

August 20, 2023 E-Newsletter



Message from the Alliance for Retired Americans Leaders

Alliance Members Mark Social Security's Anniversary



Robert Roach,
President, ARA

Monday, August 14, was Social Security's 88th birthday, and Alliance members are highlighting the importance of the earned benefits

program with events around the country.

In 1935, President Franklin Delano Roosevelt signed the Social Security Act and urged future generations to keep expanding the program's protections. Social Security is the most popular and successful government program in history, with nearly 67 million Americans receiving benefits each year.

Alliance members celebrated the anniversary with **Sen. Sheldon Whitehouse (RI)** at the New England Regional Alliance Meeting and Anniversary Celebration in North Providence, Rhode Island. **Sen. Jack Reed (RI)** and **Rep. Seth Magaziner (RI)** joined the meeting virtually.

"Democrats have plans to protect and expand Social Security by requiring millionaires and billionaires to pay their fair share. That will increase benefits so seniors and people with disabilities can retire and live in dignity," said **Robert Roach, Jr., President of the Alliance**. "It is essential that we do not allow politicians who are threatening Social Security — with ideas like raising the

retirement age and privatization — to advance their dangerous agenda."

Fiesta Speaks at A. Philip Randolph Institute Convention

Alliance Executive Director **Richard Fiesta** attended the A. Philip Randolph Institute (APRI) convention in Reno



Rich Fiesta,
Executive
Director, ARA

this week and gave a presentation on the Alliance's work on retiree issues including Medicare and Social Security; how the Inflation

Reduction Act is lowering drug prices amid strong drug industry opposition; and combatting restrictive voting laws across the country.

Founded in 1965, APRI works with black trade unionists to build relations between labor and black communities.

"Thirty-three percent of Black Social Security beneficiaries over 65 rely on Social Security for 100% of their income," noted Fiesta. "It is one more reason why we cannot allow the House Republican Study Committee proposals to raise the retirement age and cut benefits to advance in Congress."

Costliest Medicare Drugs More Than Tripled in Price Since Entering Market: Report

A new report released this week found that the 25 drugs that accounted for the highest Medicare Part D spending in 2021 more than tripled in price since they first entered the market.

The report comes just weeks before the Biden administration is to announce the first 10 Medicare Part D drugs that will be considered for price negotiations under the Inflation Reduction Act, on Sept. 1.

It found that all but one of the top 25 drugs' lifetime price increases exceeded the corresponding annual rate of general inflation. Further, the average lifetime price increase for the five products on the market for 20 years or longer was 592%. The average list price increase for all 25 drugs was 226%.

"This report reinforces what Alliance members experience every day. The price of prescription drugs is high, and has been allowed to increase unchecked for too long," said **Joseph Peters, Jr., Secretary-Treasurer of the Alliance**. "We continue to be grateful to

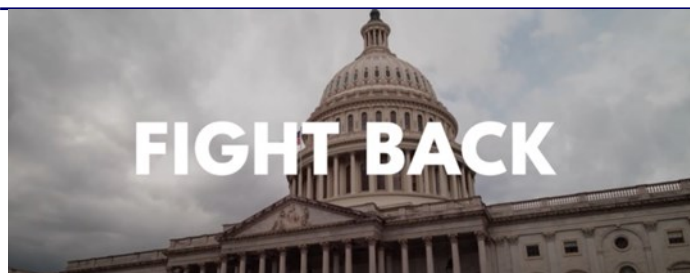


Joseph Peters
ARA
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President Biden for getting the Inflation Reduction Act passed so Medicare is finally required to negotiate a better deal for the American people."



Senator Sheldon Whitehouse (D-RI) celebrating Social Security, Medicare & Medicaid's birthday at the ARA New England Regional Conference



Social Security: Our Earned Benefits

Want to help save Social Security? [Click here to sign](#) our petition telling Congress to take action.

Watch this video on how some members of Congress want to take away our **EARNED BENEFITS**, even though they say they don't. [Watch the video.](#)

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

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Rhode Island ARA Host the ARA 2023 New England Regional Conference

On August 10th, the RI ARA hosted the New England ARA Regional Conference to discuss changes and how they have affected our members and what the future has in store for our members by way of legislation. RI Senators Reed, Whitehouse and RI Representative Magaziner attended. A Social Security, Medicare & Medicaid birthday was served.

The Conference was held at the The Institute for Labor Studies & Research. Some of the 35

participants were there in person and some were there virtually.

The Conference was a discussion on some of the program changes that have affected our members. We also discussed what the future has in store for our members by way of legislation:

- ◆ Congressman Larson's HR

5723 Social Security 2100: A Sacred Trust,

- ◆ Senator Whitehouse's S.1174 Medicare and Social Security Fair Share Act,
- ◆ HR 82 Repeal of the egregious Windfall Elimination Provision/ Government Pension Offset by Reps Graves/Sanberger

and S.597 by Senators Brown/Collins

- ◆ Prescription drug pricing just to name a few.
- ◆ A cake to Celebrate Social Security's 88th and Medicare & Medicaid's 58th Anniversaries



Medicare Advantage in 2023: Premiums, Out-of-Pocket Limits, Cost Sharing, Supplemental Benefits, Prior Authorization, and Star Ratings

People with Medicare have the option of receiving their Medicare benefits through the traditional Medicare program administered by the federal government or through a private Medicare Advantage plan, such as an HMO or PPO. In Medicare Advantage, the federal government contracts with private insurers to provide Medicare benefits to enrollees. Medicare pays insurers a set amount per enrollee per month, which varies depending on the county in which the plan is located, the health status of the plan's enrollees, and the plan's estimated costs of covering Medicare Part A and Part B services. The plans use these payments to pay for Medicare-covered services, and in most cases, also pay for additional benefits and reduced cost sharing. Plans are required to meet federal standards, including providing an out-of-pocket limit. Medicare Advantage plans are also permitted to limit provider networks, and may require prior authorization for certain services, subject to federal requirements.

This brief provides information about Medicare Advantage plans in 2023, including premiums, cost sharing, out-of-pocket limits, supplemental benefits, prior authorization, and star ratings, as well as trends over time. A **companion analysis** examines trends in Medicare Advantage enrollment.

Key highlights include:

- ◆ In 2023, more than 7 in 10 (73%) enrollees in individual Medicare Advantage plans with prescription drug

coverage pay no premium other than the Medicare Part B premium, which is a big selling point for beneficiaries.

- ◆ Most Medicare Advantage enrollees have access to benefits that are not covered by traditional Medicare, such as vision, hearing and dental. Plans are able to offer extra benefits because they are paid \$2,350 per enrollee, on average, above their estimated costs of providing Medicare-covered services (known as "the rebate"). The rebate has increased substantially in the last several years, more than doubling since 2018.
- ◆ Nearly all Medicare Advantage enrollees (99%) are in plans that require prior authorization for some services, which is generally not used in traditional Medicare. Medicare Advantage plans also have defined networks of providers, in contrast to traditional Medicare.

- ◆ Most Medicare Advantage enrollees are in plans with a quality rating of at least 4 out of 5 stars, explained in part by the fact that **more than half (51%)** of plans receive ratings at or above this threshold.

