

August 15, 2021 E-Newsletter

Retirees Mourn the Death of AFL-CIO President Richard Trumka

The 4.4 million members of the Alliance for Retired Americans are united in mourning the untimely death of **Richard Trumka**, President of the AFL-CIO. He was 72.

Richard Trumka was a legendary labor leader and he was also my friend. Working people had no more committed advocate, and he will be greatly missed but never forgotten," said **Robert Roach, Jr.**, President of the Alliance. "He was our

Alliance founding Secretary-Treasurer and he helped build a retiree movement that will be an important part of his legacy. He also established a Retirement Security Working Group at the AFL-CIO devoted to protecting the pensions that have been promised to millions of workers and retirees across the country. He fought to make sure all workers have a voice on



President Trumka at the Alliance's July, 2015 Legislative Conference in Washington, DC

the job, a fair wage and a secure retirement -- a mission we will continue to fulfill in his memory." "Richard Trumka had a special connection to the Alliance for Retired Americans and a deep commitment to retirement security for all," said **Richard Fiesta**, Executive Director of the Alliance. "As a fellow western Pennsylvanian I first met President Trumka when

he was a leader of the United Mine Workers of America, working tirelessly to make sure workers received the pension, health care and Social Security benefits they have earned. He inspired us all each and every day. We will miss him deeply." The Alliance sends its heartfelt condolences to his family, friends and all who worked with him over his many years of service to workers everywhere.

Retirees Welcome Senate Budget Resolution

Medicare Drug Price Negotiation and New Benefits Means a More Secure Retirement for All Americans

Statement by Richard Fiesta, Executive Director of the Alliance for Retired Americans regarding the Budget Resolution released today:

"The Senate budget resolution released this morning is welcome news. It will make a positive and tangible difference in the lives of all older Americans and should be passed promptly.

"Allowing Medicare to bring the wealthy drug corporations to the negotiating table to lower

drug prices is common sense and desperately needed. Drug price negotiation works, as the Department of Veterans Affairs has demonstrated, and would save billions of dollars.

"Americans pay the highest prices in the world for prescription drugs. It is time for action. Older Americans bear the brunt of these outrageous prices, with a quarter reporting not taking a prescription their doctor



prescribed due to cost. Drug corporations have used their power to increase prices and pad their bottom line at the expense of consumers and the government.

"Likewise, adding dental, vision and hearing benefits for all Medicare beneficiaries will keep seniors healthier and help families make ends meet. These are important health services that should be part of traditional Medicare.

"Finally, the budget resolution means that more older Americans and people with disabilities who can receive care safely at home will be able to, rather than enter an institution. At the same time, it will help build the caregiving workforce, which provides these critical services every day.

"We thank Chairman Sanders and Majority Leader Schumer for their work, and urge swift passage of this package by both the Senate and the House."

Top 14 Drug Corporations Could Easily Afford Medicare Price Negotiation

On Thursday, Rep. Carolyn Maloney (NY), the Chairwoman of the House Committee on Oversight and Reform, held a press conference with Speaker Nancy Pelosi (CA) to release a new report analyzing the finances of 14 of the world's largest drug corporations.

The report found that the corporations have spent \$56 million more on stock buybacks, dividends to investors and other forms of executive compensation than on research and development in recent years.

One company, Amgen, spent

nearly six times as much on buybacks, dividends, and executive compensation as it did on R&D in 2018. From 2016 to 2020, compensation for the 14 corporations' top executives totaled \$3.2 billion, with annual compensation growing by 14% over that five-year period.

In addition, many drug corporations spent a significant portion of their R&D budget on finding ways to suppress generic and biosimilar competition while continuing to raise prices, rather than on innovative research.



The pharmaceutical industry has targeted the United States for price increases for many years, while cutting prices in the rest of the world. The United States is particularly vulnerable to these pricing tactics because current law prohibits Medicare from negotiating directly with drug corporations to lower prices.

H.R. 3, the Elijah E. Cummings Lower Drug Prices Now Act, would address many of the findings in the report by empowering Medicare to negotiate directly with the

corporations, and the Congressional Budget Office estimates that would save taxpayers \$456 billion over ten years.

Even if the pharmaceutical industry collected less revenue due to pricing reforms such as H.R. 3, drug companies could maintain or exceed their current R&D expenditures if they reduced spending on buybacks and dividends... **Read the Report and More**

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New Bill Would Prepare for Future Diseases

The Covid-19 pandemic demonstrated in a vivid and tragic way how unprepared we are for new diseases of this type, even though there were warnings for years from medical and scientific experts that we would be hit by one of them in coming years.

However, in the future the U.S. could have vaccines, therapies, and other medical countermeasures ready in case of

disease outbreaks under a bill introduced last week in the Senate.

According to *Bloomberg News*, “the bill, by Sen. Tammy Baldwin (D-Wis.), would provide \$2 billion to the Biomedical Advanced Research and Development Authority over four years, starting in fiscal 2022, to create a “Disease X” program aimed at developing responses to unknown viral



threats.

“There’s currently no sustained funding, program, or strategy dedicated to medical countermeasures for previously unidentified infectious diseases.

“Infectious disease outbreaks now occur three times more often than they did 40 years ago. The next pandemic, driven by an unknown Disease X, will

come,” Baldwin said in a statement. “We must invest in the development of novel antivirals, vaccines, and diagnostics for unknown threats now so that we are better prepared to control the spread than we were at the start of the COVID-19 pandemic.”

As we all know, seniors have been particularly hit hard by the Covid so this new bill is welcomed.

How an Infrastructure Bill Could Affect Drug Prices

It seems strange that a bill that is suppose to deal with the nation’s infrastructure could affect prescription drug prices, but that’s the way Washington works.

In order to get less popular items passed, Congressional members will seek to attach them to legislation that is popular and likely to pass so that even if other members of Congress don’t like a particular provision, they’ll still vote to pass a bill because of its over-all impact.

On top of that, America’s health care system is so complicated with so many working parts that making changes to it can be extremely difficult. It is often the case that certain changes will benefit one part of the system but hurt another part and there is so much money at stake that the part or parts of the system that might be hurt by a change fight ferociously to stop the change.

That usually means spending hundreds of thousands or even millions of dollars in lobbying to prevent a change.

One of the parts of the U.S. health care system that very few people know about is the PBMs – the Pharmacy Benefit Managers. But they have a major impact on the prices of prescription drugs.

According to the PBMs, “health care plans hire PBMs to secure lower costs for prescription drugs, passing the savings directly to patients. PBMs are your first line of defense against rising prescription drug costs. They work to ensure lower costs and

better health outcomes through affordable access to medicines you need.

