durable power of**

**attorney?** You should let your agent know about all institutions with which you have financial arrangements, including your banks, credit card companies, financial advisors and insurance companies.

**Can I cancel my durable power of attorney?** You can cancel or change your durable power of attorney at any time by destroying it and notifying the financial institutions at which you have accounts that you have destroyed it or changed it.

**Is there anything more I need to do?** Yes! You should be sure to let the person to whom you give your durable power of attorney know and you might want to let other people you trust know that this person has durable power of attorney. You also need to let your bank know about your durable power of attorney. You also need to pull together a list of the bills you pay, your checking account information, and other information needed to make sure your bills are paid and have that available to the person to whom you give your durable power of attorney. Click here for [a checklist](#).

## With Medicare Advantage, less for you is always more for insurers

**David Wainer** reports for the **Wall Street Journal** that people in Medicare Advantage plans—coverage through corporate health insurers—are likely to see fewer extra benefits next year. That's no surprise, nor will it be a surprise for Wall Street when everyone enrolled in Medicare Advantage faces much higher out-of-pocket costs than they do today and no longer have government-administered traditional Medicare as an option. If the administration and Congress do not swiftly rein in tens of billions in annual overpayments to insurers offering Medicare Advantage, the only question is when people will appreciate that Medicare Advantage is a helluva disadvantage.

About 32 million people are now enrolled in a Medicare Advantage plan, just under half the Medicare population. People

are swayed by the ads offering “dental” benefits and free gym memberships and the seemingly trustworthy insurance agents steering them towards Medicare Advantage. Older adults and people with disabilities also can't afford or don't want to spend money on supplemental coverage in traditional Medicare that picks up most out-of-pocket costs, when they would like to believe they won't be needing much health care. Since at any given time the vast majority of people don't need a lot of health care, it has yet to sink in for them that insurers could take advantage of them if they are in a Medicare Advantage plan.

Wainer says that insurers now need to address greater health care spending and lower government payments to appease Wall Street and deliver handsome shareholder returns. What's concerning is that the bad actor



Medicare Advantage plans—and we don't know how many or which ones those are, but they appear to be numerous—are still raking in billions of dollars in profits from Medicare Advantage that they seem not prepared to spend on their enrollees' medically necessary care. What kind of a health care coverage model is that?

Wainer says that “if the current trends continue, plans will have to be more cautious in their offerings going forward.” Really? Truth is that people need to be more cautious about enrolling in a Medicare Advantage plan going forward. Medicare Advantage plan offerings in some, if not most, cases are concerning for people who need care—including restricted access to high quality doctors and hospitals, administrative hurdles and delays getting urgent care, inappropriate

denials of care and high out-of-pocket costs.

Even with tens of billions in annual overpayments, Medicare Advantage plans **delay and deny care inappropriately**. And, many **restrict access to high quality providers**. Some have such **high mortality rates** that one group of academics found that the government could save tens of thousands of lives a year if it ended contracts with those Medicare Advantage plans.

If all goes well, people will start to see that Medicare Advantage is no free lunch when they most need care. In fact, it can easily cost people **twice as much as what they'd spend on care in Traditional Medicare** with supplemental coverage, with huge delays and obstacles to getting care....**Read More**

## 'Behind the Times': Washington Tries to Catch Up With AI's Use in Health Care

Lawmakers and regulators in Washington are starting to puzzle over how to regulate artificial intelligence in health care — and the AI industry thinks there's a good chance they'll mess it up.

"It's an incredibly daunting problem," said Bob Wachter, the chair of the Department of Medicine at the University of California-San Francisco.

"There's a risk we come in with guns blazing and overregulate."

Already, AI's impact on health care is widespread. The Food and Drug Administration has approved some 692 AI products. Algorithms are helping to schedule patients, determine staffing levels in emergency rooms, and even transcribe and

summarize clinical visits to save physicians' time. They're starting to help radiologists read MRIs and X-rays. Wachter said he sometimes informally consults a version of GPT-4, a large language model from the company OpenAI, for complex cases.

