

### Message from Alliance for Retired Americans Leaders

#### Record High of Over 20 Million Selected Affordable Health Coverage through ACA Since the Start of Open Enrollment



Robert Roach, Jr.  
 President, ARA

The U.S. Department of Health and Human Services **reports** that a record 20 million people have selected an Affordable Care

Act (ACA) Health Insurance Marketplace plan since the 2024 Marketplace Open Enrollment Period began in early November.

3.7 million new people have selected plans using the Marketplaces for 2024, an 18% increase over 2023. The overall rise in coverage has been monumental – since Biden took office there has been an increase of over 8 million people who now have coverage.

Under the Biden Administration, the Affordable Care Act (ACA) has been bolstered alongside the passage of other key pieces of legislation – including the IRA and the **American Rescue Plan** – which have made health coverage more affordable.

Medicaid unwinding has **played a role** in increasing enrollment in the Marketplace. During the pandemic, states allowed continuous enrollment in Medicaid, but recent disenrollments have spurred a shift. Enhanced subsidies in the American Rescue Plan have aided the transition from Medicaid to private coverage.

Older Americans are much more likely to have pre-existing conditions, with up to **84%** of people aged 55- 64 having at least one. This often directly leads to a

denial of coverage by insurers. The Affordable Care Act has **put an end** to this health discrimination for millions of Americans by barring health insurance companies from refusing coverage on the basis of a pre-existing condition.

"The increased enrollment in health coverage through the Affordable Care Act is an indicator of how crucial the ACA remains," said **Robert Roach, Jr., President of the Alliance**. "The American Rescue Plan has also been key as Medicaid disenrollments continue."

#### Republican Presidential Debate Brings Back Threats to Cut Social Security and Medicare



Rich Fiesta,  
 Executive Director, ARA

Wednesday night's debate brought new attention to Republican presidential hopeful Nikki Haley's statements about cutting Social Security and

Medicare, as well as Ron DeSantis' previous votes to slash the programs while in the U.S. House.

Haley, formerly governor of South Carolina, has been the most vocal of all the Republican candidates, openly **declaring** at the debate that she plans to raise the retirement age at which younger Americans, such as those in their 20's, can become eligible for Social Security benefits. The current Full Retirement Age, or FRA, is 67 for people born in 1960 and later. While Haley did not specify what she would raise the age to, moving the FRA from 67 to 70, as some have proposed, would effectively cut currently scheduled benefits **by nearly**

#### 20%.

Previously, she **stated**, "What they need to be doing is looking at entitlements. Look at Social Security. Look at Medicaid. Look at Medicare. Look at these things, and let's actually go to the heart of what is causing government to grow, and tackle that."

DeSantis, Florida's governor, backtracked away from proposing changes to Social Security on the debate stage by pointing towards a declining U.S. life expectancy, but his record reflects otherwise. During his time as a congressman, DeSantis earned a **0% rating** in the Alliance's pro-retiree voting record. He voted numerous times to privatize and cut Social Security and Medicare through voucherization, slower cost of living increases, and raising the retirement age.

Former President Donald Trump, who was not on the debate stage despite qualifying, has said "we're going to look" at cutting Social Security and Medicare if he gets a second term. He also proposed cutting the programs every year he was President.

"Ron DeSantis, Nikki Haley and Donald Trump have shown time and again that they are willing to cut Social Security and Medicare," said Richard Fiesta, Executive Director of the Alliance. "Wednesday's debate should serve as a reminder to anyone who may have forgotten."

#### Florida's Plan to Import Lower-Cost Prescription Drugs from Canada Approved by FDA

The Food and Drug Administration has **approved** Florida's plan to import prescription drugs from Canada in an attempt to lower costs. The first drugs that Florida expects to

import will treat HIV, mental illness, and prostate cancer. These specific medications will require further FDA approval to import, and once imported, they will be made available to state-run facilities and Medicaid recipients.

This state plan comes under a wider national push from the Biden Administration to lower prescription drug prices through laws like the Inflation Reduction Act. The Florida importation plan is estimated to save state taxpayers up to \$150 million if enacted without impediment.

However, there is reason to cast doubts on the likelihood of imports ever being allowed. The U.S. pharmaceutical industry responded negatively to the decision, signaling an immediate push to prevent the policy through any option available. Additionally, Canada, seeking to avoid drug shortages, has restricted such exports.

"Florida's importation program's success in gaining FDA approval is a welcome step in the fight for lower prescription drug prices," said **Joseph Peters, Jr., Secretary-Treasurer of the Alliance**. "They complement President Biden's achievements in lowering drug prices nationally, including the



Joseph Peters, Jr.  
 Secretary  
 Treasurer ARA

Inflation Reduction Act (IRA), which finally forces drug corporations to negotiate with Medicare."

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## Here's Why Your Social Security Check Is Safe as a Government Shutdown Looms

With talk of a potential government shutdown, millions of Americans worry if they will still receive their Social Security check if an agreement is not fully reached. Although congressional leaders agreed over the weekend on spending limits in 2024, it's a step in the right direction but not enough to prevent a shutdown.

To keep the government open through September 2024, lawmakers need to pass a series of funding bills or a continuing resolution to extend funding. The early deadlines this year for these funding bills are January 19th and February 2nd. Social Security recipients can rest easy, though, as this won't affect their monthly checks. However, the broader implications of budgetary decisions may cast a shadow over some of the services the Social Security Administration provides.

### Why your Social Security check is safe

Despite the drama of budget negotiations, experts, including Max Richtman, president and CEO of the National Committee

to Preserve Social Security and Medicare, confirm the safety of Social Security checks.

Social Security is considered mandatory government spending, and because the money comes from a trust specifically designated for Social Security payouts, is immune to the varying budget discussions every year.

### How a shutdown affects your Social Security

In the event of a government shutdown, your Social Security check is safe, but it will impact other operations that support Social Security offices. For example, a shutdown won't impact applying for benefits or issuing Social Security cards, but other services like benefit verifications and replacement Medicare cards, would temporarily stop.

While the offices that sustain Social Security will remain open, a shutdown might affect other offices that offer extended support. This may result in



delayed responses but not a cutoff in payment checks.

What to expect with the government shutdown

Andrew Lautz, a senior policy analyst at the Bipartisan Policy Center, said the true impact on Americans unfolds gradually as essential programs and services face disruptions.

As agencies begin shutting down, you may feel the effects on a "rolling basis" as services start to become unavailable. Medicare and Social Security often go hand in hand, and while Medicare benefits are also considered mandatory spending and are safe, other services may be interrupted.

This means initial Medicare enrollment could be disrupted. During the 1995-1996 federal shutdown, more than 10,000 Medicare applicants were temporarily turned away every day of the shutdown.

So, while Social Security benefit checks and new applicants are safe, **lowering financial stress**, a shutdown

affects the overarching support system that extends beyond just Social Security.

That said, the government has never shut down long enough for a real effect on Social Security and Medicare benefit payments and services. If they truly happen, shutdowns usually do not last more than a couple weeks, with the longest government shutdown on record 35 days.

