

Message from the Alliance *for* Retired Americans Leaders



President Roach Addresses AFT Retirees in Massachusetts



Robert Roach, Jr.
 President, ARA

Robert Roach, Jr., President of the Alliance, traveled to Boston on Tuesday and Wednesday this week to speak with retirees from the American Federation of Teachers (AFT). His presentation included a description of the Alliance's intergenerational work, including a partnership with the State University of New York (SUNY), AFT, the United Federation of Teachers (UFT) and the Machinists (IAM) that provides pre-enrollment credits toward a college degree for high school students. The credits are for extra classes taken in a high school aviation program.

"We are working to educate young people and motivate them to be part of the labor movement," President Roach said.

The retirees and President Roach also discussed the 2022 midterm elections, Social Security expansion and pensions. **Big Pharma Spends \$150 Million Lobbying Against Lower Drug Prices**

According to a report from corporate watchdog

Accountable.US, the top five pharmaceutical firms and PhRMA have spent at least \$147 million lobbying against prescription drug price reductions since the pandemic began in 2020, despite record profits. The report also found that major drug corporation

CEOs have raked in over \$292.6 million in compensation during that period – a time when as many as 18 million Americans could not afford their needed medications

Those top 5 companies as measured by stock value – Johnson & Johnson, Eli Lilly and Company, Pfizer, AbbVie and Merck & Co. – used their political power to torpedo legislative proposals such as H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act. Working together with the industry trade group PhRMA, these corporations and individuals are asking Congress to "abandon" efforts to allow Medicare to negotiate lower prices.

Accountable US previously discovered that Republican members of the House Energy & Commerce Committee had accepted nearly \$1.7 million in contributions from top pharmaceutical firms and lobbyists opposed to Medicare price negotiations.

Now that Senate Democrats are closer to another agreement that will give Medicare the power to negotiate lower drug prices, big PhRMA is pushing even harder against reforms that will make prescriptions more affordable.

"PhRMA's combination of price gouging and controlling politicians with their purse strings has been a recipe for disaster," said Richard Fiesta, Executive Director of the Alliance. "The longer we go without giving Medicare price negotiating power, the longer we



Rich Fiesta,
 Executive Director, ARA

are allowing corporate greed to control the lives of our most vulnerable citizens." As PhRMA continues to lobby, Sen. Joe Manchin (WV) pumped the brakes this week on negotiations with Senate Majority Leader Charles Schumer (NY) on a budget reconciliation bill, saying he would only support a bill that includes provisions aimed at lowering the price of prescription drugs and a two-year extension of Affordable Care Act subsidies -- not new spending on climate change or new tax increases targeting wealthy individuals and corporations.

Congress Must Improve Customer Service by Boosting the Budget for

Social Security Administration



Joseph Peters, Jr.
 Secretary Treasurer ARA

Public access to federal agencies seems to be waning by the day, and nowhere is this more evident than in the Social Security

Administration (SSA), according to economist and retired federal employee David Weaver.

Weaver writes in The Hill that the understaffed and underfunded SSA offices designed to serve the elderly and disabled are burdening their constituents with long wait times, in part due to Congress' \$1 billion cut to President

Biden's customer service budget request for SSA. An increase in congressional funding would help prevent such problems as seniors and people with disabilities having to wait in long lines at SSA offices in the hot sun of Florida, New Mexico, and Texas. An observer in Texas noted that she had personally witnessed a woman being wheeled over and loaded into an ambulance after fainting in line on a hot day.

One solution: using Congressional offices and their staff resources to address Congress's pattern of systematically underfunding federal agencies and then blaming those agencies when problems arise. Members of Congress usually have case workers on staff who have technical expertise on federal programs such as Social Security, and they can help resolve problems with federal agencies when other efforts fail.

"Members of the public would be wise to go directly to their elected officials when they are unable to access government services, including having questions about their Social Security benefits answered," said Joseph Peters, Jr., Secretary-Treasurer of the Alliance.

"Members of Congress should not be allowed to blame federal agencies like SSA when they caused the problem by defunding them in the first place."

Historic Day!

Historic Day!

The repeal of the unfair provisions of WEP and GPO that rob teachers, police, firefighters, and public employee retirees of their Social Security benefits just took a giant step forward. This

morning 291 Congress members have now signed on as co-sponsors of HR 82. Congressman Rodney Davis and Congressman Garrett Graves walked down a written request to



the Clerk and filed to have HR 82 heard on the floor and voted on in Congress. The rules mandate a floor vote on any bill that receives 290 co-sponsors.

This will be the first time in history that a floor vote has been taken on any bill to repeal or modify WEP/GPO. The vote will likely be in September. Stay tuned.

Social Security at Retirement is not Guaranteed to many

Submitted by Bonnie Cediell

Many seniors who paid for their Social Security benefits, like everyone else, are losing part or ALL of their earned retirement benefits!

These include more than one third of America's public school teachers. They are headed for trouble, and many of them don't know it. When they retire, the Social Security benefits they paid for themselves or earned through a spouse will be severely cut or eliminated. Even half a pension from a teaching career of a few years can cost them thousands of dollars a year in earned Social Security benefits.

The pandemic has hit our education system hard. Teachers are retiring early. Some are finding lighter work loads and better pay in other careers. We can't afford a brain drain from our education system. Why are we penalizing teachers now?

When the Social Security Act was passed in 1935, public workers were not included in the system, and different public agencies started their own retirement systems. Needing more participants, in the 1950s,

the Social Security



Social Security Fairness

Administration began allowing the workers in public agencies to join the system, but many public workers who were already paying into a pension fund decided to keep the retirement plan they were already vested in.

By the early 1980s, when Social Security got an overhaul, many in Congress said that public workers should not be getting both a pension and Social Security benefits, even if they had paid into both retirement systems. Congress passed the Windfall Elimination Provision (WEP), which cuts the fully-paid-for Social Security benefits of people who have also earned a pension from a governmental entity, like a school district. Congress also passed the Government Pension Offset (GPO), which prevents spouses who earned even part of a public pension from collecting some or all of their Social Security spousal or survivor benefits.

The WEP uses a flawed benefit calculation formula. The GPO formula, reducing spousal or survivor benefits by two-thirds of

the value of one's pension,

doesn't take into account the amount of time a spouse may have been a non-earning homemaker, thereby fully earning these benefits. Both regulations hurt lower-income earners, like many teachers, more severely than retirees with higher incomes. Eighty-three percent of those affected by the GPO are women, and most people affected by the GPO lose all their benefits.

There have been bills in Congress over the years to repeal or change these penalties, but they were mired in inertia and confusion. Nothing has happened.

These penalties affect not only teachers in 15 states, but also a wide range of public workers in half our states: office workers in city and county jobs and older postal workers across the country. Police and firefighters often have partial public careers and earn Social Security in other work. They also get hit. And so does everyone with a pension earned in another country.