“By negotiating with drug manufacturers and pharmacies to control drug spending, PBMs have a significant behind-the-scenes impact in determining total drug costs for insurers, shaping patients’ access to medications, and determining how much pharmacies are paid.”

That’s what the PBMs say. However, critics of PBMs say this:

“Pharmacy Benefit Managers are one of the most problematic, least regulated and least understood aspects of the healthcare delivery system. Over 80% of pharmaceuticals in the United States are purchased through PBM networks. PBMs serve as intermediaries between health plans, pharmaceutical manufacturers and pharmacies, and PBMs establish networks for consumers to receive reimbursement for drugs. Although the primary function of a PBM initially was simply to create networks and process pharmaceutical claims, these entities have exploited the lack of transparency and created conflicts of interest which have significantly distorted competition, reduced choices for consumers and ultimately increased the cost of drugs.”

According to an article in Kaiser Health News, PBMs “negotiate with drugmakers to get significant reductions on a drug’s list price. They pass the bulk of that savings along to Medicare and the insurers, who



can pocket some of it and use it to lower overall premiums for customers who buy drug plans in Medicare Part D.

“While customers benefit from a lower premium, it doesn’t mean they actually get a better price for their drugs, said Gerard Anderson, a professor of health policy at Johns Hopkins Bloomberg School of Public Health.

“That’s because a patient’s price is not based on the rebate but on a share of the original list price of the drug. If a drug costs \$100, and a patient’s share is 25%, they pay \$25, regardless of how big a rebate the PBM got for the insurer.

“It thus serves the interest of the PBM for the drugmaker to raise prices. ‘When the list price goes up, your patient responsibility goes up, so the patient ends up paying more,’ Anderson said. ‘The PBM makes money because, when the list price goes up, the rebate is larger. But the patient loses, because their cost sharing is based often on the list price.’

“Since the PBM controls the formulary that says which drugs are covered in a given plan, Anderson and others point out, it is also in the interest of a drug company to raise list prices if it wants the PBM to give its drugs preferential treatment.

“A wrinkle in federal law allows that to happen. Typically in federal contracting, if someone sets a high price to give the buyer a cut, it’s considered a bribe or a kickback, and it’s illegal. But the law that created the Part D drug program carved

out what’s known as a safe harbor to allow such deals in the hope that negotiations would lower overall costs.”

However, a rule issued by the Trump administration would eliminate that “safe harbor” by taking it away from the PBMs and giving the rebate to customers at the pharmacy counter.

However, the PBMs went to court to challenge the rule. In addition, the Congressional Budget Office predicted that, rather than save money, it would end up costing the federal government \$177 billion over 10 years because drugmakers would be less likely to provide as many discounts, causing a spike in Medicare drug coverage premiums.

So, because of the way federal government budgeting works, if the Biden Administration delays the implementation of the rule until 2026, that \$177 billion is seen as a savings in government spending. Therefore, that money can be spent on something else until 2026 and is not counted as increasing the federal debt.

As a result, that projected savings will be used by Congress to, in part, pay for the new infrastructure bill. In addition, some of it will also be used to pay for some of the items in the budget resolution that the Democrats hope to pass without any Republican support.

Yes, it’s all very confusing, but that’s how, in brief, the infrastructure bill could affect prescription drugs.

2+2=? Senate Uses Murky Math as It Shelves Drug Pricing Rule to Fund Infrastructure

The Senate's release of its bipartisan infrastructure plan signals that lawmakers are poised to throw former President Donald Trump's belated bid to lower Medicare drug prices under the bus — not to mention trains, bridges, tunnels and broadband connections.

That's because the massive spending bill is the first of two likely to at least delay the so-called Medicare rebate rule released at the end of the Trump administration, which has yet to take effect. Congress would use the projected costs of that rule to help pay for more than half a trillion dollars in new spending on infrastructure.

What has infrastructure spending got to do with Medicare drug rebates?

Bear with us as we explain the mad logic of how Congress intends to pay for a spending program with money that doesn't really exist. Tossing Trump's reform under the steamroller to

offset other costs offers a window into the convoluted process of congressional budgeting: Senators say the plan will provide billions of dollars of savings, even though the federal government has never spent a dime on the rebate rule. And it focuses attention on the intractable problem of bringing down drug prices: The rule would take money from drug industry brokers and provide refunds to consumers, which would suggest it was saving them and Medicare money. Yet budget analysts said the process would cost the government billions of dollars.

Let's start with the Medicare drug rebates.

The way things work now, pharmacy benefit managers, which are often owned by insurance companies, negotiate with drugmakers to get significant reductions on a drug's list price. They pass the bulk of



that savings along to Medicare and the insurers, who can pocket some of it and use it to lower overall premiums for customers who buy drug plans in Medicare Part D.

While customers benefit from a lower premium, it **doesn't mean they actually get a better price** for their drugs, said Gerard Anderson, a professor of health policy at Johns Hopkins Bloomberg School of Public Health.

That's because a patient's price is not based on the rebate but on a share of the original list price of the drug. If a drug costs \$100, and a patient's share is 25%, they pay \$25, regardless of how big a rebate the PBM got for the insurer.

It thus serves the interest of the PBM for the drugmaker to raise prices. "When the list price goes up, your patient responsibility goes up, so the patient ends up paying more," Anderson said.

"The PBM makes money because, when the list price goes up, the rebate is larger. But the patient loses, because their cost sharing is based often on the list price."

Since the PBM controls the formulary that says which drugs are covered in a given plan, Anderson and others point out, it is also in the interest of a drug company to raise list prices if it wants the PBM to give its drugs preferential treatment.

"If you've got two drugs that are available to take care of some heart disease, the PBM wants the drug that's going to pay them the most money, and the money is the difference between the list price and the actual transaction price," Anderson said. "So the higher the list price, the higher the profit margin for the PBM. So the drug company who wants their drug on the formulary has to raise their price in order to give the PBM a greater profit..." [Read More](#)

New Study Connects Medicare with Reductions in Racial and Ethnic Disparities in Insurance Coverage

Medicare is associated with significant reductions in "racial and ethnic disparities in insurance coverage, access to care, and self-reported health," according to a **new study** led by the Yale School of Public Health and published in JAMA, the Journal of the American Medical Association.

Evidence has long linked Medicare eligibility with increases in **coverage** and **utilization**, and with narrowing racial and ethnic disparities in these areas. However, information on Medicare's role in reducing disparities in health outcomes, and on how these associations might differ across the country, was less established.