### Bottom line

As Congress navigates the fiscal landscape, the fate of Social Security benefits remains safe, and recipients need not worry. Budget negotiations will not interrupt your monthly benefit check. However, it might be wise for seniors and any Social Security or Medicare recipients to try to get any administrative work out of the way before any supporting offices are affected.

## Proposed Rule Would Improve Clarity and Transparency in Medicare Advantage, Boost Access to Care

Last week, the Medicare Rights Center **submitted comments** on a proposed rule that would increase awareness of and access to Medicare Advantage (MA) supplemental benefits, make the connections between Medicare and Medicaid stronger for those who are dually eligible for both programs, require evaluations of plan prior authorization patterns, and begin to realign broker incentives with beneficiary interests.

Every year, the Centers for Medicare & Medicaid Services (CMS) proposes rules that change how MA and Part D plans operate. In some years, the proposals include major changes, while other years see more minor tweaks to the programs.

The proposed rule for 2025 falls into the latter category. In our comments, Medicare Rights welcomed the small but important steps the proposals represent, while urging CMS to do more to prioritize beneficiary health and well-being. For example, if finalized, the rule would require

to enrollees if they may be eligible for supplemental benefits they have not already accessed. Such a notice could remind enrollees about the benefits and give important information about what they need to do to take advantage of the items or services. We urged CMS to move forward with this proposal and to make the notices more frequent and actionable to improve their efficacy. We know from **past analysis that many people choose MA because of the potential for supplemental benefits**, which makes it vital that those enrollees get the benefits they thought they were getting.

Another proposal would require some **Dual-Eligible Special Needs Plans (D-SNPs)**, a special kind of MA plan solely for people who have both Medicare and Medicaid, to do a better job of tying together their respective service areas and bolstering plan integration. We raised some concerns about ways these proposals might interfere with access to care and encouraged



CMS to continue to prioritize the beneficiary experience. An additional proposal would require all MA

plans to conduct a health-equity **analysis of how people in some groups are affected by prior authorization** that may deny or delay care, and how those patterns differ, if at all, with the care received by people not in those groups. The proposal would also require plans to publish this analysis so that enrollees, providers, and the public can better see the impact of prior authorization on each category of enrollee and beneficiaries as a whole. We strongly supported this proposal and urged CMS to require the analysis to include people with a wider range of backgrounds and experiences.

Another important proposal would limit how **much commission brokers and agents receive to sell MA plans**. Currently, brokers and agents have a cap on their commissions for both MA plans with Part D prescription drug coverage and

standalone Part D plans; for 2023, the caps were \$601 for each MA initial enrollment and \$92 for each Part D initial enrollment. As these numbers show, the commissions are much higher for MA than Part D. In practice, they are even higher as many MA plans skirt these rules and pay brokers additional "administrative" fees, which they claim are necessary to cover certain broker expenses. The proposed rule would bump up the commission level somewhat and eliminate these administrative fees to better level the playing field between smaller MA plans, larger MA plans, and standalone Part D plans. While we strongly support closing this loophole, we urged CMS to do much more to bring MA commissions into alignment with those for Part D to avoid the current incentive to sell MA plans even when they are not the best option for individuals.

In all, we were supportive of most of the ideas in the proposed rule and hope CMS will consider our suggestions in finalizing these important policies.

## FDA allows Florida to import lower-cost drugs from Canada

Finally, in large part thanks to former President Trump and Governor Ron DeSantis, as well as to the Biden Administration's Federal Drug Administration (FDA), the US plans to open its borders to drug importation, reports Christina Jewett and Cheryl Gay Stolberg for the **New York Times**. While that is not a long-term fix to unconscionably high drug prices in the US, it is a terrific first step—unless the pharmaceutical industry succeeds at blocking these drug imports.

To be clear, the FDA only has approved drug importation from Canada. And, as of now, only the state of Florida has approval. But, it is the camel's nose under the tent and could save Florida as much as \$150 million in drug costs in its first year.

Interestingly, while the Biden Administration supports drug importation, it took a **lawsuit by the state of Florida against the FDA** to get the the needed federal approval.

Americans already can buy drugs legally directly from Canadian pharmacies for personal use, but insurers are not required to cover those drugs. They still don't. But **Florida has approval** to buy drugs for enrolled in its Medicaid program, or using its health clinics or in prison.

It's also not clear whether drug importation from Canada will

work better for states in theory than in practice. Canada might not have enough supply to provide the drugs Florida needs, let alone the drugs other states will also want to purchase once they have FDA approval.

You can bet your bottom dollar that Pharma is pulling out all stops to keep drug importation from happening. It plans to bring a lawsuit to prevent Florida from importing drugs from Canada. Moreover, some Canadian drug wholesalers have signed contracts with pharmaceutical companies agreeing not to export their drugs. In addition, Canada does not have a bottomless supply of drugs.

Time will tell how this story unfolds. Drug importation from Canada was a long time coming. The New York Times reports that Congress passed legislation allowing drug importation 20 years ago, but it is only now that the administration is implementing it. Allegedly, there were "safety" concerns. More likely, there were concerns about PhRMA's wrath.

To be clear, patient safety concerns abound in the US because people cannot afford the drugs they need. Too often, **they die as a result**. And, even more often, they become sick or disabled because they cannot afford to fill their prescriptions.

There are no reports of people



harmed from importing drugs from abroad. **Nine million Americans import drugs from abroad every year** without incident.

Colorado, Maine, New Hampshire, New Mexico, North Dakota, Texas, Vermont and Wisconsin have passed laws to allow their states to import drugs and likely many more will do so. Canada should not be the only foreign provider. Many drugs taken in the US are manufactured in India, China and elsewhere. Americans should be permitted to import drugs from verified pharmacies in any country.

Americans support drug importation. Of course, they do. We import food safely from abroad, and automobiles, and electronics and more. There's no good reason that we cannot import prescription drugs safely.

If you support competition, you should support drug importation, especially since drugs in the US often cost **four times more** than drugs in other developed countries.

The Inflation Reduction Act allows our government to negotiate drug prices, which is arguably the best way to bring down drug prices in the US. But, it only allows **drug price negotiation for 10 high-priced drugs in the first year**, and only for people with Medicare. It's

good, but way less than what we need.

And, while helpful, Medicare Part D drug plans can still cost you a bundle. If you want to keep your drug costs down, you need to compare your drug copays against the full cost of your drugs at Costco and other low-cost pharmacies. In some cases, you'll pay less through **Costco as this JustCare reader does**.

The big problem with drug prices in the US is that **PhRMA can charge pretty much what it will for brand-name drugs**.

There's little competition. PhRMA also can keep low-cost generic alternatives off the market for years.

Florida still must specify the drugs it will import to the FDA and explain how it will ensure they are not counterfeit. Florida also must relabel the drugs.

Meanwhile, the Canadian government is none too happy about exporting drugs to Florida. The government could step in if it is not liking the consequences of drug exports. There is understandable worry that a country with fewer than 40 million people will find themselves without needed drugs if it exports them to a state with 22 million people, let alone to multiple states with tens of millions more people.