More than six million current

public servants will be penalized when they retire. Two and a half million retirees are losing all or part of their Social Security now. These cuts in retirement benefits end up hurting the communities they live in by reducing local spending and increasing the number of seniors who need financial aid.

This is not the time to undermine our public services and education. Currently 56 million retirees receive Social Security Old Age and Survivor benefits. The cost to add two and a half million more recipients is minimal. The WEP and GPO are wrong. The affected retirees paid for their benefits at the same rate as everyone else.

Sixty-seven percent of the members of the House of Representatives have shown their support for H.R. 82 and the repeal of these unfair penalties. Now it is the Senate's turn! Senators who believe in fair treatment of seniors should sign on to S.1302 and show their support for those who have dedicated themselves to make our schools and our public institutions work.

Conservative Blocs Unleash Litigation to Curb Public Health Powers

Through a wave of pandemic-related litigation, a trio of small but mighty conservative legal blocs has rolled back public health authority at the local, state, and federal levels, recasting America's future battles against infectious diseases.

Galvanized by what they've characterized as an overreach of covid-related health orders issued amid the pandemic, lawyers from the three overlapping spheres — conservative and libertarian think tanks, Republican state attorneys general, and religious liberty groups — are aggressively taking on public health mandates and the government agencies charged

with protecting community health.

"I don't think these cases have ever been about public health," said **Daniel Suhr**, managing attorney for the Liberty Justice Center, a Chicago-based libertarian litigation group. "That's the arena where these decisions are being made, but it's the fundamental constitutional principles that underlie it that are an issue."

Through lawsuits filed around the country, or by simply wielding the threat of legal action, these loosely affiliated groups have targeted individual counties and states and, in some



cases, set broader legal precedent.

In Wisconsin, a **conservative legal center** won a case before the state Supreme Court stripping local health departments of **the power to close schools** to stem the spread of disease.

In Missouri, the Republican state attorney general waged a campaign against school mask mandates. Most of the dozens of cases he filed **were dismissed** but nonetheless had a **chilling effect** on school policies.

In California, a lawsuit brought by religious groups challenging a health order that limited the size

of both secular and nonsecular in-home gatherings as covid-19 surged made it to the U.S. Supreme Court. There, the conservative majority, bolstered by three staunchly conservative justices appointed by President Donald Trump, issued an emergency injunction finding the order violated the freedom to worship.

Other cases have chipped away at the power of federal and state authorities to mandate covid vaccines for certain categories of employees or **a governor's ability** to declare emergencies.

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TSCL Makes News on Social Security COLA Increase

Once again, TSCL is being quoted in a number of media outlines regarding its forecast of the 2023 Social Security COLA.

Among them is *Yahoo Finance*, which said this: "Based on new inflation data through June, the cost-of-living adjustment for Social Security benefits, or COLA, could be an increase of 10.5% next year, according to estimates from the Senior Citizens League, boosting the average retiree benefit by \$175.10 every month."

However, the article pointed out that a larger COLA is not all good news for seniors. The COLA will not go into effect until January of next year. In addition, it is likely a Medicare Part B increase will take a large portion of the new COLA. And it could push certain seniors into a higher tax bracket resulting in increased taxes and/or a reduction in some benefits.

Quoting TSCL's Social Security Policy Analyst Mary Johnson, the article pointed out that "A bigger Social Security benefit translates to higher income, which can mean higher taxes for those with incomes above \$25,000 for individuals and \$32,000 for married couples, according to Johnson. Tens of thousands of retirees who have not paid taxes on their benefits in the past may discover they must start doing so in 2023.

"Because the income thresholds are not adjusted like ordinary tax brackets, these once-in-a-lifetime COLA increases could lead to permanently higher taxes for many retirees," Johnson said.

"Higher income can also result in cuts in income-related benefits for low-income seniors, Johnson said. A May-June survey from the Senior Citizens League found that 39% of participants who receive low-income benefits reported their low-income assistance was reduced due to this year's 5.9% COLA, while 15% reported they lost access to at least one assistance program.

"The most cruel irony is that a high COLA can lead to trims in income-related benefits such as

SNAP and rental assistance for low-income beneficiaries," Johnson said."

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Manchin Torpedoes Plan for Bill to Lower Drug Prices

For the past few weeks, we have been reporting that the Democratic majority in the Senate was going to try to pass a bill to lower prescription drug costs before Congress goes on its annual August recess.

We said that Senate Majority Leader Charles Schumer (D-N.Y.) had been working with Senator Joe Manchin (D-W.Va.) to try and come up with a bill Manchin can support. Manchin had killed the earlier Democratic plan to lower drug prices as part of a much larger "Build Back Better" bill that President Biden had wanted Congress to pass.

Manchin complained that the bill would cost too much, and he wanted part of the legislation to go toward reducing the federal deficit, among other things.

We wrote that there were reports they had reached a tentative agreement on legislation to lower drug costs and extend the solvency of Social Security, but those items were part of a larger bill that was not finalized. That bill contained contentious details on energy spending and tax provisions that were still being negotiated, but Democrats had hoped to unveil deals on those last week.

However, it was revealed last Thursday that Manchin said he could no longer support the bill. Democratic leaders thought they were close to finalizing, even though it met many of his earlier demands. He said his change of mind was due to surging inflation.

He then said he could support a smaller deal now that would lower prescription drug prices and bolster health care premiums or wait until later in the fall to see if inflation cools down. It is not clear if extending Social Security solvency as part of the smaller package is something he would support now.

Senate Democratic leaders must decide whether to accept his demands and pass the smaller



bill now or wait 6 to 8 weeks to see where inflation is and then try to pass a larger bill so close to the November elections.

After the Manchin announcement, President Biden issued a statement calling on the Senate to pass health-care provisions that the caucus can get behind and that he would sign the legislation if it can pass Congress.

Manchin's support is critical, of course, because every Democratic vote in the Senate is needed to pass the bill due to the fact that no Republican is expected to support it.

This development is very disappointing for all of us who have worked so hard for legislation to lower drug prices, but the fight is not over.

Stay tuned.

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Bill to Lower Insulin Costs Faces Delays in Senate

Last week we also reported on a bi-partisan bill in the Senate that would lower the cost of insulin and cap the out-of-pocket cost to diabetes patients at \$35 a month. Because it was developed by Senators **Jeanne Shaheen** (D-N.H.) and Susan Collins (R-Maine), it was hoped it could get a vote in the Senate this month.

We said that because of Senate rules, the Shaheen-Collins bill will require support from at least 10 Republican senators in order to clear a filibuster and pass.

However, it is far from clear that 10 Republicans can be found to support the bill. Some are citing fears of interfering with the free market as the reason for their opposition to the bill.

