

January 14, 2024 E-Newsletter



Message from Alliance for Retired Americans Leaders

Pharmaceutical Corporations Expected to Raise Prices on Over 500 Drugs This Month



Robert Roach, Jr.
President, ARA

Some of the largest American pharmaceutical companies, including Pfizer, Sanofi, and Takeda Pharmaceutical, **plan to raise**

prices on over 500 drugs

starting this month according to data analyzed by healthcare research firm 3 Axis Advisors. The price hikes will affect over 140 brands of drugs.

Pfizer, including the Hospira arm of the company, is responsible for the most price increases this month, with plans to hike prices on 146 drugs in total – more than a quarter of all price increases. Another major company, Takeda Pharmaceutical, has 53 price increases planned, ranking it second to Pfizer in number of price hikes.

January has consistently been the month with the most drug price increases, so in all likelihood, more will be announced in the coming weeks. The median price increase remains around 5%.

The price increases coincide with President Biden's policies aimed at reigning in pharmaceutical price gouging, including allowing Medicare to negotiate directly with pharmaceutical companies to lower prices beginning in 2026. The publication of discounted prices for 10 high-priced drugs will come in September.

The administration has also combatted major price hikes by

requiring that drug companies pay rebates to Medicaid when prices rise faster than the inflation rate.

"The pharmaceutical industry's greed has no bounds and seniors need protection," said **Robert Roach, Jr., President of the Alliance.**

"President Biden has taken strong action and some critical drug prices are going down but more is needed. Patient needs must come before corporate profits."

Lower Insulin Prices, Out-of-Pocket Cost Caps for Medicare Beneficiaries Kick Off 2024



Rich Fiesta,
Executive Director, ARA

Medicare beneficiaries will see a **wide array** of cost-saving benefits in the new year. Thanks to the Biden Administration, seniors will continue to pay no more than

the monthly cap of \$35 for insulin, and vaccines under Part D will be free.

Going forward, if a beneficiary's drug costs are high enough to reach the catastrophic coverage phase, they will not have to pay coinsurance or make copayments. This effectively caps out-of-pocket expenses at \$3,250 in 2024.

Another major change this year is the Part D Low-Income Subsidy program, Extra Help, which will now cover more drug costs for those who earn less than 150% of the federal poverty level. Qualifiers for the program will pay no more than \$4.50 for generic drugs and \$11.20 for brand-name drugs.

These 2024 benefits are only a

few of the annually unrolling policies that are aimed at limiting Medicare costs under the Inflation Reduction Act that President Biden signed in 2022. Last year, drug companies were forced to participate in price negotiations with Medicare, which will lead to lower prices, and in 2025, the annual Part D out-of-pocket cap will be lowered to \$2,000.

"Beginning with insulin, seniors are finally seeing the affordable prices they deserve for life-saving drugs," said **Richard Fiesta, Executive Director of the Alliance.**

"These changes in 2024 are important steps toward curbing drug corporation greed."

220 People Finished Paying Social Security Taxes on New Year's Day



Joseph Peters, Jr.
Secretary Treasurer ARA

Just a few hours into 2024, more than 220 Americans, including SpaceX/Tesla/X's Elon Musk and Apple's Tim Cook, **paid all their Social**

Security taxes for the year. This comes in sharp contrast to the over 160 million American workers who will continue to pay Social Security taxes on the income they earn all year. This wide disparity is due to the cap on maximum earnings subject to Social Security tax — \$160,200 in 2023 and now \$168,600 in 2024.

If the top ten CEO's paid Social Security tax on all their income — including stock options — the system would have received \$3.4 billion.

"If the wealthiest Americans paid their fair share, we could strengthen the Social Security program and even expand benefits," said **Joseph Peters, Jr., Secretary-Treasurer of the Elon Musk Alliance.** "It is time for Congress to adopt this common sense solution and deliver greater retirement security for all."

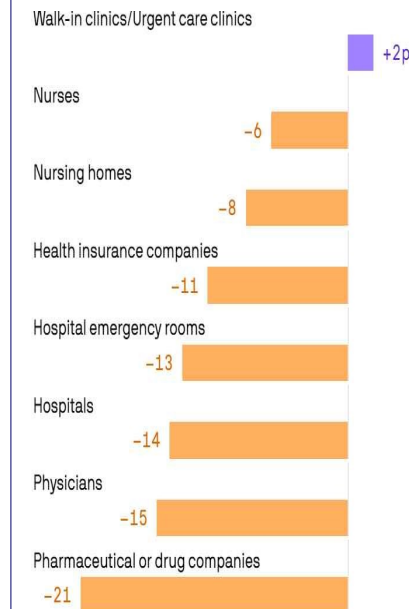


Elon Musk

Americans less satisfied with almost every part of the health system

Americans' satisfaction with almost every major part of the **health care system** has dropped since 2010, according to a new Gallup analysis.

Driving the news: Drugmakers took the biggest reputational hit, and ratings for physicians fell sharply, too.



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YOUR
NAME

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

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Older Americans Say They Feel Trapped in Medicare Advantage Plans

In 2016, Richard Timmins went to a free informational seminar to learn more about Medicare coverage.

"I listened to the insurance agent and, basically, he really promoted Medicare Advantage," Timmins said. The agent described less expensive and broader coverage offered by the plans, which are funded largely by the government but administered by private insurance companies.

For Timmins, who is now 76, it made economic sense then to sign up. And his decision was great, for a while.

Then, three years ago, he noticed a lesion on his right earlobe. "I have a family history of melanoma. And so, I was kind of tuned in to that and thinking about that," Timmins said of the growth, which doctors later diagnosed as malignant melanoma. "It started to grow and started to become rather painful."

Timmins, though, discovered that his enrollment in a Premier Blue Cross Medicare Advantage plan would mean a limited network of doctors and the potential need for preapproval, or prior authorization, from the insurer before getting care. The experience, he said, made getting care more difficult, and now he wants to switch back to traditional, government-administered Medicare.

But he can't. And he's not alone.

"I have very little control over my actual medical care," he said, adding that he now advises friends not to sign up for the private plans. "I think that people are not understanding what Medicare Advantage is all about."

Enrollment in Medicare Advantage plans has grown substantially in the past few decades, enticing more than half of all eligible people, primarily those 65 or older, with low premium costs and perks like dental and vision insurance. And as the private plans' share of the Medicare patient pie has ballooned to 30.8 million people, so too have concerns about the insurers' aggressive sales tactics

and misleading coverage claims.

Enrollees, like Timmins, who sign on when they are healthy can find themselves trapped as they grow older and sicker.

"It's one of those things that people might like them on the front end because of their low to zero premiums and if they are getting a couple of these extra benefits — the vision, dental, that kind of thing," said Christine Huberty, a lead benefit specialist supervising attorney for the Greater Wisconsin Agency on Aging Resources.

"But it's when they actually need to use it for these bigger issues," Huberty said, "that's when people realize, 'Oh no, this isn't going to help me at all.'"

Medicare pays private insurers a fixed amount per Medicare Advantage enrollee and in many cases also pays out bonuses, which the insurers can use to provide supplemental benefits. Huberty said those extra benefits work as an incentive to "get people to join the plan" but that the plans then "restrict the access to so many services and coverage for the bigger stuff."