The scope of AI's impact — and the potential for future changes — means government is already playing catch-up.

"Policymakers are terribly behind the times," Michael Yang, senior managing partner at OMERS Ventures, a venture capital firm, said in an email. Yang's peers have made vast investments in the sector. Rock



Health, a venture capital firm, says financiers have put nearly \$28 billion into digital health firms specializing in artificial intelligence.

One issue regulators are grappling with, Wachter said, is that, unlike drugs, which will have the same chemistry five years from now as they do today, AI changes over time. But governance is forming, with the White House and multiple health-focused agencies developing rules to ensure transparency and privacy. Congress is also flashing interest. The Senate Finance Committee held a hearing Feb. 8 on AI in health care.

Along with regulation and legislation comes increased lobbying. CNBC counted a 185% surge in the number of organizations disclosing AI lobbying activities in 2023. The trade group TechNet has launched a \$25 million initiative, including TV ad buys, to educate viewers on the benefits of artificial intelligence.

"It is very hard to know how to smartly regulate AI since we are so early in the invention phase of the technology," Bob Kocher, a partner with venture capital firm Venrock who previously served in the Obama administration, said in an email... [Read More](#)

## Major shift: Health insurers are suddenly coveting sicker patients

By [caitlin@axios.com](mailto:caitlin@axios.com)

People who are eligible for both Medicare and Medicaid — a group that is generally low-income with complex health needs — are expected to generate billions in profit for health insurers in the coming years, despite being a group that typically racks up expensive health care bills.

**Why it matters:** This is part of a major shift in how insurers make their money, with profits increasingly coming from their provision of government plans like Medicare Advantage and Medicaid managed care.

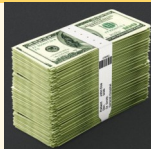
**Driving the news:** A recent McKinsey report projected that earnings before interest, taxes, depreciation, and amortization — a measure of profitability — from covering the "dual eligibles" population will see a

growth rate of greater than 10% between 2022 and 2027, and profits will grow from \$7 billion in 2022 to \$12 billion in 2027.

- "Reimbursement tends to be higher for, in the insurance lingo, the riskier population," said Shahed Al-Haque, a partner at McKinsey. "Because [plans are] getting a higher level of reimbursement and the cost does not necessarily scale at the same level of reimbursement, they're able to achieve profitability."

Plans for dual eligibles had some of the highest profit margins among private Medicare Advantage plans in 2021, according to MedPAC.

**The big picture:** The profitability of insurance plans' government segment is expected to be 65% higher than the commercial segment by 2027, per



McKinsey.

- This coincides with the rising prevalence of people with government-funded insurance enrolling in private health plans.

More than half of seniors are now enrolled in MA plans, spurring contentious debate over whether the program is a good deal for the government in light of Medicare's financial instability.

**By the numbers:** Between 12 and 13 million people receive health coverage from both Medicare and Medicaid, and in 2023, 29% of them were enrolled in a private Medicare Advantage plan specifically designed for this population, per KFF.

- About half received their coverage in 2020 from traditional Medicare while the other half were enrolled in Medicare Advantage, whether

that was a special plan or not.

- Humana recently reported that enrollment in its special dual eligible plans increased by 30% between December 2022 and December 2023.

**Zoom in:** People enrolled in both programs make up a disproportionately high amount of the total spending in each, but they vary greatly in their health needs.

- The vast majority have low incomes. In 2020, 87% of all Medicare-Medicaid enrollees had an income of less than \$20,000, per KFF.

- Nearly 40% were under age 65 but eligible because of a long-term disability, and around 1 in 10 lived in long-term institutional care, such as a nursing home. Just over a quarter of total enrollees had five or more chronic conditions.

## Retirees: How To Save on Healthcare Costs That Medicare Doesn't Cover

Medicare is undeniably a cornerstone for healthcare costs in retirement, but it doesn't cover everything. Being aware of its limitations is important for retirees, so you're not caught off guard by a huge bill you aren't prepared to pay.