Now, Senate Majority Leader Chuck Schumer has said he plans to hold a vote soon on the bill, but key Republican senators say they are not ready for a vote right now.

"I agree we've got to deal with insulin, but I don't think they've got the right mechanism to do it just yet," said Sen. Mike Crapo (R-Idaho), ranking member of the Senate Finance Committee. Crapo said he agrees with Republicans who want to hold a hearing on the legislation before it is brought to a vote on

the floor.

Sen. **Chuck Grassley** (R-Iowa) said he's waiting for the Congressional Budget Office to produce an updated analysis of the bill to understand its impact. He also wants to get a sense of how many drug-makers would voluntarily take up the bill's offer to hold prices to a 2021 level in exchange for a prohibition on rebates. Drug-makers pay rebates to insurers or other entities in the supply chain partly to get better placement on insurance networks.

Democrats fear Republicans are stalling on passing the bill because they do not want to let the Democrats claim victory before the fall elections, while Republicans think Democrats are simply "rushing" the legislation to the floor to blame Republicans for its failure.

Big Win for WEP/GPO

H.R. 82, The Social Security Fairness Act, has finally reached the magic number of over 290 co-sponsors. **The Social Security Fairness Act (H.R. 82)**, if passed into law, would eliminate the Windfall Elimination Provision and the Government Pension Offset.

The Windfall Elimination Provision and the Government Pension Offset are two provisions that unfairly reduce or even eliminate the Social Security benefits of millions of Americans who have devoted their careers to public service, as well as having worked other jobs that withheld payroll taxes from their wages for Social Security benefits.

Per a relatively new House rule, any bill with 290 cosponsors can be added to the House Consensus Calendar (The Consensus Calendar is the go-to place for common sense bipartisan bills to move out of the house closet and be enacted into law). Once on, it is teed up for a vote if it maintains those 290 cosponsors or more for 25 legislative days (that basically means days when the House is in session).

Poll: More than 75 percent of Americans support strengthening Social Security

Most Americans love Social Security. It is a national treasure that, increasingly, millions of older and disabled Americans and their families depend upon. A [new poll from Data for Progress](#) shows that more than eight in ten Americans are somewhat or very concerned that Social Security will not be able to pay out its full benefits. Not surprisingly, more than three in four Americans across the political spectrum strongly or somewhat support raising taxes on Americans earning more than \$400,000 annually to pay for expanding and strengthening Social Security.

Social Security is government-required savings—an earned benefit supported through payroll contributions during your working life, which helps guarantee financial security during your retirement years and in other special situations,

including long-term disability. Much like life insurance, you pay in, and it pays out.

Unlike other government benefits, Social Security pays for itself, including the cost of its administration. But, Republicans have tried to cripple Social Security when in power, for example, refusing to take money from its Trust Fund to cover the full cost of staff and local offices. Without enough funding, it becomes difficult for people to get their Social Security benefits.

Right now, Democrats in Congress want to expand Social Security, so that its benefits keep pace with cost of living increases. They want to raise taxes on the wealthy to make sure that Social Security continues to have the funding it needs to pay out full benefits for the next several decades.



Voters overwhelmingly prefer that Social Security benefits be expanded and that wealthy Americans contribute their fair share to ensure Social Security's solvency. And, even though Social Security's Trust Fund is designated exclusively for Social Security, Republicans want to raid the Social Security Trust Fund to fund their initiatives.

Marco Rubio is proposing to cut Social Security benefits in retirement in order to fund people's parental leave, through his [Providing for Life Act](#). His proposal would jeopardize people's retirement security. Moreover, if the parent who took paid parental leave died before she became eligible for Social Security, the government would be able to claw back the parental leave payment from her family.

Americans are already

struggling in retirement, with [few retirement savings](#) and Social Security as a lifeline. Costs are only rising. Rubio's proposal jeopardizes people's situation, reducing the amount of money they would be able to count on in retirement.

In 2005, under President George W. Bush, Republicans tried but failed to privatize Social Security. They know that Americans depend on it. Once again, they are trying to find a way to destroy its benefits, this time, by allowing people to take its benefits upfront. But, when Americans retire, Social Security would offer less financial security. If Republicans care about paid parental leave, they should pay for it through higher taxes on the wealthy or through an additional payroll contribution, not mess with Social Security and people's retirement security.

If passed, reconciliation bill in Congress is likely to strengthen Medicare Trust Fund

Senator Manchin might be terrible on climate policy or raising taxes on the wealthiest Americans, but he does not appear to have thrown a wrench into a policy that would strengthen the Medicare Trust Fund, extending its solvency three years. Jean Ross and Seth Hanlon report for the [Center for American Progress](#) on a provision agreed to in the US Senate reconciliation package that would close a Medicare loophole and raise more than \$200 billion in revenue for Medicare over the next 10 years.

The reconciliation act provision is less a tax increase and more a tax equalizer, requiring people who have in the past dodged Medicare taxes to pay the taxes that working people and small-business owners already pay.

Right now, employers and workers split a payroll contribution of 2.9 percent. The Affordable Care Act (ACA) added an additional 0.9 percent to that pot for high-income individuals. The ACA also applied a 3.8 percent contribution



to net investment income, unearned income like capital gains, dividends and interest and business

income. But, the ACA included a tax loophole for people whose income comes from an S corporation, a limited liability company or limited partnership and who participate actively in these businesses. Partners in private equity funds, doctors, lawyers, entertainers and others are among these individuals. The provision in the reconciliation

package would close this loophole for individuals with income over \$400,000 and couples with income over \$500,000 and make the tax code a bit fairer.

Almost everyone who would pay this new tax is in the top 1 percent of income earners, with annual income above \$680,000.

As of now the Medicare Trust Fund will start paying out more than it takes in in 2028. This provision would extend its solvency to 2031.

Does Medicare Part D save you money on generic drugs?

A new [Avalere analysis](#) reveals that more than half of people with Medicare Part D paid the full cost of their generic drugs in 2020, in some cases as much as they would pay for brand-name drugs. Sarai Radriguez reports for [Health Payer Intelligence](#) on the increasing number of people with Medicare Part D who pay the full cost of their generic drugs.

In the three years between 2017 and 2020, the percent of people with Medicare getting no help from their Part D

prescription drug coverage to pay for their generic drugs rose from 45 percent to 63 percent. Their copays were in the same tier as brand-name drugs.

Drugs for which people paid the full cost included drugs to treat thyroid issues as well as musculoskeletal, cardiotoxic, thyroid issues and anxiety. Curiously, a higher percentage of people in low-income subsidy benchmark plans ([Extra Help plans](#)) (68 percent) paid the full price of their generics than



people in non-benchmark plans (62 percent). Medicare Part D plans cannot charge their enrollees more for copays

than their negotiated price for a drug. But, they can put generic drugs on high copay tiers, while getting higher discounts for brand-name drugs. So, that's what they are doing increasingly to maximize their profits. As a result, [some brand-name drugs cost enrollees less out of pocket than their generic substitutes](#) during the

catastrophic coverage phase of the Part D benefit, even though they cost Medicare more.