## Senior Home Care: Services, Costs and Tip for Aging in Place

Learn about in-home caregiving options for seniors who want to stay in their houses for as long as possible

Aging is a fact of life. We simply can't stop the clock, and for most adults, there will come a time when a little extra assistance performing the tasks of daily living would be helpful.

In fact, someone who turns 65 today has a nearly 70% chance of needing some **type of long-term care** in their remaining years, according to the Department of Health and Human Services.

For some people, this support means moving into an **assisted living community** or a nursing home. For others, aging in place is a much more attractive goal.

### What Is Aging in Place?

"Aging in place" is exactly as it

sounds: Spending your twilight years in your home, without having to move to a senior care facility.

It's also a popular choice. According to AARP's 2021 Home and Community Preferences Survey, 77% of adults ages 50 and older want to stay in their homes for the long term. Only 29% of survey respondents said they plan to relocate to another community as they age.

What's key to staying in your familiar environment is **senior home care**.

"Senior home care allows seniors to continue living as independently as possible at home, with limited care provided as the individual's needs require,"



says Bob Rees, chief sales officer with eHealth Inc., a health insurance broker and online resource provider headquartered in Santa Clara, California.

### Senior Home Care vs. Senior Home Health Care

Support for aging in place can take a variety of forms – from technology to human services – but it tends to take two primary forms: senior home care and senior home health care.

#### Senior home care

This category involves personal care **assistance**, such as light housekeeping and running errands.

"Maybe they help someone get dressed or take a shower," notes Danielle Pierotti, clinical associate professor and director

of undergraduate studies with the School of Nursing at Idaho State University in Pocatello.

These caregivers are not usually licensed to provide health care services, and the training they receive varies from company to company. This form of care is also typically paid for out of pocket by the senior or the family.

#### Senior home health care

This category of care, which can include both medical and personal care components, involves a licensed professional, such as a registered nurse or a physical therapist, and a physician's orders, Pierotti says. Senior home care, on the other hand, may not involve a physician.... **Read More**

## Why won't the government protect people from prior authorization hell?

Lauren Sausser reports for **KFF Health News** on the failure of the Centers for Medicare and Medicaid Services to protect people enrolled in Medicare Advantage plans from prior authorization rules that lead to inappropriate denials and delays of care and endanger their health and well-being. For those of you who don't quite understand "prior authorization," it is a process that allows health insurers to second-guess treating physicians, delay or deny coverage for your care before you receive it, and it is pure hell if you need care quickly. Because insurers profit more the more prior authorization they require, they use it without justification.

Like patients, doctors do not like prior authorization rules. These rules allow the insurers to overrule them, even when the insurers know little about patient

needs. Prior authorization rules often require doctors to submit additional paperwork and evidence of the need for care, making it costly and resource intensive for the doctor to deliver the care that is needed.

Back in 2021, Medicare data reveal **1.5 prior authorization requests** for each Medicare Advantage enrollee. When you consider that about half the Medicare population uses few or no services and 10 percent are responsible for 70 percent of services, we're talking a lot of prior authorization hurdles to surmount for the people who most need care.

Congress can't seem to get it act together to pass helpful legislation on prior authorization. At the very least, prior authorization rules should be public and evidence-based. Truly they should be consistent across



all Medicare Advantage plans. Otherwise, how can people distinguish among the MA plans that require prior authorization and those that do not?

Right now, CMS is **considering a proposed prior authorization rule** that could help streamline and expedite the prior authorization process for people in Medicare Advantage, Medicaid or a state health insurance exchange. It would **automate prior authorization**, require insurers to make prior authorization decisions more quickly and explain the reason for their denials.

But, CMS has yet to act on its proposed rule even though the comment period ended last fall. Moreover, its proposed rule really does not go far enough. The American Medical Association agrees, as does the

AHA. Congress is going to need to step in.

The insurance industry hides behind a lame rationale for prior authorization—ensuring enrollees get the care they need when they need it. In fact, prior authorization prevents just that. If the rationale for insurance provider networks is to ensure good care, insurers should not be second-guessing network providers.

Of course, prior authorization takes its biggest toll on the most vulnerable people with Medicare, who struggle to navigate the process and who who most need care urgently. Sometimes it takes weeks or months to get insurance company approvals for care.

At the very least we need an electronic process for prior authorization, physicians and patients should not have to be spending precious time on the phone trying to get needed care.

## Mary Lou Retton's Explanation of Health Insurance Takes Some Somersaults

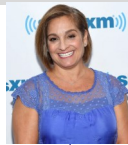
Former Olympic gymnast Mary Lou Retton spoke out last week **on the NBC "Today" show** about what she said was a rare pneumonia that almost killed her and resulted in an expensive, monthlong hospital stay.

It was a shocking reveal. One key comment jumped out for those who follow health policy: Retton said she was uninsured, blaming that lack of coverage on 30 orthopedic surgeries that count as "preexisting conditions," a divorce, and her poor finances.

"I just couldn't afford it," Retton told host Hoda Kotb, who did not challenge the assertion.

Retton, who after winning the gold medal in 1984 became a well-known figure — "America's sweetheart," appearing on **Wheaties boxes** and claiming a variety of other endorsements — did not provide details of her income, the illness, the hospital where she was treated, or the type of insurance she was seeking, so it's hard to nail down specifics.

Nonetheless, her situation can be informative because the reasons she cited for not buying coverage — preexisting conditions and cost — are among the things the Affordable Care



Act directly addresses. Under the law, which has offered coverage through state and federal marketplaces since 2014, insurers are barred from rejecting people with preexisting conditions and cannot charge higher premiums for them, either. This is one of the law's **most popular provisions**, according to opinion surveys.

The ACA also includes subsidies that offset all or part of the premium costs for the majority of low- to moderate-income people who seek to buy their own insurance. An estimated "four out of five

people can find a plan for \$10 or less a month after subsidies on HealthCare.gov," Health and Human Services Secretary Xavier Becerra said **in a written statement** when kicking off the annual open enrollment period in November.

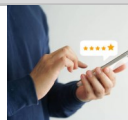
**Subsidies are set on a sliding scale** based on household income with a sizable portion going to those who make less than twice the federal poverty level, which this year is \$29,160 for an individual, or \$60,000 for a family of four. Premium costs for consumers are capped at 8.5% of household income...**Read More**

## Elevance Health sues to undo changes to Medicare Advantage star-rating system

For years, the Centers for Medicare and Medicaid Services (CMS) has been giving additional money to Medicare Advantage plans that get four and five-star ratings. The goal was to promote quality, but the reality is that the five-star rating system is a farce and needs an overhaul. CMS has taken some steps to overhaul it but Jakob Emerson reports for **Becker's** that Elevance Health is **suing** HHS for

"unlawful, and arbitrary and capricious" methodology changes to how Medicare Advantage and Part D star ratings are calculated.