**What Healthcare Costs Does Medicare Not Cover?** According to Medicare.gov, here are some of the items and services Medicare doesn't cover:

- ◆ Long-term care or custodial care
- ◆ The majority of dental care
- ◆ Eye exams for the purpose of prescription glasses
- ◆ Dentures
- ◆ Cosmetic surgery
- ◆ Massage therapy
- ◆ Routine physical exams
- ◆ Hearing aids and exams for



fitting

- ◆ Concierge care (also known as platinum practice, direct care or concierge, retainer-based or boutique medicine)
- ◆ Covered items or services from an opt-out doctor or other provider (except when it's an urgent need or emergency)

**How To Save on Healthcare Expenses Medicare Doesn't Cover**

Here are some options for covering those healthcare costs that Medicare won't cover.

- ◆ **Health Savings Account**
  - ◆ **Local Community Healthcare Options**
  - ◆ **Long-Term Care Insurance**
  - ◆ **Standalone Dental and Vision Insurance**
  - ◆ **Pay in Cash**
  - ◆ **Be Proactive**
- [Read More on the above.](#)



## Weight-loss drugs are a hot commodity and hard to get

Weight loss drugs are a hot commodity. They can be hard to come by. Getting them can try your patience and your pocketbook. Reed Abelson and Rebecca Robbins offer six reasons why it is so hard for people to get weight-loss drugs in the [New York Times](#).

**1. A lot of people want these drugs.** Already nearly four million people are taking weight-loss drugs. Between TikTok and advertisements, more and more people are wanting to take weight-loss drugs.

**2. Production of these drugs is slow.** Few factories can manufacture the latest weight-loss drugs. And, they come in five or more strengths. Eli Lilly also needs to make enough of its

pens used to inject Zepbound.

**3. Insurance often won't cover these drugs, making them unaffordable to most.** Medicare will only cover these drugs for people with diabetes. It does not cover weight-loss drugs for obesity. However, Medicare covers nutrition and weight-loss counseling.

Medicaid does not either. The insurers consider them "lifestyle" drugs, rather than medically necessary drugs. As a result about 40 percent of employers also do not offer this coverage to their workers.

These are injectable drugs that can cost as much as \$16,000 a year. With discounts or coupons



from Eli Lilly, people can get Zepbound, one of the weight-loss drugs, for \$550 a month, if they have insurance. They can get a coupon from Novo Nordisk for Wegovy, another weight-loss drug, and pay \$1,000 a month instead of \$1,500 a month.

**4. People can't find these drugs at their pharmacies.** While these drugs are often not in stock at pharmacies, they will order them when requested. The drugs cost too much money, literally tens of thousands of dollars for a pharmacy to stock.

**5. Pharmacies sometimes claim that these drugs provide them no profit.** In fact, some say that they lose money on weight-

loss drugs because the insurers do not reimburse them adequately for the drugs. The insurers' pharmacy benefit managers or PBMs reimburse the pharmacies below cost in some cases. This seems like a way for the insurers to avoid covering weight-loss drugs.

**6. Most insurers create hurdles in order to cover weight-loss drugs.** People need their doctors to verify they qualify for coverage. In some cases, before the insurer will cover these drugs, enrollees must take a six-month nutrition and exercise program. Some insurers require people to try other less expensive drugs before they will cover these drugs.

## CDC says it has no plans to ease Covid isolation yet, despite urging from doctors

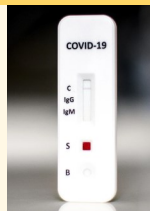
People who **test positive for Covid** should still isolate for five days, according to the Centers for Disease Control and Prevention, even though many Americans are already ignoring the policy. That guidance is likely to change at some point, however.

Following reports that the CDC was considering easing Covid isolation restrictions — including guidelines that people can leave their homes after being fever-free for 24 hours — the agency refused to confirm that such plans were in the works. The potential change was first reported by [The Washington Post](#).

But an official at the Department of Health and Human Services who asked not to be identified said federal health officials are considering relaxing Covid isolation guidelines, although the discussions are at an early stage and no definitive decisions have been made.