To better understand how the access to insurance that Medicare confers impacts diverse populations, the authors compared coverage and health data for adults above and below age 65, breaking it down by race, ethnicity, and state.

Their findings were clear—Medicare eligibility translates into meaningful reductions in access and health disparities. For example, racial and ethnic differences in coverage fell by more than 50% at age 65, significantly improving upon pre-Medicare imbalances. Black and Hispanic respondents experienced greater gains in coverage—from 86% to 96% and 77% to 91%, respectively—than white respondents, for whom coverage rates grew from 92% to 99%.

In the other studied measures, Black and Hispanic individuals similarly closed gaps with their white counterparts. Medicare eligibility generally narrowed disparities in access to a usual source of care, cost-related barriers to care, and influenza vaccination rates. The share of people in "poor" self-reported health decreased by four percentage points for Hispanic respondents, three percentage points for Black respondents, and



0.2 percentage points for white respondents. These changes were widespread, occurring in economically, politically, and geographically diverse states. Areas with the highest uninsured rates and coverage discrepancies saw the largest gains, but those states were not confined to one region or to states that did not expand Medicaid under the Affordable Care Act.

Notably, the report shows that Medicare reduced but did not eliminate inequities. The authors attribute this to the view that "disparities are shaped not only by policy decisions but also other social determinants of health, such as structural racism, that persist among elderly individuals."

Although a comprehensive solution is needed to bridge the remaining divides, understanding Medicare's role in improving access to care and health outcomes across populations can help inform policymaker efforts.

The study concludes that Medicare "may be a viable means to reduce racial and ethnic disparities and advance health equity by closing gaps in insurance coverage." At Medicare Rights, we understand that realizing this goal means all who are Medicare-eligible must be able to quickly and easily enroll and that the program's coverage must be comprehensive, high quality, and affordable.

Accordingly, we continue to urge the Biden administration to ensure older adults and people with disabilities can access their earned benefits during the pandemic and its aftermath by reinstating **two critical coverage pathways**—Equitable Relief for Premium Part A and Part B and a Special Enrollment Period for Part C and Part D—and by allowing people to correct pandemic-related Medicare enrollment errors whenever they are discovered... [Read More](#)

Allworth Advice: Why a full Social Security benefit isn't always guaranteed

Question: R.K. from Hamilton: I've been a teacher for almost 30 years and I'm starting to think about retirement. I've also had some side jobs through the years. Will I be able to claim Social Security and my teacher's pension?

A: The short answer is yes. But assuming you're a teacher in Ohio, you might not be able to claim your full Social Security benefit. And the reason why has to do with something called the 'Windfall Elimination Provision' (WEP).

Here's the gist. As an Ohio public employee with a pension, you're in what's called a 'non-covered' job in the eyes of the

Social Security Administration since you don't pay into Social Security. Because of this, any Social Security benefits from work for which you did pay Social Security taxes could be reduced (though not completely eliminated). WEP essentially tweaks how your Social Security benefit is calculated, though there are some circumstances in which WEP does not apply (the most common being you have 30 or more years of 'substantial earnings' as defined by the Social Security Administration).

According to the Center for Retirement Research at Boston



College, about 25% of all state and local government employees in the U.S. (about 6.5 million) are not covered by Social Security, but the impact is concentrated in just a handful of states – and, as of 2018, Ohio just happens to be one of the few states in which 100% of these workers are not covered (it's just 29% in Kentucky). In fact, the Ohio Public Employees Retirement System reports that Ohio has the largest percentage of non-covered public employees in the entire country (as of 2019).

Here's The Allworth Advice: The Windfall Elimination Provision should be on the radar

of any Ohio public worker who is nearing retirement and who has also earned an income in the private sector. Because what you're expecting from Social Security might not be what you actually receive. To get a better idea of how your benefit could be reduced, check out the Social Security Administration's WEP calculator at ssa.gov. And if you need more guidance, consider consulting a fiduciary financial advisor who can help you navigate these tricky – and often confusing – waters.

Why our ARA Repeal the WEP/GPO Task Force is working so hard.

U.S. Health System Gets Failing Grade According to New Study

The U.S. health care system ranks last among 11 high-income countries in providing equitably accessible, affordable, high-quality health care.

That's according to a recent study by the Commonwealth Fund, whose mission is to "promote a high-performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, and people of color.

The Fund carries out this

mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. An international program in health policy is designed to stimulate innovative policies and practices in the United States and other industrialized countries."

The study compared the performance of health care systems of 11 high-income countries in five areas: access to care, care process, administrative efficiency, equity,



and health care outcomes.

The top-performing countries overall are Norway, the Netherlands, and Australia. **The United States ranks last overall, despite spending far more of its gross domestic product on health care.** The U.S. ranks last on access to care, administrative efficiency, equity, and health care outcomes, but second on measures of care process.

Four features distinguish top performing countries from the United States: 1) they provide

for universal coverage and remove cost barriers; 2) they invest in primary care systems to ensure that high-value services are equitably available in all communities to all people; 3) they reduce administrative burdens that divert time, efforts, and spending from health improvement efforts; and 4) they invest in social services, especially for children and working-age adults.

Largest Operator of Nursing Homes in U.S. Issues Vaccine Mandate for All Workers

(HealthDay News) -- The United States' largest operator of nursing homes said Wednesday that its workers must get vaccinated against COVID-19 if they want to keep their jobs.

The announcement from Pennsylvania-based Genesis Healthcare -- which has 70,000 employees at nearly 400 nursing homes and senior communities - - suggests the nursing home industry's reluctance to force employees to get vaccinated due to fears about losing too many workers may be shifting, the *Associated Press* reported.

Understaffing is a major problem in the sector, but concerns about the surging

Delta variant may convince nursing home owners they need to take action to quickly vaccinate the 40% of employees who still haven't received shots.

Voluntary vaccination was appropriate earlier in the pandemic, but only 65% of Genesis staff have received shots, according to the company. Employees have until Aug. 23 to get their first shot.

"To succeed against the Delta variant is going to require much higher vaccination rates," Genesis Chief Medical Officer Richard Feifer told the *AP*. "Our tactics in the fight have to



change." Unvaccinated staff members endanger residents, warn experts who are calling for

mandatory vaccinations at nursing homes. Some workers have avoided the vaccine because they think it was rushed into development and is unsafe, or they feel protected because they already had a bout of COVID-19, the *AP* reported.

About 80% of nursing home residents have been vaccinated, but even vaccinated residents are at risk because many are frail and have weak immune systems, the *AP* reported.

More than 130,000 U.S.

nursing home residents have died from COVID-19, according to the *AP*.