David Meyers, assistant professor of health services, policy, and practice at the Brown University School of Public Health, analyzed a decade of Medicare Advantage enrollment and found that about 50% of beneficiaries — rural and urban — left their contract by the end of five years. Most of those enrollees switched to another Medicare Advantage plan rather than traditional Medicare.

In the study, Meyers and his co-authors muse that switching plans could be a positive sign of a free marketplace but that it could also signal "unmeasured discontent" with Medicare Advantage.

"The problem is that once you get into Medicare Advantage, if you have a couple of chronic conditions and you want to leave Medicare Advantage, even if Medicare Advantage isn't meeting your needs, you might not have any ability to switch back to traditional Medicare," Meyers said.



Traditional Medicare can be too expensive for beneficiaries switching back from Medicare Advantage, he said. In traditional Medicare, enrollees pay a monthly premium and, after reaching a deductible, in most cases are expected to pay 20% of the cost of each nonhospital service or item they use. And there is no limit on how much an enrollee may have to pay as part of that 20% coinsurance if they end up using a lot of care, Meyers said.

To limit what they spend out-of-pocket, traditional Medicare enrollees typically sign up for supplemental insurance, such as employer coverage or a private Medigap policy. If they are low-income, Medicaid may provide that supplemental coverage.

But, Meyers said, there's a catch: While beneficiaries who enrolled first in traditional Medicare are guaranteed to qualify for a Medigap policy without pricing based on their medical history, Medigap insurers can deny coverage to beneficiaries transferring from Medicare Advantage plans or base their prices on medical underwriting.

Only four states — Connecticut, Maine, Massachusetts, and New York — prohibit insurers from denying a Medigap policy if the enrollee has preexisting conditions such as diabetes or heart disease.

Paul Ginsburg is a former commissioner on the Medicare Payment Advisory Commission, also known as MedPAC. It's a legislative branch agency that advises Congress on the Medicare program. He said the inability of enrollees to easily switch between Medicare Advantage and traditional Medicare during open enrollment periods is "a real concern in our system; it shouldn't be that way."

The federal government offers specific enrollment periods every year for switching plans. During Medicare's open enrollment period, from Oct. 15 to Dec. 7, enrollees can switch out of their private plans to traditional,

government-administered Medicare.

Medicare Advantage enrollees can also switch plans or transfer to traditional Medicare during another open enrollment period, from **Jan. 1 to March 31**.

"There are a lot of people that say, 'Hey, I'd love to come back, but I can't get Medigap anymore, or I'll have to just pay a lot more,'" said Ginsburg, who is now a professor of health policy at the University of Southern California. **Read More**

Point of information.

Medicare pays the 80%, and Supplemental insurance pays the 20%.

As the RI ARA President, I have both Traditional Medicare and a Medicare supplement. I pay \$290.00 a month for my supplemental insurance



John A. Pernorio
RI ARA
President

I spent from October 12, 2023 to November 1, 2023 in a hospital and Skilled Nursing Facility (SNF). I just received my Medicare Explanations of Benefits and for those three weeks, the cost was over \$24,000.

Let me make this immensely clear, because I have both insurances, I PAID \$0, NOTHING, out-of-pocket co-payments or anything else. The supplemental insurance even picks up the yearly Medicare Deductible.

I have no co-payments for doctor visits, X-Rays, Specialist, ER visits, MRI's, CAT Scans, or SMF. If fact, Medicare and the supplement is paying in full for my new \$3600 power Chair.

I also have a home health care company that comes for nursing, PT and OT twice a week at a billed rate of \$900 per week. Again, NO-COPAYMENT.

Moral of the POINT OF INFORMATION is, if you can afford the Medicare Advantage plans \$5-8 thousand dollar a year deductible and still have to pay co-payments, why don't you look into Traditional Medicare and a Medicare supplement plan????

Social Security Has an Immigration Problem -- and It's Getting Progressively Worse



Based on the responses of retirees from more than 20 years of annual surveys from national pollster Gallup, **Social Security income** is indispensable.

Between 80% and 90% of then-current retirees said they lean on their monthly Social Security check to cover at least a portion of their expenses.

Ensuring that the foundation of America's top retirement program remains strong for current and future generations of retired workers is paramount.

Unfortunately, this 88-year-old program is exhibiting signs of distress, and immigration issues are one of the core reasons why.

America's top retirement program is facing a long-term funding shortfall of \$22.4 trillion

Every year since monthly retired-worker payouts began in 1940, the Social Security Board of Trustees has released a report that examines the program's current balance sheet and forecasts its financial health over the short run (next 10 years) and long term (next 75 years). The trustees take into account a number of factors, including demographics changes, along with shifts in fiscal and monetary policy, when issuing their forecast on Social Security's financial outlook.

Since 1985, the Trustees Report has cautioned that America's leading retirement program can't meet its long-term funding obligations. In plainer English, the projected revenue collection in the 75 years

following the release of a report won't be sufficient, including cost-of-living adjustments, to cover benefit outlays and administrative expenses. As of the 2023 Trustees Report, Social Security is **facing a \$22.4 trillion (and growing) unfunded obligation shortfall.**

The more immediate issue is the asset reserves for the Old-Age and Survivors Insurance (OASI) Trust Fund. This is the fund responsible for dishing out benefits to 50 million retired workers and roughly 5.8 million survivor beneficiaries each month. If the OASI's excess cash built up since inception were to be depleted by 2033, as currently forecast, **sweeping benefit cuts of up to 23% may be necessary** to sustain payouts through 2097 without the need for any further cuts.

Put another way, **Social Security is in no danger of going bankrupt**, or becoming insolvent and disappearing. But it may not be able to sustain its existing payout schedule as soon as nine years from now. The bulk of Social Security's growing cash shortfall can be traced to ongoing demographic shifts. Some of these are well known, such as the retirement of baby boomers and increased longevity since Social Security payouts began more than eight decades ago. Others are perhaps less obvious, such as **growing income inequality and historically low birth rates.**

But the one demographic shift that's causing all sorts of



problems for Social Security has to do with the rate of immigration into the United States.

Social Security's immigration problem has been worsening for 25 years

Peruse social media message boards and you'll undoubtedly find some very heated and contentious discussion of the role immigration appears to be playing on our nation's top retirement program.

In particular, there's the belief that undocumented workers are a strain on Social Security and one of the root causes of the program's growing funding obligation shortfall. However, this thesis couldn't be further from the truth.

Social Security is a program that's **heavily reliant on people legally migrating into the U.S. each year.** Most people who move to the U.S. tend to be younger, which means they'll spend decades in the labor force. Social Security collects approximately 90% of its annual revenue from the 12.4% payroll tax on wages and salaries (up to \$168,600 in 2024).

The dilemma for Social Security is that **net migration into the U.S. peaked a quarter of a century ago** and has been precipitously declining every year since then. According to data from the United Nations, the net migration rate for the U.S. per 1,000 people has fallen from 6.48 in 1998 to 2.748 in 2023, representing a nearly 58% drop in legal net immigration.