Don't be misled by the government's Medicare Advantage star-rating system. As of now, Medicare Advantage plans with four and five stars could have high denial rates, high mortality rates, endless prior authorization requirements and



narrow networks that undermine access to care. CMS uses 40 quality measures to rate Medicare Advantage plans, but these measures don't give you a good clue as to whether a Medicare Advantage plan will actually cover the care you need, when you need it from physicians and hospitals you want to use.

CMS has gotten a bit stricter in giving out four and five-star ratings. And, Elevance says it is

losing revenue because fewer of its Medicare Advantage plans are getting at least four stars.

For reasons that are unclear to me, CMS cannot change MA plan star-rating scores more than five percent from one year to the next. Somehow, Elevance claims that CMS did not abide by this restriction. Elevance therefore asks the court to require CMS to recalculate all scores for purposes of star-ratings for 2024.

## Take advantage of the Medicare Advantage Open Enrollment period

If you're in a Medicare Advantage plan, you should seriously consider taking advantage of the Medicare Advantage open enrollment period between January 1 and March 31 that allows you to switch to Traditional Medicare or to a different Medicare Advantage plan. This opportunity for change is an important consumer protection. Medicare Advantage plans could have changed their provider networks or drug coverage between the fall Medicare Advantage Open Enrollment Period and now, to your detriment.

I've written at length about all the reasons to avoid enrolling in a Medicare Advantage plan, especially if you have Medicaid or can afford the supplemental coverage that you need in Traditional Medicare to limit your out-of-pocket costs. Upfront costs in Medicare Advantage are

less than those in Traditional Medicare with supplemental coverage. But, if you get sick and need care—the reason you have health insurance—your out-of-pocket costs are likely to be a lot higher in Medicare Advantage than in Traditional Medicare. Moreover, access to care is much simpler in Traditional Medicare than in Medicare Advantage. In Traditional Medicare, your treating physicians decide the care you need without an insurance company second-guessing your doctor and profiting every time it denies you care. And, there's no **prior authorization** requirements needed that can unduly delay care nor is there a restricted network. You are covered for care from the vast majority of physicians and hospitals in the US. With **supplemental**



**coverage**, your costs are predictable and often very little.

Medicare Advantage HMOs restrict your coverage to the doctors and hospitals in their networks. You can go out of network for some coverage only if you're in a PPO. But, even in a PPO, coverage tends to be limited and unpredictable. Driving your costs up further and/or endangering your health, Medicare Advantage plans impose prior authorization requirements before they will cover your care and inappropriately deny care, particularly to people with costly conditions—people needing **rehab care, people with cancer** and people with other complex care needs.

The Centers for Medicare and Medicaid Services, which oversees Medicare, should be protecting you from bad actor

Medicare Advantage plans, but it cannot. It does not have the capability, the money, or the power to oversee the more than 4,000 Medicare Advantage plans, much less to hold them to account for their bad acts.

You should also bear in mind that you can't count on the providers in Medicare Advantage directories actually being willing to see you. Multiple reports reveal "**ghost networks**" in some Medicare Advantage plans. As well, I've reported many times in Just Care on hospitals terminating their Medicare Advantage contracts, leaving Medicare Advantage plan enrollees scrambling to find alternative care or forced to drive long distances for inpatient services. **Memorial Hermann in Houston, Texas** is the most recent hospital system to do so, ending its Medicare Advantage contract with Humana.

## Do I really need supplemental insurance (Medigap) with Medicare?

About 41% of Original Medicare beneficiaries had **Medicare Supplement Insurance**, or Medigap, in 2021, according to a February 2023 report summarizing enrollment data from AHIP, a national health insurance trade association. For the other 59%, Medicare has some "gaps" that could be costly.

"There are many gaps in Medicare that a beneficiary has to pay if they don't have a Medigap," Kelli Jo Greiner, Minnesota State Health Insurance Assistance Program director, said in an email. "This can add up to be thousands of dollars per year."

While it's not mandatory, you might want to purchase a Medigap policy to fill some of the gaps in Medicare Part A and/or Part B. (Medigap doesn't work with Medicare Advantage policies.)

### DEDUCTIBLES

Medicare Part A has a deductible of \$1,632 in 2024, which you owe before Medicare starts to pay for inpatient hospital care.

"Just one hospital stay, you're going to be paying that \$1,632 deductible — so, really fast, your costs can add up," says Joanne Giardini-Russell, CEO of

Giardini Medicare, an independent insurance agency.

Most Medigap plans cover the Part A deductible. And plans with premiums below \$136 per month could put you ahead based on that benefit alone.

(New Medicare members can't buy Medigap plans that cover Part B's relatively smaller deductible of \$240 in 2024, so you'd still owe that amount out of pocket.)

### COINSURANCE AND COPAYS

After you've met your deductible, there are out-of-pocket costs for many Medicare services. For example, you pay a 20% coinsurance for most medically necessary outpatient services covered by Part B.

Medicare Part A copays kick in after your 60th day in the hospital. They start at \$408 per day in 2024 and get more expensive for longer stays.

All Medigap policies include at least some coverage for Part A and Part B coinsurance and copays. If you use a lot of health care, that coverage could mean big out-of-pocket savings.

### OUT-OF-POCKET LIMITS



Unlike many other kinds of insurance, Medicare Part A and Part B don't have maximum out-of-pocket caps. There's no limit on what you could owe as copays and coinsurance add up.

"Original Medicare without Medigap would be perilous because we need Medigap for the out-of-pocket limit," Michael Dayoub, a certified financial planner in Savannah, Georgia, said in an email.

Buying a Medigap policy is one way to put a cap on your yearly costs. Paying more upfront for premiums could pay off by limiting your future out-of-pocket spending.

### IS MEDIGAP WORTH THE COST?

You can expect to pay \$100-\$150 per month or more for the most popular Medigap plan, Plan G, when you sign up at age 65. And premiums can go up based on plan type, age, location and sometimes health status.

That's a significant added expense — so is it worth it?

Giardini-Russell compares Medigap to car insurance, which you pay for each month, even though you hope not to need it.

"It comes down a lot of times to the psychology and peace of mind," she says. "Are you willing to pay \$150 per month for peace of mind?"

"We tend to hear from beneficiaries that they are very satisfied with their policy," Greiner said. Medigap is worth it if you can afford to pay the Medigap premiums along with your premiums for Medicare Part B and a Medicare Part D prescription drug plan, according to Greiner.

If Medigap isn't affordable, you might want to look into programs that can help with Medicare costs, such as Medicare Savings Programs and Extra Help subsidies.

People who can't afford Medigap premiums could also consider Medicare Advantage, according to Dayoub. Medicare Advantage plans are bundled alternatives to Original Medicare sold by private insurance companies. They have out-of-pocket limits, but there are trade-offs to consider, such as limited provider networks.

### ENROLLMENT TIME LIMITS...[Read More](#)

## Cigna plans to sell its Medicare Advantage business

The **Wall Street Journal** reports that Cigna is planning to sell its Medicare Advantage book of business. For nearly \$4 billion, why not? While Cigna is a big health insurer, it has the smallest Medicare Advantage footprint of the big insurers. The sale signals the inevitable future of Medicare Advantage—one or two mega insurers with the vast majority of the Medicare Advantage business and all the power to undermine access to care in order to maximize profits.

