Rhode Island Alliance for Retired Americans®

RI ARA

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Message from Alliance *for* Retired Americans Leaders

Alliance Celebrates International Women's Day, Women's History Month


Robert Roach, Jr
President, ARA

International Women's Day is today — Friday, March 8 — and the Alliance joins the AFL-CIO in celebrating the occasion, as well as Women's History Month throughout March.

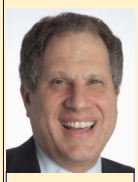
In this year's White House Women's History Month **proclamation**, President Biden noted that he had launched the White House Initiative on Women's Health Research to change how the nation approaches and funds women's health research, in order to pioneer the next generation of discoveries in women's health care.

In addition, thanks to the American Rescue Plan, the Biden-Harris administration has delivered **$37 billion** to all states to improve the quality of caregiving jobs, which are overwhelmingly filled by women. The administration is taking steps to make sure home care workers get a bigger share of Medicaid payments for the critical services they provide and is working to improve the quality of caregivers' jobs and wages.

"Today and during this month, we celebrate and applaud the accomplishments of not only the women of Labor, but all women, for the progress they have made across countless industries and sectors," said **ARA President Robrt Roach, Jr.**. "From caregivers to CEOs of major firms and throughout the government, they are the backbone of our country."

House Budget Resolution (Again) Includes Tax Cuts for the Ultra-Wealthy and Will Lead to Cuts to Social Security and Medicare

On Thursday, the House Budget Committee held a markup on the House Republican FY2025 budget resolution. The budget resolution was reported out of committee with support from every Republican present, while every Democrat voted against it.


Rich Fiesta, Executive Director, ARA

ARA Executive Director Rich Fiesta issued a **statement** Wednesday in anticipation of the vote, saying the budget proposal would make trillions of dollars in cuts to older Americans' earned benefits.

He added, "The budget resolution is bringing back the Fiscal Commission and the GOP leadership doesn't even know that Social Security cannot add to the debt. Incredibly, the resolution states that Social Security is a driver of the federal debt when, in fact, Social Security by law can't borrow one thin dime."

He went on to say that the House Budget Committee "evidently thinks they can unilaterally decide our spending priorities. It is highly unusual for Congress to preempt the White House and vote on their own budget before waiting for the President's budget to arrive on Capitol Hill." "This is nothing but a political stunt that shows we have a Congress more interested in headlines than doing the work of the people," Fiesta concluded.

"This budget resolution puts seniors on a path to cuts to their earned Social Security and Medicare benefits. Our members will continue to fight against these cruel measures."

In his State of the Union Address, President Biden Calls for Continued Lowering of Prescription Drug Prices, Pledges to Keep Social Security and Medicare Cuts off the Table

President Biden delivered his State of the Union address Thursday, mentioning seniors and labor multiple times in his remarks. The Alliance issued a statement supporting his accomplishments on behalf of older Americans.

"Tonight President Biden told the American people that the state of the Union is strong," said **ARA Executive Director Rich Fiesta**. "That's not news to older Americans who are paying less for prescription drugs now than they were before President Biden took office in 2021."

"Of course, there is more to be done to ensure every American has a secure retirement," Fiesta continued. "President Biden laid out a plan tonight to move us far closer to that goal."

Fiesta noted the President's plan to defend Social Security and Medicare from politicians who want to slash benefits or even end these programs as we know them, adding, "President Biden made clear that he gets it when he again stated his firm opposition to any legislation that will cut the benefits Americans earn over a lifetime of work or raise the retirement age."

Biden pledged to keep the pressure on the pharmaceutical industry to lower prices, stating that Americans pay the highest prices in the world for prescription drugs. He also said he wants Medicare to negotiate the lower prices for 500 drugs over ten years, a dramatic increase from current policy.

Negotiating lower prices will save seniors and taxpayers billions of dollars and strengthen the Medicare system for years to come. "President Biden has continued to meet seniors' highest expectations and even surpass them," Fiesta concluded. "With another term he can continue to lower drug prices and protect their hard earned Social Security, Medicare and pension benefits from attack."

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40% of Older Americans Think Social Security Will Be Their Largest Source of Retirement Income. Here's Why That's a Bad Thing.

The Motley Fool

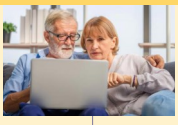
Retirement is often hailed as a magical period in life. But for a lot of people, it's hard.

Losing the steady paycheck from work you once relied on can deal a blow to your finances. So it's important to have a plan for generating the retirement income you need to pay the bills.

Your retirement income could come from a variety of sources. But in a recent **MassMutual survey** of Americans aged 55 to 65, 40% said they anticipate Social Security will be their greatest source of retirement income. And that's quite problematic.

When you're reliant on benefits that may be smaller than you think

You don't necessarily need to replace 100% of your pre-retirement paycheck to live comfortably once your career wraps up. But most seniors find that to cover their bills without worry and have enough money left over for leisure spending, they need enough income to replace about 70% to 80% of their former paychecks.



The problem with **Social Security** is that it won't give you that much replacement income. If you earn an average wage, the monthly Social Security benefit you'll collect in retirement might replace about 40% of your former pay. That's unlikely to be enough to support the lifestyle you want.

This also makes one huge assumption -- that Social Security benefits won't be cut. Social Security is facing significant financial challenges that could force the program to slash benefits starting in about 10 years.

Those cuts aren't guaranteed to happen -- but they might. At that point, your benefits might give you even less replacement income.

You need a better plan

If you're counting on Social Security for most of your retirement income, you may want to rethink your plan and come up with a new one that has more of your senior income arriving from different sources. If you're nearing retirement and only have limited savings, aim to continue working a few extra years to boost your **401(k) or IRA** balance. Doing so might also allow you to delay your Social Security claim, which could result in a higher monthly benefit than the one you're eligible to receive at **full retirement age**. You can also look at continuing to work on a part-time basis, even once you decide to resign from your primary job. The gig economy makes it especially easy to find work that isn't too restrictive from a scheduling standpoint.

Plus, you could always get creative and use your home to generate income. If you have a larger space, find a year-round tenant. Or if you tend to spend larger chunks of time away from home (say, to visit your grown kids in another state), rent out your property when you're not occupying it if it's in a desirable location.

Planning to retire mostly on Social Security could mean setting yourself up for disaster. Instead of doing that, it pays to set yourself up with various income streams so that the monthly benefits you'll receive won't be your go-to source of income.

Medicare Advantage Plans Face Uncertainty Due to Changing Costs

As Medicare Advantage enrollment continues to grow, reaching over 30 million people in 2024, plans must adjust to both rising healthcare costs and potential policy changes aimed at reducing federal spending

A key challenge is that payments to Medicare Advantage plans are determined annually based on plan bids and benchmarks set by Medicare. If costs increase faster than benchmarks, plans may have to reduce benefits or increase out-of-pocket costs for enrollees.

