

July 9, 2023 E-Newsletter



Message from the Alliance for Retired Americans Leaders

Sen. Peter Welch, President Roach and Protect Our Care Discuss Importance of Medicare Negotiation



Robert Roach,
President, ARA

On Thursday, Senator Peter Welch (VT) joined Alliance President Robert Roach, Jr., officials from Protect Our Care and health care

example, the cancer drugs Imbruvica and Ibrance, respectively, cost most Medicare patients an average of \$7,118 and \$6,459 per year out-of-pocket.

The report was issued as more big drug corporations turn to the courts seeking to dismantle the Drug Price Negotiation Program. Drug corporation giants Merck and Bristol Myers Squibb, as well as industry lobbying groups

increase the price of a drug faster than inflation, Americans who take 43 prescription drugs will save between \$1 and \$499 per average dose from July through September of this year. That's real results. However, drug company executives are unwilling to see their exorbitant profit margins decline."

Supreme Court Rules Against Giving State Legislatures Unchecked Control in North Carolina Elections Dispute



Rich Fiesta,
Executive
Director, ARA

The U.S. Supreme Court ruled 6-3 Tuesday that the North Carolina Supreme Court was acting within its authority in concluding that

the state's electoral district map constituted a partisan gerrymander under the state's constitution.

By ruling against Republicans in North Carolina fighting for a congressional district map that would heavily favor their candidates, the Court declined to impose new limits on state courts' reviewing certain election-related issues

"Allowing partisan state legislators to overturn the will of the voters whenever they choose would have dismantled the system of checks and balances that we have relied on since our country began," said **Richard Fiesta, Executive Director of the Alliance**. "This decision goes a long way in assuring that ballots cast will actually continue to count. However, we must still be vigilant against other threats to our right to vote."

Pickleball Craze is Driving Medical Costs Higher



Joseph Peters
ARA
Sec.-Trea.

Pickleball is the nation's fastest-growing sport, but with an increasing number of new players comes an increasing number of hospital visits, especially among older players.

Pickleball injuries are creating \$250 million to \$500 million in medical costs annually, UBS investment banking company analyst Andrew Mok estimated after assessing data from the Sports and Fitness Industry Association and studies about the sport.

Mok says that 80% of the costs are for outpatient treatment and Medicare is picking up 85% of the tab. More than 8 in 10 Pickleball injuries are to patients over 60 years old.

Roughly 22.3 million people are expected to play pickleball this year, up from 8.9 million in 2022 and 3.5 million in 2019.

"Clearly many seniors find pickleball fun and it is a good way to stay active," said **Joseph Peters, Jr., Secretary-Treasurer of the Alliance**. "But as with all exercise, people should talk to their physicians about how to minimize the risk of injury."

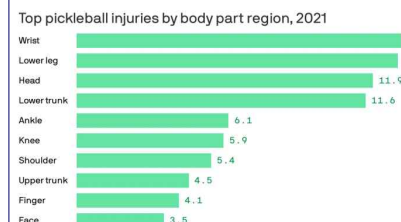


Photo from Zoom call June 29, clockwise from upper left: Leslie Dach, Chair, Protect Our Care; President Roach; Tahir Amin, Co-Founder and Co-Executive Director, Initiative for Medicines, Access & Knowledge (I-MAK); Andrea Harris, Director of Policy Programs, Protect Our Care; Sen. Welch

experts for a press conference to discuss the Biden-Harris administration's next steps in implementing the Inflation Reduction Act's Medicare Drug Price Negotiation Program. Watch a recording of the full news conference [here](#).

During the call, Protect Our Care released a new report that underscores the importance of Medicare drug price negotiation. The report focuses on five expensive drugs that will likely qualify for the first round of negotiation. Together, the Medicare program spent \$16.69 billion for these 5 drugs alone in 2021; the Medicare beneficiaries who need those medications also have to pay thousands of dollars out-of-pocket per year. For

PhRMA and the U.S. Chamber of Commerce, have sued the federal government in an effort to stop Medicare from negotiating lower prescription drug prices and prevent seniors from getting relief from skyrocketing costs.