"It's way too preliminary," the source said. There's "lots more consultation to be had."

The CDC is looking at changes to its overall Covid guidance, which could include recommendations about masking



as well as isolation, said a public health official who was involved with a recent call with the CDC. The CDC currently recommends masking for **10 days following a Covid diagnosis**.

There's no evidence that the virus that causes Covid has evolved to become less dangerous or contagious. What has changed is Americans' attitudes about Covid restrictions. People are no longer willing or able to spend a week out of work or school because of Covid, experts say.

Dr. William Schaffner, an

infectious diseases expert at Vanderbilt University Medical Center in Nashville, Tennessee, said he and his colleagues have privately encouraged the CDC to drop the five-day isolation period, in part because there's little evidence it's stopping the spread of Covid.

The "rigorous recommendations that are currently in place do not reflect common practice," Schaffner said. "It's difficult to demonstrate that strict isolation has had a notable impact on transmission." ....[Read More](#)

## FDA Approves New Treatment for Advanced Melanoma

The U.S. Food and Drug Administration has approved a novel treatment for advanced melanoma, the most deadly form of skin cancer.

Amtagvi, made by Iovance Biotherapeutics Inc., becomes the first cellular therapy approved to treat this form of solid tumor cancer.

"Unresectable, or metastatic, melanoma is an aggressive form of cancer that can be fatal," [Dr. Peter Marks](#), director of the FDA's Center for Biologics Evaluation and Research, said in an agency [news release](#). "The approval of Amtagvi represents

the culmination of scientific and clinical research efforts leading to a novel T-cell immunotherapy for patients with limited treatment options."

The therapy works by using a person's own immune cells to fight the cancer.

"The approval of Amtagvi offers hope to those with advanced melanoma who have progressed following initial standard-of-care therapies, as the current treatment options are not effective for many patients," [Samantha Guild](#), president of the AIM at Melanoma Foundation, said in a Iovance [news release](#). "This one-



time cell therapy represents a promising innovation for the melanoma community, and we are excited by its potential to transform care for patients who are in dire need of additional therapeutic options."

With the treatment, doctors surgically remove tissue from the patient's tumor and grow immune cells from that tissue in the lab. Then, they infuse those new immune cells into the patient, where they attack and kill the cancer.

Importantly, only one treatment is needed for the treatment to work, sometimes for years, [Dr. Ryan](#)

[Sullivan](#), associate director of the Melanoma Program at Mass General Cancer Center in Boston, told *CNN*. The center was one of the sites where Amtagvi was tested.

"While patients with melanoma have a lot more treatment options than they had 15 years ago, we still have a lot of our patients who are diagnosed with metastatic melanoma dying," Sullivan said. "It's a very good day to have another option, particularly an option in a population of patients where our standard therapies have failed them." ...[Read More](#)

## Scientists Discover New Way to Fight Estrogen-Fueled Breast Cancer

Everyone's heard of fighting fire with fire.

Now that tactic is coming to breast cancer treatment.

Researchers think they've figured out a better way to fight breast cancer fueled by the female hormone estrogen – by employing mechanisms used by the male hormone androgen.

An experimental drug called enobosarm stimulates the androgen receptor on cancer cells, which functions as a tumor suppressor, researchers reported recently in ***The Lancet Oncology*** journal.

The drug caused advanced breast cancers to slow or stop in 32% of patients taking a lower

dose and 29% of patients taking a higher dose after about six months, phase 2 clinical trial results show.

"Our findings are very promising. They demonstrate that stimulating the androgen receptor pathway with enobosarm can be beneficial," said senior co-author **Dr. Beth Overmoyer**, director of the Inflammatory Breast Cancer Program at Dana-Farber Cancer Institute in Boston.

Estrogen receptor-positive (ER+) breast cancers represent up to 80% of all breast cancer cases, researchers said in background notes. Up to now,



hormone therapies have focused on suppressing the activity of estrogen in these cases.