Jae Oh, author of Maximize Your Medicare, explains that Medicare Advantage is an "annual contract" where private insurers create benefit packages based on a budget set per enrollee by the Centers for Medicare and Medicaid Services (CMS). Plans compete to offer the most valuable benefits within this budget. However, the budget and resulting benefits often change each year, confusing enrollees who are used to more consistent plan offerings.

In 2023, multiple major insurers reported higher-than-expected costs and some divested from Medicare Advantage entirely, indicating real financial pressures. Proposed legislation seeks to increase scrutiny and potentially reduce payments to plans. Oh notes that headlines about policy and costs are unlikely to slow given trends like the growing senior population.

While it remains unclear how costs and policy will impact plans and enrollees long-term, experts emphasize that beneficiaries should review their options carefully each year. Key factors to weigh include premiums, provider networks, prescription coverage, and supplemental benefits. Vigilance about changes will help enrollees find the best available coverage despite Medicare Advantage uncertainty.

Alliance Marks the 5th National "Slam the Scam" Day

The Social Security Administration's (SSA's) 5th National "Slam the Scam" Day took place on Thursday as a part of the National Consumer Protection Week. "Slam the Scam" Day has been designated by SSA to raise public awareness of Social Security and other government imposter scams, and the Alliance promoted it on social media.

According to a report by the Federal Trade Commission, Social Security scams remain the top government imposter crimes, with older adults being disproportionately impacted.

Knowing the common signs of a scam is crucial to spotting and reporting them. Scammers often show fake federal credentials, demand secrecy, or pressure targets to take immediate action through specific methods of payment. These scams will often pretend to be from an agency or organization that you know. They'll usually either say that there is a problem or there is a prize if you participate.

Social Security will never use these approaches when contacting beneficiaries. If you receive a suspicious phone call, email, text, or message on social media, remain calm, hang up, and protect your money and personal information. Also, report it immediately at oig.ssa.gov and spread the word about the threat to others.

"Protecting retirees from fraud is extremely important," said **Joseph Peters, Jr., Secretary Treasurer** of the Alliance. "Please contact SSA if you suspect a message is a scam."

Joseph Peters, Jr.
Secretary
Treasurer ARA

5 Things Retirees Need to Know About Social Security and Taxes

by GHAZAL AHMED in News,

This article takes a look at 5 things retirees need to know about social security and taxes. If you wish to check out our detailed analysis of insights on social security benefits and taxes, you may go to **12 Things Retirees Need to Know About Social Security and Taxes.**

5. You Can Reverse a Benefits Claim

For those who decided to claim their Social Security benefits and then realized that they should have waited instead, the Social Security Administration allows for a one-time do-over. To initiate a withdrawal of Social Security retirement benefits, individuals must submit their request within the initial 12 months of commencing benefits, regardless of the age at which they began receiving them (which can be as early as age 62). However, all social security benefits received previously must be repaid in their entirety.

4. Partial Taxation: Not All Social Security Benefits Are Taxed

As of January 2024, the average social security benefit is $1,860. For those who have social security as their sole source of income in retirement, they can expect to keep the full amount.

3. Tax Credits for Retirees: Maximizing Your Financial Benefits

Retirees can enhance their financial well-being by capitalizing on tax deductions and credits. Exploring deductions for medical expenses, charitable donations, and mortgage interest can lower taxable income. Specific credits, like those for elderly or disabled individuals, offer direct reductions in tax owed. Maximizing contributions to retirement accounts further optimizes tax benefits.

2. Residency Impact: How Your State of Residence Affects Taxes

Quite a few states that don't tax social security, while there are yet others don't tax retirement income at all. However, the retirees who live in states such as Connecticut, Kansas, Montana, Nebraska, and a few others, have a portion of their social security subject to state income taxes. Many of these states have different criteria from the federal government when taxing Social Security payments. They either have higher income thresholds, provide diverse deductions, or impose limitations on the taxation of benefits.

1. COLA Effects: Understanding the Impact of Cost-of-Living Adjustments

The 8.7% Cost of Living Adjustment (COLA) last year gave a considerable bump to retirees' social security beneficiaries. However, this COLA increased social security income for the average retiree by about $1,760 for the year. While this may have been good news for many, it pushed many others into a higher tax bracket.

Widely used diabetes, heart disease, autoimmune drugs for Medicare price negotiation

The first 10 prescription drugs the federal government **will negotiate under a new federal law** were revealed Tuesday, launching a process that could deliver drug discounts by 2026. The batch of 10 medications include some of the most widely prescribed or expensive drugs older Americans use for conditions such as heart disease, diabetes and autoimmune conditions.

The Biden administration will negotiate prices for these nine drugs: Eliquis, Jardiance, Xarelto, Januvia, Farxiga, Entresto, Enbrel, Imbruvica and Stelara. The other drug includes the **insulin** medications Fiasp and NovoLog, including versions named Fiasp FlexTouch, Fiasp PenFill, NovoLog FlexPen and NovoLog PenFill, the Centers for Medicare & Medicaid Services said Tuesday. "For far too long, Americans have paid more for prescription drugs than any major economy," President Joe Biden **said in a statement early Tuesday**. "And while the pharmaceutical industry makes record profits, millions of Americans are forced to choose between paying for medications they need to live or paying for food, rent, and other basic necessities. Those days are ending.".

Price changes for the first batch of 10 negotiated drugs won't take effect until 2026. Over the next two years, another 30 drugs will be selected for negotiated prices beginning in 2027 and 2028.

Limits on which prescription drug prices can be negotiated

The 10 selected drugs accounted for about 20% of total spending for Medicare Part D prescription drugs over the past year, officials said….**Read More**

4 in 10 Near-Retirees Just Failed a Social Security Quiz. Here Are Some Key Things to Know About the Program.

The Motley Fool.

1. You need to be at least 62 years old to get benefits

The earliest age you can sign up for Social Security is 62. But you should know that filing at that age will result in a substantial reduction in your monthly benefits -- for life. If you don't have a lot of savings going into retirement, you might want to plan to file at a later age.

2. You can collect your full monthly benefit at full retirement age

Full retirement age, or FRA, is when you're entitled to your complete monthly Social Security benefit based on your personal income history. That age hinges on your year of birth, and it's either 66, 67, or somewhere in between.

In the aforementioned survey, many respondents thought that FRA was 65, regardless of their year of birth. Age 65 *is* when **Medicare** eligibility begins for everyone. But claiming Social Security at 65 will mean locking in a reduced monthly benefit for all of your retirement.