If the skinny version of Build Back Better passes—the reconciliation bill—it would allow federal drug price negotiation for some brand-name drugs without generic substitutes. But, it does nothing to ensure that Part D prescription drug insurers are offering their enrollees coverage at the lowest price possible, for example, at the prices you can get through [Mark Cuban's Cost Plus Pharmacy](#).

Senate Democrats Release Updated Prescription Drug Pricing Bill

Last week, Senate Democrats released updated prescription drug pricing **legislation**, with the goal of passing it through the reconciliation process in the coming weeks.

Like previous versions, the package would allow Medicare to negotiate some drug prices, cap beneficiary out-of-pocket (OOP) Part D drug costs at \$2,000 a year, and penalize drug manufacturers for price hikes that outpace inflation. It also includes new provisions that would make Part D vaccines available with no cost sharing and expand eligibility for the Part D Low Income Subsidy (LIS) program to individuals

with incomes up to 150% of the federal poverty level (FPL). Currently, the threshold is up to 135% FPL, about \$18,000 a year in 2022.

Medicare Rights has long supported these critical reforms. Together, they would achieve historic coverage and affordability gains, better ensuring that all people with Medicare have meaningful access to care. We urge Congress to advance these vital policies without delay. As surveys consistently show, voters agree. There is overwhelming bipartisan agreement on the need



for comprehensive prescription drug reform: **more than 80%** of Americans support steps such as allowing Medicare to negotiate drug prices and capping drug price inflation, and **addressing** high and rising drug prices is the top health care issue Americans want Congress to tackle this year.

Polling also continues to find that high health care and prescription drug prices are weighing heavily on consumers. In a recent Kaiser Family Foundation **survey**, half of all respondents reported delaying or going without care in the past year due to costs, and nearly one

-third—including 43% of those with annual incomes under \$40,000—did not fill a prescription or skipped doses due to affordability concerns. Immediate action is needed to improve the nation's drug pricing system in ways that will strengthen Medicare as well as beneficiary well-being. Absent such interventions, unaffordability will continue to rise, pricing an ever-growing number of Americans out of needed **medications** and **coverage**, leading to worse health outcomes and higher costs in the future.

America's 988 Suicide and Crisis Lifeline Launched Saturday July 16, 2020

Starting Saturday, July 16, 2022, if you or someone you know is contemplating **suicide** or having a mental health crisis, you can dial just three numbers -- **988** -- to get help.

Callers will be connected to a trained counselor at a local call center and ultimately routed to potentially lifesaving support services. The three-digit code for the 988 Suicide and Crisis Lifeline replaces the 10-digit number for what was formerly known as the National Suicide Prevention Lifeline.

The new three-digit number is easy to remember, free, available 24/7 and confidential, said Thea Gallagher, a clinical assistant professor in the Department of Psychiatry at NYU Langone Health in New York City.

"If 988 becomes just as ubiquitous as 911, we are saying that mental health and physical

health are on the same level, and that breaks stigma," she said.

The need for such access and services has never been greater, Gallagher said.

"With the ongoing **pandemic**, we have seen an increase in depression, anxiety and suicidal thoughts and behavior, so we know mental health has never been more negatively impacted," she said.

In 2020, more than 47,000 Americans died by suicide, a 33% increase from 2000, according to The Pew Charitable Trusts.

The new number will also accept texts, and live chat is available, said Dr. May Lau. She is a pediatrician at the University of Texas Southwestern Medical Center and the medical director of the Adolescent and Young Adult Clinic at Children's Medical Center Dallas.



Crisis counselors speak multiple languages and are culturally competent at counseling members of the LGBTQ community.

There are also resources available for people who are deaf or hearing-impaired, Lau said.

"The text function is only in English for now, but most of the people who feel comfortable texting are younger, and many of them are bilingual," Lau noted.

The new line is not just for people who are contemplating suicide. Counselors are also skilled in discussing **self-harm, addiction, domestic violence** and other mental health issues. If a caller needs immediate medical attention, 988 will collaborate with local police or hospitals to dispatch services.

"We are trying to help people deal with crises before they

become life-threatening," said Anthony Wood, interim CEO and COO of the American Association for Suicidology. The group has been calling for a three-digit suicide hotline for years.

And while a three-digit number is a big step forward, there are still some kinks to work out, Wood said.

For starters, local crisis centers will need more counselors to handle the expected surge in calls, he said.

"Member centers are gearing up for more volume and accountability to their communities, and while funding has been expanded, we are still in a situation where there are not enough dollars to cover the cost for every part of the country," Wood said. "Every state is struggling with how to fund the program."

How will inflation affect your Social Security tax bill? It's not pretty

TAX GUY

Employers, employees, and self-employed individuals all pay the Social Security tax. For many self-employed individuals, the tax equals or exceeds their federal income tax bill. And yet, the Social Security tax gets little attention. And what about the impact of inflation? Let's discuss.

How big can my Social

Security tax bill be?

Probably a lot bigger than you think. As an employee, your wages are hit with the 12.4% Social Security tax up to the annual wage ceiling. Half the Social Security tax bill (equal to 6.2%) is withheld from your paychecks. The other half (also 6.2%) is paid by your employer, so you never actually see the second



half. Unless you understand how the Social Security tax works and closely examine your pay statements, you may be blissfully unaware of how much the tax actually costs. Potentially a lot! Here's why.

The Social Security tax wage ceiling for 2022 is \$147,000. If your wages meet or exceed this year's ceiling, the Social

Security tax hit for this year will be a whopping \$18,228 (12.4% x \$147,000 = \$18,228). Ouch. Half of that comes out of your paychecks. Your employer pays the other half.

The wage ceiling is projected to rise to \$155,100 next year. The projected future-year increases are shown later in this column....**Read More**

RI ARA HealthLink Wellness News

Novavax Covid-19 vaccine wins FDA authorization

The Food and Drug Administration on Wednesday granted emergency use authorization to Novavax's Covid-19 vaccine, opening up another option for adults who have not received immunization against the virus.

The vaccine, a two-dose series administered three weeks apart, is manufactured using a lab-made spike protein produced in insect cells and an adjuvant obtained from the bark of a tree native to Chile, offering a different and older vaccine technology than is used in the messenger RNA vaccines and Johnson & Johnson shot. It is authorized for people ages 18 and older as a primary series, meaning the shot is intended for the roughly 10 percent of adults who have not yet received a Covid-19 vaccine.

Novavax executives have said they hope the shot will see uptake in individuals who have

expressed hesitancy toward other Covid-19 vaccines or are allergic to components of the others' ingredients.