With the U.S. population reaching nearly 340 million in

2023, a net migration rate of 2.748 per 1,000 people translates to roughly 934,300 net legal migrants entering the United States. The 2023 Trustees Report bases its \$22.4 trillion funding shortfall estimate on average annual net immigration of 1.245 million people through 2097. In other words, a continued decline in the legal net migration rate will almost certainly result in a larger expected funding obligation shortfall over the coming 75 years.

Immigration is a net positive for the traditional Social Security program

Interestingly enough, legal immigration isn't the only thing that provides a net benefit to the traditional Social Security program, which includes payments made by the Social Security Administration (SSA) to retired workers, workers with disabilities, and survivor beneficiaries.

One of the most common issues with immigration discussions surrounding Social Security is that the traditional Social Security program and **Supplemental Security Income (SSI)** are conflated.

Although both programs are overseen by the SSA, **they have very different funding sources.** Whereas traditional Social Security is funded through a combination of payroll taxation, the taxation of benefits, and interest income earned on the program's asset reserves, SSI is funded via the General Fund..
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Few Beneficiaries Know Part D Out-of-Pocket Cap Now in Effect

A newly effective Inflation Reduction Act (IRA) provision is improving prescription drug affordability for **many people** with Medicare Part D — but too few know about it, potentially limiting its efficacy.

As of January 1, 2024, Part D enrollees are no longer required to pay 5% coinsurance after they reach the catastrophic threshold. According to a new **KFF report**, this means that in 2024, Part D enrollees will pay no more than about \$3,300 for all brand-name drugs they take. And starting in

2025, out-of-pocket (OOP) drug spending will be capped at an even lower amount, \$2,000, indexed annually for growth in Part D costs.

Although 5% may not seem like much, with many drugs priced at **\$150,000 or more** per year, it can add up quickly. Affording thousands of dollars in medication costs a year can be particularly burdensome for people with Medicare, many of whom live on fixed or limited incomes that cannot keep pace



with high and rising prescription drug prices. To illustrate the impact of this coinsurance change, KFF examined three commonly taken cancer drugs, each priced at well over \$100,000 a year. In 2023, Medicare Part D enrollees who used any of these drugs for the entire year faced nearly \$12,000 in OOP costs. In 2024, their portion will drop by eight to nine thousand dollars. And next year, when the \$2,000 cap takes effect, they'll save even more.

Notably, recent **KFF polling** finds only a quarter of older adults know about this change to Part D coinsurance rules. This suggests an urgent need for beneficiary outreach and education, as cost concerns may be preventing some people from getting the treatment they need. If you or someone you know has questions about navigating or affording Medicare, **call Medicare Rights** National Helpline at 800-333-4114, or your local SHIP

FDA finally clears Florida to import prescription drugs from Canada

The Food and Drug Administration on Friday cleared the way for Florida's first-in-the-nation plan to import lower-priced prescription drugs from Canada, a long-sought approach to accessing cheaper medications that follows decades of frustration with U.S. drug prices.

Gov. Ron DeSantis signed the plan into law in 2019, but it required federal review and approval by the FDA, which controls prescription drug imports.

Democratic President Joe Biden has backed such programs as a way to lower prices, signing an executive order in 2021 that directed the FDA to work with states on imports.

The policy change represented a seismic shift after decades of lobbying by the pharmaceutical industry, which said imports would expose U.S. patients to risks of counterfeit or adulterated drugs. The FDA also previously warned of the difficulties of assuring the safety of drugs originating from outside the U.S.

But the politics have shifted in recent years, with both parties — including former President

Donald Trump — doubling down on the import approach.

The FDA said Florida's program will be authorized for two years. Under federal requirements, state officials must test the drugs to make sure they're authentic and relabel them so that they comply with U.S. standards.

The state must also provide a quarterly report to the FDA on the types of drugs imported, cost savings and any potential safety and quality issues.

"These proposals must demonstrate the programs would result in significant cost savings to consumers without adding risk of exposure to unsafe or ineffective drugs," FDA Commissioner Dr. Robert Califf said in a statement.

Friday's approval came after lengthy wrangling about the plan and the state filing two lawsuits against the FDA.

"They have set up a number of hoops," state Agency for Health Care Administration Secretary Jason Weida told the House Health Care Appropriations Subcommittee last month. "We



have jumped through them all."

DeSantis and then-Florida House Speaker Jose Oliva, R-Miami

Lakes, made the issue a priority, with the state submitting a proposal to the FDA in November 2020.

The lengthy review included the FDA seeking revisions to the plan. The state filed a revised proposal in October to try to address the federal agency's concerns, according to court documents.

Among the issues was the FDA noting Florida's proposal lacked a secured warehouse within 30 miles of an "authorized port of entry" for prescription drugs. The only authorized port of entry was Detroit, while Florida planned to store shipments at a facility in Indiana.

In one of the lawsuits, the state said the program was "stuck in the starting blocks" and that "the FDA has dragged its feet for so long."

The state's lawyers wrote that "it seems the most likely explanation for the FDA's delay, in the face of near universal

support for importation programs, is the FDA's longstanding symbiotic relationship with big pharmaceutical companies that stand to lose hundreds of millions of dollars if Florida's SIP proposal is approved."

In a reply, the Biden administration denied the allegations.

Many people already buy at least some of their medicines from pharmacies in Canada or Mexico, although technically it's illegal to import them.

Work on allowing state imports began under Trump, a relentless critic of industry pricing.

Under the current regulations, states can import certain medicines through pharmacies and wholesalers. DeSantis has previously estimated taxpayers could save up to \$150 million annually under the program. The state's proposal includes a number of drug classes, including medications for asthma; chronic obstructive pulmonary disease, or COPD; diabetes; HIV and AIDS; and mental illness....[Read More](#)

UnitedHealth's denials of critical rehab services is under investigation

[Stat News](#) reports on United HealthCare's secret rules that deny Medicare Advantage enrollees critical and costly rehab care when they most need it. UnitedHealth literally singled out people with cognitive impairments and nursing home residents for exclusion from coverage of rehab services, even though they needed these services. But, Congressional and administrative scrutiny on UnitedHealth's practices appear to be affecting the insurer's behavior for the better, at least for now.

Stat News obtained internal UnitedHealth documents that advised clinicians who worked for the insurer to deny people care that their treating physicians said was medically necessary. But, in November 2023, the clinicians' managers told the clinicians that they could consider the individual needs of each patient to determine whether rehab services were medically necessary. Not

surprisingly, that directive came on the heels of a [Congressional investigation](#) into UnitedHealth's practices and the Centers for Medicare and Medicaid Services (CMS) saying that it was about to look more closely at UnitedHealth's denials of services to its Medicare Advantage enrollees.

Stat News has been reporting on the use of AI by UnitedHealth and other insurers offering Medicare Advantage plans to deny care without regard to patient needs. According to some experts, UnitedHealth has been denying care based on rules that have no evidence base. For example, UnitedHealth's AI algorithms for determining whether care is medically necessary apparently denied rehab care across the board to most nursing home residents rather than looking at people's individual care needs as required under Medicare law.