Jennifer Moore, of Hollywood, Fla., has a husband living at a nursing home where only 35% of the staff is vaccinated.

"Whenever I see a story about somebody being anti-vax, I just want to scream," said Moore, whose husband, Thomas, has Parkinson's disease. "I understand people have concerns about the vaccine, but these people are working with the most vulnerable population. They have a duty to their patients."

Annuity vs. IRA: What's the difference?

Retirement planning can often be a challenging and confusing process. Complex products and financial jargon make what should be a simple endeavor seem downright tortuous. Many investors turn to annuities and IRAs to plan for retirement. Let's look at some of the key advantages and differences between these two popular options.

What is an IRA?

An IRA, or **individual retirement account**, is a structure that allows for tax-advantaged growth. It's sort of like a wrapper that you put around assets that shields them from paying taxes for a period of time, or forever **in the case of a Roth IRA**.

IRAs are a great way to save for retirement beyond traditional workplace plans such as **401(k)s**. You'll have more options on what you can invest in with an IRA, such as individual stocks and a much broader offering of mutual funds and ETFs.

Two basic types of IRAs

You have two options when it comes to IRAs:

◆ **Traditional IRA:** A traditional IRA may allow you to receive a tax break on contributions you make to the account. Contributions will grow tax-free, but withdrawals will be fully taxed as ordinary income. You can start making withdrawals penalty-free at age 59 1/2, but aren't required to take withdrawals until age 72.

◆ **Roth IRA:** The main benefit of a **Roth IRA** is that your withdrawals will be tax-free, but you won't receive a tax break on contributions. Your assets will be allowed to grow tax-free inside a Roth IRA, but you won't be required to make withdrawals at any time. Withdrawals before the age of 59 1/2 will typically face taxes on any gains and a **penalty** of 10 percent.

What is an annuity?

An annuity is an insurance contract designed to provide



investors with a steady income stream during their retirement. Similar to an IRA, it has some tax advantages, in that money invested in an annuity grows tax-deferred until you start receiving payments.

But an annuity is an asset you can invest in, while an IRA is a tax-advantaged structure that you can use to invest in assets such as stocks, bonds, or **ETFs**.

How an annuity works

Like any insurance product, you'll pay premiums in return for protection the insurer provides, which in this case is the income stream the **annuity** pays to you. Depending on the annuity, you can choose to pay the premium all at once or gradually over time. You'll also be able to choose when the payments start, how long they last and whether they'll continue to be made to your spouse or partner after your death.

Types of annuities

Annuities come in a few basic varieties, though they can be

adapted in a variety of ways:

◆ **Fixed:** You'll receive a **fixed payment** from the insurance company. This might sound appealing, but remember that inflation can eat away at fixed dollar amounts over time.

◆ **Variable:** Your payments will be tied to investment performance of the funds your premium is invested in.

◆ **Equity-indexed:** This annuity will combine features of fixed and variable annuities. A portion of the annuity will be tied to the performance of an index such as the **S&P 500**, but will also have guaranteed minimum payments.

Something appealing about annuities is that they can be customized to your needs. One popular feature that some people like to add to annuities is a death benefit that functions similar to life insurance and goes to your beneficiaries upon your death. Be aware though that the more features you add to your annuity, the more costly it will be.

Medicare Advantage Disenrollment in Final Year of Life Continues Troubling Pattern

Late last month, the Government Accountability Office (GAO), a watchdog agency in the legislative branch, **released a report** showing that people in their last year of life disproportionately disenrolled from Medicare Advantage (MA) into Original Medicare. For some MA plans, these enrollees switched to Original Medicare at a rate nearly 10 times higher than other enrollees. As GAO notes, these shifts may point to problems in access to or quality of care that arise as needs increase.

MA plans are offered by private insurance companies that receive a fixed amount of money from Medicare each month, called capitation, for each enrollee. In theory, capitation has the potential to reduce costs by creating incentives for plans to curtail unnecessary spending. But such an incentive has risks as well. Insurers may benefit by **denying needed care**, finding ways to **drive up their capitation rates that do not**

reflect reality, or structuring their coverage in such a way that it appeals to people who need less care and dissuades those who need more—such as offering **gym memberships to attract healthier enrollees**.

Beneficiaries in the last year of life tend to be in poorer health and have higher health care costs. GAO notes that “Beneficiaries in the last year of life are generally high-cost and disproportionately require specialized care, with a few studies estimating that they may account for as much as a fifth to a quarter of all [Original Medicare] spending.”

Similarly, a **previous GAO report** showed that some MA plans had very high disenrollment rates among beneficiaries who were in poorer than average health. Beneficiaries who disenrolled cited barriers to getting needed care and problems accessing their preferred providers as reasons for switching coverage. This report spurred the Centers



for Medicare & Medicaid Services (CMS), the agency that oversees the Medicare program, to begin tracking MA disenrollments by health status.

But CMS does not specifically track disenrollments by year of life, which this latest GAO research found to be disproportionately high. GAO interviewed many stakeholders, including Medicare Rights, who pointed to several potential causes for such shifts, specifically that MA provider networks may limit access to specialized care, MA plans may contract with lower quality **nursing homes or home health agencies**, and prior authorization alone or coupled with inappropriate denials may cause significant administrative burdens when the need is acute.

This disenrollment pattern is important for several reasons. The affected beneficiaries may face increased out-of-pocket costs because they may not be able to enroll in supplemental coverage, such as a Medigap or

Medicaid, when they transition to Original Medicare. They may have suffered without appropriate care while in MA, or they or their caregivers may have been significantly burdened as they attempted to find care. In addition, it may reveal that MA plans are inappropriately benefiting by **cherry-picking healthier enrollees** and squeezing out enrollees when they become less profitable.

This analysis comes on the heels of other reports showing MA enrollees are **more likely to face issues affording their care** than are people with Original Medicare and supplemental coverage.

We support Medicare beneficiaries having meaningful choices in how they access coverage, and it is clear that strong MA oversight is long overdue. We urge policymakers to correct this and to prioritize beneficiary health, safety, and well-being over the profits of private insurers.

'Wisdom and Fear' Lead 90% of U.S. Seniors to Covid Vaccines

Amid the latest surge in covid-19 cases and hospitalizations, the United States on Tuesday hit a milestone that some thought was unattainable: 90% of people 65 and older are at least partly vaccinated against the disease.

That's more than **49 million seniors** vaccinated. Overall, 70% of adults have been inoculated, at least partly, and nearly 68% of people over 12.

"This really shows our elders are wiser than the rest of us," said Dr. David Wohl, professor of medicine in the division of infectious diseases and director of the vaccine clinics at the University of North Carolina School of Medicine.