3. You can grow your benefits by delaying your filing

You don't have to sign up for Social Security once FRA arrives. For each year you wait, your monthly benefits get a permanent 8% boost. However, that incentive runs out at age 70. So while there's technically no such thing as a final age to claim Social Security, you'll often hear that 70 is the "latest age" to sign up because there's no financial upside to waiting any longer.

4. Spouses can receive benefits based on their partners' earnings records

Your individual wage history helps dictate what monthly Social Security benefit you get. But if you never worked, you might still be eligible via spousal benefits. Those benefits could equal up to 50% of the benefit your spouse receives.

And it's not just married people who are eligible for Social Security spousal benefits. You might also be entitled to spousal benefits as a divorcee. If you're married, though, you'll need to wait until your spouse files for Social Security to get spousal benefits of your own.

You also can't collect more than one benefit from Social Security at the same time. So if you're getting a benefit based on your own earnings history, you can't *also* receive a spousal benefit. You'll only get the higher of the two.

These are just some of the many rules associated with Social Security. If you're nearing retirement, it pays to read up on the program so you know what to expect. It's also really important to know the ins and outs so you can land on a filing age that's right for you.

Biden Is Right. The US Generally Pays Double That of Other Countries for Rx Drugs.

If you went "anywhere in the world," you could get a prescription filled for 40% to 60% less than it costs in the U.S.

It's well documented that Americans pay high prices for health care. But do they pay double or more for prescriptions compared with the rest of the world? President Joe Biden said they did.

"If I put you on Air Force One with me, and you have a prescription — no matter what it's for, minor or major — and I flew you to Toronto or flew to London or flew you to Brazil or flew you anywhere in the world, I can get you that prescription filled for somewhere between 40 to 60% less than it costs here," Biden **said Feb**. 22 at a campaign reception in California. He followed up by touting provisions in the 2022 Inflation Reduction Act to lower drug prices, including capping insulin at **$35 a month** for Medicare enrollees and limiting older Americans' **out-of-pocket prescription spending** to $2,000 a year starting in 2025. The law also authorized Medicare to negotiate prices directly with drug companies for 10 prescription drugs, a list that will expand over time.

Research has consistently found that, overall, U.S. prescription drug prices are significantly higher, sometimes two to four times as high, compared with prices in other high-income industrialized countries. Unbranded generic drugs are an exception and are typically cheaper in the U.S. compared with other countries. (Branded generics, **a different category**, are close to breaking even with other countries.)

However, such factors as country-specific pricing, confidential rebates, and other discounts can obscure actual prices, making comparisons harder.

"The available evidence suggests that the U.S., on average, has higher prices for prescription drugs, and that's particularly true for brand-name drugs," said Cynthia Cox, director of the **Peterson-KFF Health System Tracker**, which tracks trends and issues affecting U.S. health care system performance. "Americans also have relatively high out-of-pocket spending on prescription drugs, compared to people in similarly large and wealthy nations."

Andrew Mulcahy, a senior health economist at Rand Corp., a nonpartisan research organization, agreed that Biden's overall sentiment is on target but ignores some complexities.

He said price comparisons his team has conducted reflect the amounts wholesalers pay manufacturers for their drugs, which can differ sharply from prices consumers and their drug plans pay.

"In many of those other countries, [patients] pay nothing," Mulcahy said. "So I think that's part of the complication here when we talk about prices; there are so many different drugs, prices, and systems at work."

What International Drug Pricing Comparisons Show

A **2024 Rand study** that Mulcahy led found that, across all drugs, U.S. prices were 2.78 times as high as prices in 33 other countries, based on 2022 data. The report evaluated most countries in the Organization for Economic Co-operation and Development, or OECD, a group of 38 advanced, industrialized nations.

The gap was largest for brand-name drugs, the study found, with U.S. prices averaging 4.22 times as high as those in the studied nations. After adjusting for manufacturer-funded rebates, U.S. prices for brand-name drugs remained more than triple those in other countries.

The U.S. pays less for one prescription category: unbranded, generic drugs, which are about 33% less than in other studied countries. These types of drugs account for about 90% of filled prescriptions in the U.S., yet make up only one-fifth of overall prescription spending.

"The analysis used manufacturer gross prices for drugs because net prices — the amounts ultimately retained by manufacturers after negotiated rebates and other discounts are applied — are not systematically available," a **news release** about the report said….**Read More**

Lawmakers Might Increase Social Security's Full Retirement Age to Avoid Benefit Cuts. Here's How That Could Hurt Today's Workers Big Time

The Motley Fool

Social Security is not in the best financial shape. The program gets the bulk of its funding from payroll taxes. But in the coming years, that revenue stream is expected to shrink as baby boomers exit the workforce in droves.

Social Security can tap its trust funds to keep up with scheduled benefits for a period of time. But once those trust funds run dry, benefit cuts may have to happen. And recent projections call for a trust fund depletion date of 2034, which isn't so far away.

Of course, it's in lawmakers' best interest to try to avoid benefit cuts and the senior poverty crisis they have the potential to cause. To that end, several solutions have been brought up to prevent that unwanted scenario.

One idea that's been gaining traction is increasing Social Security's **full retirement age** (FRA), which is the age at which seniors can claim their monthly benefits in full without a reduction. For workers born in 1960 or later, FRA is 67. But some lawmakers suggest increasing FRA to 68 to 69, so that Social Security has more time before it needs to pay out those benefits in full. 1. You may have to work longer

It's possible to claim Social Security before reaching FRA. You can take benefits once you turn 62. But for each month you claim them ahead of FRA, they get reduced on a permanent basis.

You may not be able to afford a hit to your Social Security income due to a lack of retirement savings. But if FRA is

raised, you'll have to wait longer to get your full monthly benefit without a reduction. That means you may have to work longer, which is something you may not want to do -- especially if your job is stressful or bad for your health.

2. You may have less opportunity to earn delayed retirement credits

Right now, seniors who postpone their Social Security claims past FRA get to accrue delayed retirement credits. Those credits boost benefits by 8% a year, so that someone with a FRA of 67 who files at 70 gets to snag a permanent 24% increase to their monthly Social Security check.

3. You may be subject to an earnings-test limit for longer

You're allowed to work and collect Social Security at the same time. And once FRA arrives, you can earn any amount of money without risking having benefits withheld.

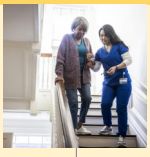
However, the current rules dictate that Social Security recipients who work and have not reached FRA are subject to an **earnings-test limit**. Earnings beyond that limit result in withheld Social Security income. If FRA is raised to help prevent Social Security cuts, workers could end up subject to an earnings-test limit for longer.

All told, there are clearly some serious drawbacks to increasing FRA for Social Security. Lawmakers will have to work though the pros and cons to determine whether pushing FRA to 68 or 69 is really a good idea.