These results represent the first advancement in treatment of ER+ breast cancer in decades, researchers said.

"The effectiveness of enobosarm lies in its ability to activate the (androgen receptor) and trigger a natural defense mechanism in breast tissue, thereby slowing the growth of ER+ breast cancer, which relies on the hormone estrogen to grow and spread," said senior co-author **Wayne Tilley**, director of the Dame Roma Mitchell Cancer Research Laboratories at the

University of Adelaide in Australia.

For the phase 2 study, which focuses on safety and potential effectiveness, 136 women with estrogen-positive breast cancer were randomly assigned to take either 9 milligrams or 18 milligrams of enobosarm a day. The drug is taken as a pill.

Results showed that the drug had significant anti-tumor activity and was well-tolerated by patients, researchers said.

Average progression-free survival was 5.6 months in the lower-dose group and 4.2 months in the higher-dose group, results show....[\*\*Read More\*\*](#)

## Acupuncture May Lower Stroke Risk in Rheumatoid Arthritis Patients

Acupuncture may protect people with rheumatoid arthritis (RA) from stroke, new research suggests.

The study indicates that a course of acupuncture treatment may lower blood levels of inflammatory proteins called cytokines that are linked to heart disease, the No. 1 cause of death in people with RA.

"Inflammation is a consistent and independent predictor of cardiovascular disease in [rheumatoid arthritis]," researchers wrote in the Feb. 13 issue of ***BMJ Open***. "Unstable blood pressure and lipid profiles are two risk factors for ischemic stroke, and acupuncture has the

advantage of controlling both."

Ischemic strokes are caused by a blood clot in the brain.

For this study, a team led by **Dr. Hung-Rong Yen**, of the School of Chinese Medicine at China Medical University in Taiwan, looked at a database of more than 23,000 RA patients in Taiwan.

That included nearly 12,300 patients who were treated with acupuncture between 1997 and 2010. On average, patients began acupuncture treatment 2.9 years after getting their RA diagnosis.

The vast majority (87%) were treated with manual acupuncture.



Three percent were treated with electroacupuncture, in which an electrode producing a low electrical pulse is attached to the needle, and 10% received both treatments.

Patients were monitored through 2011.

Stroke risk rose with patients' age and coexisting conditions. For instance, those who had high blood pressure had twice the risk as those with normal blood pressure, and patients with diabetes were 58% more likely to have a stroke.

But acupuncture still offered protection that was independent of sex, age, types of drugs used

and coexisting conditions, researchers found.

Of those who had acupuncture, 341 had a stroke over the study period, compared to 605 patients in the other group. That translated into a 43% lower risk of stroke.

Researchers noted that the study cannot prove cause and effect, only that there is an association between acupuncture and stroke risk. They added that they lacked information on other factors that might influence risk — such as height, weight, lab tests or physical activity levels.

## FDA Approves First Treatment for Severe Frostbite

The U.S. Food and Drug Administration (FDA) on Wednesday approved the first treatment for severe frostbite.

Known as Aurlumyn (iloprost), the injected medication lowers the risk of finger or toe amputation in cases of profound frostbite, the agency said.

"This approval provides patients with the first-ever treatment option for severe frostbite," **Dr. Norman Stockbridge**, director of the Division of Cardiology and Nephrology in the FDA's Center for Drug Evaluation and Research, said in an agency [\*\*news release\*\*](#). "Having this new option provides physicians with a tool that will help prevent the life-changing

amputation of one's frostbitten fingers or toes."

Frostbite can range from mild cases that don't require medical intervention and don't cause permanent skin damage to severe cases where both the skin and underlying tissue are frozen and blood flow is stopped. In those instances, amputation is sometimes required, the FDA said.

Iloprost is a vasodilator, which opens up blood vessels and prevents blood from clotting.

The FDA approval hinged on the results of a trial that randomized 47 adults with severe frostbite, all of whom received aspirin by IV and standard of care, into one of



three treatment groups.

Group 1 received iloprost intravenously for six hours a day for up to eight days.