"Today's authorization offers adults in the United States who have not yet received a Covid-19 vaccine another option that meets the FDA's rigorous standards for safety, effectiveness and manufacturing quality needed to support emergency use authorization," FDA Commissioner Robert Califf said in a statement.

Background: The Novavax vaccine contains a synthetic coronavirus spike protein made with moth cells and compounds that encourage an immune response. This formulation is similar to older vaccines.

In a trial of more than 26,000 adults in the U.S. and Mexico, two doses of the Novavax Covid vaccine were more than 90 percent effective at preventing



symptomatic disease. For adults 65 and older, effectiveness was more than 78 percent. There were no serious side effects or safety concerns, including for the approximately 21,000 adults who were followed for more than two months after their second shot.

In a press release, the FDA noted that it had conducted a thorough analysis of Novavax's production capacity as part of its decision to authorize the shot. The shot **received strong backing from the Trump-era Operation Warp Speed** effort, but faced **difficulties with manufacturing** throughout its lengthy vaccine development process.

What's next: The Centers for Disease Control and Prevention will next decide whether it will endorse the vaccine for adults. The agency's Advisory Committee on Immunization

Practices is scheduled to convene on July 19, but an agenda for the meeting has not yet been published.

The Biden administration announced earlier this week that it had purchased 3.2 million doses of the Novavax vaccine. The Department of Health and Human Services said Monday that Novavax is "expected to complete all necessary quality testing in the next few weeks, which would support final release of the product."

If the vaccine garners a favorable recommendation from the CDC, HHS said the protein-based vaccine will be made available at no cost to states, jurisdictions, federal pharmacy partners and federally qualified health centers.

The FDA said it expects Novavax to continue clinical trials to obtain data that would support full approval of the vaccine.

As Big Pharma Loses Interest in New Antibiotics, Infections Are Only Growing Stronger

Forget covid-19, monkeypox, and other viruses for the moment and consider another threat troubling infectious disease specialists: common urinary tract infections, or UTIs, that lead to emergency room visits and even hospitalizations because of the failure of oral antibiotics.

There's no Operation Warp Speed charging to rescue us from the germs that cause these infections, which expanded their range during the first year of the pandemic, according to a new Centers for Disease Control and Prevention report. In the past



year, the FDA declined to approve two promising oral drugs — sulopenem and tebipenem — to treat drug-resistant UTIs, saying it needed more evidence they work as well as current drugs.

In the meantime, some UTI patients "have to get admitted

and get an IV treatment for a bladder infection that typically would be treated with oral antibiotics," said **Dr. Sarah Doernberg**, an infectious disease specialist at the University of California-San Francisco Medical Center....**Read More**

White House COVID-19 coordinator says virus 'still evolving rapidly'

As variants continue to circulate and develop, White House COVID-19 response coordinator **Ashish Jha** says the U.S. has "got to stay on top of this virus" as it quickly evolves.

"We're still in the middle of this pandemic," Jha said Sunday on ABC's "This Week."

The latest COVID-19 subvariant, BA.5, is the most highly transmissible to date, Jha said. It's also "immune-evasive," leading to high levels of reinfection and breakthrough infections.

Vaccines are still effective at staving off severe illness, he added, but they're not as

protective against BA.5 compared to other iterations of the virus.

"If you got your booster, let's say, last November or December, you don't have as much protection against this virus as you'd like."

Jha added that it's "absolutely critical" for those over 50 years of age who have not received a shot this year to get one as soon as possible. "It will offer a very high degree of protection."

"We've got to keep building new generations of vaccines. We've got to make sure we have adequate treatments. We can get through this but it is not — if we



take our eye off our ball, we've got to really stay focused."

The country is in a better place now than it was at the start of the Biden administration, Jha acknowledged, but "we still have work to do."

Last week, the White House held a **teleconference** to address the new, highly transmissible BA.5 subvariant.

"We are experiencing about 300 to 350 deaths a day. That is unacceptable. It's too high," Jha said at the briefing, in conversation with Centers for Disease Control and Prevention

Director **Rochelle Walensky** and chief White House medical adviser Anthony Fauci.

The omicron variant and its subvariants have been "particularly problematic" for public health, Fauci said.

COVID-19 hospitalizations have doubled since early May, Walensky reported, to more than 5,000 admissions per day.

The experts emphasized that even those with a full vaccine regimen, as well as those infected with earlier BA.1 or BA.2 subvariants, are still at risk for BA.4 and BA.5 infections.

Repair or Reconstruction: What's Best for ACL Tears?

Adults who tear a key ligament in the knee can fare well with a less extensive type of surgery, preliminary research suggests.

The study involved patients treated for a ruptured **anterior cruciate ligament** (ACL), a strong band of tissue that helps stabilize the knee joint. ACL tears commonly happen during sports that involve jumping or sudden stops and pivots, like basketball, soccer and skiing.

The injury is often treated with surgery, and the "gold standard" is ACL reconstruction: A surgeon removes the torn ligament remnant and replaces it with a portion of a tendon from elsewhere in the body, or with donated tissue from a cadaver.

For many years, reconstruction has been the preferred choice over repairing the tear in the existing ligament. Studies going several decades back showed that those repaired ligaments often did not hold up over time.

"Historically, repair was associated with poor results," said lead researcher Dr. Adnan Saithna, an orthopedic surgeon at AZBSC Orthopedics, in Phoenix, Ariz.

But repair techniques have been modernized, he explained, and there is growing interest in offering ACL repair to at least some patients. Both **ACL reconstruction** and repair are minimally invasive procedures, done via small incisions, but repair is thought to have some potential advantages. It avoids borrowing tissue from a patient's tendon (usually a tendon connecting to the kneecap or one of the **hamstring muscles**), and it might allow a faster recovery.

But, Saithna said, there has not been much data on how modern ACL repair stacks up against reconstruction.

For the study, his team compared 75 patients who'd



undergone ACL repair at one medical center with 75 patients who'd had a standard reconstruction. Each repair patient was "matched" with a

reconstruction patient of the same age, sex, body weight, sports participation and general physical activity level.

"So we compared patients who were very similar to each other," Saithna said.

Overall, the study found, repair patients did better in certain respects: Six months after surgery, they had better hamstring strength. And farther out — 2.5 years, on average — they typically had better scores on a "forgotten joint" scale: Essentially, they were giving less thought to their injured knee, possibly because it felt normal again.

There was a significant downside, however. Repair patients were more likely to re-

injure the joint: 5% suffered another ACL tear, while none of the reconstruction patients ruptured their ligament replacement.

Age did seem to make a big difference in that risk: Many repeat tears were among patients younger than 22.

According to Saithna, the age divide makes sense. High school and college athletes, eager to get back into the game, may simply have more chances at a re-rupture. He added, though, that the risk might partly stem from the biology of those younger knees, too.