In 2023, more than 7 in 10 Medicare Advantage enrollees (73%) are in plans with no supplemental premium (other than the Part B premium)

In 2023, most people (73%) enrolled in individual Medicare Advantage plans with prescription drug coverage (MA-PDs) pay no

premium other than the Medicare Part B premium (\$164.90 in 2023) (Figure 1). The MA-PD premium includes both the cost of Medicare-covered Part A and Part B benefits and Part D prescription drug coverage. In 2023, 97% of Medicare Advantage enrollees in individual plans open for general enrollment are in plans that offer prescription drug coverage.

Altogether, including those who do not pay a premium, the average enrollment-weighted premium in 2023 is \$15 per month, and averages \$10 per month for just the Part D portion of covered benefits, substantially lower than the average

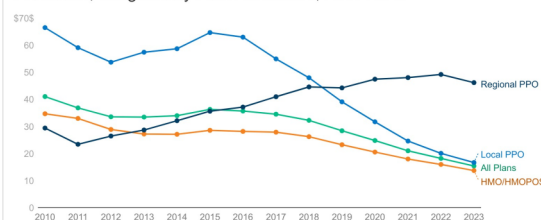
premium of \$40 for stand-alone prescription drug plan (PDP) premiums in 2023. Higher average PDP premiums compared to the MA-PD drug portion of premiums is due in part to the ability of MA-PD sponsors to use rebate dollars from Medicare payments to lower their Part D premiums. When a plan's estimated costs for Medicare-covered services are below the maximum amount the federal government will pay private plans

in an area (known as the benchmark), the plan retains a portion of the difference, known as the "rebate". According to the Medicare Payment Advisory Commission

(MedPAC), rebates **average over \$2,300 per enrollee in 2023**.

For the remaining 27% of beneficiaries who are in plans with a MA-PD premium (5.1 million), the average premium is \$57 per month, and averages \$38 for the Part D portion of covered benefits – slightly lower than the \$40 monthly PDP premium....**Read More and to view charts**

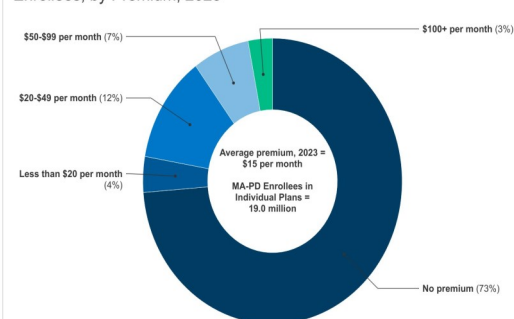
Figure 2
Average Monthly Medicare Advantage Prescription Drug Plan Premiums, Weighted by Plan Enrollment, 2010-2023



NOTE: Includes only Medicare Advantage plans that offer Part D benefits (MA-PDs) as they comprise the majority of Medicare Advantage plans. Excludes SNPs, employer group health plans, cost plans, HCPs, PACE plans, MIPs, and plans for special populations. All data shown include plans with zero premiums. The premiums for a subset of sanctioned plans were not available in 2021, and were excluded from this analysis. SOURCE: KFF analysis of CMS Medicare Advantage Landscape and Enrollment Files, 2010-2023.

KFF

Distribution of Medicare Advantage Prescription Drug Plan (MA-PD) Enrollees, by Premium, 2023



NOTE: The MA-PD premium is in addition to the Part B premium. Excludes SNPs, employer group health plans, cost plans, HCPs, PACE plans, MIPs, and plans for special populations, and Medicare Advantage plans that do not provide prescription drug coverage. Premiums were missing for less than 1% of enrollees. Percentages may not sum to 100% due to rounding. SOURCE: KFF analysis of CMS Medicare Advantage Landscape and Enrollment Files, 2023.

KFF

CMS again pauses out-of-network billing arbitration after judge sides with providers

The Centers for Medicare & Medicaid Services (CMS) has again suspended arbitration of out-of-network payment disputes between providers and payers due to a court order that the agency's implementation of the No Surprises Act had run afoul of proper notice-and-comment procedure.

The decision stems from a Texas Medical Association (TMA) complaint filed in the U.S. District Court for the Eastern District of Texas back in January. **The provider group argued** that an increase in administrative fees from \$50 to \$350 that was implemented earlier that month was "arbitrary and capricious" and would curtail certain physician organizations' ability to contest a health plan's reimbursement offer.

The No Surprises Act gives payers and providers 30 days to settle any disputes on an out-of-

network charge. If an agreement can't be reached, both parties submit a preferred amount

to a third-party arbitrator, which then chooses one—a process referred to as Independent Dispute Resolution (IDR).

CMS said its fee increase was necessary to cover expenses related to the arbitration process.

Additionally, TMA took issue with CMS' updated requirement that joint consideration of multiple disputed items and services, a process referred to as "batching," must be billed under the same or comparable code. The change, which CMS said was made to enable greater efficiency, would force providers to submit for multiple IDR processes, which, combined with the price hike would be prohibitive for certain providers, TMA argued.

In an order signed Aug. 3, Judge Jeremy Kernodle granted-



in-part TMA's motion for summary judgment. The court struck the higher fee and vacated and remanded three portions of the rule outlining the IDR process.

"In sum, the Court holds that the Departments improperly bypassed the [Administrative Procedure Act]'s notice-and-comment requirement in issuing the Fee Guidance and the September Rule's batching regulations," Kernodle wrote in the order. "The Court finds that vacatur of these rules is the proper remedy."

TMA had also sought a refund of previously paid fees and an extension of the IDR deadline, though the judge ruled that the plaintiffs had not done enough to demonstrate that these were warranted under his court's jurisdiction.

"While the court declined to provide deadline extensions and

certain other requested relief, we remain pleased with the overall outcome," TMA President Rick Snyder, M.D., said in a Friday release. "Yesterday's decisions on batching rule provisions and administrative fees will aid in reducing barriers to physician access to the law's arbitration process, which is vital to both patient access to care and practice viability."

As a result of the decision, CMS wrote in an online notice that it has "temporarily suspended the Federal IDR process, including the ability to initiate new disputes until the Departments can provide additional instructions," effective immediately. **Read More**

No Surprises Act largely successful in protecting consumers though gaps remain, stakeholders say

Public Supports More Drug Price Regulation, Unaware of Inflation Reduction Act Provisions

As we near the first anniversary of the Inflation Reduction Act (IRA), **recent public polling** by KFF shows that many adults cannot afford their medications as prescribed, and a large majority say there is not enough regulation of drug pricing and that they do not trust pharmaceutical companies to set fair prices. Despite this interest in drug costs, a majority of adults in the US say they are unaware of the IRA's major drug provisions. The polling shows that 28% of adults say it is either "somewhat" or "very" difficult to afford prescriptions. Similarly, 31% say

that drug costs have prevented them from taking their medicine as prescribed—either by not filling the prescription or by skipping or reducing dosages. This accords with recent research. **One study** showed that over 20% of older adults did not take medications as prescribed due to cost. **Another showed** that many adults have been rationing their insulin by delaying purchase, using lower dosages than prescribed, or not filling prescriptions at all.