Currently, Cigna operates in 29 states. A sale to Blue Cross Blue Shield would boost its power in the Medicare Advantage marketplace. Originally, Cigna

had considered buying Humana's Medicare Advantage book of business, but investors did not receive that plan favorably.

Cigna is a relatively small Medicare Advantage player with only 599,000 Medicare Advantage enrollees as of September 2023. UnitedHealth has more than twelve times as many enrollees, 7.6 million. Humana has nearly 10 times as many enrollees, 5.9 million.

Cigna's departure from the Medicare Advantage marketplace will be unsettling for its enrollees, but should not come as a surprise. Nothing about a Medicare Advantage plan is reliable.



Medicare Advantage management, along with coverage and payment practices, can change all the time. Plans can grow larger through acquisitions or shrink in size.

Medicare Advantage provider networks also are ever-changing and unreliable. Denial rates and prior authorization rules are not even knowable and according to the Office of the Inspector General, there are **widespread and persistent inappropriate delays and denials of care and coverage in some Medicare Advantage plans.**

Hospitals and specialists are increasingly canceling their Medicare Advantage contracts,

meaning unreliable access to care for tens of thousands of Medicare Advantage enrollees. But, these providers are cancelling in part because of patient safety concerns, meaning risks to health and well-being in Medicare Advantage. The **AMA's doctors report serious concerns with MA prior authorization** to the detriment of patients.

The **Medicare Advantage Open Enrollment** period began January 1 and continues through March 31. If you want to be sure you get the care you need when you need it, take advantage of it and switch to Traditional Medicare.

## These 3 Factors Will Impact Your Social Security Checks in 2024

It's natural to grow reliant on the monthly benefit you receive from Social Security, especially if you're someone without a ton of money in savings. But the amount of money you collect from Social Security can change from one year to the next. And these three factors could influence what your benefits look like in 2024.

### 1. Your cost-of-living adjustment

Each year, **Social Security** benefits are subject to a cost-of-living adjustment (COLA). COLAs are based on inflation, and as you may have noticed, living costs have been cooling to some degree.

Because of this, your 2024 COLA won't be as high as the raise you got in 2023. Last year, Social Security benefits increased 8.7% at the start of the year. This year, they're only going up 3.2%. However, that might still give

you a bit of extra buying power.

### 2. Your earnings from a job

It's not against the rules to collect Social Security if you're still working. And once you **reach full retirement age (FRA)**, which is the age at which you're entitled to your monthly Social Security benefit in full based on your personal wage history, you can earn any amount of income from a job without risking having any benefits withheld.

However, if you're working and collecting Social Security now and have not gotten to FRA yet, you'll be subject to an earnings-test limit. And exceeding that limit could mean having some of your Social Security income withheld until your FRA arrives.

### 3. Your Medicare costs

Seniors who are enrolled in Medicare and Social Security at



the same time have their Part B premiums deducted from their benefits automatically. Because of the cost of Medicare is

rising this year, you may not get your full Social Security COLA.

Last year, the standard Medicare Part B premium was \$164.90 a month. This year, it's gone up to \$174.70. And unfortunately, that extra money is going to come out of your Social Security benefits.

### Know what to expect

If Social Security is a key income source for you, then it's important to understand the factors that could cause your benefits to change for better or worse. Keep all of these items in mind so you can budget accordingly for 2024.

Here's how it works. Let's say your FRA is 67 and you're currently 65. In that case, you can

earn \$22,320 this year without having benefits withheld. Beyond that point, you'll have \$1 in Social Security withheld per \$2 of earnings.

Now let's imagine you were reaching FRA at some point in 2024. In that case, you'd have a higher earnings-test limit -- \$59,520. And the rules of withheld benefits would skew slightly more in your favor, with \$1 in Social Security getting withheld per \$3 of earnings instead of \$2.

Either way, depending on your age and income, the amount of money you receive from Social Security this year could be different than what you expect it to be. If you don't want to risk having benefits withheld, make sure to keep your income below the aforementioned thresholds.

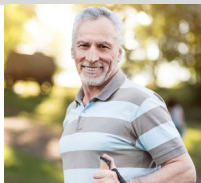
## Aging in Place: What You Need to Know About Healthy Aging

Aging in place means living in the home of your choice—safely and independently—as you get older. It's about living out your golden years in comfort. But it requires planning for how you will deal with any challenges that may arise. In essence, healthy aging involves creating the right environment and putting supports in place that allow you to meet your ongoing physical and emotional needs.

Did you know that American

seniors are healthier today than they have been in years past? One study found that older adults were **14 percent more likely** to say they were in excellent or very good health in 2014 than in 2000.

Successful aging is influenced by a range of factors, including diet, lifestyle, and genetics. The reality is that you can be healthy at 50 or any other age by adopting a lifestyle that features



regular exercise and a well-balanced diet. Of course, staying healthy and safe may require adapting your home to accommodate your changing needs, which you can read more about below.

This article outlines how the definition of successful aging has evolved over the past few decades. It also describes some common diseases that often come with age and explains what you

can do to reduce your chances of being affected by them. And it provides practical tips on how to successfully age in place.

- ◆ **What is successful aging? Changing definitions**
- ◆ **7 common diseases of aging and how to lower your odds of getting them**
- ◆ **4 tips on aging in place**

## As Blizzards Bear Down, Stay Safe From Carbon Monoxide Dangers

With blizzards and possible power outages threatening much of America this week, some dangers might not be immediately obvious: carbon monoxide poisoning, fires and electric shock.

"I urge consumers to follow CPSC's safety tips to prepare ahead of storms to prevent loss of life in a storm's aftermath," said **Alex Hoehn-Saric**, chair of the U.S. Consumer Product Safety Commission.

Carbon monoxide (CO) from gasoline-powered portable generators can kill within minutes if used improperly. It has no color or odor, so can render a person unconscious even before they recognize the symptoms of nausea, dizziness or weakness, the CPSC warns.

This gas kills nearly 100 Americans using portable generators each year. Black individuals have a higher risk of death, accounting for 23% of those who died between 2011 and 2021, according to the CPSC.

To stay safe, the commission advises following these recommendations:

- ◆ Never operate a portable

generator inside a home, garage, basement, crawl space or shed. It's not enough to open doors or windows. Lethal levels of CO can still build up.

- ◆ Use these generators outside only, at least 20 feet away from the house. Direct the exhaust away from the home and any other buildings that someone could enter.
- ◆ Keep windows and other openings closed that are in the pathway of the exhaust.
- ◆ Never use a generator on a porch or in a carport. They are too close to the house.
- ◆ Follow portable generator instructions about electrical shock hazards. These include use of an NFPA-rated non-combustible generator tent or waiting until the rain has stopped.
- ◆ Make sure portable generators are maintained properly. Read and follow the labels, instructions and warnings on the generator and in the owner's manual.



- ◆ Choose a portable generator with a CO shut-off safety feature.