Some of these nursing home residents were recovering from strokes, big falls and cancer and desperately required rehab services to regain function. Yet, while Medicare Advantage enrollees are supposed to have coverage for the same benefits as people in traditional Medicare, they too often do not.

Even if you are not enrolled in a UnitedHealth Medicare Advantage plan, you may still have cause for concern. Many Medicare Advantage insurers use NaviHealth's AI algorithms to deny rehab care. In total, around 15 million Medicare enrollees are at risk.

NaviHealth has denied the charges against it, claiming that it does review "complex" cases to determine medical necessity. It also claims that the change in protocols to give clinicians more discretion in approving care was unrelated to Congressional and CMS investigations into its

practices. "Following a standard review of protocols, we identified an opportunity to simplify care approvals in certain clinically complex conditions that do not require escalated review by a physician medical director for approval. Any adverse coverage decision is made by physician medical directors based on Medicare coverage criteria and supporting clinical records."

Unfortunately, CMS does not begin to have the resources or the power to hold UnitedHealth and other Medicare Advantage insurers accountable for their bad acts in meaningful ways. Consequently, people enrolled in these Medicare Advantage plans who end up needing costly and complex care could be at serious risk. Moreover, UnitedHealth and other Medicare Advantage insurers can change their practices at any time to restrict care access, with near impunity, as CMS is not likely to know and penalties are at most mild.

Some hospitals gouge Americans because they can

One of the many benefits of Medicare is that your costs are the same no matter where you get care in a community. Consequently, people with Medicare do not have to “shop” for where they get care in order to keep their costs down. But, as **Bloomberg News** reports, some hospitals gouge non-elderly Americans because they can; people can reduce their costs only if they are willing to “shop” for where they get their care.

Our health care system should not encourage shopping for health care. Everyone in a given region should pay the same price. Otherwise, people who need care urgently, people with cognitive conditions, people who cannot drive long distances, among others, could be forced to forgo needed care or to pay a

premium to get that care. Moreover, since the cost of hospital services is generally not bundled and rarely do people know the range of services they will need, it's near impossible to know whether the whole bundle of costs will be lower at one place or another.

Bloomberg News describes how one woman, who was in labor, drove 45 minutes to get to a hospital that would charge her less to deliver her baby. It saved her “thousands of dollars.” Her total cost was \$8,354 and she was responsible for \$2,500. But, had she gone to a hospital closer to home in Monterey County, the cost for delivery of her baby could have been as much as \$40,000.

Throughout the US, some hospitals charge a lot more than



other nearby hospitals. And, there is **no correlation between higher hospital prices and better quality**

care. But, high hospital costs drive up health insurance premiums.

In 2023, Americans spent \$4.5 trillion on health care. A lot of that money goes to hospitals.

As a result of recent legislation, hospitals must post their prices for public review. But, is that enough? And, what explains the large price disparities within a region?

While high hospital costs can stem from high staffing or maintenance costs or the simple ability of hospitals to set their prices as they will, some hospitals charge some insurers way more for their services than others because some insurers

deny a lot of their claims or otherwise require them to expend more resources to get patients the care they need.

Today, according to Rand research, companies pay more than double what Medicare pays for the same services. In Indiana, companies pay almost three times what Medicare pays.

Hospital prices are likely to continue to rise at an unsustainable rate if the government does not step in. Meaningful hospital competition is lacking. Ninety-six percent of hospitals are in non-competitive markets. **MedPAC**, which oversees Medicare payment and quality issues, recommends that Medicare continues to put financial pressure on hospitals to keep costs down.

Administration Provides More Data on First 10 Drugs Subject to Price Negotiation

Last month, the office of the Assistant Secretary for Planning and Evaluation (ASPE), a research arm of the Department of Health and Human Services (HHS), **released a report** on the background, use, and costs of the **10 drugs** selected for the first-ever Medicare price negotiation process.

The medications were chosen based on criteria outlined in the Inflation Reduction Act. The law requires HHS to prioritize drugs with the highest Medicare spending and no competition, among other factors. The resulting list includes medications that millions of Medicare beneficiaries rely on to treat conditions such as cancer, diabetes, blood clots, heart failure, autoimmune conditions, and chronic kidney disease. Price negotiations between CMS and the participating drug manufacturers are in process. CMS will publish the final prices this fall, and they will take effect in 2026. **Additional medications** will be selected for negotiation in the **coming years**.

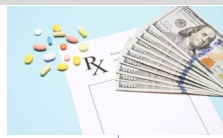
The ASPE analysis addressed not just how much the drugs cost Medicare and beneficiaries, including specific populations; how long they have been on the market; whether federal funding

aided their development; what conditions the drugs treat and the prevalence of those conditions in the Medicare population; health disparities in their use; and affordability concerns.

According to the report, Medicare spending for the 10 selected drugs—Eliquis, Jardiance, Xarelto, Januvia, Farxiga, Entresto, Enbrel, Imbruvica, Stelara, and NovoLog—represented around 19% of all Part D spending at \$46.4 billion in 2022. This is up from \$20 billion in 2018.

Beneficiaries paid around \$3.4 billion out-of-pocket for these drugs in 2022.

There is a wide variation in the costs of the individual drugs. For example, the first and most prescribed drug on the list, Eliquis—used to prevent and treat blood clots—was not as expensive as some of the other drugs at \$4,342 per enrollee per year but is being taken by a relatively high portion of the Medicare population, 6.6%. In total, Medicare, beneficiaries, and plans spent over \$15.2 billion on Eliquis in 2022 and 17% of the 3.5 million enrollees taking Eliquis spent over \$1,000



out-of-pocket for the drug that year.

By comparison, Imbruvica—used to treat blood cancers—

was the most expensive drug on the 2022 list per enrollee at \$128,548 for the year, with 64% of users spending more than \$1,000 out-of-pocket. Total Imbruvica spending was lower, \$2.8 billion in 2022, because it was only taken by 22,000 people. The least expensive drug on the list was Novolog at \$3,323 per enrollee for the year, with 763,000 users. Unsurprisingly, people taking Imbruvica spent the most out-of-pocket for their drug, averaging \$5,290 annually, while those taking Novolog spent the least, averaging \$208 annually.

The report also contains spending information broken down across demographics, states and territories, and low-income subsidy (LIS) enrollment. It touches briefly on whether the drugs received federal financial support in their development. ASPE examined several specific forms of such assistance, finding seven of the 10 drugs received at least one form of support. To illustrate the impact of federal contributions on biomedical research and development, ASPE

gives a case study comparing one drug, Jardiance—which publicly disclosed receiving support—to another drug, Entresto, which did not. Notably, ASPE clarifies its methodology is based on proxy measures, and the true levels of government support for each drug may vary.

This report sheds light on the potential impact of drug price negotiation for these drugs. While the savings that any individual beneficiary may see will depend on the yet-to-be-achieved price reductions, lower costs are expected system-wide. Notably, the Congressional Budget Office (CBO) anticipates the negotiations to save Medicare **\$98.5 billion** over a decade **as well as** reduce expenses for beneficiaries and taxpayers. Critically, the program will do so while bolstering health outcomes and program solvency. CBO notes the lower drug prices will increase medication adherence, improving beneficiary health and reducing the need for, and Medicare spending on, more costly care. At Medicare Rights, we **strongly support** efforts to bring down drug prices for individuals and the programs that serve them.