Wohl said political leanings that have skewed vaccination rates across the country have had much less of an impact on older adults. "The threat of covid-19 is so real for those 65 and over that

it transcends many of the other issues that are complicating vaccination rates," he said. "Wisdom and fear have really led to impressive immunization rates."

The pandemic has been especially vicious to older adults. Nearly **80% of deaths** have been among people age 65 and up. Nursing homes and other long-term care facilities were hit hard, and many banned family members and other visitors from entering, isolating residents. Even older adults living at home often kept their distance from family and friends as they sought to avoid the coronavirus. So when vaccines became available in December, many states targeted seniors first.

That effort has proved successful, although rates vary among states. Hawaii,



Pennsylvania and Vermont vaccinated more than 99% of their seniors, while West Virginia ranks last with 78%.

In Connecticut, **96% of people 65 and older** are vaccinated against covid. "I didn't think we would get that high, and I am really pleased about it," said Dr. Thomas Balcezak, chief medical officer at Yale New Haven Health. "But until everyone is vaccinated, older folks are still at some risk, though their risk of severe disease or death is much less."

He said older adults clearly heard the message that they were in danger from covid and the vaccine could help. "But saying older folks are at highest risk was a double-edged sword" in terms of messaging, said Balcezak. "That's because younger adults heard that and it

may have given them a wrong sense of security."

The Yale health system's five hospitals had 57 covid patients as of Monday, he said. In contrast, in April 2020, as the virus was taking hold across the country, the system had about 850 covid patients.

Another factor in the successful push to inoculate older adults is that they have been exposed to vaccines more than younger adults, said Wohl. Seniors typically are counseled by doctors to get immunizations for flu, pneumonia, shingles and other diseases that are especially risky for them. And many likely remember getting the polio vaccine when it first came out in the 1950s.

"This is not their first vaccine rodeo," Wohl said.... **[Read More](#)**

Incomplete Polyp Removal During Colonoscopy Can Bring Cancer Danger

(HealthDay News) -- Colonoscopy screening can help prevent colon cancer by allowing doctors to find and remove potentially pre-cancerous growths called polyps. But if they fail to get the whole growth, the odds of a recurrence are high, a new study shows.

The likelihood that it will occur within the next few years more than doubled.

Repeat exams found a new growth in the same colon segment 52% of the time compared to 23% in colon segments where polyps had been completely removed, the findings showed.

And the prevalence of advanced polyps — ones with a greater cancer potential — was six times higher in colon segments where there'd been an incomplete removal: 18% versus 3%.

Experts said the findings point to the importance of doctors' technical skills, not only in finding polyps, but in removing them.

Polyps are growths in the

lining of the colon that are most often benign, but in some cases develop into cancer. For that reason, doctors usually remove any polyps they spot during routine colonoscopy screening.

Doctors' polyp detection rate has long been seen as a measure of their skill. In fact, patients are encouraged to ask their doctor what her or his polyp detection rate is before having a colonoscopy, said Dr. Douglas Rex, president of the American Society for Gastrointestinal Endoscopy, in Downers Grove, Ill.

"Some [doctors] are very good at it, and others aren't good," Rex said.

But it's only more recently that doctors' variance in removing polyps has come under scrutiny. The new findings add to evidence that competence in polyp removal "clearly needs to be addressed," said Rex, who was not involved in the research.

At the same time, he stressed that no one should be deterred



from getting a colonoscopy. "It detects a lot of colon cancers, and can prevent colon cancer," Rex said. "Overall, it's a very powerful tool."

Plus, he noted, the large majority of polyps in this study were completely removed.

The findings were published online Aug. 10 in the *Annals of Internal Medicine*.

Past studies have estimated that incomplete polyp removal contributes to anywhere from 10% to 30% of colon cancers that develop after colonoscopy screening.

But it has not been clear the incomplete removal, per se, is to blame.

It's a tricky matter to parse out, explained Dr. Heiko Pohl, lead researcher on the new study. Even when a polyp is incompletely removed, a new one detected at a follow-up exam may or may not be a regrowth.

It could be a polyp that was missed before, said Pohl, a gastroenterologist at the VA Medical Center in White River

Junction, Vt.

For their study, his team looked at data on 166 patients who'd taken part in an earlier research project. There, the researchers had found that of 346 polyps removed by 11 gastroenterologists, 10% were incompletely removed.

The researchers verified that by analyzing biopsied tissue from the margins of the removed polyp: If polyp tissue was present, that meant removal was incomplete. Those patients were advised to return for a repeat exam within a year.

Of the 166 patients in the current study, 32 had at least one polyp that was incompletely removed. Pohl's team found that in colon segments where there had been an incomplete removal, the odds of new growth were significantly higher.

The researchers estimated that incomplete polyp removal accounted for 28% of all new growths detected in the study group..... **[Read More](#)**

Time to Rethink Suicide Warnings on Labels for Anti-Seizure Meds?

Since 2008, anti-seizure drugs have carried a warning that they may increase users' suicide risk. But a new analysis finds no evidence of such a risk with newer medications.

Researchers found that five medications approved since 2008 showed no link to suicide risk among patients who participated in clinical trials of the drugs.

The findings, they said, argue against the "blanket" warning the U.S. Food and Drug Administration requires for all anti-seizure medications.

"It's our opinion that lumping all these drugs together is not good," said senior researcher Dr.

Michael Sperling, a professor of neurology at Thomas Jefferson University, in Philadelphia.

Anti-seizure medications are commonly prescribed for epilepsy, a broad term for various chronic seizure disorders. They are also sometimes used for other conditions, including migraines and bipolar disorder.

Back in 2008, the FDA issued a warning that anti-seizure medications may raise the risk of suicidality — suicidal thoughts and behavior. That was based on an analysis of about 200 clinical trials of 11



medications, where some of the drugs were tied to a heightened risk of suicide, compared to placebo pills.

However, only two medications showed a statistically significant increase in that risk. Two others, meanwhile, were linked to a decreased risk of suicide.

Yet, Sperling said, the FDA required all anti-seizure medications — including ones approved since 2008 — to carry a suicidality warning.

For the latest study, published online Aug. 2 in the journal *JAMA Neurology*, his team analyzed 17 clinical trials

of five of those newer drugs: eslicarbazepine (Aptiom), perampanel (Fycompa), brivaracetam (Briviact), cannabidiol (CBD) and cenobamate (Xcopri). In total, the trials included 4,000 patients randomly assigned to take anti-seizure medication and just under 2,000 given a placebo.