Long-term care insurance dos and don'ts to know, according to experts

Long-term care insurance can be an important type of coverage to consider as you get closer to retirement. And, because the cost of this coverage is based, in large part, on your age and health status, it's typically advisable to **purchase coverage before you turn 60**. That said, **there may be affordable policy options** for older Americans, too.

But when you **compare long-term care insurance policies**, it may be tough to understand what you should and shouldn't do. After all, there are several coverage options available, and it's important to choose a policy that meets your unique needs.



Long-term care insurance dos and don'ts to know

If you're looking for the best long-term care insurance policy for your needs, consider the following dos and don'ts as you shop:

Do: Be proactive

"Buy when health and finances allow you to buy," says Kelly Augspurger, CSA and instructor at Certification for Long-Term Care. "Your health enables you to buy long-term care insurance and your wealth pays the premium."

But, if you're proactive, **it may be easier to afford long-term care coverage**.

"The healthier and younger you are, the less expensive it will be and more options you will have," Augspurger says.

Don't: Think Medicare will cover your long-term care needs

"Don't make the mistake of thinking Medicare will cover your long-term care needs," says Larry Nisenson, CGO at Assured Allies. "This is one of the most common and biggest mistakes that consumers make."

Medicare typically doesn't cover long-term care services. However, Medicaid will in some cases, but there are **caveats to consider**, including:

- **Income limits**: To qualify for Medicaid long-term care coverage, your income must be less than $2,829 per month (as a single applicant).
- **Asset limits**: Your Medicaid application for long-term care coverage will likely be denied if you have more than $2,000 in assets as a single applicant age 65 or older. Though, there are some states with significantly higher limits. For example, the limit is $30,182 in New York.
- **Coverage limits**: If you qualify for long-term care coverage through Medicaid, that coverage may be limited….**Read More**

Medicare Advantage and other HMOs compromise continuity of care

If you're in a Medicare Advantage plan or any health insurance plan that requires you to use in-network health care providers and you have not thought about the fact that you can't count on your health plan covering those physicians and hospitals over time, you should. In fact, right now, hospitals and physicians are dropping like flies from a large number of health plans. Melanie Evans reports for the **Wall Street Journal** about the ugly situations patients in these health plans are facing.

One reason to stay away from Medicare Advantage plans–which cover your care from in-network providers only or which cover only some of the cost of your care from out-of-network providers–is that you might end up having to switch physicians mid-course of treatment. That seems to be happening to tens of thousands of people in Medicare Advantage plans and other health plans in the last couple of years. The corporate health insurers offering Medicare Advantage plans too often are denying payments to

hospital systems and forcing physicians to go through multiple hoops to get care approved, at enormous cost to them. So, the hospitals and physicians are fighting back, refusing to contract with the insurers.

Lots of patients are hearing from their local hospitals and physicians that their insurance will no longer cover their care from these providers. Hospitals want more money and less headache. They say that insurer **prior authorization rules are endangering the health and well-being of their patients.**

Patients, in turn, are left in a serious quandary. Stay with their longtime physicians and hospitals and be liable for the full cost of their care, often thousands or tens of thousands of dollars. Or, switch to new hospitals and physicians, which can compromise their health. Moreover, switching care providers is almost always a total headache and challenging in and of itself….**Read More**

Poll: Health care costs are a top economic priority for voters

As you've likely been reading, voters continue to have negative views about the US economy. High health care costs (and inflation, which is actually in check) feed into that view, with voters saying they are big concerns. The **Kaiser Family Foundation's** latest poll finds that voters want to hear President Biden and former President Trump discuss these issues.

Americans believe that their cost of living, including housing, is rising; health care costs also represent a piece of that expense. They do not seem to consider that unemployment is low and the stock market has been climbing. Almost three in four Americans are concerned about paying unexpected medical bills; more than half are worried that they won't be able to afford their prescription drugs and nearly half express concern about paying their health insurance premiums.

What's particularly noteworthy is that even though former President Trump would likely cut some of the benefits voters enjoy and President Biden has worked hard to boost them, nine in ten Republicans say they would vote for former President Trump. Curiously, Republican voters believe that former President Trump did more to address high health care costs than President Biden, although not enough. Nearly six in ten Republicans (59 percent) say Trump did enough to address health care costs, whereas only one third (33 percent) of Democrats say Biden has done enough.

Voters who say they support Trump recognize that he does not have a vision for replacing the Affordable Care Act, only for ending it. But, they don't appreciate that President Biden was the Vice President when the ACA was passed and played a significant role in its passage.

The ACA is not well understood, likely because only a fraction of the population benefits from it today. Most people don't appreciate the protections it offers people who lose their employer coverage or who are self-employed, particularly those who have pre-existing conditions, and why it needs to be strengthened. Many Republicans suggest they would be happy to see it cut or repealed.

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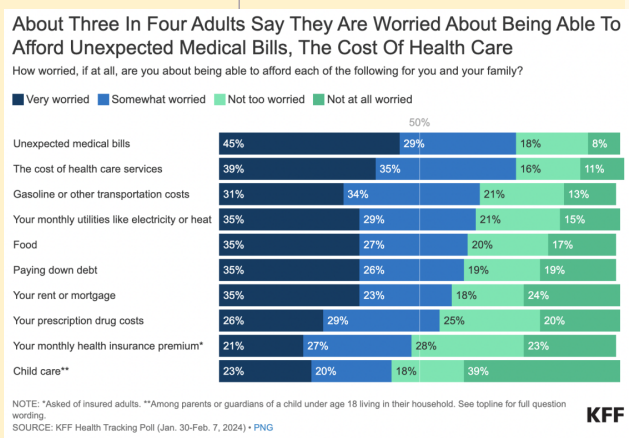

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How to switch to Traditional Medicare from Medicare Advantage?

For years, I've been advising people to enroll in Traditional Medicare for easy access to medically reasonable and necessary care. And, I continue to believe that anyone who can afford the upfront costs of Traditional Medicare with supplemental coverage should enroll in Traditional Medicare. Medicare Advantage plans save you money, so long as you're healthy; but your health care coverage should cover the care you need when you're sick and you can't count on a Medicare Advantage plan to do that. So, one Just Care reader asks, how easy is it to switch from a Medicare Advantage plan to Traditional Medicare?

First things first: Twice a year, during the annual **Medicare Open Enrollment period** between October 15 and December 7 and during the **Medicare Advantage Open Enrollment period** between January 1 and March 31, you have the right to disenroll from Medicare Advantage and switch to Traditional Medicare. The issue becomes getting supplemental coverage to fill gaps in traditional Medicare if you don't have Medicaid or retiree coverage that fills those gaps.

Here are the benefits of enrolling in Traditional Medicare, along with the challenges of doing so, and your rights.