The two other groups received other medications that aren't approved for frostbite, given with iloprost (Group 2) or without iloprost (Group 3). The main measure of efficacy was a bone scan taken seven days after the initial frostbite that predicted the need for amputation of at least one finger or toe.

None of the 16 patients receiving iloprost alone was found to need amputation, compared to 19% of patients in Group 2 and 60% of patients in Group 3.

Aurlumyn's most common side

effects included headache, flushing, heart palpitations, fast heart rate, nausea, vomiting, dizziness and hypotension (very low blood pressure). Aurlumyn also carries a warning noting that it may cause symptomatic low hypotension, the FDA noted.

Iloprost was first approved in 2004 for the treatment of pulmonary arterial hypertension (high blood pressure).



## Salt Substitutes Help Prevent High Blood Pressure

Replacing regular salt with a salt substitute can reduce high blood pressure in older adults, a new study has found.

Older adults who use a salt substitute are 40% less likely to develop high blood pressure compared to those who use regular salt, according to findings published Feb. 12 in the *[Journal of the American College of Cardiology](#).*

"Adults frequently fall into the trap of consuming excess salt through easily accessible and budget-friendly processed foods," said lead researcher **[Dr. Yangfeng Wu](#)**, executive director of the Peking University Clinical Research Institute in Beijing.

"It's crucial to recognize the impact of our dietary choices on heart health and increase the public's awareness of lower-sodium options," he added in a journal news release.

High blood pressure is the

leading risk factor for heart disease and heart-related death, according to the World Health Organization. It affects more than 1.4 billion adults worldwide and results in 10.8 million deaths each year.

For this study, researchers evaluated how sodium reduction might help the blood pressure of seniors residing in care facilities in China.

The study involved more than 600 participants, age 55 and older, from 48 care facilities. All patients had blood pressure under 104/90 mmHG, and were not on any blood pressure medications.

Half of the care facilities replaced salt with a salt substitute in residents' meals, while the other half kept using regular salt, researchers said.

After two years, the incidence of high blood pressure was more than double at the facilities that



kept using salt – 24.3 cases per 100 people-years versus 11.7 cases per 100 people-years at the facilities using salt substitute.

People-years take into account both the number of people in a study and the amount of time each person spends in the study.

What's more, the salt substitutes did not cause dangerously low blood pressure, which also commonly affects older adults.

"Our results showcase an exciting breakthrough in maintaining blood pressure that offers a way for people to safeguard their health and minimize the potential for cardiovascular risks, all while being able to enjoy the perks of adding delicious flavor to their favorite meals," Wu said.

In an accompanying editorial, nephrologist **[Dr. Rik Olde](#)**

**[Engberink](#)** said the study offers an alternative to simply asking patients to cut back on salt intake – a strategy that has failed to gain wide support among the public.

In this trial, "the salt substitute was given to the kitchen staff, and the facilities were not allowed to provide externally sourced food more than once per week," Olde Engberink, who practices at Amsterdam University Medical Center in The Netherlands, said in a news release.

"This approach potentially has a greater impact on blood pressure outcomes, and for this reason, salt substitutes should be adopted early in the food chain by the food industry so that the sodium-potassium ratio of processed foods will improve," he added.

## New Treatment Brings Hope for Rare, Deadly Cancer Linked to Asbestos

Mick worked in a factory boiler room in the 1970s, where he was exposed to asbestos.

He didn't think much of it until 2018, when he began to feel ill and dropped more than 40 pounds.

The diagnosis: malignant mesothelioma, a rare but rapidly fatal cancer linked to asbestos.

"It was a bit of a shock: I was given four months to live," Mick recalled in a Queen Mary University of London news release that did not provide his last name.

Luckily, Mick is still around, thanks to a cutting-edge therapy

that significantly increases the survival of patients with malignant mesothelioma.

An experimental drug called ADI-PEG20 increased average survival of mesothelioma patients by 1.6 months, and quadrupled the three-year survival rate, when combined with traditional chemotherapy, trial results show.