According to the survey, a large bipartisan majority (73%)



say there is not enough regulation of prescription drug prices. KFF notes that the percentages for both

Democrats and Republicans has increased by about 10% since **a similar poll in 2021**. Across party lines, people largely agree on major factors contributing to high costs. For example, 89% of Republicans, 84% of Democrats, and 78% of Independents say profits made by pharmaceutical companies are a major factor. Research and development costs also score high, with 57% of Republicans, 56% of Independents, and 53% of

Democrats flagging them as a major factor.

The IRA took **some steps to address these issues for people with Medicare**. The law **caps monthly insulin costs at \$35 per prescription**, creates new programs to negotiate the price of some drugs and **penalize companies for raising prices faster than inflation**, and redesigns Part D prescription drug coverage to include an out-of-pocket cap for enrollees**Read More**

Can creditors take your Social Security?

Most people don't borrow money with the intention of not paying it back. However, sometimes unfortunate circumstances, like job loss or illness, can make it difficult to keep up with your previous financial commitments. Unfortunately, defaulted debts can lead to a host of problems, including credit damage, lawsuits and sometimes even wage garnishment. But can a creditor take your Social Security if they're collecting on past-due debts?

In general, the answer is no, creditors and debt collectors cannot seize your Social Security benefits. Even if the creditor wins a court judgment against you for the outstanding debt, Social Security benefits are considered exempt from garnishment, says debt settlement attorney Leslie Tayne, founder of Tayne Law Group

However, there are certain types of debt that can be taken from your Social Security benefits such as delinquent taxes,



alimony, child support and student loans owed to the Department of Education. Protected Social Security benefits

Most creditors and debt collectors cannot seize your Social Security benefits, as long as you receive them via direct deposit to your bank account. If you receive your benefits on a prepaid card, these funds are generally safe as well. This protection applies even if a company sues you, you lose the case and a court enters a

judgment against you.

The following benefits are protected from garnishment and bank levies thanks to federal law:

- ◆ Social Security benefits
- ◆ Supplemental Social Security Income (SSI)
- ◆ Veterans benefits
- ◆ Federal Employee Retirement System
- ◆ Civil Service Retirement System
- ◆ Federal Railroad Retirement, Unemployment and Sickness Benefits....**Read More**

Majority of Medicare Advantage enrollees don't fully understand their plan

Most Medicare Advantage (MA) beneficiaries are satisfied with their health plan, but many enrollees feel they are overbilled, have struggled navigating the prior authorization process or are confused by the features of their plan, a **new survey** from Retirement Living recently revealed.

The survey found that 71% of beneficiaries are satisfied with their MA plan, with most people choosing a MA plan due to the plan's affordable costs and out-of-pocket expenses. Other factors that contributed to the decision included coverage of prescription drugs, access to providers and the ability to choose a doctor, comprehensive coverage options and medical and preventive care options.

In addition, 61% of people said their MA plan outperforms their

previous coverage plan.

However, only 44% of MA enrollees say they fully understand their plan, with 68% saying certain details have caused confusion. Dental coverage was the most reported area of confusion, followed by out-of-pocket costs, transportation to medical appointments, caregiver support services, home health services and vision and hearing coverage. At least 20% of beneficiaries said they didn't understand one or more of these plan elements.

Other respondents believed a lack of familiarity with the plan (56%) caused confusion, while some (44%) believed there was inadequate communication and education about benefits offered. More than 1 in 4 beneficiaries reported paying out-of-pocket costs for services they believed



were covered by their plan, while 1 in 10 said they thought were overbilled for their MA plan.

Some MA enrollees felt unsatisfied by various elements of their plan, including telehealth services, online and mobile app management and chronic disease management programs, while almost 20% of respondents said they experienced delays in care caused by the prior authorization process.

Of the nearly 1 in 10 enrollees who thought they might switch coverage plans in the next year, 50% cited cost and 39% wanted to switch provider networks.

Recent studies have highlighted the positive impacts of MA plans for enrollees, including a report from the Elevance Health Public Policy Institute that found 83% of

dual-eligible and 75% of non-dual-eligible individuals **used at least one supplemental benefit** a year. The analysis concluded that MA enrollees find value in plans when they need to meet personalized needs.

MA plans are also more popular with individuals from marginalized backgrounds. Analysis from ATI Advisory showed that a **higher percentage of Black, Latino and Asian enrollees choose MA** than fee-for-service plans. The report showed that MA beneficiaries also tend to live in more socially vulnerable counties.

Retirement Living surveyed 351 beneficiaries, asking them about premiums, customer service and provider networks. The median age of respondents was 69 years old.

Amazon Clinic now offers telehealth in all states but doesn't take insurance

Since the Covid-19 pandemic, Medicare has been covering a wide range of telehealth services, which have eased access to care for millions of older adults and people with disabilities. Telehealth services have been available through a wide range of providers. Now, Amazon is launching Amazon Clinic in all 50 states and the District of Columbia to treat basic medical needs through health messages and video visits 24 hours a day every day.

It was nine months ago that **Amazon came out with its virtual medical clinic**. Back then

Amazon's clinic addressed 35 common ailments, such as pink eye, acid reflux, birth control, hair loss, skin conditions and urinary tract infections. It now offers video consults and operates throughout the US.

Wheel, which has a panel of board-certified physicians and nurse practitioners across the US, is partnering with Amazon to offer the video visits. Amazon Clinic will work with a host of telehealth companies to provide virtual consults. To help people choose among providers, Amazon will provide information



on wait times and costs with different telehealth providers. Appointments are not needed.

In February, Amazon bought **One Medical**, a company that delivers primary care and owns 188 medical clinics in 29 markets. One Medical has 815,000 members. Amazon also now owns **PillPack** a prescription drug pharmacy, providing drugs through mail order.

It's not yet clear whether Medicare will cover **telehealth services** through Amazon Clinic and, if so, whether Amazon

Clinic will accept Medicare coverage for its Medicare patients.

Right now, Amazon Clinic is not taking insurance. It is a cash pay business. But, unlike most medical visits, patients will know the cost in advance of their visit.

Questions and concerns about Amazon Clinic remain, including patient health data privacy. Of course, if you have a primary care doctor and are able to schedule an appointment, it's often best to visit in person.

Social Security: 2024 COLA Predicted to Drop by 5.7% — But It Could Save You on Taxes

It's almost a sure bet that **the 2024 Social Security cost-of-living adjustment (COLA) will be around 3%**, based on the U.S. Department of Labor's latest inflation data. That's well down from **the 8.7% annual adjustment approved for 2023** — the highest in more than 40 years — but there could be a silver lining in a much lower COLA. Overall inflation in July 2023 rose 3.2% from the previous year, according to data released Thursday by the Bureau of Labor Statistics (BLS). That was up slightly from the previous month, but represented a major dip from

the 8.5% inflation rate in July 2022.

Inflation has been on a steady decline in recent months, which means Social Security recipients can expect a 2024 COLA decline as well. In an Aug. 10 press release shared with GOBankingRates, The Senior Citizens League (TSCL) indicated the COLA for 2024 is "looking increasingly like it may be around 3%" based on consumer price index data.