The benefits of enrolling in Traditional Medicare:

- You will have easy access to the medical and hospital care you deserve, without the need for prior authorization or a referral from your doctor to a specialist; you won't need to go through hoops to get care, nor will you face care delays or denials of care your treating physician says you need.
- You and your doctor decide the care you need, not an insurance company that profits from denying you care.
- You will be covered for care from virtually any doctor or hospital in the US; you will not be limited to coverage from a narrow group of physicians in your community.
- With supplemental coverage, either through Medicaid, your former employer or union or a Medigap plan that you buy in the individual market, you are likely to have almost all your care covered without having to pay out of pocket for that care.

The challenges of switching to Traditional Medicare:

- With certain exceptions, if you want to sign up for Traditional Medicare after you've been in a Medicare Advantage plan for more than a year, you have **no guaranteed right to buy supplemental coverage in all but four states**, New York, Massachusetts, Connecticut and Maine. And, because Traditional Medicare has no out-of-pocket limit, you could have higher out-of-pocket costs in Traditional Medicare than you would in a Medicare Advantage plan, which tends to limit your out-of-pocket expenses for medical services to an average of $5,000 for in-network care but could cap those costs as high as $8,700 in 2024.
- Even if your Medicare Advantage plan is not covering the care you need from the providers you need to see, you can only switch to Traditional Medicare during the **Medicare Open Enrollment Period between October 15 and December 7**, effective January 1 of the following year and during the **Medicare Advantage Open Enrollment Period** between January 1 and March 30, effective the month after you disenroll from your Medicare Advantage plan.
- If you are able to switch to Traditional Medicare and you don't have Medicaid or a union or employer retiree plan to provide supplemental coverage, supplemental coverage could cost a lot, easily $200 a month or more. Medigap Plans K and L tend to be lower cost and cap your out-of-pocket expenses.

Your rights to buy a Medigap without medical underwriting or a waiting period:

- When you first enroll in Medicare, you have a guaranteed right to buy Medigap coverage to fill gaps in Traditional Medicare during a six month open enrollment period beginning the month you turn 65.
- If you enrolled in a Medicare Advantage plan when you were first eligible for Medicare and disenroll within 12 months, you have a guaranteed right to buy Medigap coverage.
- If you move out of your Medicare Advantage plan's service area, you have a right to switch to Traditional Medicare and a guaranteed right to buy Medigap coverage.
- If you had supplemental coverage from your employer or union and that coverage ends, you have a guaranteed right to buy Medigap coverage.
- If your Medicare Advantage plan ends its coverage or commits fraud, you have a guaranteed right to buy Medigap coverage.

Insurers still might sell you Medigap coverage even if none of the above federal rights apply to your situation:

You still might be able to buy a Medigap policy in your state if you want to switch from a Medicare Advantage plan to Traditional Medicare and none of the above guaranteed federal rights to buy Medigap apply. Contact your **State Health Insurance assistance Program or SHIP** for free help. Or call your state department of insurance to see if you can buy a policy. Some Medigap plans have out-of-pocket limits like Medicare Advantage and cost much less than more comprehensive Medigap plans.

Pros and Cons of Active Adult Communities

Active adult communities offer a unique lifestyle for those age 55 and older. Learn what they are, the amenities they offer and how to find the perfect one for you.

About three years ago, Lori Felix's husband needed a double knee replacement. To accommodate his recovery, they needed to move before the surgery.

After some searching, they landed at La Floresta, a 55-plus community with about 300 units – including ones all on one level – in Brea, California. It was exactly the right fit.

"We are so happy here," says Felix, now 66.

What Are 55-Plus and Active Adult Communities?

The terms "55-plus community," "active adult community," "lifestyle communities" and "planned communities" refer to a setting that caters to the needs and preferences of adults over the age of 55.

These communities are designed for seniors who are able to care for themselves but may be looking to **downsize** to a community with others their same age and with similar interests.

Pros and Cons of 55-Plus Communities

These communities come with a range of benefits, particularly amenities and activities.

"Typically, residents may enjoy in-house dining, scheduled activities, outings into the general community, field trips and in-house events that bring about social interaction," says Dr. Elizabeth Landsverk, a geriatrician based in the San Francisco area.

Other pros can include:

- **Safety and security.** Communities may be gated or have security personnel on-site.
- **Low maintenance.** Services may include landscaping, gardening and housekeeping so residents don't have to maintain the property on their own.
- **Social connection.** Many older adults seek out these communities, particularly after the loss of a spouse, for the social network and to live alongside other people in the same stage of life….**Read More**

Five concerning policy outcomes of Medicare Advantage program

We frequently think about aspects of Medicare and MA in isolation from their effects on our healthcare system. But when we step back, we see the following Medicare Advantage policy outcomes that we would never choose to accomplish on a stand-alone basis.

- Medicare Advantage program incentivizes insurer **competition around attracting healthy people and avoiding people with costly conditions**—with **networks that avoid top specialists and specialty hospitals**, with coverage protocols that delay and deny care inappropriately—increasing costs for providers and patients in the system and maximizing profits for insurers.
- Medicare Advantage program is **effectively unaccountable**, operating largely on trust, with no real-time oversight or meaningful enforcement, which prevents people from knowing which MA plans will provide high value care if they have cancer or heart disease and which to avoid, forcing them to gamble when they choose an MA plan and **leading more than 10,000 people to die needlessly each year when they choose the wrong MA plan**.

- Medicare Advantage program **misleads people, particularly those with low incomes,** into believing that they will get the same benefits as people in traditional Medicare with an out-of-pocket cap, when **insurers can game Medicare coverage requirements** so as not to deliver the same benefits. In fact, mounting evidence indicates insurers too often **inappropriately deny critical care** and provider payments, threatening the health and financial security of the most vulnerable enrollees with complex conditions.
- Medicare Advantage program uses a **payment system that insurers can game to achieve 23 percent more per enrollee than the government spends on enrollees in traditional Medicare**, driving up Medicare spending and Medicare premiums by **$260 billion in the 10 years ending in 2033**, and threatening the Medicare program. And, while MA offers a valuable out-of-pocket cap to people with low incomes and "extra" benefits, unlike TM, when they get sick, they are often faced with financial and administrative barriers to care wealthier people in TM do not face, which aggravate health inequities.
- Medicare Advantage program is **financially unsustainable over the middle to long term** and, left to its own devices, likely will lead to the withering away of traditional Medicare, the end of Medicare negotiated rates as providers acquire more leverage over insurers, greater financial and administrative barriers to care and much higher costs for enrollees with costly conditions.
- **Here's what MA policy should be designed to do:**
- MA policy should incentivize MA plans to compete to deliver high value care to the people with complex and costly conditions.
- MA policy should bar bad actors from participating in the program; at the very least, it should identify the bad actors so that people can avoid enrolling in them.
- MA policy should ensure that MA enrollees get the same benefits as people in Traditional Medicare and that providers are paid appropriately for the care they deliver.
- MA policy should ensure that insurer administrative costs and profits total no more than 15 percent more than insurers spend on care.
- MA policy should not allow the MA program to cost any more per enrollee than Traditional Medicare.