As for whether repair led to a faster recovery, the study found no clear proof of that: 75% of repair patients had returned to their pre-injury level of sports participation, versus 60% of the reconstruction group — but that difference was not significant in statistical terms....[Read More](#)

Fewer Americans Are Dying of Heart Disease Than a Decade Ago

Deaths from heart-related causes have dropped over the past 20 years, though differences persist by race and ethnicity as well as where people live and their access to care.

The U.S. National Institutes of Health (NIH), which partially funded the research, detailed the results of three papers. The findings were published July 18 in the American Heart Association journal *Circulation*.

One study used data from the

U.S. Centers for Disease Control and Prevention, finding that death rates linked to heart disease dropped between 1999 and 2019 for both Black and white adults.

While **gaps** between the two groups lessened, Black adults continued to have higher death rates than white adults. This was especially true in rural or segregated areas and among younger Black adults.



"The persistent disparities observed in our study likely reflect the fact that Black adults disproportionately experience social, economic and environmental barriers to optimal health due to systemic inequities and structural racism," co-author Dr. Rishi Wadhwa said in an NIH news release. He's an assistant professor at Harvard Medical School.

Initiatives in Black communities to expand access to heart disease risk screenings, prevention and care, including blood pressure screenings at barbershops, have helped to close the gaps, researchers said.

In **a second study**, researchers with the Multi-Ethnic Study of Atherosclerosis (MESA) described similar associations....[Read More](#)

Special Brain Scans May Diagnose Early Parkinson's

It may not be long before highly sensitive scans might spot **Parkinson's disease** in its early stages, researchers report.

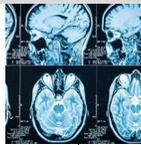
A disease of the brain that is characterized by shaking hands, Parkinson's is a condition that worsens over time, compromising a person's ability to walk, hold items or even talk.

Unfortunately, it can take a year or more to diagnose, and even longer to assess how the patient may do over time with treatments.

The typical way Parkinson's is diagnosed is with an MRI brain scan. But the researchers argue

this scan isn't sensitive enough, and it can't reveal some of the biological changes that play out in the brains of these patients. Instead, MRIs are used more often to eliminate other diagnoses.

Now, scientists at the Hebrew University of Jerusalem, in Israel, have worked on a different way to diagnose the disease, called **quantitative MRI** (qMRI). The qMRI scans looked at a part of the deep brain called the striatum, which helps the body move voluntarily and rapidly deteriorates as the disease



progresses. The results, published July 15 in the journal *Science Advances*, found that their qMRI analysis, a technique they compared to taking the same photograph with different lighting, was able to show changes in the tissue structure within distinct sections of the striatum. Before, this technique would have only been possible to see in lab tests after a patient had died.

"When you don't have measurements, you don't know what is normal and what is abnormal brain structure, and

what is changing during the progress of the disease," explained researcher Aviv Mezer, a professor at Hebrew University.

"What we have discovered is the tip of the iceberg," Mezer added in a university news release.

Next, the team hopes to examine tiny changes in other regions of the brain using this technique. Mezer said he anticipates the scans will be used in clinical settings three to five years down the road.

Cancer Med Might Be Powerful Treatment for MS

A drug used "off-label" for **multiple sclerosis** (MS) is more effective than a standard medication at preventing symptom flare-ups, a new clinical trial has found.

The drug, called **rituximab**, is approved in the United States for treating certain cancers and autoimmune diseases. It is not approved for treating MS, but some doctors do prescribe it off-label for that reason.

That's based partly on how rituximab works, as well as some early-stage trials that suggested the drug reduces MS relapses, which are periods of new or worsening symptoms.

The new study from Sweden is the first phase 3 trial to test rituximab against MS -- the type of trial that is designed to prove

a treatment's efficacy, said lead researcher Dr. Anders Svenningsson.

And it found that compared with an approved MS medication -- dimethyl fumarate (Tecfidera) -- patients given rituximab had a fivefold lower risk of relapse over two years.

"Our findings add the necessary data on clinical efficacy, in a trial designed for that purpose," said Svenningsson, chief physician of the neurology clinic at Danderyd Hospital in Stockholm.

That might be enough, he added, to get more authorities to recommend rituximab as an MS treatment, and more insurance companies to pay for it.

MS is a neurological disorder



caused by a misguided immune system attack on the body's own myelin -- the protective sheath around nerve fibers in the spine and brain.

Depending on where the damage occurs, symptoms include vision problems, muscle weakness, numbness and difficulty with balance and coordination.

Most people with MS have the relapsing-remitting form -- where symptoms flare for a time, then ease. Over time, the disease steadily worsens.

Immune system cells called B-cells seem to play a key role in MS. That understanding led some doctors to start prescribing rituximab to MS patients, as the drug depletes the number of B-cells in the blood.

But research went in a different direction, with drug companies developing new B-cell-depleting drugs. One, called ocrelizumab (Ocrevus), was **approved** in the United States in 2017. A second -- ofatumumab (**Kesimpta**) -- followed in 2020.

Both Ocrevus and rituximab require patients to go to a medical facility for infusions every six months. Kesimpta, on the other hand, is taken at home once a month, with an auto-injector.

But an advantage of rituximab is cost. It's available as a generic, and is priced far lower than the two newer drugs, Svenningsson said...[Read More](#)

Thyroid Trouble May Raise Dementia Risks

Millions of older adults try to manage an underactive thyroid gland with daily medication, but a new study suggests they may still be vulnerable to developing **dementia** as they age.

Researchers found that among over 15,000 older Taiwanese adults, those who'd been treated for hypothyroidism were substantially more likely to be diagnosed with dementia. **Hypothyroidism** occurs when the body is not producing enough thyroid hormones, which control metabolism.

That underproduction can cause an array of symptoms, including fatigue, intolerance to cold, constipation, body aches, depression and weight gain. Studies show that waning thyroid hormones may also dull a person's thinking skills -- in a way that's reversible with thyroid medication.

But whether hypothyroidism can contribute to irreversible dementia has been unclear. And the new study, published recently in the journal **Neurology**, does not



answer that question definitively.

"We found that for patients with hypothyroidism that required medication, the risk of dementia was much higher," said researcher Dr. Chien-Hsiang Weng, of Brown University's Alpert Medical School, in Providence, R.I.

"But it's hard to know why," he stressed. "We can't really say that hypothyroidism causes dementia."

In addition, the vast majority of patients with dementia in the study had no history of

diagnosed hypothyroidism: Just under 1% did.

Still, Weng said, it's useful to know that older people with hypothyroidism -- for whatever reason -- may have a heightened likelihood of developing dementia. That way, patients and doctors can be on the lookout for potential signs of declines in memory and thinking.