"Overall, the rate of inflation in July is significantly lower than a year ago, but most older



Americans are reporting that persistently high prices still affect their household budgets according to results from a new survey," Mary

Johnson, TSCL's Social Security and Medicare policy analyst, stated in the press release.

The Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) — the index used to determine the yearly COLA — rose 2.6% year over year in July. But because the overall inflation rate is slightly higher, TSCL is keeping its COLA estimate at 3%.

As The Senior Citizens League noted, July CPI data is important because the COLA is calculated based on inflation during the third quarter — July, August, and September — as measured by the CPI-W. Inflation for those three months is added together and averaged, then compared with the Q3 average from a year earlier. The percentage difference between the two is the amount of the COLA, which would be payable for checks received in January 2024.

Silver Lining to a Lower COLA Increase
...Read More

Does Medicare cover hospice services? Yes—and here's exactly what it pays for

In 2021, **1.7 million Americans chose hospice services**, which provide comfort, care, and support for those nearing the end of life.

To receive hospice care, a patient must meet these **three conditions**:

- ◆ Have a terminal diagnosis as determined by a hospice doctor and another doctor (often the referring physician), who must confirm that the patient has a life expectancy of six months or less.
- ◆ The patient must agree to accept comfort care (also known as palliative care) instead of medical care to cure the illness.
- ◆ The patient must sign a statement electing hospice

care instead of other treatments for the terminal illness and related health issues, although the document can be revoked at any time by the patient or surrogate decisionmaker.

If you're unsure about how hospice works, you're not alone. "There are many misconceptions about hospice care, and we often receive questions about where, what, and how hospice services are provided," says Amy Tucci, president of **Hospice Foundation of America**.

One of the biggest questions Tucci and her team receive is how to pay for hospice care. Medicare and other coverage of



hospice care While many types of Medicare coverage can be confusing, Medicare hospice coverage is straightforward: it's covered. In full, for the most part. If you have **Medicare Part A**, you may have a **few expenses**:

- ◆ A copayment of up to \$5 for each prescription drug received on an outpatient basis. However, Medicare **Part D** may also cover it.
 - ◆ A 5% fee of the Medicare-approved amount for inpatient respite care. This copay can't be greater than the annual inpatient hospital deductible.
- Medicare Advantage** plans cover hospice services and may even offer **additional**

coverage beyond basic Medicare, such as a certain number of hours of help from an aide outside of your hospice program. Patients can choose from any of the Medicare-certified **hospice providers** in their local area, which vary from one or two to 10 or even 50 in some states, like **California**.

Most state **Medicaid** programs cover hospice services, and those that don't says Tucci, typically have state programs that cover hospice services. Veterans often have hospice services through their VA insurance, which can contract with community hospice providers as well as providing care through VA facilities, she says.....**Read More**

The Most Popular Ages to Collect Social Security

If you qualify for Social Security retirement benefits you can sign up to begin getting them any time after age 62. While it may sound appealing to start collecting the money as soon as possible, your monthly payments will be larger if you delay claiming them.

According to 2022 **data** from the Social Security Administration, there's a wide range of ages at which people start to claim their benefits, as well as some marked differences

in when men and women typically start.

How Much Your Payment Will Be Reduced if You Start Collecting at 62

Your full retirement age, as defined by Social Security, depends on your birth year. It's crucial to realize that the Social Security payments you qualify for will be reduced if you claim them before your full retirement age.

Here is the amount your



payment will be reduced by if you start to take your retirement benefits at age 62.

Raw HTML : [Canva]

The Most Popular Ages to Collect Social Security

"A lot of people just take it as soon as they can, and if you take it too early, you're really leaving a lot of money on the table," says Joel Shaps, retired president, owner and financial advisor at Bedrock Capital Management.

So, **should you start early or wait it out?** Here is what people who qualified for Social Security retirement benefits did in 2022 and how it affected their monthly payouts.

Age 62

Age 62 is the earliest possible age you can sign up for Social Security retirement benefits. According to the SSA data, 22.9% of men chose this age to start to collect compared with 24.5% of women.....**Read More**

These 10 medications are likely targets for Medicare price negotiations this fall

- ◆ Medicare, in the coming weeks, will announce the 10 drugs that will be subject to price negotiations this year.
- ◆ It is the first time the program for seniors has directly negotiated prices with the pharmaceutical industry.
- ◆ It is still unclear which 10 drugs Medicare will select, but several pharmaceutical companies have already revealed in court filings that they expect four of their blockbuster medications to be targeted.
- ◆ The pharmaceutical industry has filed a torrent of lawsuits to block the negotiations, arguing that the program is an unconstitutional seizure of

their property. Medicare is poised to directly negotiate drug prices with the pharmaceutical industry this fall for the first time in the program's nearly six-decade history. The Centers for Medicare and Medicaid Services will unveil, no later than Sept. 1, the list of 10 drugs that it is targeting this year, an agency spokesperson said.

Though it is still unclear which 10 drugs Medicare will select, several pharmaceutical companies have already revealed in court filings that they expect four of their blockbuster medications to be targeted.

Merck's lawyers said the company's Type 2 diabetes drug Januvia will be on the list, with its blockbuster cancer immune



therapy treatment Keytruda to become a target in subsequent years.

Bristol-Myers Squibb and Johnson & Johnson, in separate filings, said their blood thinners Eliquis and Xarelto will be subject to the negotiations this year. Abbvie said in its own filing that the company expects its blood cancer drug Imbruvica will also be a target in the fall.

These are the other six drugs that will likely be subject to negotiations this year, according to an **analysis** by the Journal of Managed Care and Specialty Pharmacy published in March:

- ◆ Jardiance, made by Boehringer Ingelheim, used to treat heart failure
- ◆ Enbrel, made by Amgen,

used to treat rheumatoid arthritis

- ◆ Symbicort, made by AstraZeneca, used to treat asthma
- ◆ Ibrance, made by Pfizer, used to treat breast cancer
- ◆ Xtandi, made by Astellas Pharma, used to treat prostate cancer
- ◆ Breo Ellipta, made by GSK, used to manage pulmonary disease

The historic negotiations, established by the Inflation Reduction Act, are the cornerstone of the Biden administration's efforts to slash drug costs....**Read More**

Five Congressional committees seek to regulate prescription drug middlemen, without fixing the broken system

For years now, Pharmacy Benefit Managers or PBMs, as they are widely known, have been profiting handsomely from negotiating drug discounts with pharmaceutical corporations and keeping much of the savings. While these prescription drug middlemen succeed at bringing down prescription drug costs, patients are still paying high prices for their drugs. Five Congressional committees now seek to regulate these PBMs, reports **MedPage Today**, without helping to lower drug costs in a meaningful way. The system is broken.

You might think that bulk purchasing of pharmaceuticals would lead to steep discounts for patients. Instead, when the discounts are negotiated, they tend to go largely to PBMs and insurance companies. What's even more problematic is that PBMs and insurers (some of which own PBMs) stock prescription drug formularies—the drugs an insurer covers—with drugs on which they earn

significant revenue. Sometimes, formularies do not include generic or lower-cost alternative drugs because lower-cost drugs would cut into PBM and insurer profits.