Changes to Part D: Lower Out-Of-Pocket Drug Costs in 2024 and 2025; Simplifications in 2025

Many people with Medicare Part D drug coverage—in particular those who reach the **catastrophic coverage phase**—may experience unexpected costs and significant confusion as their out-of-pocket obligations change throughout the year.

The Inflation Reduction Act (IRA) brings much-needed consumer protections and predictability to these coverage phases, limiting financial exposure for everyone and generating significant savings for those with extreme costs.

As of 2024, Part D enrollees are **no longer required to pay 5% coinsurance** after they reach catastrophic coverage. This threshold is set at $8,000 in what's called "true out-of-pocket," or TrOOP costs. These amounts include what the beneficiary spends on covered prescriptions, what others, like family members, friends or certain charitable organizations spend on their behalf, and any manufacturer discounts during the coverage gap phase. This calculation is different than what's called "total drug costs," which includes TrOOP amounts plus the what the Part D plan has paid.

Most people will **pay roughly** $3,400 of their own money by the time they reach $8,000 in TrOOP costs. After this point, they will pay $0 for covered Part D drugs for the rest of 2024. Exactly how much a person will pay before they reach the TrOOP limit of $8,000 depends on their plan design, and the mix of brand name and generic drugs they take – this is because while the brand-name manufacturer discount in the coverage gap is included in TrOOP, the government-funded generic discount is not. If a person takes only brand-name medications, they will pay around $3,300 before they hit the catastrophic cap, while a person who takes an average amount of brand and generic drugs will pay about $3,400. A person who takes only generic drugs will pay close to the full $8,000 before they reach the catastrophic phase.

Further savings and simplifications are coming. Starting in 2025, beneficiary drug costs will be capped at $2,000, indexed annually for growth in Part D. There will be no change of payment responsibility in the coverage gap, and no differential treatment of the manufacturer discounts for brand and generic drugs. Instead, out-of-pocket expenses will be defined in a way that more closely matches the usual understanding of that term, and once a beneficiary spends $2,000 in the deductible and initial coverage phases, they will pay $0 out-of-pocket for the rest of the year.

To illustrate the impact of these changes, a recent **KFF report** 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 out-of-pocket costs. In 2024, they will no longer be responsible for $8,000 to $9,000 of that amount. And next year, when the $2,000 cap takes effect, they'll save even more.

The IRA's Part D redesign will help millions of current and future enrollees afford needed care. These reforms come on top of the law's other beneficiary cost saving provisions, many of which have **flown under the radar**—such as **vaccines without cost sharing**, **reduced insulin costs**, expanded access to "**Extra Help**," and the **drug negotiation program** that is already underway and in 2026 will bring down prices for some of the most expensive Part D drugs. Medicare Rights applauds these reforms and urges policymakers to build upon them, to make high quality coverage more available and affordable for more Americans.

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RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

FDA Clears First OTC Continuous Blood Glucose Monitor

The U.S. Food and Drug Administration on Tuesday approved the country's first over-the-counter continuous glucose monitor for type 2 diabetes.

The new Dexcom Stelo Glucose Biosensor System, which will be available by summer, is intended for people 18 and older who have type 2 diabetes but do not take insulin, according to the agency.

Also known as CGMs, these monitors consist of tiny sensors that prick the skin and track blood sugar levels 24 hours a day. That information is sent wirelessly to a smartphone, which can help alert users, their families and their doctors to blood sugar swings.

"CGMs can be a powerful tool to help monitor blood glucose. Today's clearance expands access to these devices by allowing individuals to purchase a CGM without the involvement of a health care provider," **Dr. Jeff Shuren**, director of the FDA's Center for Devices and Radiological Health, said in an agency **news release** announcing the approval. "Giving more individuals valuable information about their health, regardless of their access to a doctor or health insurance, is an important step forward in advancing health equity for U.S. patients."

However, the agency warned that the new system is not intended for patients with problematic hypoglycemia (low blood sugar), noting it was "not designed to alert the user to this potentially dangerous condition."

More than 25 million Americans have type 2 diabetes and do not use insulin, Dexcom noted. While the company's G7 CGM system is available to these folks, patients have to get a prescription for it.

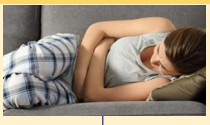
That changes with the arrival of an over-the-counter version of the tracking system.

“Use of CGM can help empower people with diabetes to understand the impact of different foods and activity on their glucose values,” **Dr. Tamara Oser**, a family physician, said in a Dexcom news release. “For people newly diagnosed with Type 2 diabetes or not taking insulin, these devices are often not covered by insurance and Stelo presents an opportunity to provide valuable information that can impact their diabetes management.”

The sensor will be worn on the upper arm, and it lasts for up to 15 days before it needs to be replaced, according to **Dexcom’s website**.

Data from a clinical study provided to the FDA showed the device performed similarly to other iCGMs, the FDA said. Adverse events reported in the study included local infection, skin irritation and pain or discomfort.

How to Deal With Endometriosis Pain



Endometriosis causes crippling pain in women, with some spending up to a month of every year debilitated by it.

“We’re talking about pain that’s beyond ‘I took two ibuprofen and went to work,’” said **Dr. Kristin Riley**, chief of minimally invasive gynecologic surgery at Penn State Health Medical Center. “We’re talking about pain that keeps people from living their lives.”

The condition involves tissue normally found in the uterus instead growing in the ovaries, bowels, bladder and elsewhere, Riley said. It affects roughly 190 million women around the world.

The pain caused by endometriosis ranges from endurable to excruciating, Riley said. Sometimes women can shrug it off, while at other times leaving the house or getting out of bed isn’t an option for days at a time.

There’s no cure, but doctors have become adept at diminishing its agony, Riley said. Women with endometriosis or chronic pelvic pain now have a wealth of options to choose from, including some geared to very specific kinds of pain.

“It’s not a one size-fits-all approach,” Riley said in a Penn State news release. “It’s very individualized.”

Pain during a period doesn’t necessarily mean there’s a problem, Riley said. But when it becomes debilitating, a woman should speak with her doctor.

Some questions Riley asks of her new patients include what the pain is like, where it is coming from and what it keeps them from doing.