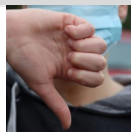
For-profit hospitals urge CMS to hold Medicare Advantage plans to account for wrongful denials

Over the last several decades, US hospitals, particularly the for-profit hospitals, generally have not been the best of allies with the organizations representing people with Medicare and other Americans. But, when it comes to Medicare Advantage, the hospitals continue to speak out vociferously against corporate health insurers for delaying and denying critical treatment and failing to pay the hospitals appropriately for the care they deliver. The Federation of American Hospitals, which represents the for-profit hospitals, is now asking the Centers for Medicare and Medicaid Services (CMS) to evaluate Medicare Advantage plans based on how frequently their prior authorization denials are overturned, reports Rylee Wilson for **Becker's**.

The **star-rating system for evaluating Medicare Advantage**

plans is a farce. Medicare Advantage plans with five-star ratings could still have high denial and delay rates. The system misleads people. The star-rating system should be an important measure for assessing Medicare Advantage plans. If CMS's star-rating system gave substantial weight to Medicare Advantage plan denial and delay rates as well as overturn rates for prior authorization denials, it could help warn people about poor performing health plans.

The Federation of American Hospitals shared its proposal to CMS with Becker's but does not appear to have posted it online. It argues that adding prior authorization denial overturn rates as a measure in its Medicare Advantage star-ratings system "will enhance CMS's oversight of MA plans' denial of prior authorization and payments and



provide beneficiaries with needed insight to inform their decision-making." Of course, adding prior authorization denial

overturn rates as a measure is only as valuable as the data CMS collects is accurate and timely. Right now, CMS does not get complete, accurate or timely data from the Medicare Advantage plans. Without a complete overhaul in how CMS collects data—prior authorization denials should go to CMS at the same time as they go to providers—it's not clear that this new measure will help Medicare enrollees or enhance CMS oversight.

The Medicare Payment Advisory Commission reports that 80 percent of prior authorization denials were ultimately approved on appeal in 2021. The Federation of American Hospitals argues that this high overturn rate shows that

insurers are "intentionally" denying and delaying needed care.

Many members of Congress are also concerned about prior authorization denials and **want MA plans to report more data.**

Because insurers know that they can maximize their profits through delays and denials of care and coverage and can do so with near impunity, it appears that inappropriate delays and denials are on the rise. And, **hospitals are cancelling their contracts with MA insurers** to protect themselves and their patients. CMS has not addressed this issue effectively to date.

People enrolled in Medicare Advantage plans should beware, especially given the likelihood that they will face these obstacles to care when they develop a complex or costly conditions.

Employer-based health care doesn't work for people with lower incomes

About 60 percent of people who are not over 65 have employer-sponsored health insurance, reports the **Kaiser Family Foundation**. But, a significant portion of people eligible for employer coverage, primarily people with incomes under 200 percent of the federal poverty level, **do not take it because of the cost.**

Nearly 165 million people or about half the US population has employer-based health insurance. More than four in five employers offer coverage. As health care costs continue to rise and insurers delay and deny care and narrow their health care provider networks, even with insurance it can be hard to get care.

The high cost of health insurance and the ability of employers to charge their workers for it mean that our health care system discriminates against people with lower incomes even when they are eligible for employer coverage. Not even one in four (23.9 percent) people with incomes under 200 percent of the federal poverty level, who are eligible for employer-sponsored health insurance, elect it. Six in ten eligible (59 percent) people with incomes between 200 and 400 percent of the federal poverty level elect it. But, more than eight in ten (84.2 percent) people with incomes above 400 percent of the federal poverty level elect it.



Similarly, people with incomes under 200 percent of the poverty level were far less likely to work at a job that offered employer-sponsored health insurance than people with incomes over 400 percent of the poverty level, 60.6 percent versus 88.2 percent. Because employers do not have to offer health insurance to all their workers, people with lower incomes end up less likely to have a job that offers them health insurance. About half of workers (49.5 percent) with incomes under 200 percent of the poverty level were eligible for coverage as compared to 84.6% of workers with incomes above 400% of the federal poverty level.

Employer-based health insurance also leads to racial discrimination, benefiting White individuals far more than non-White people. Black people, Hispanic people and American Indians are significantly less likely to take advantage of employer-based coverage than White people. Not even four in ten American Indians (39.6 percent) get employer-based coverage for which they are eligible, as compared to 68.4 percent of White people. Forty-five percent of Hispanic people and 52.6 percent of Black people get employer-based coverage....**Read More**

Seniors: These are the issues you need to care about this year

We've turned the page on a new year. What will 2024 hold for America's seniors? In interviews, four of the country's leading senior advocates outlined their priorities and stressed one constant — the urgent need to bolster the long-term viability of Social Security and Medicare.

The clock is ticking "Social Security and hospital benefits in Medicare are funded by trust funds that, to put it

bluntly, are going broke," warns **Maya MacGuineas**, president of the Washington, D.C.-based Committee for a Responsible Federal Budget. With both programs' trust funds scheduled to run out within a decade — which would mean projected cuts of 23% for Social Security and of 11% for Medicare hospital-insurance payments — she warns that time is running out



for lawmakers to act. Hard choices and trade-offs are inevitable, MacGuineas says, and by that she means what's needed is "a combination of revenue increases and spending cuts to bring the two in line." There is still time to act, she says, but not much.

"The worst option is to do nothing and let these automatic cuts happen," says MacGuineas.

"And the path we're on right now would cause that to happen."

She is encouraged, meanwhile, by some developments in 2023, which she said was "the largest year for deficit reduction in a decade with the passage of the Fiscal Responsibility Act, which will reduce 10-year projected debt by \$1.5 trillion. But much more is needed to prevent trust-fund exhaustion and stabilize the debt." **Read More**

Could 'Early Birds' Be at Higher Risk for Anorexia?

People who are early risers appear to be at greater risk of developing anorexia, a new study claims.

This differs from other disorders like depression, binge eating and schizophrenia, all of which appear to be associated with folks being “night owls,” the researchers noted.

“Our findings implicate anorexia nervosa as a morning disorder in contrast to most other evening-based psychiatric diseases and support the association between anorexia nervosa and insomnia as seen in earlier studies,” said senior study author **Hassan Dashti**, an

assistant investigator in Massachusetts General Hospital’s Department of Anesthesia, Critical Care and Pain Medicine in Boston.

Previous research has suggested a link between eating disorders and the internal clock of the human body, which controls sleep cycles and affects nearly every organ in the body, researchers said in background notes.

For this study, the team examined genes specifically associated with anorexia, looking to see whether people with a higher genetic risk for the disorder also tended to have a



specific sleep cycle. The team discovered a two-way association between genes linked to anorexia and genes associated with waking early and going to bed early. Having anorexia could lead a person to be an early bird, and an earlier wake time could mean a person is at higher risk of anorexia.

An elevated genetic risk score for anorexia was also associated with a higher risk of insomnia, researchers found.