The PBM bills in Congress right now are of seemingly little if any value to Americans, as they would not lower drug prices in any meaningful way. They simply require PBMs to disclose some details concerning what they end up paying for drugs and how much they are paid for their work. To what end?

Three PBMs control the vast majority of the market, which allows them to profit wildly. It's hard to see how knowing more about what they pay for drugs or how much they earn from their work would benefit consumers. Perhaps large corporations could use the information to achieve slightly better drug prices.

Even the Congressional Budget Office (CBO) sees precious little financial benefit from these PBM disclosures. The CBO estimates only \$900 million in savings



early on, diminishing over time. The PBMs profit \$18 billion a year now. What would the Congressional bills do specifically?

Bernie Sanders, who chairs the Senate Help Committee, has a PBM bill that would require more disclosure from PBMs. The bill calls for disclosure of copayment assistance by drug corporations, as well as which drugs the insurer covered, and how much insurers spend on prescription drugs. It also forbids PBMs from "spread pricing," or requiring insurers to pay more for a drug than the PBM pays the pharmacy for the drug.

The bill does require PBMs to give the health "plan sponsor," aka the insurance corporation, all rebates, fees, alternative discounts, and other remuneration received from a drug manufacturer. Who benefits here is not clear.

The Senate Finance Committee bill would require that insurers pay PBMs "a bona fide service fee," rather than an amount tied

to a drug's price. PBMs would also need to disclose drug prices to Medicare Part D insurers and the HHS Secretary. Delinking PBM fees from the price of a drug would at least arguably disincentivize PBMs from putting expensive drugs for which they negotiate large savings on a formulary in place of generic drugs. The PBMs should have no more incentive to have higher-cost drugs on a formulary than lower-cost drugs.

The question remains as to why our government allows insurers and PBMs to decide which drugs are on their formularies. If the government is not going to mandate which drugs are covered, an independent agency should evaluate drugs based on their price, efficacy and safety and come up with the drugs all insurers must cover. At the very least, formularies should all include low-cost generic alternatives, when available.

Nearly 50,000 Americans died by suicide in 2022, new CDC report reveals

Nearly 50,000 Americans died by suicide in 2022, the U.S. Centers for Disease Control and Prevention **reported** Thursday.

The number of suicide deaths was on a downward trend in 2019 and 2020, but it increased by 5% in 2021, and then further increased by 2.6% in 2022 to 49,449, the CDC found.

"Mental health has become the defining public health and societal challenge of our time," said Surgeon General Dr. Vivek Murthy in a statement. "Far too many people and their families are suffering and feeling alone."

"These numbers are a sobering reminder of how urgent it is that we further expand access to mental health care, address the root causes of mental health struggles, and recognize the importance of checking on and supporting one another," Murthy added.

Adults 65 and older saw the largest increase in suicide deaths of any age group from 2021 to 2022, with an 8.1% rise to 10,433 deaths.

Children and young adults 10 to 24 saw the largest decrease over that time span of any age

group, with a decline of 8.4%, to 6,529 suicide deaths, the CDC said. However, a **CDC study published in June** found that the suicide rate among that age group has trended upwards over the last two decades, rising 62% from 2007 to 2021.

Research also shows **youth mental health** is in crisis more generally, with particularly concerning numbers surrounding teen girls. A March CDC survey found around **1 in 3 high school girls** in the U.S. have seriously considered attempting suicide and more than half of teen girls, 57%, reported feeling "persistently sad or hopeless."

Teen mental health is in crisis, study shows. What can parents do?

Meanwhile, adults 24 to 44 saw the largest number of suicide deaths of any age group with 16,843. It marked an increase of just 0.7% over last year.

Most racial and ethnic groups saw an increase in suicide deaths, with Native Hawaiians and other Pacific Islanders seeing the largest jump at 15.9%.



The CDC found that those who identify as American Indian or Alaska Native saw the largest percentage decrease in suicide deaths of any racial or ethnic group, dropping 6.1% from last year.

Americans who identify as White saw the largest number of deaths by suicide with 37,459, an increase of 2.1% from 2021.

More men died by suicide than women, following a trend from 2021, but both men and women saw their suicide death numbers increase by 2.3% and 3.8% respectively.

"Nine in ten Americans believe America is facing a mental health crisis. The new suicide death data reported by CDC illustrates why," Health and Human Services Secretary Xavier Becerra said in a statement. "One life lost to suicide is one too many. Yet, too many people still believe asking for help is a sign of weakness."

Since 2000, with the exception of 2019 and 2020, suicide deaths in the U.S. have been steadily rising, CDC **data shows**, leading officials to urge for better mental

health resources.

"The troubling increase in suicides requires immediate action across our society to address the staggering loss of life from tragedies that are preventable," said Dr. Debra Houry, the CDC's chief medical officer. "Everyone can play a role in efforts to save lives and reverse the rise in suicide deaths."

In June, the CDC used data collected in 2020 to **examine depression rates**, finding 18.4% of U.S. adults — nearly 1 in 5 — reported having ever been diagnosed with depression.

The numbers were much higher in some communities than others. When looking at state levels specifically, estimates ranged from 12.7% in Hawaii to 27.5% in West Virginia. County-level estimates ranged even wider, from 10.7% to 31.9%.

*If you or someone you know is in emotional distress or a suicidal crisis, you can reach the **988 Suicide & Crisis Lifeline** by calling or texting 988. You can also **chat with the 988 Suicide & Crisis Lifeline here***

Medicare Advantage 101: The Rise of Quality Bonuses

Medicare Rights **recently** released **Medicare Advantage 101**, a series of explainers and videos covering the rise and potential downfalls of the Medicare Advantage (MA) program. The series delves into MA history and the current system of overpayment that is burdening Medicare and taxpayers.

One factor driving increased MA payment is the quality bonus program. This program was intended to reward MA plans for increasing the quality of care they provide but, in practice, the payments appear simply to drive up costs and reward mediocre plan offerings.

A **new report from KFF** shows that this problem is only escalating. Quality bonus payments have risen every year since 2015, more than quadrupling in total dollars. In

2023, plans will be paid at least \$12.8 billion, a 30% increase over 2022.

Importantly, this increase does not appear to be aligned with any discernible quality improvement. In its **annual report to Congress in March**, the Medicare Payment Advisory Commission (MedPAC) stated outright that “The current state of quality reporting is such that the Commission’s yearly updates can no longer provide an accurate description of the quality of care across MA plans.”

As KFF flags, 85% of MA enrollees are in plans that are receiving bonus payments, showing that these payments do not reward extraordinary quality. And the outcomes for MA enrollees do not appear to show marked improvement over those in Original Medicare.



A **KFF review of dozens of studies** found that “Medicare Advantage outperformed traditional Medicare on some

measures, such as use of preventive services, having a usual source of care, and lower hospital readmission rates. However, traditional Medicare outperformed Medicare Advantage on other measures, such as receiving care in the highest-rated hospitals for cancer care or in the highest-quality skilled nursing facilities and home health agencies. Additionally, a somewhat smaller share of traditional Medicare beneficiaries than Medicare Advantage enrollees experienced a cost-related problem, mainly due to lower rates of cost-related problems among traditional Medicare beneficiaries with supplemental coverage. Several

studies found lower use of post-acute care among Medicare Advantage enrollees but were inconclusive as to whether that was associated with better or worse outcomes.” These inconclusive data, especially when coupled with **high profits, inappropriate coverage denials, and rising burdens on people with Medicare**, make it essential to investigate the utility of the quality bonus program.