During the trials, the analysis found, patients on medication were no more likely to contemplate or attempt suicide than placebo patients were: About 0.3% of patients in both groups had those experiences....[Read More](#)

Two-Thirds of Mild COVID Cases Leave Long-Term Symptoms

(HealthDay News) -- A little more than two out of every three people who have mild or moderate cases of COVID-19 will go on to develop long-term symptoms.

That's the troubling takeaway from a University of Arizona Health Sciences' study launched in May 2020.

"This is a real wake-up call for anyone who has not been vaccinated," said lead researcher Melanie Bell, a professor of biostatistics in the university's College of Public Health. "If you get COVID, the chances that you'll experience long-term symptoms are surprisingly high."

The CoVHORT study has

followed Arizonans who had COVID-19 since May 2020, as well as those who have not been infected.

Among participants who tested positive for COVID-19, nearly 69% still had at least one symptom after 30 days, and the rate rose to 77% after 60 days.

Those with long COVID tended to be less educated, to have seasonal allergies and pre-existing health conditions, and to self-report greater symptom severity, according to findings published online Aug. 4 in the journal *PLOS ONE*.

Thirty days after their positive test, the most common symptoms among patients with



long COVID were fatigue, shortness of breath, brain fog, stress/anxiety, altered taste and smell, body aches and

muscle pain, insomnia, headaches, joint pain and congestion.

The median number of symptoms was three, but some patients had as many as 20. (Median means half had fewer symptoms, half had more.)

The rate of long COVID among the patients in this study was just slightly less than that estimated for hospitalized COVID-19 patients, the authors noted.

Much of the research on long COVID has focused on

hospitalized patients with severe infection. The CoVHORT study aims to fill in gaps by focusing on non-hospitalized COVID-19 patients.

The researchers said their study continues to provide important data that can help identify which COVID-19 patients are most susceptible to severe infection and long-term health consequences.

"I study reproductive health," said Leslie Farland, an assistant professor of public health. "And the data from the CoVHORT longitudinal study is already providing new insights," she explained in a university news release.

New Drug Might Be Non-Surgical Option for Common Skin Cancers

An experimental gel has shown early promise in treating the most common form of skin cancer — hinting at a potential alternative to surgery in the future.

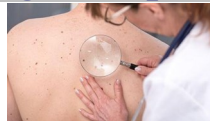
Researchers tested the gel in 30 patients with basal cell carcinoma (BCC), a skin cancer diagnosed in more than 3 million Americans each year. The tumors rarely spread and are highly curable, usually through surgical removal.

Even so, non-surgical options are needed, said senior researcher Dr. Kavita Sarin, an associate professor of

dermatology at Stanford University, in Redwood City, Calif.

In some cases, for example, the skin cancer may be located in an area — like the face — where surgery could leave scarring that patients want to avoid. Plus, Sarin said, many people develop multiple basal cell carcinomas over time, which means returning for repeat surgeries.

A couple of topical medications are approved for BCC, but only for "superficial" cancers, which account for a minority of cases, Sarin said.



For the new study, her team tested an experimental topical drug called

retinostat, which blocks an enzyme known as histone deacetylase. Lab research has shown that inhibiting the enzyme can suppress BCC growth.

The study — published Aug. 6 in *Clinical Cancer Research* — was a small mid-stage trial, designed to see whether the topical medication worked at all.

And for most of the patients, Sarin's team found, it did: Of 33

skin cancers treated for six weeks, 17 completely resolved, and six more partially responded — meaning they shrunk by at least 30% in diameter.

The gel seemed most effective against superficial BCC, with all of those skin tumors shrinking or disappearing, the researchers found. But about two-thirds of other tumor types responded, too — including nodular BCC, the most common form of the cancer, and "infiltrative" tumors, which can invade the skin more deeply and widely....[Read More](#)

CAR T-Cell Immunotherapy Rids Woman of Tough-to-Treat Lupus

In a first, researchers have used genetically tweaked immune system cells to send a woman's severe lupus into remission.

The treatment -- called CAR T-cell therapy -- is already approved in the United States for fighting certain cases of blood cancer. It involves removing a patient's own immune system T-cells, genetically altering them to target the cancer, then infusing them back into the patient.

Here, researchers tested the cell therapy in a 20-year-old woman with severe systemic lupus erythematosus (SLE), an autoimmune disease that can

cause organ damage throughout the body.

They found the approach quickly sent her disease into remission, with no significant side effects at the six-week mark.

The woman is the first lupus patient in the world to be treated with CAR T-cells, said researcher Dr. Georg Schett of Friedrich-Alexander University Erlangen-Nuremberg in Germany.

That means much more research lies ahead before the therapy could become widely available.

But based on this initial report, it's a promising avenue to study,



according to U.S. lupus experts who were not involved in the case.

"Although this is a case report, the treatment makes theoretical sense," said Dr. Donald Thomas, a rheumatologist with Arthritis and Pain Associates of PG County in Greenbelt, Md., and author of "The Lupus Encyclopedia."

"With such a rapid, complete and safe response, this therapy should be tried in other patients with severe disease," Thomas said.

At this point, Schett noted, the patient in this report is "completely healthy," and has

not needed lupus treatment for more than four months. He said his team is now treating two additional lupus patients with CAR T-cells.

The researchers detailed the new findings in the Aug. 5 issue of the *New England Journal of Medicine*.

To perform CAR T-cell therapy, doctors take a sample of a patient's T-cells -- key players in marshaling the body's immune response. Those cells are then genetically altered in the lab to be armed with chimeric antigen receptors, or CARs...[Read More](#)

Covid vaccinations surging in states hit hardest by latest wave of infections

NBC News: The United States has seen a steady uptick in the number of individuals getting their first **Covid** vaccine, driven by those living in states with some of the lowest vaccination **rates** — the very states hardest hit by the recent surge in infections.

Over the last 24 hours, the U.S. saw the highest number of daily shots administered since July 3, with 864,000 vaccinations administered. Alabama, Arkansas, Louisiana, Mississippi, Missouri and Oklahoma are now vaccinating people at a pace not seen since April, White House Covid coordinator Jeffrey Zients said

Thursday.

In those states, less than half of the population has gotten at least one dose, below the national average of 58 percent, and **hospitals** are running out of beds and staff to treat those in need.

Biden administration officials said they believed the trend is driven by residents in the hardest-hit states seeing the effects of the virus first-hand, and growing concern about the risk the delta variant poses to younger adults and children.

"We're seeing the most significant increases in states with the highest case rates — we've more than doubled the



average number of people newly vaccinated each day over the past three weeks in the states with the highest case rates," Zients said.