Anorexia has the second-highest death rate among psychiatric diseases and is very difficult to treat, researchers

noted. Current therapies for anorexia have relapse rates up to 52%.

The researchers hope these new findings could help the development of new sleep-based treatments for anorexia.

“The clinical implications of our new findings are currently unclear; however, our results could direct future investigations into circadian-based therapies for anorexia nervosa prevention and treatment,” lead author **Hannah Wilcox**, a researcher at Massachusetts General, said in a hospital news release.

The U.S. Health Care Spending Exceeds Six Countries Combined

According to a report in StatNews, “... the U.S. government spent more on health care last year than the governments of Germany, the U.K., Italy, Spain, Austria, and France combined spent to provide universal health care coverage to the whole of their population (335 million in total), which is comparable in size to the U.S. population of 331 million.”

The article points out that “This isn’t an aberration. The fact that, for many years, more

taxpayer dollars have gone to health care in the U.S. than in countries where the health system is actually meant to be taxpayer-funded is central to the argument made by economists Amy Finkelstein and Liran Einav in their recent book, ‘We’ve Got You Covered: Rebooting American Health Care.’”

The U.S. devotes more resources to health care than any other country, with patients, employers, and government health programs spending \$4.5



trillion last year. Hospitals get the biggest share by far, taking in more than three times what Americans pay at

the pharmacy on prescription drugs. Rising hospital prices have helped make health insurance more costly..

Yet higher prices generally aren’t linked to better care, according to a 2020 review of dozens of studies. And while hospitals often say they must charge insurers more to make up for lower reimbursements from

U.S. government health plans, facilities that treat more patients on public plans don’t always charge the highest prices.

Thanks to decades of consolidation, most U.S. hospitals don’t have a nearby competitor. Just 4% of hospitals are in competitive markets based on standard measures of market concentration, according to a Bloomberg News analysis of data from Yale University’s Tobin Center for Economic Policy.

Medicare IRMAA: What You Should Know for 2024

Medicare can be a complex web, and untangling its various strands to ensure you’re getting the most appropriate coverage can be daunting. One thread you might find yourself unsnarling is income-related monthly adjustment amounts, or IRMAA.

In this article, we’ll go through the basics of what IRMAA entails and who might qualify for this additional fee.

What Is IRMAA?

Medicare IRMAA is an income-based surcharge that couples or individuals must pay on top of existing premiums for **Medicare Part B** (coverage for preventive care, doctor visits and outpatient care) and Medicare Part D (prescription drug coverage).

IRMAA is based on your modified adjusted gross income,

also referred to as MAGI, from your tax filings two years prior to your enrollment date. For example, you would qualify for IRMAA in 2024 if your MAGI from your 2022 tax returns meets the 2024 income thresholds (\$103,000 for beneficiaries who file individual tax returns and \$206,000 for those who file joint tax returns), according to the Centers for Medicare & Medicaid.

“I call it the Robin Hood theory because the government takes from the rich, but instead of giving it to the poor, they just use it to fund the Medicare trust fund,” says Darren Hotton, associate director of community health and benefits at the National Council on Aging, based in the Washington, D.C.,



area. Who pays IRMAA fees? Only those enrolled in Medicare Parts B and D

need to pay IRMAA fees. If you’re enrolled in Part A (hospital, skilled nursing facility and other inpatient coverage), IRMAA doesn’t apply.

Do IRMAA fees apply if I have Medicare Advantage?

Medicare Advantage, also known as Part C, differs from Medicare Parts A and B. Known as “original Medicare,” Parts A and B are government-funded. With Medicare Advantage, government-approved private insurance companies provide comparable coverage.

If you’re enrolled in Medicare Advantage, you are still required to pay for Medicare Part B. If

you qualify for IRMAA, then you’re paying:

- ◆ The monthly Part B premium.
- ◆ The IRMAA fee.
- ◆ The Medicare Advantage plan’s monthly premium.

IRMAA also applies if you’re enrolled in **Medicare Part D**, which is the separate drug prescription plan, though some Medicare Advantage plans fold in prescription coverage. If you’re enrolled in Part D in addition to your Medicare Advantage plan, you’ll pay:

- ◆ The monthly Part D premium.
- ◆ The IRMAA fee.
- ◆ The Medicare Advantage plan’s monthly premium....**Read More**

Coronavirus: Beware of the latest Covid strain

If you're careful and lucky, you have yet to fall prey to the latest strain of Covid hitting people in the US, JN.1. But, large numbers of Americans are coming down with it, reports Adriel Bettelheim for [Axios](#), so beware. Fortunately, the symptoms tend to be mild, including dry coughs and fatigue.

I recently caught Covid, for the first time, sitting next to someone who did not stop coughing and sneezing, on a plane trip to visit my 88-year old aunt. As soon as I saw that my seatmate was ill, I put on two

masks, but it was too late. So, instead of caring for my aunt, she ended up having to take care of me!

I had a very mild case of Covid and recovered in a few days, though I continued to test positive for a week. My worst symptom was exhaustion. I think I slept 12 hours for the first two nights, but I had no respiratory symptoms. I'd like to believe that all the Covid booster shots I've gotten helped minimize symptoms, but who knows.

The experts at the Centers for Disease Control and Prevention



(CDC) believe that this latest Covid strain is likely better at getting around our immune systems than other strains because so many people are catching it. Time will tell whether more people will be hospitalized as a result of catching it. As of now, there are relatively few hospitalizations.

People in the Northeast have been most likely to be infected by the JN.1 Covid strain.

According to the CDC, people who have had vaccines should be better off fighting the JN.1 strain. And, the World Health

Organization believes it poses low risks to the public health. If you end up with respiratory symptoms, you should talk to your doctor.

If you do catch Covid, you should be immune for at least a few months afterwards. Once your body has successfully fought off the virus, it is as if you have been vaccinated.

Keep in mind that Covid symptoms tend to be similar to flu symptoms. And, there are a lot of people who are catching the flu this winter. To know whether you have Covid, take a Covid test.

Paxlovid Won't Cut Odds for Long COVID: Study

Paxlovid might help shorten and diminish a COVID infection, but the antiviral doesn't reduce the risk of developing long COVID, a new study shows.

About 16% of COVID patients treated with Paxlovid wound up with long COVID symptoms, compared to 14% of those not given the oral medication, researchers found.

"Our finding that Paxlovid treatment during acute infection is not associated with lower odds

of long COVID surprised us, but it is consistent with two other rigorously conducted studies finding no difference in post-COVID conditions between 4 and 6 months after infection," said lead author [Dr. Matthew Durstenfeld](#), an assistant professor of medicine at the University of California, San Francisco.

Paxlovid is recommended for treating people at high risk for



severe COVID infection, to ease symptoms and keep them out of the hospital.

But there's been some debate regarding whether the drug could prevent long COVID, in which symptoms caused by the initial infection can last for weeks, months or even years.

For this study, Durstenfeld and his colleagues followed up on COVID patients treated between March and August 2022, to see if

they had developed long COVID.

Not only did Paxlovid not prevent long COVID, but the researchers found those who took the drug went on to have as many long COVID symptoms as those who didn't.