Republican lawmakers have also introduced legislation to repeal the prescription drug provisions of the Inflation Reduction Act in their effort to line the pockets of drug company executives and raise costs on patients. "Our members know when a law truly changes people's lives," said **Robert Roach, Jr., President of the Alliance**. "And President Biden's Inflation Reduction Act does that in a number of ways. Because the law penalizes corporations that

Democracy advocates cheer unexpected Supreme Court election law wins

A Supreme Court term that began with dread among voting rights advocates that the justices could upend the rules governing elections is ending with relief and surprise that they have opted instead to largely uphold the status quo.

Three weeks ago, the conservative-led court astonished observers with a ruling in an Alabama case that **upheld its interpretation** of the Voting Rights Act. On Monday, it cited that decision in **lifting a hold on a Louisiana redistricting case**, raising the prospect that the state would have to draw another congressional district where Black voters have an opportunity to elect a candidate of their choice.

And on Tuesday, it **rejected the**

most extreme version of a novel legal theory that

could have prevented state supreme courts from exercising oversight of state lawmakers' handling of redistricting, voter ID and other policies for federal elections. Voting rights advocates welcomed the ruling, saying it reduces — while not eliminating — the opportunities for losing candidates to inject confusion into the 2024 election by appealing to state legislatures, judges or Congress for help overturning the results.

Richard Hasen, a UCLA law professor and director of the Safeguarding Democracy Project, was among those who expressed surprise at the court's decisions on election matters this term.



Voting rights didn't make gains so much as prevent setbacks, he said.

"Preserving the status quo on this Supreme

Court is a win," he said, referring to this month's Alabama decision. "This is a court that is not friendly to voting rights, but it's also a court that is not going to adopt the most radical theories that would subvert democracy."

Tuesday's case came out of North Carolina, where the state Supreme Court initially struck down election maps drawn by Republican lawmakers as overly partisan. The GOP lawmakers asked the U.S. Supreme Court to adopt what is known as the independent state legislature theory and rule that the state

justices lacked the power to consider the maps because the U.S. Constitution says election issues should be left to legislatures.

The 6-3 majority rejected that argument, finding that state courts have a role to play in election disputes. The lawsuit was brought by North Carolina voters backed by voting rights groups against Republicans who control the legislature. Those opposing the GOP lawmakers' theory **won support** from the Biden administration as well as from retired Republican judges, the chief justices of the nation's state supreme courts and the co-founder of the conservative Federalist Society....**Read More**

Medicare Advantage Insurers Are Making Bank by Denying Care to Seniors

Care denials by Medicare Advantage insurers are threatening the foundational premise of the government's health care safety net: that people on Medicare should get the treatments that are recommended by a doctor.

Jenn Coffey was so tired of having her care denied by her Medicare Advantage insurer that she considered signing a do-not-resuscitate order. "There was no more hope," she said. "There was nothing left for me to hope for."

Coffey, a former emergency medical technician (EMT) from Manchester, New Hampshire, went on Medicare, the government health insurance

program for seniors and others with disabilities, after a breast cancer diagnosis left her unable to work. Like an increasing number of Medicare beneficiaries, she ended up on a for-profit Medicare Advantage plan; a marketer directed her to an option administered by UnitedHealth Group, a \$450 billion insurer.

But instead of finding the program a relief, Coffey, fifty-one, says UnitedHealth constantly rejected or second-guessed the care options her doctors suggested for her cancer recovery and for a rare and painful secondary disease that has no



standard treatment plan. "There's lots of ways that they deny stuff that you need," she said. "So many times that I had the opportunity to try different treatments and medications, the response was, 'They won't cover.'"

UnitedHealth's routine denials led Coffey to frequently end up in the emergency room, and she eventually became so sick of struggling through the system that she nearly waived her right to be resuscitated if her condition was irrecoverable. "Mentally, it was very destructive," she said. "I have been an EMT and worked in a hospital, knew there were

treatments, but never thought about not having access."

Coffey's experience with Medicare Advantage transformed her views. Coffey is a former two-term Republican state representative in New Hampshire who, like many GOP faithfuls, believed private insurers could solve the health care crisis if they were allowed to do things like sell policies **across state lines**.