At Medicare Rights, we support an overhaul, or even elimination, of the program as well as heightened scrutiny of MA more generally. Without vigorous reforms, the rise of MA threatens access to care, financial stability, and taxpayer pocketbooks.

Explore Medicare Advantage 101

Does Joe Biden's 4-Point Plan to Change Social Security Resolve the Program's Massive Funding Shortfall?

In June, more than 49 million retired workers took home a Social Security check. Although the average payout to these retirees totaled just \$1,837.29, more than 20 years of annual surveys have shown that between 80% and 90% of retired workers lean on their Social Security income, to some degree, to cover their expenses.

Considering how vital **Social Security** is to the financial well-being of our nation's seniors, sustaining the health of the program is of the utmost importance. Unfortunately, the foundation that supports America's top retirement program is deteriorating and at risk of crumbling without changes from Washington, D.C.

With Social Security on shaky ground, Americans are looking to Capitol Hill for solutions, and that generally starts with the President of the United States, Joe Biden.

Social Security is facing a \$22.4 trillion long-term funding obligation shortfall

To make one thing clear, Social Security is in **absolutely no danger** of going bankrupt or becoming insolvent.

The program generated 90% of its revenue in 2022 from the payroll tax on earned

income (wages and salary, but not investment income), and an additional 4% from the taxation of Social Security benefits. As long as Americans keep working and paying their taxes, there will always be money flowing into the program that can be disbursed to eligible beneficiaries. In other words, if you qualify for a Social Security benefit, you're going to receive one, when eligible.

The issue is that Social Security's projected outlays, as outlined in the 2023 Social Security Board of Trustees Report, are vastly outpacing estimated revenue collection over the long term (i.e., the 75 years following the release of a report). Through 2097, the Trustees Report estimates a \$22.4 trillion funding obligation shortfall.

According to the Trustees Report, if the asset reserves (excess capital collected since inception) of the Old-Age and Survivors Insurance Trust Fund (OASI) were to be exhausted, sweeping benefit cuts of up to 23% may be needed by as early as 2033 to avoid any additional benefit reductions over the long term. Once again, it's not an issue of solvency so much as avoiding a possible 23% reduction to Social Security



benefits for OASI recipients in the not-too-distant future.

If you're wondering why Social Security finds itself on such shaky ground, look no further than an assortment of demographic shifts. Some of these shifts you're probably familiar with, such as baby boomers retiring in greater numbers and reducing the worker-to-beneficiary ratio. Others might come as a surprise, such as **growing income inequality, historically low U.S. birth rates, and a more-than-halving in legal immigration into the U.S.** over the past 25 years.

Joe Biden wants to make four key changes to Social Security Social Security's deepening financial woes aren't lost on lawmakers. During his campaign for the presidency, then-candidate Joe Biden released a four-point plan designed to strengthen America's leading retirement program.

1. Reinstate the payroll tax on earned income above \$400,000
2. Swap out the CPI-W with the CPI-E
3. Increase the special minimum benefit

4. Lift the primary insurance amount for aged beneficiaries
After running the math, here's how Biden's Social Security plan scored

The trillion-dollar question is: Would Joe Biden's four-point plan actually work to resolve Social Security's massive funding shortfall?

This is the question Washington, D.C.-based think tank Urban Institute tackled in 2020 when they painstakingly modeled all of Biden's proposals. Keep in mind that when Urban Institute conducted its study, it was utilizing funding shortfall figures from the 2020 Social Security Trustees Report, and that none of its assumptions included any economic impacts from the COVID-19 pandemic.

At the time of the study, Social Security was facing a 75-year financial funding shortfall that equated to 2.59% of taxable payroll. Urban Institute found that increasing taxation on the rich reduced this long-term deficit by 1.84% of taxable payroll. In other words, subjecting all earned income above \$400,000 to the payroll tax, as of 2020, eliminated 71% of Social Security's funding shortfall. ...**Read More**

Bad Sleep Can Harm Your Heart, and Weekend 'Catch-Up' Sleep Won't Help

Poor sleep takes a toll, and catching up on the weekends just won't fix it, researchers report.

A small new study showed that heart rate and blood pressure, important measures of cardiovascular health, worsen as the week goes on when someone sleeps only about five hours a night.

Catching up on sleep over the weekends didn't return those health measures back to normal.

"Only 65% of adults in the U.S. regularly sleep the recommended seven hours per night, and there's a lot of evidence suggesting that this lack of sleep is associated with cardiovascular disease in the

long term," said study co-author **Anne-Marie Chang**, associate professor of biobehavioral health at Penn State University.

"Our research reveals a potential mechanism for this longitudinal relationship, where enough successive hits to your cardiovascular health while you're young could make your heart more prone to cardiovascular disease in the future," Chang said in a university news release.

The researchers studied 15 healthy men ages 20 to 35 over an 11-day period.



Participants were allowed to sleep up to 10 hours a night over the first three nights, which let researchers note their baseline.

Over the next five nights, the men were limited to five hours sleep per night. That was followed by two recovery nights, when they were allowed to sleep up to 10 hours per night.

Throughout the study, researchers measured participants' resting heart rates and blood pressure every two hours during the day. This made it possible to account for any effects that time of day might have, such as a naturally lower

heart rate upon waking.

Participants' heart rates increased nearly one beat per minute (BPM) with each successive day of the study.

The average baseline heart rate was 69 BPM. By the end of the study, it was 78 BPM.

Systolic blood pressure rose each day, from a baseline average of 116 mm Hg to nearly 119.5 mm Hg by the end of the recovery period. Systolic blood pressure, the top number in a blood pressure reading, measures pressure in the arteries when the heart beats. (A reading of 120 or less is considered normal.)

...[Read More](#)

'The greatest feeling in the world': Deep brain stimulation helps stroke survivor regain independence

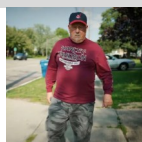
On any given weekend for more than 40 years, you could find Stan Nicholas jamming away on his guitar, playing motorcycle rallies and festivals all over the Cleveland area. The Ford retiree and his Burnt River Band's rock and blues had been drawing crowds since they were teens. Nicholas thought he'd be playing for life, but the music stopped for him one night in 2017.

The 66-year-old, who lived alone, was mashing potatoes for his dinner when he lost his balance, fell to the floor and couldn't get back up. "Every time I got halfway up, my knees would buckle, and I'd fall down again," Nicholas remembered. Nicholas was one

of the nearly 795,000 people in the United States who have a **stroke** every year.

Stroke is the fifth most common killer in the US, but it's also one of the leading causes of disability. For now, physical and occupational therapy is really the only option to help people like Nicholas, but it wasn't enough to get back all his physical abilities.

Nicholas volunteered to become one of the first people in the world to try to regain his body's function with the help of a little device planted in his brain and chest that the doctors hoped would stimulate them into action, even the parts of



the brain that the stroke seemed to wipe out. The results — detailed in a study published Monday in the journal

Nature Medicine — have been hopeful for Nicholas, and if they could be replicated, they could show promise for thousands of people left disabled by a stroke.