This is meant to shut the generator off automatically when high levels of CO are present. These generators may be advertised as certified to the latest safety standards for portable generators -- PGMA G300-2018 and UL 2201. They are estimated to reduce deaths from CO poisoning by 87% and 100%, respectively. The UL 2201 certified models have reduced CO emissions in addition to the CO shut-off feature.

- ◆ Be sure your smoke and CO alarms are working properly.
- ◆ Install battery-operated CO alarms or CO alarms with battery backup on each level and outside separate sleeping areas at home. The best alarms are interconnected.
- ◆ Install a smoke alarm on every level of the home and in each bedroom. Test these alarms monthly and replace batteries, if needed. Never ignore an alarm when it sounds. Get outside immediately. Then call 911.

The CPSC offers some additional tips for charcoal and candles. Never use charcoal indoors because that can lead to lethal levels of CO to build up. Don't cook on charcoal in the garage, even with the door open.

Use flashlights or battery-operated candles rather than those with flames. If you do use them, do not burn them near anything that can catch fire and never leave them unattended. Extinguish them before leaving the room or sleeping.

Use caution if appliances may have gotten wet. Do not touch wet appliances that are still plugged into an electrical source. Have a professional or your gas or electric company evaluate appliances for safety.

Replace all gas control valves, electrical wiring, circuit breakers and fuses that have been under water.

If you smell or hear gas leaking, leave your home immediately. Call local gas authorities from outside the home. Do not operate any electronics, including lights and your phone, before leaving.

## Top Drugs With Greater Health Risks for People Over 60

We all know even the best of medications come with side effects, but there's a large portion of the population that's even *more* vulnerable to the harmful side effects of common prescriptions than everyone else. If you're 60 and over, there are many medications that your body does not process like it used to; unfortunately, at times this can be overlooked by your doctor and the responsibility for being mindful of these risks lies in your own hands.

With most adults middle-aged and overtaking an average of *four* prescription medications every day (1), things can get complicated. But there are a few experts in older adult health that have come forward with helpful advice.

### Why Older Adults Have A Greater Health Risk From Prescription Medications

So, why does age matter? Over time, your liver, which is the

primary organ for metabolizing drugs can become less and less efficient. However, it's important to note that everyone has their own natural metabolism speed- and it can be difficult for doctors to pinpoint a 100% safe dosage of a prescription drug. Someone with a fast drug metabolism may process their medications so quickly that they aren't as effective as they are expected to be; someone with a slow drug metabolism may absorb too much of a medication before it's excreted from the body: even toxic levels.

Kirby Lee, a pharmacist and associate professor of clinical pharmacy at the University of California at San Francisco explains:

"As your body ages, it absorbs medications differently. They can be metabolized differently by your liver and excreted differently by



your kidneys, so you may be more sensitive to some medications. Prescribing medications for people 65 and older can be more challenging, because some drugs can be more toxic or cause more side effects than when you were younger."

To make matters even more complicated, changes to your diet can impact your drug metabolism in unexpected ways; doctors aren't able to predict how your body might respond to a particular dosage of a medication. And unfortunately, specialists in the field are few and far between:

"Only about 7,500 physicians in the U.S. specialize in the care of older adults, according to the American Geriatrics Society. With 46 million Americans age 65 and older today, that works out to about **one geriatrician per 6,100 patients.**"

### Which Medications are More Dangerous for People Over 60?

In 1991, American geriatrician, Mark Beers, M.D. developed his signature list of medication types that posed a unique risk to seniors. This list is now known as the *Beers Criteria*, and is widely circulated and updated by American geriatricians as newer prescription drugs are created.

The criteria is meant to help both older patients and their doctors have increased awareness about which medications may have greater health risks than their intended benefits, thanks to their physiological makeup and their effect on the aging metabolic system. While it isn't meant to overrule a physician's recommendations, it's important to be aware of your body's unique needs and to *ask questions and raise concerns* for your medical care provider and pharmacist... **[Read More](#)**

## Hydroxychloroquine could have caused 17,000 deaths during Covid, study finds

Nearly 17,000 people may have died after taking hydroxychloroquine during the first wave of Covid-19, according **to a study** by French researchers.

The anti-malaria drug was prescribed to some patients hospitalized with Covid-19 during the first wave of the pandemic, "despite the absence of evidence documenting its clinical benefits," the researchers point out in their paper, published in the February issue of *Biomedicine &*

*Pharmacotherapy*.

Now, researchers have estimated that some 16,990 people in six countries — France, Belgium, Italy, Spain, Turkey and the U.S. — may have died as a result.

That figure stems from a study published in the *Nature scientific journal* in 2021 **which reported** an 11 percent increase in the mortality rate, linked to its prescription against Covid-19, because of the potential adverse effects like heart rhythm



disorders, and its use instead of other effective treatments.

Researchers from universities in Lyon, France, and Québec, Canada, used that figure to analyze hospitalization data for Covid in each of the six countries, exposure to hydroxychloroquine and the increase in the relative risk of death linked to the drug.

In fact, they say the figure may be far higher given the study only concerns six countries from

March to July 2020, when the drug was prescribed much more widely.

Hydroxychloroquine gained prominence partly due to French virologist Didier Raoult who had headed the Méditerranée Infection Foundation hospital, but was later removed amid growing controversy.

It was also **considered** something of a "miracle cure" by the then-U.S. President Donald Trump, who said: "What do you have to lose? Take it."

## Overuse of Antifungal Skin Meds Could Be Driving Drug-Resistant Disease

U.S. doctors are prescribing antifungal creams to patients with skin complaints at rates so high they could be contributing to the rise of drug-resistant infections, new research shows.

These are "severe antimicrobial-resistant superficial fungal infections, which have recently been detected in the United States," noted a team led by Jeremy Gold, a researcher at the U.S. Centers for Disease Control and Prevention.

One of the biggest emerging threats: Drug-resistant forms of ringworm (a form of dermatophytosis).

In Southeast Asia, major outbreaks of this itchy, circular rash have occurred that are not

responding to either topical antifungal creams or pills.

Cases of ringworm resistant to drugs have also now been spotted in 11 U.S. states, Gold's team noted. This is leading to "patients experiencing extensive lesions and delays in diagnosis," the team said.

As is seen with the overuse of antibiotics, fungi naturally build up resistance to antifungal meds the more they are exposed to them. The CDC team believes that antifungal topical creams are being overprescribed.

Looking at 2021 Medicare Part D data, they found that 6.5 million prescriptions for creams containing antifungals, such as



ketoconazole, nystatin and clotrimazole-betamethasone, were prescribed that year.

In sheer numbers, primary care doctors wrote the biggest percentage of these prescriptions, but dermatologists and podiatrists had much higher rates on a prescriptions-per-doctor basis.

One of the big issues, according to Gold's team, is that most doctors diagnose a skin condition simply by looking at it, a method that is "frequently incorrect," even among board-certified dermatologists.

"Confirmatory diagnostic testing" of a skin lesion beyond just looking at it is rarely done, they added.