These findings are significant because malignant mesothelioma has one of the lowest five-year survival rates of any solid cancer, around 5% to 10%, researchers said.

ADI-PEG20 works by cutting



off the cancer's food supply, researchers explained. The drug blocks the ability of cancer cells to absorb the amino acid arginine from the bloodstream.

Mesothelioma cells lack a protein called ASS1, which allows cells to create their own arginine. If they can't get arginine from blood, their ability to grow and multiply is thwarted, researchers said.

"It's truly wonderful to see the research into the arginine starvation of cancer cells come to fruition. This discovery is something I have been driving

from its earliest stages in the lab," said lead researcher **[Dr. Peter Szlosarek](#)**, a professor at Queen Mary's Barts Cancer Institute in London.

Mesothelioma is a rare, aggressive cancer that affects the lining of the lungs.

About 4 in 5 cases of mesothelioma are caused by workplace exposure to asbestos, researchers said. Inhaled asbestos fibers that settle in the lungs can cause irritation that might trigger mesothelioma....**[Read More](#)**

## Brain Cancer Risk Rises in Vets After Serious Head Injury

People who've suffered a moderate to severe traumatic brain injury have a greatly increased risk of brain cancer, a new study of military service members finds.

Brain cancer is relatively uncommon, occurring in fewer than 1% of people in the United States, researchers said.

But service members who had a moderate or severe brain injury were at 90% increased risk for developing malignant brain cancer, according to analysis of health data for more than 1.9

million veterans.

And penetrating traumatic brain injury -- where an object punctures the skull and enters the brain -- was associated with a tripled risk of brain cancer, results show.

While this was observed only in the military, civilians might be expected to run similar risks from brain injuries, researchers said.

"Traumatic brain injury is not only common in the military, but also in the general population as well," said lead researcher **[Dr.](#)**



**[Ian Stewart](#)**, an Air Force colonel and professor of medicine at the Uniformed Services University of the Health Sciences.

"While these results may not be generalizable to the population at large, given that military cohorts are different from the general population in many ways, it is possible that more severe TBI increases risk in the civilian population as well," Stewart added in a university news release.

However, the study also found that mild traumatic brain injury -- a common concussion -- is not linked to an increased risk of brain cancer.

The study relied on traumatic brain injury data collected by the Departments of Defense and Veterans Affairs, in which service members were tracked more than seven years, on average.

## Half of U.S. Health Care Workers Say They've Witnessed Racism Against Patients

Nearly half of health care workers nationwide say they've seen discrimination against patients while on the job, a new report reveals.

While 47% of health workers said they've witnessed discrimination against patients in their facilities, 52% said racism against patients is a major problem, according to the [report](#) from the Commonwealth Fund and the African American Research Collaborative (AARC). "The study shines a light on the discrimination and racism health care workers observe and the implications for negative health outcomes of patients in many communities," said lead report author [Henry Fernandez](#), CEO of the AARC.

"Understanding this connection at a national level is critical to measuring and addressing discrimination in the health care

system to mitigate harm to patients and produce better health outcomes overall," Fernandez added in a Commonwealth Fund news release.

For the report, researchers surveyed more than 3,000 health care workers across the United States.

### Here's what they found:

- ◆ More than half of health care workers (57%) witnessed discrimination against a patient who spoke a language other than English
- ◆ About half (48%) said medical providers are more accepting of what white patients tell them than Black patients
- ◆ Around half (47%) said dealing with discrimination at work causes them stress

Health care workers at facilities that help more patients of color were more likely to witness



discrimination.

About 70% of workers at facilities with predominantly Black patients and 61% of those at facilities with predominantly Hispanic patients witnessed discrimination, compared to 43% at facilities with mostly white patients.

The survey also found that health care professionals themselves also are subjected to racism.

About 44% of health care workers have observed discrimination against coworkers. When provided examples of workplace discrimination, that percentage rose to two-thirds.