"We wanted to let clinicians know that hypothyroidism might be one of the risk factors," Weng said...[Read More](#)

Cancer patients face particularly severe medical debt

Noam Levey reports for **Kaiser Health News** on the particularly severe medical debt people with cancer often bear. Levey profiles a breast cancer patient who faces \$30,000 of debt, along with constant threats from collection agencies. She, like many people with cancer, must make tradeoffs that no one should have to make to pay off the debt.

Cancer kills hundreds of thousands of Americans each year. People with and without insurance, young and old. New treatments are saving more lives but at an extremely high price. More than six in ten people with

cancer have had to reduce their spending on necessities like food and clothing because of the high cost of their treatment. One in four of them have been pushed into bankruptcy, been evicted from their homes or had their homes foreclosed on them. According to the National Cancer Institute, treating someone with cancer can cost **more than \$1 million** in the first year. On average, it **costs \$42,000 in the first year**. People with Medicare are not spared high out-of-pocket costs. Those with blood cancer



typically pay \$17,000 of their own money for treatment in year one.

About **100 million Americans have medical debt**. Having cancer has been found to increase your likelihood of medical debt by 71 percent. It also makes it more than twice as likely that you will declare bankruptcy than people without cancer. And, the data show that those with cancer in bankruptcy were more likely to die than those not in bankruptcy.

People with cancer are more likely than other people with medical debt to owe a lot of

money and are also more likely to believe they will never be able to afford to pay off the debt. A Kaiser Family Foundation poll found that about 20 percent of people with cancer who face medical debt owe more than \$10,000.

High out-of-pocket costs leave patients making unconscionable choices. Many end up forgoing life-saving treatment so as not to incur more costs. **Research** shows that 18 percent of people on chemotherapy stop treatment. Of those, nearly half stop treatment when their costs rise above \$2,000.

Coronaviruses Can Survive on Frozen Meat for a Month

(HealthDay News) -- Had COVID? You might want to clean your freezer out.

A **new study** suggests that cousins of the SARS-CoV-2 virus can survive on frozen meat and fish for up to 30 days.

The research -- prompted by COVID outbreaks in Asia in which packaged meat was suspected as the virus' source -- was conducted on frozen chicken, beef, pork and salmon. The findings were published June 11 in **Applied and Environmental Microbiology**, a journal of the American Society for Microbiology.

"Although you might not store

meat in the fridge for 30 days, you might store it in the freezer for that long,"

said first author Emily Bailey, assistant professor of public health at Campbell University in Buies Creek, N.C.

Her team conducted its research without use of the actual coronavirus that causes COVID-19. Instead, researchers relied on **surrogate viruses** with similar protein spikes.

These similar viruses were placed on frozen meat and fish, which was then stored in both refrigerator temperatures (39.2 degrees Fahrenheit) and freezer temperatures (-4 F.)



"We even found that the viruses could be cultured after [being frozen for] that length of time," Bailey said in a journal news release.

Researchers said their findings are significant because SARS-CoV-2 can reproduce in the gut, not just in the respiratory tract where most people feel its effects.

Three virus strains were used as surrogates in the study, including two **animal coronaviruses**. All three have been used as stand-ins in previous studies of SARS-CoV-2.

The researchers found that the viruses didn't fare as well in

refrigerated temperatures as in freezer temperatures. The numbers also differed by food item.

They said this study underlines the importance of rigorous sanitation in the harvest, transport, packaging and distribution of food products.

"Continued efforts are needed to prevent contamination of foods and food processing surfaces, worker hands, and food processing utensils such as knives," the authors wrote, adding that the disinfection of foods prior to packaging also needs to be addressed.

Medicare's Proposed Payment Rule Offers Critical "Clarification" and Possible Expansion of Necessary Dental Coverage

Millions of older adults and people with disabilities **lack access** to affordable, essential dental care. This care is **critically important** to maintaining overall health, and the lack of coverage in the Medicare program exacerbates underlying racial, geographic, and disability-related health and economic disparities and inequities.

Currently, Medicare Part B only pays for dental services when that service is integral to medically necessary services needed to treat a beneficiary's primary medical condition, which is extremely narrowly defined. Last week, the Centers for Medicare & Medicaid Services (CMS) **issued** the

Calendar Year 2023 Physician Fee Schedule (PFS), which includes proposals to pay for additional services.

We strongly support these changes. The Medicare statute provides ample flexibility for CMS to use its authority in this area more thoroughly. The current regulatory scheme provides for medically necessary dental care in a very limited way, providing coverage in only specifically listed circumstances. The statute, however, **allows for CMS to ensure** "medically necessary" care follows the more common usage of that phrase--including needed oral health services for people undergoing



organ transplants, treatment for cardiovascular diseases, cancer therapies, and other critically important medical care.

While comprehensive coverage remains the most complete solution, the interim step of providing meaningful coverage of dental services that are more intimately connected to particular health care services covered by Medicare would help mitigate some of the disparities caused by the status quo.

The PFS changes would be an important advancement in ensuring that Medicare beneficiaries who need dental treatment as part of their covered medical care are no longer forced

to make impossible financial trade-offs or delay or go without necessary services to access the full scope of care they require. Medicare Rights applauds the advocates, including the **Medicare Oral Health Coalition**, as well as policymakers and beneficiaries who have worked towards this goal for years.

Medicare Rights will be submitting comments strongly urging CMS and the Biden Administration to use this opportunity to deliver on this critically needed benefit and addressing the proposed rule in more detail.

Depression Can Follow Stroke, But It Often Precedes It, Too

While many people suffer from depression after a **stroke**, a new study suggests depression often occurs beforehand and may be a warning sign.

"The study underscores why doctors need to monitor for symptoms of depression long term in people who have had strokes," said study author Maria Blöchl of the University of Münster, in Germany.

For the study, Blöchl and her colleagues looked at more than 10,000 adults without a history of stroke (average age, 65). Over about 12 years of follow-up, 425 had a stroke. These patients were compared to more than 4,200 people with similar backgrounds who did not have a stroke.

The study participants were surveyed every two years. They were asked whether they had experienced **symptoms of depression** in the past week, including feelings of loneliness, sadness, restless sleep, or feelings that everything was difficult to accomplish.

The surveys revealed that symptoms of **depression** often preceded strokes and got worse afterwards.

While both groups had similar scores from six years before, as the years went on, participants who were about to suffer a stroke became increasingly depressed, up until they fell ill, the study authors said.



"Depression is among the most pressing problems in people who have had a stroke and it is so common it is referred to as **post-stroke depression**," Blöchl said in a news release from the American Academy of Neurology. "But our study found depressive symptoms not only markedly increase after stroke, it found people already had developed some depressive symptoms before the stroke even occurred."

In the pre-stroke assessments, 29% of people who were about to have a stroke met the criteria for probable depression, compared to 24% of those who did not have a stroke. At the time of the stroke,

34% met the criteria for probable depression, the investigators found.