"Now I've realized that you can't fix or repair the system," she said. "The insurance companies don't offer anything. They serve as a roadblock... The only way forward is Medicare for All."....**Read More**

CMS Continues Push for Nursing Home Ownership Transparency

This week, the Centers for Medicare & Medicaid Services (CMS) **released two new** data tools as part of the Biden-Harris administration's **ongoing initiative** to increase transparency around the corporate ownership and operation of nursing homes.

The announcement builds on **reforms CMS launched** last fall to make it easier for researchers and consumers to find owners of multiple nursing homes and track the performance of those facilities. Under that effort, CMS published previously unavailable data identifying

groups of nursing homes linked together by common owners and operators, referred to as "affiliated entities."

CMS is now making this affiliated entity information available on **Nursing Home Care Compare**, its primary tool to help consumers evaluate Medicare-certified nursing homes. In so doing, **CMS aims** to "increase the transparency of nursing homes' ownership and operatorship for consumers, allowing them to make more informed decisions about their care."



CMS is also publishing **new data** on safety, staffing, and quality for nursing homes

with shared owners and operators. This is similarly intended to improve access to and awareness of safety and quality data regarding nursing homes with shared ownership and operatorship structures. CMS notes it can also be used by states to gain insights prior to certifying new nursing homes and during change of ownership requests.

Medicare Rights appreciates the administration's attention to nursing home transparency and

oversight. Such changes could better protect older adults and people with disabilities, improve consumer decision-making, and hold nursing homes accountable.

Importantly, no nursing home reforms can alter the desires of people with Medicare who prefer to remain in or return to their homes and communities safely. We continue to call on Congress to better fund Medicaid home- and community-based services and to otherwise help more people live with dignity and choice.

The Inflation Reduction Act's Part B Insulin Price Takes Effect July 1

The Inflation Reduction Act (IRA) capped out-of-pocket costs for insulin medications for people with Medicare. Coinsurances and copays for insulin covered under Part D have been limited to \$35 a month for a month's supply of each medication since January 1. Starting Saturday, July 1, beneficiaries whose insulin is covered under Part B will also enjoy these protections.

Medicare **covers insulin** and insulin containing products in two ways depending on how the medicine is administered. Insulin used in conjunction with a covered infusion pump is covered through the Durable Medical Equipment (DME) benefit under Part B. All other insulin is covered under Part D, including insulin that



people inject using syringes, fillable or pre-filled pens, or non-durable patch pumps.

A recent report from the U.S. Department of Health and Human Services (HHS) indicates Medicare beneficiaries **would have saved \$734 million in Part D costs and \$27 million in Part B costs if the IRA's insulin cap had been in effect in**

2020. Specifically, the report notes that around 31,000 people with Part B would have saved money if the IRA's provisions were in effect in 2020, savings of about **\$866 per beneficiary**. Prior to the IRA's changes, the national average out-of-pocket cost for a month's supply of insulin for people with Medicare or private insurance was about **\$63 per fill**.

This Easily Preventable Mistake Could Shrink Your Social Security Checks



Social Security is slated to fall short of its financial obligations in about a decade, and after that, benefit cuts are a real possibility unless the government finds another way to resolve the funding issue. With so much still up in the air, it's important for all workers hoping to claim benefits to avoid mistakes that could short-change them even further.

There's one mistake in particular that could prove especially costly, and sadly, it happens all the time. Here's what you need to know.

Don't make the mistake of not double-checking your Social

Security data

You may already know that your **Social Security benefit** is based on your average monthly earnings during your working years with adjustments made for inflation. But not everyone thinks about where the Social Security Administration gets your income data in the first place.

It actually comes directly from the Internal Revenue Service (IRS). It's usually a pretty seamless process, but mistakes sometimes happen. It could be that you or your employer transposed some digits in your Social Security number on your employment paperwork. Or you may have failed to notify the



Social Security Administration of a name change. Or someone could've confused you with another person who has the same name and incorrectly applied your income to them.

In the worst-case scenario, the Social Security Administration might think you didn't work at all during a year you paid Social Security taxes. This will probably shrink your monthly benefit because the Social Security Administration won't include any of that money when calculating your Social Security checks.

But you can help ensure accurate data

Fortunately, avoiding this

problem is pretty simple. The Social Security Administration tracks all the income you've paid Social Security taxes on in your earnings record. You can view yours by creating a **my Social Security account**. The first time you set it up, you'll need to answer some identity verification questions, but after that, you should be able to log in with just a username and password.