A small percentage of physicians are prescribing antifungal drugs at exceedingly high rates. In 2021, "10% of antifungal prescribers prescribed nearly one half of these medications," Gold's group found.

The new study probably only captures a fraction of the overuse of antifungals, since "most topical antifungals can be purchased over the counter without a prescription," the researchers noted.

The high use of clotrimazole-betamethasone, in particular, is thought to be a big factor in the emergence of drug-resistant ringworm.... **Read More**

## A 'Universal' COVID Vaccine Could Save Billions If Another Pandemic Strikes

A universal coronavirus vaccine could have saved millions of lives and billions of dollars if one had been available prior to the pandemic, a new study argues.

Further, a universal vaccine -- one that targets parts of the virus common to all coronaviruses -- could still be a game-changer in the future, researchers say.

But that's only possible if one is developed before another variant mutates and runs rampant through the human population.

"COVID-19 was the third major and serious coronavirus epidemic or pandemic following SARS in 2002 and MERS in 2012, thus, we should anticipate a fourth coronavirus outbreak within the next decade or so," said researcher **Dr. Peter Hotez**, dean of Baylor College's

National School of Tropical Medicine and co-director of the Texas Children's Hospital Center for Vaccine Development.

"A universal vaccine is cost-effective and cost-saving, and a priority for advancement," Hotez added.

To figure out the potential value of having had a universal vaccine at the start of the pandemic, Hotez and his colleagues developed a computer model that simulated the entire U.S. population through the introduction and spread of COVID in 2020.

Specifically, the simulation weighed what might have happened if a universal coronavirus vaccine had been available at the start.

As history shows, scientists



developed a strain-specific COVID vaccine in record time, but that still left 10 months of unchecked infection, illness and death.

Using the simulation, researchers determined that a universal vaccine would have saved money even if it had only been 10% effective against COVID and a minority of the populace had received the jab.

For example, a vaccine with 10% efficacy administered to a quarter of the U.S. population within two months of the start of the pandemic would have averted 14.6 million infections and saved more than \$27 billion in direct medical costs, researchers estimate.

The benefits of a universal coronavirus vaccine would have

held even if pharmaceutical companies had later crafted a better, more variant-specific vaccine, the model showed.

The findings were published Jan. 11 in the journal *eClinicalMedicine*.

"Our study shows the importance of giving as many people as possible in a population at least some degree of immune protection as soon as possible," said researcher **Dr. Bruce Lee**, a professor at the CUNY Graduate School of Public Health and Health Policy in New York.

"Having a universal vaccine developed, stockpiled and ready to go in the event of a pandemic could be a game-changer, even if a more specific vaccine could be developed three to four months later," Lee added in a CUNY news release.



## Vicious Cycle: Depression and Weight Gain Often Go Together

A bout of depression can trigger a bump in body weight among people struggling with obesity, a new study has found.

People who had an increase in symptoms related to depression experienced an increase in their weight a month later, researchers report in the journal **PLOS One**.

"Overall, this suggests that individuals with overweight or obesity are more vulnerable to weight gain in response to feeling more depressed," lead researcher **Julia Mueller** from the University of Cambridge's Medical Research Council said in a university news release.

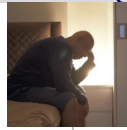
The results support prior research pointing to a link between weight and mental

health, with each potentially influencing the other.

For the study, researchers examined data from more than 2,000 adults in the United Kingdom who were participating in a COVID-19 study.

Participants completed monthly digital questionnaires on their mental well-being and body weight, using a mobile app. Questions in the study assessed each person's symptoms of depression, anxiety and perceived stress.

For every incremental increase in a person's usual depression score, their weight increased by about a tenth of a pound one month later, results show.



It might seem like a small weight gain, but researchers noted that if a person's depression rose from five to 10 on the scale they used, it would relate to an average weight gain of a half-pound.

"Although the weight gain was relatively small, even small weight changes occurring over short periods of time can lead to larger weight changes in the long-term, particularly among those with overweight and obesity," Mueller said.

This effect was only observed in people who are overweight or obese, researchers said. People with a healthy weight did not appear to gain weight as their mood fluctuated.

The researchers also found no evidence that stress or anxiety prompted weight gain, or that a person's weight predicted any increase in depression.

"People with a high BMI are already at greater risk from other health conditions, so this could potentially lead to a further deterioration in their health," Mueller said. (BMI is short for body mass index, an estimate of body fat based on height and weight.)

"Monitoring and addressing depressive symptoms in individuals with overweight or obesity could help prevent further weight gain and be beneficial to both their mental and physical health," she added.

## U.S. Has Seen Steady Rise in Role of Alcohol, Drugs in Heart Deaths

Heart disease deaths linked with alcohol or drug use have been steadily increasing in the United States, a new study has found.

Deaths from heart disease in which substance use was cited as a contributor rose an average of 4% per year between 1999 and 2019, researchers report.

Further, the death rate accelerated in recent years, rising more than 6% from 2012 to 2019, according to findings published in the *Journal of the American Heart Association*.

This occurred even though overall deaths from heart disease declined during the same period. "The study results were

generally consistent with what we see in our clinic while caring for patients with cardiovascular

disease," senior author **Dr. Dmitry Abramov**, a cardiologist and associate professor of medicine at Loma Linda University Health in Loma Linda, Calif., said in a news release.

For the study, researchers reviewed publicly available death certificate data provided by the U.S. Centers for Disease Control and Prevention (CDC). They analyzed more than 636,000 heart disease deaths associated with substance use that occurred between 1999 and 2019. Overall,



that rate rose from 9.9 deaths per 100,000 people in 1999 to 21.4 deaths per 100,000 in 2019.

Alcohol was most often implicated, playing a role in 65% of the deaths from heart disease, researchers found.

Heavy drinking is associated with high blood pressure, heart failure, stroke and obesity, according to Johns Hopkins Medicine.

Other substances involved in fatal heart disease included opioids (13.7%); cocaine (9.8%); stimulants (6.5%); sedatives (4.1%); and cannabis (0.5%).

"Although alcohol and opioids were the substances most

associated with cardiovascular deaths, the increases in cardiovascular deaths related to stimulants (predominantly amphetamines) during the study period were particularly prominent," Abramov said.

"This highlights both the ongoing risk of common substances, including alcohol and opioids, and also demonstrates the need to tackle amphetamines as a substance whose contribution to CVD deaths is growing more rapidly," he added.

The largest increase in deaths occurred among 25- to 39-year-olds (5.3%), followed by adults age 55 to 69 (4.9%), results show... **Read More**

## Hormonal Changes May Help Trigger Rheumatoid Arthritis in Women

Women are four to five times more likely than men to develop early-onset rheumatoid arthritis, and a few hormonal factors could be why, new research suggests.

Entering menopause early (before age 45), taking hormone replacement therapy (HRT), and having four or more kids are all related to heightened odds for developing rheumatoid arthritis, the study found.

Rheumatoid arthritis is an autoimmune disease in which the body's immune system attacks its own tissue, including the joints. Damage can progress to other organs.