The most common long COVID symptoms included fatigue, shortness of breath, confusion, headache and altered taste and smell...[Read More](#)

FDA Looking Into New Risks With Popular Weight-Loss Drugs

The U.S. Food and Drug Administration is investigating reports of additional dangers linked to several wildly popular weight-loss drugs.

In a [quarterly report](#) issued this week, the agency said it is investigating cases of hair loss; aspiration (when food or other objects get into the airways); and suicidal ideation in people who used the medications. Some of the drugs in this class, known as GLP-1 receptor agonists (GLP-1 RA), include Ozempic, Wegovy, Mounjaro and Zepbound.

While these reports can turn out to be false alarms, previous investigations have prompted the FDA to update a drug's labeling or call for additional study on the issue.

This isn't the first time the agency has looked into potential complications with these weight-

loss drugs: Last year, the agency investigated [reports](#) of intestinal obstructions linked to the medications. Ozempic's labeling was subsequently updated to acknowledge that risk, *CBS News* reported.

"We are aware that, as part of those monitoring efforts, [the] FDA is evaluating several potential signals related to GLP-1 RA medicines and has posted information about those ongoing assessments on its website," a spokesperson for Novo Nordisk, which makes Ozempic and Wegovy, told *CBS News*.

"Novo Nordisk stands behind the safety and efficacy of all of our GLP-1 RA medicines when they are used as indicated and when they are taken under the care of a licensed healthcare



professional," the spokesperson added. A spokesperson for Eli Lilly, which produces

Zepbound and Mounjaro, told *CBS News* the "FDA is reviewing data on certain potential risks for GLP-1 receptor agonist medicines. Patient safety is our priority, and we are collaborating with the FDA on these potential signals."

Through September, there have been 201 reports of suicide or suicidal ideation among patients taking medications with semaglutide, the key ingredient in Ozempic and Wegovy, or tirzepatide, the key ingredient for Zepbound and Mounjaro.

Meanwhile, there have been at least 422 reports of hair loss. A number of other medications have been linked to hair loss, including some

antidepressants and birth control pills, *CBS News* reported.

A less common danger has also been reported to the FDA: There were 18 cases of patients taking semaglutide or tirzepatide that mention aspiration, when people accidentally inhale food or other objects into their airways.

In a [case report](#) published in March, Canadian doctors said a patient who had too much food left in the stomach despite fasting for 18 hours before an operation. Two months earlier, the patient had begun injections of semaglutide for weight loss.

In June, the American Society of Anesthesiologists [called](#) for patients to stop taking these weight-loss medications before elective operations because of this potential complication.

Hearing Aids May Boost Longevity But Must Be Used Regularly

A new study has found that restoring hearing loss with hearing aids may lengthen people's lives.

Dr. Janet Choi, an otolaryngologist with Keck Medicine of USC, wanted to evaluate whether restoring hearing with hearing aids could increase the chances of living longer, so she and her colleagues tracked the status of nearly 1,900 adults who had been shown to have hearing loss during screenings.

They found that patients using hearing aids regularly had a 24% lower risk of mortality compared

to the group who never used hearing aids. The researchers had hypothesized this would be the case, given previous studies pointing to the negative impacts of untreated hearing loss, but they did not expect such a big difference in mortality risk.

The study, which was published in *The Lancet Healthy Longevity* Wednesday, adds to the evidence of benefits from hearing aids found in prior research but does not necessarily prove that it's the hearing aids that lead to longer life — it could be that people who regularly use



hearing aids are also more likely to stave off isolation, remain more active or have reduced risk of falls, which could explain the increased

longevity. The effect held up even when the researchers took into account differences such as age, ethnicity, education and medical history.

Approximately 40 million adults in the U.S. have hearing loss, but most don't use hearing aids. Given the benefits, Choi says it's stunning how few people with hearing loss wear hearing aids regularly — just 12%, according to her study.

Another striking finding was that the people in the study who had hearing aids but didn't use them regularly were as likely to die prematurely as those who never used them.

"We now have more affordable over-the-counter hearing aids thanks to President Biden's policies," said **President of the Alliance, Roach**. "They make an enormous difference for the hearing-impaired, both socially and in their overall health — we just need to use them."

Crohn's, Colitis Vary by Race, Gender

Crohn's disease and ulcerative colitis show different patterns of incidence by race, gender and even place of birth, a new U.S. study finds.

The two illnesses are each classified as an inflammatory bowel disorder (IBD) -- conditions that trigger a chronic inflammation of the gastrointestinal tract.

The new research, from Rutgers University and other centers, found IBDs vary widely, according to patient demographics.

"IBD has historically been a disease of Caucasian populations in Europe and North America, but now we're seeing it among all races and in people all over the globe, so it's now important to study how it manifests in different groups," noted study senior author **Lea Ann Chen**. She's an assistant professor of

medicine and pharmacology at Rutgers Robert Wood Johnson Medical School in New Brunswick, N.J.

Chen's team analyzed the medical records of 525 patients who underwent treatment for an IBD at New York City's Bellevue Hospital between 1997 and 2017.

Bellevue is a "safety net" hospital, where most patients are of similar income, the researchers noted. The patients were racially diverse, however: 29.8% white, 27.4% Hispanic, 21.7% Black and 13% Asian.

That diversity was mirrored in the patient profiles for both Crohn's and ulcerative colitis. Using white patients for comparison purposes, Chen's team found that:

◆ Among Asian patients, men were twice as likely to have an IBD as women, regardless of



whether they'd been born in the United States or abroad.

◆ Black patients were more than twice as likely to require a resection (surgical removal) of part of their intestine, compared to white patients.

◆ Crohn's diagnoses were more likely among Black patients born in the United States, whereas colitis was more likely among Black patients born abroad.

◆ Symptoms of ulcerative colitis and Crohn's tended to be milder if the patient had not been born in the United States, regardless of their race. These patients typically were diagnosed later in life, required fewer surgeries and medications, and had fewer complications, compared to

native-born Americans.

The last finding was "particularly true among Black patients," Chen noted in a Rutgers news release. "Those who were born here were far more likely to develop Crohn's disease and its complications compared to those who were born abroad."

In other cases, genes may have played a role.

For example, "the difference in case numbers between Asian men and women was striking, and that difference appeared both among U.S.-born and foreign-born patients," Chen noted. "It appears that East Asian women -- because most of the Asian patients in our study population were East Asian -- may have some sort of genetic protection against IBD."

The study was published recently in the journal ***Gastro Hep Advances***.

Understanding Sundowning: Symptoms, Causes and Coping Strategies

Learn about sundowning syndrome, a condition characterized by increased confusion and agitation in the late afternoon and evening.

For many of our elderly loved ones, late afternoons and evenings are filled with panic, confusion and behavioral changes. It's called sundowning. A broad term for behavioral disturbances that commonly peak later in the day — though they can occur at other times — sundowning can be especially unsettling on first appearance "Sundowning as a caregiver is

difficult," shares Dezarae Stone, a patient care assistant with CareYara in Chapel Hill, North Carolina.

Attending to her grandmother with sundowning syndrome was demanding.