Initial attempt at recovery

After that terrible night in 2017, Nicholas went through months of physical and occupational therapy, regaining some of his abilities but not all of them.

"I thought that I was going to be disabled for life, and I made it a priority to walk again," he said.

Movement on his left side remained extremely difficult. An early scan showed that one of the main arteries in his brain had lost its blood supply, causing part of the right side of his brain to die and affecting the left side of his body.

He worked hard in therapy and started to walk some. He also regained some movement in his shoulder and elbow, but his hand didn't want to move at all at first. He eventually got better at grasping objects, but moving his wrist up and down or even opening his hand seemed impossible....[Read More](#)

After U.S. Warns of Counterfeit Pills Laced With Fentanyl, Mexico Shuts Down 23 Pharmacies

Following a four-day raid, Mexico has closed 23 pharmacies in Caribbean resorts of Cancun, Playa del Carmen and Tulum for irregular pill sales.

Last spring, the United States **warned** of dangerous pill sales to foreigners and tourists where counterfeit drugs contained fentanyl, heroin and methamphetamine.

Mexican investigators went to 55 drug stores, finding irregular sales at 23 of them, according to the Mexican Navy Department.

In a January **study** from researchers at the University of

California, Los Angeles (UCLA), the scientists said they visited 40 pharmacies in four Northern Mexico cities, finding that 68% sold oxycodone, Xanax or Adderall.

About 27% of those pharmacies were selling fake pills, according to the report, which said "brick and mortar pharmacies in Northern Mexican tourist towns are selling counterfeit pills containing fentanyl, heroin and methamphetamine. These pills are sold mainly to U.S. tourists,



and are often passed off as controlled substances such as oxycodone, Percocet and Adderall."

In the raids, the Navy said it found outdated medications and those with no supplier record, the *Associated Press* reported. Also found were blank and unsigned prescription forms.

The Navy did not confirm finding fentanyl-laced pills, but it did say that the medications would be tested for the presence of fentanyl.

Fentanyl is a powerful

synthetic opioid responsible for about 70,000 deaths each year in the United States, the *AP* reported, noting that Mexican cartels produce it from chemicals smuggled in from China.

"These counterfeit pills represent a serious overdose risk to buyers who think they are getting a known quantity of a weaker drug," researcher **Chelsea Shover**, an assistant professor-in-residence of medicine at the David Geffen School of Medicine at UCLA, told the *AP* in February.

The many ways to ease knee and hip pain

If you're suffering from pain or stiffness in your knees and hips and you're over 65, you're not alone. According to **Consumer Reports**, three in four people over 65 have joint pain. Fortunately, there are many ways to ease this pain.

Osteoarthritis is the common cause of joint pain in older age. People lose the cartilage that cushions their bones, leading their bones to rub together. The pain is often most pronounced first thing in the morning and when rising from a seated position.

Many people take ibuprofen—Advil, Motrin or some other nonsteroidal anti-inflammatory drug—to ease their pain. Or, they take acetaminophen. These drugs can all help relieve pain, but you should avoid taking them all the time. They come with some risks. Similarly, you can take steroid injections or hyaluronic

acid injections for mild or moderate pain, but you don't want to take more than a couple of them. (N.B. Some people do platelet-rich plasma treatment, but there's not a lot of evidence that it is effective.)

You can also sometimes ease pain through a variety of different physical activity. People who move around produce synovial fluid, which helps cushion the bones. The problem with physical activity is that it can hurt, so people resist it.

One way to go if walking hurts is to do a work-out at the pool or to use a stationary bike that allows you to lean back. Leaning back while biking relieves pressure on your knees. **Tai chi** is yet another way to go to get your synovial fluid flowing. For people with serious pain, physical therapy can help



increase flexibility and strengthen joint muscles. Strengthening these muscles tends to ease pain. Medicare often covers **physical therapy**.

You can also try changing your diet to eat more **plant-based foods**. There's some evidence that eating more beans, nuts, fruits and vegetables can reduce pain from osteoarthritis because it reduces inflammation. Salmon and other fatty fish can also help, as can foods with vitamin K, such as kale and spinach.

If you're overweight, you might be able to ease joint pain by losing five or ten pounds. Each pound you lose lowers pressure on your knees and hips by five to six pounds.

You should also try to get a good night's sleep and ease any stress. If you're not sleeping enough, you are more likely to feel your joint pain. When you're

stressed out, you produce more inflammation-causing hormones that adds to your pain. Try to take deep breaths for a few minutes to relieve tension.

If diet, exercise, physical therapy and over-the-counter medicines are not able to ease your pain, you should talk to your doctor about the value of a hip or **knee replacement**. An orthopedic surgeon can help you understand the benefits and risks. These are quite common effective procedures—even for people in their 80's—that can last a long time. But, they involve surgery, from which it could take you a while to recover.

Consumer Report warns that if you do decide to have a hip or knee replacement, you are best off using a surgeon who has done hundreds of these procedures and going to a hospital that does thousands of these procedures each year.

TENS Device Could Ease Sleep Apnea, Freeing Patients From CPAP

A small battery-operated device long used as a treatment for pain may also help patients with sleep apnea, a British study suggests.

Sleep apnea is a condition that impedes breathing during sleep, reduces oxygen intake and undermines sleep itself.

The remedy: zapping sleepers with continuous but controlled electric pulses to open obstructed airways, improve breathing and restore sleep.

"Patients with sleep apnea frequently stop breathing when asleep," said study author **Joerg Steier**, a professor of respiratory and sleep medicine at the Lane Fox Unit/Sleep Disorders Center

at King's College London.

The condition is often associated with snoring, and often results in fragmented sleep so that patients are excessively tired the next day, Steier said.

To address the problem, patients are usually prescribed a continuous positive airway pressure (CPAP) machine.

During sleep, they wear a mask over the mouth or nose. It's attached to a machine that pumps air in to keep airways open. Though CPAPs help many patients, some struggle to get used to it.

"This treatment only works



when people use it," said **Dr. Andrew Varga**, a neuroscientist and physician with the Mount

Sinai Integrative Sleep Center in New York City. "And people can find CPAP machines difficult to tolerate, so they may only use it for some nights, or some portion of the night."

In fact, researchers pointed out, within three months, 75% of CPAP users stop using it.

For this study, recently published online in **eClinical Medicine**, Steier's team looked at a low-cost, battery-operated machine available over the counter called TENS. The name is shorthand for transcutaneous

electrical neurostimulator.

It stimulates the hypoglossal nerve, which travels from the base of the brain down the neck and ends under the base of the tongue.

At bedtime, users affix electrodes embedded in sticky pads to the base of their neck and upper back. When the machine is flipped on, it delivers continuous light pulses of electricity to nerves and muscles, prompting the airway to stay open.