It's long been known that women face higher risks for the

disease than men, and a team led by **Dr. Hai-Feng Pan** at Anhui Medical University School of Public Health in Hefei, China, sought to determine why.

They analyzed British data on more than 223,500 UK Biobank participants whose health was tracked for an average of 12 years. Over that period, 3,313 women (1.5%) went on to develop rheumatoid arthritis.

Later onset of periods (having first period at age 14 rather than 13) was linked to a 17% higher risk for rheumatoid arthritis, as was an earlier start to menopause (before age 45).

Women who entered



menopause before age 45 had a 46% higher risk for rheumatoid arthritis compared women who began menopause at 50 or 51, Pan's group found.

If a woman's "reproductive years" -- the time between her first period and when menopause began -- were 33 years or less, she faced a 39% higher risk for rheumatoid arthritis compared to women with more reproductive years, the team added.

Hysterectomy or oophorectomy (removal of the ovaries) also caused an uptick in risk.

Women who took birth control pills showed no increase in rheumatoid arthritis risk,

although hormone replacement therapy use did up the odds by 46%.

Finally, women who bore four children had an 18% higher odds for the disease compared to women who had two kids, the research showed.

Pan's team stressed that the findings could not prove cause and effect, only associations.

"The findings of this study are significant and form a basis on which novel and target-specific intervention measures to curb the risk of [rheumatoid arthritis] in women may be developed," Pan's group said.

## Meat-Free Diet Could Cut Your Risk for COVID

Vegetarian diets have been tied to a variety of health benefits – lower blood pressure, better blood sugar control and weight loss among them.

Now a new study suggests those benefits might even extend to a person's ability to ward off COVID-19.

A predominantly plant-based diet is linked to 39% lower odds of contracting COVID, according to a report in *BMJ Nutrition Prevention and Health*.

"In light of these findings and the findings of other studies, and because of the importance of

identifying factors that can influence the incidence of COVID-19, we recommend the practice of following plant-based diets or vegetarian dietary patterns," concluded the research team led by **Dr. Júlio César Acosta-Navarro**, an assistant physician with the Hospital das Clinicas in Sao Paulo, Brazil.

For this study, researchers tracked more than 700 adult volunteers between March and July 2022.

The participants were surveyed on their diet, and divided into



either omnivorous (both plant and animal products) or primarily plant-based dietary groups.

The plant-based diet group also was divided into flexitarians who ate meat three or fewer times a week, and vegetarians or vegans who don't eat meat at all.

Of the total group, about 47% said they had a COVID infection, including 32% with mild symptoms and 15% with moderate to severe symptoms.

About 52% of meat-eaters became infected with COVID, compared with 40% of

vegetarians/vegans.

Overall, people following a plant-based diet were 39% less likely to become infected with COVID.

However, there was no difference in symptom severity between omnivores and vegetarians, after accounting for other potentially influential factors like weight, chronic health problems and physical activity levels...[Read More](#)

## Race Still Plays Role in U.S. Cancer Death Rates

While cancer death rates have fallen among Americans generally over the past two decades, a new study finds Black Americans are still more likely than whites to die from the disease.

There has been some improvement in closing the gap -- in 2000, Black Americans were 26% more likely to die of cancer than whites, but by 2020 that disparity had shrunk to 12%, researchers at Duke University found.

American Cancer Society statistics show that cancer deaths for all Americans have fallen by a third since 1991.

However, the new analysis finds that "substantial racial and ethnic disparities persisted for many common and preventable cancers," said study co-

authors **Tomi Akinjemiju and Anjali Gupta**.

Akinjemiju is associate professor of population health and global health at Duke's Global Health Institute, and Gupta was a university scholar at Duke when the research was conducted.

The research focused on U.S. National Center Health Statistics data collected between 2000 and 2020. The investigators tracked death rates for the four most common cancers: lung, breast, prostate and colon.

Crunching the numbers, they found that death rates have declined overall, regardless of race.

In 2000, about 252 of every 100,000 Black people died of cancer, and that number had



tumbled to about 167 two decades later.

But Black Americans' death rates remained higher than those of whites. White Americans had a cancer death rate of about 198 per 100,000 in 2000 and about 149 per 100,000 by 2020, the Duke team noted.

The racial gap for breast cancer deaths actually widened: In 2000, Black women were 31% more likely than white women to die from the disease, and by 2020 that number had risen to 37%.

Black men face more than double the odds of dying from prostate cancer than white men, and they have a 45% higher odds for fatal colon cancer, compared to their white peers.

Why, despite steady

improvements in cancer detection and treatment, do these disparities persist?

According to the researchers, it's probably due to a "confluence of factors" including structural racism, mistrust of the medical profession by some Black Americans, inequities in accessing quality health care, poverty and "aggressive tumor biology" that can be traced to genetics and other factors.

The new findings, published in the Jan. 12 issue of *JAMA Health Forum*, "underscore the importance of sustained, focused efforts to reduce cancer burden among Black patients across the continuum of cancer care," the researchers wrote.

## FDA Finds No Link to Suicide With Drugs Like Wegovy, Ozempic

Drugs like Wegovy and Ozempic, which have become a wildly popular way to lose weight or battle diabetes, show no link to suicidal thoughts or actions, the U.S. Food and Drug Administration said Thursday.

"Our preliminary evaluation has not found evidence that use of these medicines causes suicidal thoughts or actions," an FDA [review](#) released Thursday stated.

Still, the agency noted officials can't rule out that "a small risk may exist," and it will continue to look into similar reports involving this class of weight-loss drugs, known as GLP-1 medications.

The FDA review comes on the heels of a [study](#) funded by the National Institutes of Health that

showed people taking semaglutide, the active ingredient in both Ozempic and Wegovy, had a lower risk of suicidal thoughts than those taking other drugs to treat obesity and diabetes.

In that study, researchers tracked over 240,000 obese people and more than 1.5 million people with type 2 diabetes. They looked at the risk of suicidal ideation within six months of starting the medicines, as well as at later times.

At six months, it found that among people taking the drug for weight loss, semaglutide was linked to a 73% lower risk of first



-time suicidal ideation and a 56% lower risk of recurrent suicidal ideation. The drugs that semaglutide was compared to included bupropion, naltrexone, orlistat, topiramate and phentermine.

For people with type 2 diabetes, the reductions were 64% and 49%, respectively. Here, the drugs that semaglutide was compared to included insulin, metformin and newer classes of medications known as DPP-4 and SGLT-2 inhibitors.

Study author **Dr. Rong Xu**, a professor of biomedical informatics at Case Western Reserve University School of

Medicine in Cleveland, told *CNN* that she decided to look into the issue after European regulators opened a probe into semaglutide and reports of suicidal thoughts last summer. Even though semaglutide was associated with a lower risk of suicidal ideation in the NIH study, the investigators wrote in a research briefing that the data "do not yet justify off-label treatment" for suicidal thoughts.

Both Wegovy and another recently approved weight-loss drug known as Zepbound have warnings in their U.S. prescribing information about the risk of suicidal behavior and ideation.