When asked about potential solutions, more than two-thirds of health care workers suggested steps like:

- ◆ Anonymous reporting of racism or discrimination

- ◆ Better communication with patients and health care professionals of color
- ◆ Examination of how non-English-speaking patients are treated
- ◆ Training that helps better spot and stop discrimination
- ◆ "If we are going to build truly equitable health care systems, we have to start by listening to voices of those on the front lines," said report co-author [Dr. Laurie Zephyrin](#), senior vice president for advancing health equity at the Commonwealth Fund.
- ◆ "Understanding what health care workers are experiencing, and what they want and need from their employers and colleagues to address discrimination, is critical to successful and sustainable change," Zephyrin added.

## Drug Used to Treat Rheumatoid Arthritis May Also Help Prevent It

Philip Day loved playing soccer so much that the 35-year-old software engineer founded a website – FootballMatcher.com – to help people connect for pickup games.

The fun went on pause when Day developed joint pain so bad it kept him from his favorite sport.

"The pain got so terrible I stopped going to football, and I got lazier and felt progressively worse physically and mentally," Day, who lives in the London district of Eltham, said in a news release.

"The pain was unpredictable,"

he recalled. "It would show up in my knees one day, my elbows the next, and then my wrists or even my neck."

But Day is now back to playing, thanks to a biologic drug that prevented him from developing full-blown rheumatoid arthritis.

Day participated in a clinical trial that showed the drug abatacept ([Orencia](#)) – which is already used to treat diagnosed rheumatoid arthritis – also can prevent people from progressing to the painful inflammatory disease.



Abatacept eases symptoms and prevents joint damage in rheumatoid arthritis patients by dampening the immune system, researchers said.

About 1.3 million Americans live with rheumatoid arthritis, which occurs when the body's immune system starts attacking tissues in the joints, causing inflammation, pain and swelling.

Day's clinical trial showed that abatacept also is effective in preventing the onset of rheumatoid arthritis.

About 6% of patients treated with abatacept developed arthritis

compared to 29% given a placebo following a year of treatment, according to clinical trial results published Feb. 13 in [The Lancet](#).

"This is the largest rheumatoid arthritis prevention trial to date and the first to show that a therapy licensed for use in treating established rheumatoid arthritis is also effective in preventing the onset of disease in people at risk," researcher [Andrew Cope](#), head of the King's College London Center for Rheumatic Diseases, said in a news release.... [Read More](#)

## CDC May Recommend COVID Boosters for Some This Spring

The U.S. Centers for Disease Control and Prevention is weighing whether to recommend another COVID booster shot this spring, most likely for those who are vulnerable to severe illness.

An advisory panel to the CDC is expected to vote on whether to recommend a spring booster during a [Feb. 28 meeting](#), a source close to the panel told *NBC News*. The panel is expected to focus on the safety of high-risk Americans, including people 65 and older and anyone with a weakened immune system.

"The discussion will be aimed at the people who are most accepting

of public health recommendations," [Dr. William Schaffner](#), an infectious diseases expert

at Vanderbilt University Medical Center in Nashville, Tenn., told *NBC News*. "The committee, in its rigorous fashion since the question has come up, will be considering a second dose for people at high risk or for people who wish to get it." A spring booster would be the same shot [approved](#) last fall, which targets the XBB.1.5 subvariant. Luckily, that booster formulation also works well against the JN.1 subvariant, the



leading cause of most COVID infections in the United States at the moment.

Experts said a spring booster shot makes sense. "Waiting till the fall, I think, is a mistake," [Michael Osterholm](#), an infectious disease expert and director of the Center for Infectious Disease Research and Policy at the University of Minnesota, told *NBC News*. "We have clear evidence that either vaccine or previous infection probably gives four to six months of relative protection against serious illness, hospitalizations

and deaths, but wanes substantially after that."

"Some people have had seven, eight vaccines," Werbel said. "Transplant recipients would be more receptive and much more likely to follow recommendations, particularly if recommended by the transplant center, but the ceiling is kind of lowered because of this societal fatigue and societal disenchantment with COVID."

Experts generally recommend that even high-risk patients wait at least two months after a COVID vaccination or COVID infection before getting another shot.