"This suggests that increasing symptoms of depression before stroke are mostly subtle changes and may not always be clinically detectable. But even slight increases in depressive symptoms, especially mood and fatigue-related symptoms, may be a signal a stroke ... is about to occur," Blöchl said. "Whether these pre-stroke changes can be used to predict who will have a stroke is unclear."

She said further study is needed to learn exactly why depressive symptoms occur before a stroke.

Prevent dementia: Take care of your eyes

If you're like me, you're wondering what it's going to take to stave off dementia as you grow older. While it might not be possible, there are things you can do. But, Paula Span reports for the **New York Times** on research finding that people who take care of their health, including their eyes, are more likely to forestall or prevent dementia.

More people are being diagnosed with dementia. At the moment, there's no drug to keep dementia at bay. Your genes play a big role in whether you will be diagnosed with dementia, and there's little you can do about that. Some risk factors, however,

are within your control, including high blood pressure, hearing loss and smoking. Simple behavior changes—which are not so easy to undertake in practice—such as **stopping smoking**, wearing a **hearing aid** and taking medications to bring **blood pressure down**, are all important. In addition, it's important to keep a healthy weight, stay physically active, not drink **too much alcohol** and be **socially engaged**. Staving off dementia is also about keeping your neural system stimulated through sensory organs. **People with**



healthy vision are less likely to suffer from dementia. So, get your eyes checked, wear glasses and get cataract surgery, if necessary. Without good hearing and **vision**, your neurons die. And, your brain function deteriorates.

A paper in JAMA Neurology finds that these types of behavior changes could have prevented more than 60 percent of dementia cases today. Medicare does not cover most vision care, but there are ways to get **free or low-cost treatment for your eyes**. By doing so, almost everyone can avoid blindness or serious vision

impairment. Medicare also does not cover hearing aids or most treatment for hearing loss. But, there are **ways to get treatment for hearing loss as well**.

Medicare does cover treatment for **glaucoma** and macular degeneration as well as cataract surgery. People tend to think that Medicare Advantage plans will cover hearing aids. In fact, typically, coverage is extremely limited, just a few hundred dollars off a total cost that is usually several thousand dollars. So, out-of-pocket costs remain very high and a barrier to getting hearing aids.

Adding salt to your diet could be bad for your health. . . unless you also eat fruits and vegetables

A new study published in the **European Heart Journal** finds that adding salt to your food, as distinct from using salt in a recipe, could be bad for your health, leading to a greater risk of a lower life expectancy and premature death. However, people who eat lots of fruits and vegetables rich in potassium, along with added salt, should have no greater risk to their life expectancy.

Nicole Lou writes in **MedPageToday** that this study, over nine years, found that people who add salt to their diet often ended up more likely to die of cardiovascular disease, stroke and cancer. People eating more salt did not see a heightened risk of death from dementia.

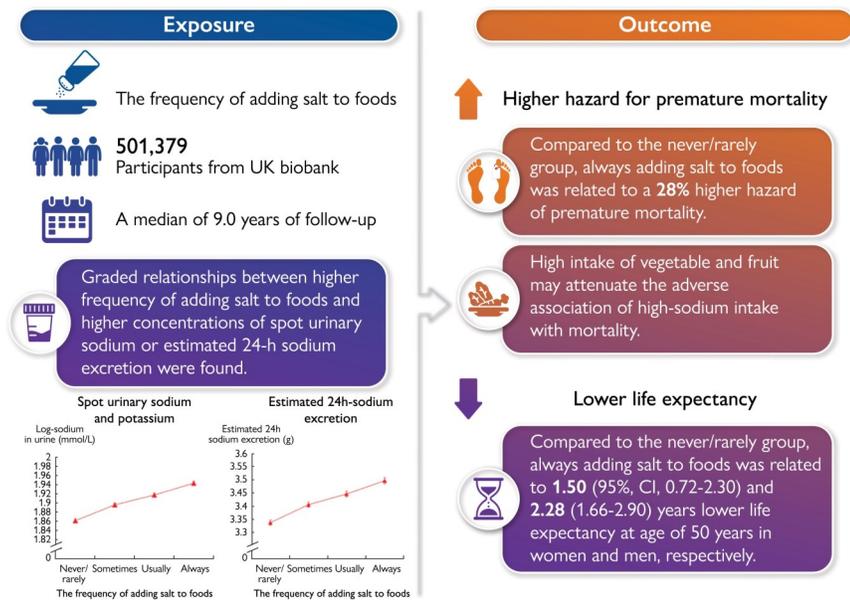
In the US, the salt that people

add to their meals, before digging in, represents between six and 20 percent of the total amount of sodium chloride they consume. So, if you are healthy, and you eat fruits and vegetables rich in potassium, you likely do not need to give another thought to the salt you add to your meals. Focus more on the fruits and vegetables!

No one knows how much salt is the “right amount” to use. But, if you are not healthy, there is every reason for you to reduce the amount of salt you add to your meals at the table. It should help

to lower your blood pressure and

your risk of premature death.



Skip the keto diet, go Mediterranean

As you get older, it's especially important to maintain a healthy weight. But, there are better and worse ways to do so. If you're looking to lose weight, the Mediterranean diet is likely a better way to go than the ketogenic or “keto” diet. The keto diet comes with several risks.

Harvard Health recommends that you not try the keto diet because it's not clear that it's safe. The idea behind the keto diet is that you will get your energy from fat rather than carbohydrates, which leads to a

state of “ketosis.”

The keto diet has you eating three-quarters of your calories from fat, including a lot of saturated fat. It does not distinguish between lean proteins and fatty ones from bacon, beef and pork. You can eat protein from meat as well as saturated fat from palm and coconut oils and butter. You can also eat unsaturated fats such as almonds, walnuts, seeds, tofu, olive oil and **avocados**.

Eating too much saturated fat is linked to **heart disease and high LDL**



cholesterol. It also reduces your fiber intake which can lead to **constipation**. With the keto diet, you could end up with **low blood pressure and kidney stones**.

The keto diet deprives your brain of healthy carbohydrates, such as whole grains, vegetables, and fruits, which are rich in a wide range of nutrients. Your body needs healthy carbohydrates to operate well, regulate your mood and keep you clear-headed.

You can eat Swiss chard, spinach and other leafy vegetables. You

can also eat bell peppers, **mushrooms**, cauliflower, garlic, onions, celery, Brussels sprouts and cucumber. But, you are not getting key **micronutrients** from these vegetables, such as vitamins B and C, phosphorus, selenium, and **magnesium**.

The keto diet is fundamentally different from the Paleo, South Beach and Atkins diets. Eating a balanced diet is all about not having too many saturated fats and proteins in your diet or too few carbohydrates. You want to strike a healthy balance.