It's a much-needed boost for the administration's vaccination efforts, which had been on a steady decline since April despite growing efforts by the White House to encourage people to get vaccinated with incentives, celebrity endorsements and community programs. Biden just met his July Fourth **goal** of having 70 percent of adults at least patricianly vaccinated this week.

Because it can take up to six

weeks for a vaccinated individual to receive full protection from the virus, it will likely take time before the increase in vaccinations translates into a drop in cases.

Other states seeing a surge in vaccination demand include Tennessee, which has seen a 90 percent increase in first shots over the past two weeks; Oklahoma, with a 82 percent increase; and Georgia, with a 66 percent increase, Zients said.

"Clearly, Americans are seeing the impact of being unvaccinated and unprotected," Zients said. "And they responded by doing their part, rolling up their sleeves and getting vaccinated."

Where You Live Could Predict Your Survival After Heart Attack

(HealthDay News) -- There are many factors that affect your longevity after experiencing a heart attack. And now, new research finds that your neighborhood could play a key role in your long-term survival.

The researchers found that patients in poorer neighborhoods had a lower chance of survival over five years, and that Black patients in those neighborhoods had a lower chance than white patients.

"This study suggests that social and environmental factors can affect a person's outcome after a heart attack, and where a

person lives can have a powerful impact on health outcomes," said senior study author Dr. Ming Sum Lee, a cardiologist at Kaiser Permanente Los Angeles Medical Center.

For the study, Lee's team looked at records from more than 31,000 people treated for a heart attack at the same hospital between 2006 and 2016.

The investigators assessed patients' neighborhoods based on 17 factors that reflected education, income, employment and household characteristics.

The researchers discovered



that Black patients from poorer neighborhoods were 19% more likely to die within five years of their heart attack than their white neighbors.

But five-year survival rates for Black patients in wealthier neighborhoods were similar to those of white patients from the same neighborhoods.

"These findings may be of particular interest to health systems, since most health systems invest heavily to improve the quality of care provided to heart attack patients within the medical system," Lee

said in a Kaiser Permanente news release.

"However, what this study shows is that a patient's post-discharge environment also matters when it comes to long-term health outcomes," she added.

The findings were recently published in the *Journal of the American College of Cardiology*.

More information

The American Heart Association has more on [heart attack recovery](#).

What Depression in the Elderly Looks Like & How to Get Help

When you think of depression in the elderly, what comes to mind? You aren't alone if your first thought includes stereotypical images of frail and sad-looking older adults. After all, many of us naturally associate depression with characteristics like misery and weakness. But here's the thing: Those stereotypes represent only a narrow slice of this medical condition's broad spectrum of possible effects. You might be surprised to know that many depressed people over the age of 65 don't exhibit those traits. So it's essential to understand what this illness is all about if you want greater vitality for yourself

or a loved one.

The more you know about the effects of depression in elderly people, the more empowered you'll be when it comes to creating enjoyable retirement years for you or those you care about. You'll rise above common misunderstandings and discover the benefits of having a broader, more informed perspective on the issue. For many older adults with this condition, the prognosis is good. Safe and effective treatments are widely available. You just need to know all the facts.

This article will educate you about the signs of elderly



depression (also known as geriatric depression), the challenges it presents, and the options for treatment.

The earlier you recognize the condition, the better. It doesn't have to cause long-term problems. With professional help, you can overcome it. You can feel good again, regardless of your age.

Contents

- ◆ [What is depression? How does it affect the elderly?](#)
- ◆ [The differences between depression, grief, and dementia](#)
- ◆ [Risk factors for elderly depression](#)

- ◆ [Signs, symptoms, and effects of depression in elderly people](#)
- ◆ [Risk of suicide in older adults](#)
- ◆ [Why depression is often overlooked in the elderly](#)
- ◆ [Help and treatment for seniors with depression](#)
 - [Counseling and psychotherapy](#)
 - [Antidepressants](#)
 - [Lifestyle changes](#)
 - [Electroconvulsive therapy \(ECT\)](#)
 - [Self-help books](#)
- ◆ [How to help an elderly loved one who has depression](#)

The Delta Variant & the Vaccinated: One Expert's Take on the Data

(HealthDay News) -- News that the highly contagious Delta variant of COVID-19 can be picked up and spread by vaccinated folks has sparked confusion and concern, and an infectious disease expert wants to clarify.

These worries follow a recent U.S. Centers for Disease Control and Prevention recommendation that urged even vaccinated folks to wear masks indoors in areas with substantial or high rates of COVID-19 transmission.

The advisory came soon after a July 4th COVID-19 outbreak in Provincetown, Mass., in which three-quarters of people who got infected were fully vaccinated.

The finding — detailed in a CDC report — suggested that even vaccinated people could spread the virus between each other.

However, Dr. Adam Lauring, an infectious disease specialist at

Michigan Medicine-University of Michigan, is telling people to not to read too much into that one case.

"While this is clearly something to pay attention to, in the CDC report, they are pretty clear in the discussion about the limitations and what they are saying and not saying," Lauring said in a university news release. "Of course, not everyone [reading the advisory] made it that far."

For example, he said, as more people get their shots, of course more 'breakthrough' cases will be detected in the ever-growing number of people who are vaccinated.

As well, a nasal swab COVID-19 test can measure how much viral RNA is present in a person's nose -- but not how much of that virus is infectious.

"The amount of genome present is a marker, but it is not



the same thing as saying these people are equally as infectious," Lauring said.

Also, a swab is taken at one moment in time, so it can't conform how long someone is infectious.

"You could picture a situation where vaccinated people with Delta have a really steep rise and then a really steep fall in the amount of virus shed, whereas an unvaccinated person would have a steep rise that would remain high for longer," Lauring said.

While a majority of infections will be in unvaccinated people, the big change is that it now appears that vaccinated folks with the Delta variant will transmit the virus more often than with other variants.

That means additional measures — like wearing masks in certain situations, such as indoor spaces in areas where case

levels are high — will be required in addition to vaccines to stop the spread of COVID-19.

Early data show the vaccines are more than 80% effective at preventing severe illness and death and are still reducing transmission.

Case counts in the United States are highest in areas with low vaccination rates — evidence that the vaccines are working against all variants, according to Lauring.

As for boosters, he said: "I'm more concerned about people who have not been vaccinated at all."

Lauring also noted that high vaccination rates are needed to protect younger children who aren't yet eligible for vaccination, as well as immunocompromised people. Vaccination is also key to reducing emergence of even more contagious variants, he added.

Knee Replacement Won't Keep Golfers Off the Course

Golf after total knee replacement is apparently par for the course.