The technology has already helped patients dealing with the pain of arthritis and childbirth... **Read More**

Healthy Aging Tips for the Older Adults in Your Life

If you have older family members or loved ones, you may worry about their health as they age. Aging increases the risk of chronic diseases such as heart disease, type 2 diabetes, arthritis, cancer, and dementia. The good news is that adopting and maintaining a few key behaviors can help older adults live longer, healthier lives. As a family member, it's important to encourage healthy lifestyle behaviors in your loved ones — it's never too late to start!

Healthy behavior changes can help older adults live more independently later in life. That's important both for their quality of life and for yours. If a family member loses independence — whether it's due to disability or chronic disease — you may find yourself in a caregiving role earlier than expected, which can affect family dynamics as well as finances.

Healthy behavior changes can help older adults live more



independently later in life. That's important both for their quality of life and for yours. If a family member loses independence — whether it's due to disability or chronic disease — you may find yourself in a caregiving role earlier than expected, which can affect family dynamics as well as finances.

So, what can you do to help the older adults in your life manage their health, live as independently as possible, and

maintain quality of life as they age? Read on to learn about four ways to help support and promote healthy habits in your older loved ones' lives.

- ◆ **Prevent social isolation and loneliness**
 - ◆ **Promote physical activity**
 - ◆ **Encourage healthy eating**
 - ◆ **Schedule regular check-ups with a doctor**
-**Read More**

Watercress is the healthiest vegetable in the world

This might be news to you, but the Centers for Disease Control ranks the health benefits of vegetables and fruits on a scale of 1 to 100. If you had to guess which vegetables get high marks, I bet you'd come up with spinach or kale. But, would you believe that watercress gets a perfect score of 100 as the healthiest vegetable in the world?

What's interesting is that the CDC's ranking appears to have been around for a while, with no media attention. Recently, the **watercress industry** has promoted the information and all of a sudden, there are lots of stories!

For background, the CDC has a list of what it calls "**powerhouse**

fruits and vegetables" or PFV. These are foods that it says are most closely tied to lower risk of chronic disease. The lists includes green leafy vegetables, yellow/orange, citrus, and "cruciferous" or cross-bearing (thanks to their four petals) vegetables such as broccoli, cabbage and brussels sprouts.

According to the CDC, watercress is a superfood. The CDC gives it a nutrition density score of 100, based on the amount of essential vitamins and minerals it contains. After watercress comes chinese cabbage with a score of 91.99 and chard with a score of 89.27.



Beet greens, spinach, chicory and leaf lettuce also are at the top of the CDC foods with high nutrient density list with high scores, but their scores are in the 70s and 80s.

Watercress is a leafy green that is related to kale, cabbage, mustard and radishes. It has a strong peppery taste, perhaps a bit like horseradish. It has a lot of vitamin A, potassium, and vitamin C.

Watercress has been around for a long time. What's interesting is that in Europe and Asia people have been eating watercress for its health benefits over many centuries.

If you can find watercress at the supermarket, add it to your salads. Watercress with smaller leaves has a less strong taste than older watercress with large leaves. You can eat the younger watercress leaves raw, but you might want to quickly saute the older watercress leaves.

What's at the bottom of the CDC's list, with the lowest nutrient density? While all the fruits and vegetables on the list are very healthy, the CDC says that raspberries, leek, sweet potato, tangerines, cranberries, grapefruit, garlic, onions, and blueberries are not powerhouse foods.

How Many Daily Steps to Lengthen Your Life? Fewer Than You Might Think

If you're one of the millions of folks bent on racking up at least 10,000 steps a day, read on.

A new study finds that heart health starts to improve with as few as 2,300 steps a day. The research also indicates your risk of dying from any disease starts to decrease with only about 4,000 daily steps.

However, the more daily steps you get, the bigger the benefit becomes, the study also found.

"Ten thousand steps per day is, in fact, still a correct way of thinking if we take into account the most pronounced [death] reduction," said study author **Dr. Maciej Banach**. He is a professor of cardiology at the Medical University of Lodz in Poland, and an adjunct professor at the Center for the Prevention of Cardiovascular Disease at Johns

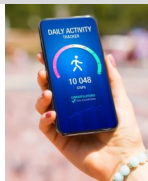
Hopkins University School of Medicine.

Ten thousand steps equates to about 4-5 miles of walking, experts say.

For the study, researchers analyzed 17 prior studies involving about 227,000 people. They were followed for roughly seven years.

Adults over age 60 saw risk of death reduced by 42% if they clocked between 6,000 and 10,000 steps a day. Among younger adults, there was a 49% reduction when they walked between 7,000 and 13,000 steps a day, the study showed.

"Every increase of steps by 1,000 steps/day is associated with a 15% reduction in the risk of dying from any cause, and every increase by 500 steps per day is associated with a 7% reduction in



dying from cardiovascular disease," Banach said. And there is no such thing as too many steps. The researchers have not found an upper step limit yet.

The study wasn't designed to say how, or if, walking lowers the risk of dying, just that there is an association. Research has shown that leading a sedentary lifestyle can shave years off of your life. According to World Health Organization data, 3.2 million deaths a year are related to physical inactivity.

Amanda Paluch is an assistant professor of kinesiology at the Institute for Applied Life Sciences at the University of Massachusetts-Amherst.

"This study is consistent and reiterates what we have previously seen," said Paluch,

who was not involved in the study.

The bottom line? "Move more and sit less," she advised.

The health benefits of walking begin at levels much lower than 10,000 steps a day, Paluch said. "It is not an all-or-nothing situation."

Don't feel overwhelmed if you don't get 10,000 steps, she added. "Start where you are. There is benefit to making small, incremental increases in steps per day," Paluch said.

If you are starting at 3,000, work your way up to 4,000, then 5,000, she recommended. "These gradual improvements can be meaningful for your health, and for those people already at higher levels of steps per day, keep it up."

AHA News: Confused About Carbs? This Might Help

If you get cross-eyed thinking about carbohydrates, that's understandable.

They can be, quite literally, both simple and complex. They abound in snacks that nobody would call healthy but also appear in foods considered essential to good health.

"It gets a little confusing," said Andrew Odegaard, associate professor of epidemiology and biostatistics at the University of California, Irvine. Even experts disagree on some aspects of how carbohydrates function.

To understand how carbs work in your diet, it helps to know a few details.

"When people think of carbohydrates, what they're thinking of can vary a lot," said Odegaard, whose work has included studies on diet, diabetes and heart disease. But from the most basic perspective, a carbohydrate is a molecule made up of carbon, hydrogen and oxygen. When digested, carbs are converted into blood glucose, or sugar, which provide fuel for cells throughout the body.



"For most people, it's the fundamental source of energy in their diet,"

Odegaard said.

Carbohydrates often have been classified as either "simple" – also known as "refined" – or "complex" based on how quickly the body turns them into blood glucose.

Dietary sugars, such as glucose and fructose, are simple carbs that when broken down can be a fast source of energy. Highly processed foods such as cake, candy and sugary sodas are full of

simple carbs. Christopher Gardner, the Rehnberg Farquhar Professor of Medicine at Stanford University in California, noted that Americans get more than 40% of their calories from simple, low-quality carbs.

Complex carbs include starches, which are molecular chains of simple sugars. They have to be broken apart before the body can use them, making them a steady, longer-lasting supply of energy. Peas, beans, whole grains and vegetables are sources of complex carbs....**Read More**