"At the end of the day, you're tired from working and caring for your loved one ... but that's when my grandma had the highest level of confusion and needed the most," she recalls. "Nights were often accompanied by many soft spoken words of reassurance to combat paranoia, redirection to



her bed after wandering and showing her the clock or opening up the blinds as proof it's the middle of the night."

Although sundowning is a challenge, arming yourself with knowledge about how sundowning occurs and how to cope will shape you into a better support person or caregiver.

What Is Sundowning (Sundowner's Syndrome)?

Sundowning isn't a disease on its own. Rather, sundowning is the emergence or worsening of neuropsychiatric symptoms, like

agitation, confusion or aggressiveness, in the late afternoon or early evening, according to *Frontiers in Medicine*.

Sundowning affects up to two-thirds of patients with **dementia**, and it may be a sign that the disease is progressing. Dementia is an umbrella term for cognitive decline interfering with daily activities, while **Alzheimer's disease** is a specific type of dementia....**[Read More](#)**

New Antibiotic Slays Deadly Superbug in Early Trial

Researchers report that a new type of antibiotic has proved its mettle against a deadly superbug.

Acinetobacter baumannii, a bacteria that goes by the nickname CRAB when it becomes antibiotic-resistant, can trigger serious infections in the lungs, urinary tract and blood, according to the U.S. Centers for Disease Control and Prevention. Unfortunately, it's resistant to a class of powerful broad-spectrum antibiotics called carbapenems.

Now, in a study published Jan. 3 in the journal *Nature*, researchers from Harvard University and the pharmaceutical company Hoffmann-La Roche discovered that a new type of antibiotic, zosurabalpin, can kill *A. baumannii*.

Zosurabalpin employs a unique method of action, researcher **Dr. Kenneth Bradley**, global head of infectious disease discovery with Roche Pharma Research and Early Development, told *CNN*.

"This is a novel approach, both in terms of the compound itself

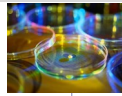
but as well as the mechanism by which it kills bacteria," he explained. *A. baumannii* is a Gram-negative bacteria, meaning it is protected by both inner and outer membranes, making it difficult to attack.

In this study, the scientists first tried to identify and then fine-tune a molecule that could cross those double membranes and eliminate the bacteria.

After years of improving the potency and safety of a number of compounds, the researchers chose one modified molecule.

How does it work? Zosurabalpin prevents the movement of large molecules called lipopolysaccharides to the outer membrane of the bacteria, where they keep the protective membrane intact. This causes the molecules to accumulate inside the bacteria's cell to the point where the cell becomes so toxic that it dies.

In the study, zosurabalpin worked against more than 100 CRAB samples. It also reduced



the levels of bacteria in mice with CRAB-induced pneumonia and prevented the death of mice with sepsis triggered by the bacteria.

Zosurabalpin is now being tested in phase 1 clinical trials, to assess its safety in humans, the researchers told *CNN*.

Still, the public health threat of antimicrobial resistance remains a huge problem globally due to a lack of effective treatments, **Dr. Michael Lobritz**, worldwide leader of infectious diseases at Roche Pharma Research and Early Development, told *CNN*.

In the United States, there are more than 2.8 million antimicrobial-resistant infections each year. More than 35,000 people die as a result, according to the CDC's **2019 Antibiotic Resistance Threats Report**.

Even though zosurabalpin is years away from human use, it's an extremely promising development, **Dr. César de la Fuente**, presidential assistant professor at the University of Pennsylvania, told *CNN*.

"I think from an academic perspective, it is exciting to see a new type of molecule that kills bacteria in a different way," de la Fuente said. "We certainly need new out-of-the-box ways of thinking about antibiotic discovery, and I think this is a good example of that."

The only drawback to the discovery is that the modified molecule will work only against the specific bacteria it is designed to kill, the researchers noted.

However, de la Fuente said this new method could turn out to be better than many broad-spectrum antibiotics.

"For decades, we've been obsessed with creating or discovering broad-spectrum antibiotics that kill everything," he noted. "Why not try to come up with specific, more targeted antibiotics that only target the pathogen that is causing the infection and not all the other things that might be good for us?"

Tejocote Supplements Sold Online at Amazon, Etsy May Contain Fatal Poison: FDA

Tejocote weight-loss supplements sold online through Amazon or Etsy could contain a highly toxic substance, the U.S. Food and Drug Administration is warning.

FDA tests revealed that capsules labeled as tejocote instead contained yellow oleander, a poisonous plant native to Mexico and Central America.

The FDA found yellow oleander in nine different products labeled as tejocote, the agency said. Those products were purchased through Amazon, Etsy and online natural food or supplement retailers.

According to the **FDA**

warning, the adulterated products included Alipotec Tejocote Root, Nutraholics ELV Tejocote Root, ELV Nutraholics Mexican Tejocote Root, ELVPOTEC Tejocote Root, Science of Alpha Mexican Tejocote Root, Niwali Raiz de Tejocote, Alipotec Tejocote Root, Tejocotex and ELV Alipotec Raiz de Tejocote, the FDA said.

"Ingestion of yellow oleander can cause neurologic, gastrointestinal and cardiovascular adverse health effects that may be severe, or even fatal," the FDA said in its **official warning**. Symptoms



may include nausea, vomiting, dizziness, diarrhea, abdominal pain and heart rhythm problems, the agency noted.

Tejocote, also known as Mexican hawthorn root, has been promoted through social media for weight loss, according to the U.S. Centers for Disease Control and Prevention.

Concerns about the supplement arose in September 2022 after a 23-month-old New Jersey toddler developed nausea, vomiting, slowed heart rate and low blood pressure after getting into the mom's tejocote capsules, according to a **CDC**

report issued in September 2023.

The New Jersey Poison Information and Education System subsequently purchased 10 different tejocote products online, and found that nine of the 10 contained yellow oleander, the CDC report said.

The FDA says it is concerned that there are more products touted as tejocote that instead contain yellow oleander.

Tejocote also is sold under other names, including *Crataegus mexicana*, Raiz de Tejocote, and Mexican Hawthorn, the FDA said.

One Liter of Bottled Water Contains 240,000 Tiny Bits of Plastic

Folks quenching their thirst with bottled water can expect to chug down hundreds of thousands of minute plastic particles with their refreshing H₂O, a new study reports.

On average, a liter of bottled water contains some 240,000 detectable plastic fragments – 10 to 100 times more than previously estimated, researchers said.

Nine in 10 of these plastic

particles were nanoplastics, they added.

Nanoplastic particles are so tiny that they can pass through the intestines and lungs directly into the bloodstream, eventually lodging in organs like the heart and brain, researchers said.

Because of this, medical researchers are racing to study how these nanoplastics might do



harm to the human body. "Previously this was just a dark area, uncharted.

Toxicity studies were just guessing what's in there," researcher **Beizhan Yan**, an environmental chemist at Columbia University's Lamont-Doherty Earth Observatory, said in a news release. "This opens a window where we can look into a world that was not exposed to us

before."

Microplastics are defined as fragments ranging from less than a quarter-inch to 1/25,000th of an inch.

Nanoplastics are even tinier particles, measuring smaller than 1 micrometer. By comparison, a human hair is about 70 to 75 micrometers across. **Read More**