Researchers say most golfers can return to the links within five months of surgery and play as well -- or as poorly -- as they did before.

"A lot of patients come to the office wondering when they're going to be able to play or if they are going to ever be able to play,

and if they can expect to be better or worse at the game after the total knee replacement," said study lead author Dr. Joseph Tramer, a resident in orthopedic surgery at Henry Ford Hospital in Detroit.

"Patients can reliably get back to golf, but it does take a few months," he added.

If taking a swing was limited



by knee pain, a total knee replacement can help alleviate discomfort so players can take less pain medication, Tramer said. Most golfers can drive the ball as far as before surgery, and their handicaps do not significantly change, he added.

The key is rehabilitation after surgery. Tramer said patients

have to keep the knee moving from the start to get best results.

"We actually get people out and walking on it the same day of the surgery, and we're not keeping patients in the hospital as much as we used to," he said.

Tramer noted that many patients leave the hospital the same day and they're encouraged to move the knee right away.....[Read More](#)

AHA News: Are Figs Good for You? Get the Whole Sweet Story

The ancient world had a reverential affection for figs. They're celebrated in both the Bible and in Islamic texts. In Egypt, they were offered to the gods, while the Greeks considered figs a gift from them.

Today, scientists would consider the common fig, *Ficus carica*, to be slightly less than a miracle food. But if you're looking for a healthy treat that's divinely sweet, you could do worse.

"It's not going to be a go-to for anything," said Christopher Gardner, a professor of medicine at Stanford University in California. "But I think it's a great and underappreciated ingredient that could be used in multiple ways."

Plus, he said, "They're super

easy to snack on."

Gardner is a nutrition scientist the Stanford Prevention Research Center, but his fig expertise comes from being a fan. He buys dried figs at his local farmers market and eats about a pound a week.

He also has a fig tree in his yard, but he prefers dried to fresh. It can be hard to catch a fig at peak ripeness, he said. Once picked, they last only five to seven days, although the California Fig Advisory board says they can be refrigerated and kept up to two weeks.

Either way, figs offer plenty of good stuff.

One raw fig has about 37 calories, according to the U.S. Department of Agriculture. With



that you get about 2.5% of the recommended daily amount of potassium, plus magnesium (2%), iron (1%) and calcium (1%).

Six dried figs, the USDA says, gets you about 125 calories and higher amounts of magnesium (8%), potassium (7%), calcium (6%) and iron (6%).

Figs also have vitamin K, which can alter the effectiveness of the blood-thinning medication warfarin.

Dried figs also contain healthy phytochemicals (plant-based nutrients) and antioxidants (chemicals that can help prevent cell damage), although not in a way that makes them stand out, Gardner said. "I don't think you're ever going to go to a

physician who says, 'Oh my God, you have fig deficiency disease – there's almost nothing else that carries this phytochemical!'"

Figs are delectably sweet, and there's a reason for that: lots of natural sugar. Six dried figs have about 24 grams. That's offset by a reasonable amount of fiber, Gardner said – about 5 grams, or more that 17% of the recommended daily value.

That fiber helps slow the absorption of sugar into the bloodstream. Dried figs have a glycemic index of 61 and a glycemic load of 16, putting them in the middle of the pack in terms of how they affect blood glucose....[Read More](#)

How a Doctor's Presence May Alter Blood Pressure Readings

(American Heart Association News) -- A doctor's presence during a blood pressure reading triggers a "fight or flight" response that can affect the results, say researchers who studied the effect by measuring nerve activity.

"White coat hypertension" – the phenomenon when blood pressure rises in some people who are measured by a medical professional – has been known about for decades. It occurs in about a third of people with high blood pressure.

In a small study published Monday in the American Heart Association journal

Hypertension, Italian researchers examined the effect's roots by measuring blood pressure, heart rate and nerve traffic in the skin and muscles with and without a doctor present.

The researchers found a "drastic reduction" in the body's alarm response when a doctor was not present, said co-lead author Dr. Guido Grassi, professor of internal medicine at the University of Milano-Bicocca in Milan.

An increase in blood pressure and heart rate is part of the body's reaction to a perceived threat, said Dr. Meena Madhur,



associate professor of medicine in the divisions of clinical pharmacology and cardiology at Vanderbilt University in Nashville, Tennessee.

"If you're out in the wild and a bear was charging after you, you'd want your blood vessels in your skin, for example, to constrict and the blood vessels in your muscles to dilate to provide more blood flow to those organs so that you can run really fast," said Madhur, who also is associate director of the Vanderbilt Institute for Infection, Immunology and Inflammation. She was not involved in the new

research.

The study included 18 people, 14 of them men, with mild to moderately high blood pressure that was not being treated. Each participant was examined in a lab, where an electrode measured nerve activity in the skin and muscles. Readings were taken twice in the presence of a doctor and twice without.

In the doctor's presence, both blood pressure and heart rate rose, and nerve traffic patterns to the skin and skeletal muscle suggested a classic fight or flight reaction....[Read More](#)

Changing Diets Mean More Americans Are Anemic Now

Growing numbers of Americans aren't getting enough iron in their diets most likely due to changes in farming practices and a shift away from red meat, researchers report.

The upshot: Rates of iron-deficiency anemia are on the rise.

"Iron deficiency remains a major public health issue even in a developed country such as the United States," Dr. Ian Griffin and Dr. Marta Rogido wrote in an editorial published along with the new research. They practice at Biomedical Research of New Jersey in Cedar Knolls.

Iron helps make hemoglobin, a component of red blood cells that carries oxygen from the lungs to the rest of the body.

Anemia results from a drop in red blood cells. It can cause fatigue, pale skin, dizziness and/or weakness, and can lead to other health problems, including heart failure, if left untreated, according to the U.S. National Heart, Lung, and Blood Institute.

For this study, researchers used three large government databases to track trends in anemia rates; the amount of iron



found in U.S. food products; and deaths from iron-deficiency anemia between 1999 and 2018.

During that time, iron intake dropped 6.6% in men and 9.5% in women as levels of the nutrient fell in more than 500 food products assessed, including pork, turkey, fruit, vegetables, corn and beans, the researchers reported.

This was most likely due to changes in farming practices, the study authors said. Previous studies have pointed to a push to increase crop yield per acre and

irrigation runoff as among those changes.

Another big change? More folks are eating chicken instead of red meat for health purposes, and red meat contains much more iron, said study author Connie Weaver, professor emerita of nutrition science at Purdue University in West Lafayette, Ind.

"Fortified grains and cereals increase iron intake, but low-carb diets and switching away from fortified cereal has also decreased iron intake," she added....[Read More](#)