“Some people have this cramping pain,” Riley said. “Some people have sharp shooting nerve pain or muscle pain. Some people have something that starts out as bad period pain, and then it moves on to other organs – gastrointestinal pain, bladder pain, abdominal wall pain, back pain -- or all of those things.”

The organs in a woman’s pelvis all function in a cavity about five inches wide, meaning that when one organ is inflamed, the problem often affects others. Women with endometriosis pain often discover bladder or bowel aches, as well as problems with sexual function and fertility.

...Read More on Potential treatments that include:

Many Older Americans Pop Daily Aspirin, Even Though It's No Longer Recommended: Poll

Lots of seniors are regularly taking low-dose aspirin in hopes of preventing heart attacks and strokes, even though updated guidelines often advise against it.

About one in four older adults take aspirin at least three times a week, according to results from the University of Michigan’s National Poll on Health Aging.

However, many seniors who take low-dose aspirin may not need to do this, researchers said.

Nearly three in five (57%) of people ages 50 to 80 who take aspirin regularly don’t have a history of heart disease, poll results show.

Those folks should talk with a doctor before starting or stopping aspirin use, because current guidelines mostly call for daily aspirin in people who already have heart disease or have survived a stroke or heart attack, experts said.

“Aspirin is no longer a one-size-fits-all preventive tool for older adults, which for decades it was touted as,” said Dr. Jordan Schaefer, a hematologist at the University of Michigan School of Medicine. “This poll shows we have a long way to go to make sure aspirin use is consistent with current knowledge.”

National guidelines for aspirin use have evolved in recent years because the over-the-counter drug can increase a person’s risk of dangerous bleeding. Experts now weigh the risk of bleeding against the benefits of preventing blood clots that can cause heart attacks and strokes.

Because of this, guidelines now mostly focus on people who have heart health problems or are at high risk due to their personal or family health history, experts said.

The U.S. Preventive Services Task Force now recommends against initiating aspirin for the prevention of heart disease in adults 60 or older.

Meanwhile, the American Heart Association (AHA) and the American College of Cardiology (ACC) say daily low-dose aspirin might be considered for heart disease prevention in select adults 40 to 70 who are at increased risk of heart problems but not bleeding.

The AHA and ACC offer online calculators to help doctors estimate a person’s 10-year risk of heart disease....**Read More**

FDA Approves Wegovy to Help Prevent Heart Attack, Stroke

Wegovy (semaglutide), the weight-loss version of blockbuster diabetes drug Ozempic, was approved on Friday by the U.S. Food and Drug Administration to help prevent heart attack, stroke and heart death.

“Wegovy is now the first weight-loss medication to also be approved to help prevent life-threatening cardiovascular events in adults with cardiovascular disease and either obesity or overweight,” **Dr. John Sharretts,** director of the Division of Diabetes, Lipid Disorders and Obesity in the FDA’s Center for Drug Evaluation and Research, said in an **agency statement**.

“This patient population has a higher risk of cardiovascular death, heart attack and stroke," Sharretts explained. "Providing a treatment option that is proven to lower this cardiovascular risk is a major advance for public health.”

According to the FDA, over 70% of U.S. adults are overweight or obese, putting them at added risk for **heart attack** or stroke.

In one multinational study involving over 17,600 people, participants received either injected Wegovy or a placebo injection. All participants also got standard-of-care management of their blood pressure and cholesterol plus counseling on exercise and healthy eating.

"Wegovy significantly reduced the risk of major adverse cardiovascular events [cardiovascular death, heart attack and stroke], which occurred in 6.5% of participants who received Wegovy compared to 8% of participants who received placebo," the FDA said.

It's thought that this expanded approval from the FDA could remove barriers from insurance companies when it comes to covering Wegovy. That could greatly expand the number of people who might be prescribed the drug.

Wegovy does have potential side effects, the agency said, including nausea, diarrhea, vomiting, constipation, abdominal (stomach) pain, headache, fatigue, dyspepsia (indigestion), dizziness, abdominal distension, belching, flatulence, low blood sugar in patients with diabetes, flatulence and heartburn.

Patient taking Wegovy may also face upped risks for inflammation of the pancreas (pancreatitis), gallbladder problems (including gallstones), low blood sugar, acute kidney injury, hypersensitivity reactions, diabetic retinopathy (damage to the eye's retina), increased heart rate and suicidal behavior or thinking.

Using Wegovy along with insulin also raises risks for low blood sugar, so people who take insulin should talk with their doctor before starting Wegovy, the FDA said.

"The prescribing information for Wegovy [also] contains a boxed warning to inform health care professionals and patients about the risk of thyroid C-cell tumors," the FDA said, so it should not be used by people with a personal or family history of medullary thyroid carcinoma.

More Evidence Sleep Apnea Harms Thinking, Memory

Sleep apnea could have detrimental effects on the brain, causing memory or thinking problems, a new study suggests.

People suffering from sleep apnea are about 50% more likely to also report having memory or thinking problems, compared to those without sleep apnea, researchers say.

“These findings highlight the importance of early screening for sleep apnea,” said researcher Dr. Dominique Low, a clinical fellow with the Boston Medical Center.

Sleep apnea occurs when people stop and restart breathing repeatedly as they sleep. Symptoms include snoring, gasping and breathing pauses.

People with sleep apnea often suffer from unexplained fatigue and mood swings, because their breathing interruptions continually wake them as their blood oxygen levels dip. They are unable to settle into a deep and nourishing sleep.

For this study, researchers surveyed nearly 4,300 people about their sleep quality, memory and brain function.

About a quarter of the participants reported symptoms of sleep apnea.

Of those with sleep apnea, a third (33%) reported memory or thinking problems, compared to just 20% of people without sleep apnea.

Low plans to present her study at the American Academy of Neurology annual meeting, which takes place in April in Denver. Research presented at medical meetings should be considered preliminary until published in a peer-reviewed journal.

Low said the findings point to the importance of taking sleep apnea seriously.

“Effective treatments like continuous positive airway pressure (CPAP) machines are readily available,” Low said in a meeting news release. “Quality sleep, along with eating a healthy diet, regular exercise, social engagement and cognitive stimulation, may ultimately reduce a person’s risk of thinking and memory problems, improving their quality of life.”

Yogurt Makers Can Make Limited Claims About Type 2 Diabetes Prevention: FDA

Yogurt makers can now make limited claims about the food's power to help prevent type 2 diabetes, the U.S. Food and Drug Administration says.

In a **statement** released Friday, the agency said it will not object to "qualified health claims" that say there is some evidence that eating at least 2 cups of yogurt a week may lower the chances of developing the blood sugar disease.

The FDA has allowed "qualified health claims" for dietary supplements since 2000 and for foods since 2002, the *Associated Press* reported.

According to the agency, a qualified health claim is supported by scientific evidence but it doesn't meet the more rigorous “significant scientific agreement” standard required for an authorized health claim.

Some of the qualified health claims that the FDA has allowed in the past include that consuming some types of cocoa may reduce heart disease and cranberry juice might reduce the risk of urinary tract infections in women.

In the case of yogurt, the saga began in 2018 when Danone North America, whose yogurt brands include Dannon, Activa and Horizon Organics, **petitioned** the FDA for approval to make the health claim.

In its petition, the company pointed to studies that observed participants over time and found a link between eating yogurt and lower markers of diabetes. The FDA agreed there “is some credible evidence” of benefit from eating yogurt as a whole food, but not because of any particular nutrient in the product.

Still, critics said the label change is not based on gold-standard randomized controlled trials.

Food policy expert **Marion Nestle** told the *Associated Press* that qualified health claims are “ridiculous on their face.”

“Translation: If you want to believe this, go ahead, but it’s not on the basis of evidence,” she added.

Even a Little Daily Exercise Cuts Your Stroke Risk

Even a little physical activity can cut a person's stroke risk compared to being a complete couch potato, a new review shows.

Folks whose physical activity levels fell short of recommended guidelines still had a lower risk of stroke than those who got no exercise, researchers report.

Compared with no exercise, the highest "ideal" amount of physical activity cut stroke risk by 29%, researchers said.

However, even "below target" activity still reduced risk by 18%, results show.

"According to our results, all levels of leisure-time physical activity can be beneficial for stroke prevention, including levels currently regarded as low or insufficient," said the team led by senior researcher **Raffaele Ornello**, a postdoctoral investigator of applied clinical sciences and Biotechnology at the University of L'Aquila in Italy.

"People should be encouraged to be physically active even at the lowest levels," the researchers concluded.

For their paper, the team pooled the results of 15 previous studies on physical activity levels and stroke risk, involving more than 752,000 adults followed for more than a decade, on average.

Overall, moderate levels of physical activity that fell below recommended levels still cut stroke risk between 27% and 29%, when compared to no exercise, researchers found.

The effects were independent of sex or age, researchers said. Essentially, everyone can benefit from whatever physical activity they can manage in their spare time. The new study was published March 5 in the ***Journal of Neurology Neurosurgery & Psychiatry***.

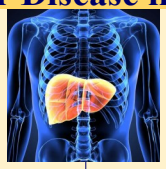
International guidelines recommend 150 minutes or more each week of moderate-intensity physical activity, or 75 minutes or more of vigorous activity, researchers said in background notes.

Examples of moderate-intensity activity include brisk walking, water aerobics, ballroom dancing, gardening, doubles tennis and casual bicycling, according to the American Heart Association (AHA).

Vigorous-intensity activity includes running, swimming laps, jumping rope, fast cycling and heavy yard work shoveling or hoeing, the AHA says.

"Our results are in line with a key principle of the 2020 World Health Organization evidence-based recommendations for physical activity, that is, that some physical activity is better than none," the researchers wrote in a journal news release.

Ozempic Eases Fatty Liver Disease in People Living With HIV



. There's more good news around the diabetes and weight-loss drug Ozempic: It might help ease fatty liver disease in people living with HIV, new research shows.

Six months of weekly injections of **Ozempic** (semaglutide) resulted in an average 31% reduction of a harmful buildup of fat in the liver of HIV-positive patients, the **study** found.

What's more, the trial had "29% of participants experiencing a complete resolution of [fatty liver], meaning their liver fat decreased to 5% or less of overall liver content," according to a news release from the U.S. National Institute of Allergy and Infectious Disease (NIAID), which funded the research.

The clinical name for the condition targeted by the trial is metabolic dysfunction-associated steatotic liver disease (MASLD). It's the most common cause of liver disease in the United States and often occurs among people with obesity and/or type 2 diabetes.

People living with HIV can also be afflicted with MASLD. According to the NIAID, up to 40% of patients will develop MASLD, often as a side effect of treatment.

If left untreated, MASLD can lead to a need for liver transplant.

Because Ozempic helps ease obesity and type 2 diabetes, researchers led by **Dr. Jordan Lake**, of the University of Texas (UT) Health Houston, wondered if it might help folks with HIV.

The study involved 49 people living with HIV, 40 of who were taking HIV-suppressing drugs that contained some form of integrase strand transfer inhibitor medications. Those medications are known to have the side effect of weight gain, upping the odds that a patient might develop MASLD.

After six months of weekly self-injected doses of Ozempic, Lake's team used MRIs to examine the livers of the patients.

Besides the dramatic reduction in fat in the liver, patients also lost weight, improved their blood sugar control and showed improvements in their blood triglyceride levels, the study found.

"Semaglutide was generally well tolerated, with an adverse event profile similar to that observed in people without HIV," the NIAID news release noted. When side effects did occur they usually involved nausea, diarrhea, vomiting and abdominal pain. No participants dropped out of the trial due to side effects.

The findings support the notion that Ozempic could bring boost liver health in folks living with HIV, researchers said.

Further research is underway to see if people with HIV react any differently to the drug (in terms of immune or inflammatory responses) than patients not infected by the virus.

The findings were presented Tuesday at the annual Conference on Retroviruses and Opportunistic Infections (**CROI**) meeting in Denver. Because the findings were presented at a meeting, they should be considered preliminary until published in a peer-reviewed journal.

FDA Delays Decision on New Alzheimer's Drug

Instead of approving the new Alzheimer's drug donanemab this month, as was expected, the U.S. Food and Drug Administration will now require the experimental medication be scrutinized more closely by an expert panel, the drug's maker said Friday.

"The FDA has informed Lilly it wants to further understand topics related to evaluating the safety and efficacy of donanemab, including the safety results in donanemab-treated patients and the efficacy implications of the unique trial design," the company said in a **statement**.

The move surprised the company, which had believed the agency would give its blessing to the drug during the first quarter of this year.

"We were not expecting this," **Anne White**, a Lilly executive vice president and president of its neuroscience division, told the *Times*.

While independent FDA advisory committees are often called upon when the agency has questions about drugs, it was unusual to do so "at the end of the review cycle and beyond the action date that the FDA had given us," White noted.

While the FDA did not comment on the news, Lilly officials said they expected it would be a few months before the appropriate advisory committee meets to weigh the benefits of the drug, the *Times* reported.

"The FDA did commit to us to move quickly, so we would hope that they would then take action shortly after the advisory committee," White added.

For decades, one experimental Alzheimer's drug after another has been disappointing. However, donanemab, which is given by infusion once a month, belongs to a new class of medications that attack amyloid plaques, a hallmark of the disease.

Last year, another drug in the class, Leqembi, was **approved** by the FDA. An infusion given every two weeks, Leqembi can modestly slow cognitive decline in the early stages of Alzheimer's….**Read More**