Review your earnings record at least once per year to make sure that all the information there appears accurate. The simplest way to do this is to compare the income shown in your earnings record against your own tax returns for that year. ...**Read More**

Medicare Advantage plans protect people from making a bad choice?

The Medicare Payment Advisory Commission, "MedPAC," in its **June 2023 report to Congress**, makes the compelling case that the government should standardize Medicare Advantage plans. The MedPAC report underscores how difficult it is for people to choose among these health plans offered by corporate health insurers. But, standardization alone will not allow people to make a meaningful choice or to protect themselves against corporate health insurers that are bad actors.

MedPAC does not explain that the Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees Medicare, either does not have or withholds information about Medicare Advantage plans that people need in order to make an informed choice. It does not make the case that more information should be provided

to people choosing a Medicare option. Without additional information on plan delay and denial rates, for example, it's hard to imagine that people could make a meaningful choice.

People enrolling in a Medicare Advantage plan today take a risk that they will end up in a plan that inappropriately delays and denies them the care they need, potentially endangering their health and well-being. According to the HHS Office of the Inspector General (OIG), some Medicare Advantage plans engage in widespread and persistent inappropriate delays and denials of care and coverage but CMS does not name these plans. Rather CMS' star-rating system misleads people into believing that they will get the care they need in a Medicare Advantage plan with a four or five-star rating, even though those plans might be engaged in



widespread inappropriate delays and denials of care.

Right now, it is impossible for people to compare their Medicare Advantage options; they have 41 of them on average. Even the smartest people out there and the people most knowledgeable about Medicare Advantage can't compare these plans in a meaningful way. People with cognitive impairments, low health literacy levels or who speak English as a second language are at a total loss.

Medicare Compare is the government tool designed to help people choose among Medicare Advantage plans. But, Medicare Compare doesn't let you know which plans have the highest denial and delay rates, the highest mortality rates, the poorest provider networks and other telling quality measures. The most you know is whether a plan

has a four or-five star rating, and the government gives out high ratings regardless of delay and denial and mortality rates.

CMS needs to standardize benefits in Medicare Advantage plans and limit the choices available to people. Too much choice is confusing and unhelpful. CMS also needs to disclose in an easily accessible form information about the plans that are violating their contractual obligations and putting their enrollees at risk, which CMS has so far failed to do.

With the plans in the State Health Exchanges, CMS offers four options, bronze, silver, gold and platinum. For each metal type, it standardized the plan's deductible, out-of-pocket limit, and cost sharing amount for most major service categories, including prescription drugs.

Data Shows Older Americans Are Underestimating Their Social Security Benefits

Many seniors end up struggling financially once their careers wrap up. And part of the problem is that they overestimate the amount of money Social Security will pay them and don't save enough as a result.

But new **data** from the National Bureau of Economic Research reveals that many older Americans are actually underestimating the amount of income they'll get from Social Security. In fact, on average, pre-retirees are underestimating their annual Social Security income by approximately \$1,896, or 11.5%.

Now on the one hand, that's not such a terrible thing. If you go into retirement thinking you'll get a certain monthly benefit from **Social Security** only to wind up with more, you'll be in a position where you suddenly have extra cash to spend. And it's

certainly better to underestimate your annual Social Security income than overestimate it.

But at the end of the day, it's important to have a solid handle on what Social Security will pay you. And there's a really easy way to do that. Get an estimate of your personal benefits

Social Security does not pay all recipients the same amount of money. Rather, your benefits will be calculated based on the amount of money you earned during your 35 most profitable years in the workforce.

If you want to know how much money to expect from Social Security in retirement, all you have to do is access your most recent earnings statement. If you're 60 or older, it should arrive in the mail each year.



Otherwise, you can create an account on the Social Security Administration's **website** and access it there.

That earnings statement will give you an estimate of your monthly benefit. Multiply that figure by 12, and you've got a great idea of what Social Security will pay you yearly. It's that simple.

Of course, the closer you are to retirement age, the more accurate your benefits estimate will be. If you're 40 years old, you may not want to rely on that number too heavily since you have a lot of working years ahead of you, during which time your income could change significantly.

But if you're 62 years old with plans to retire in a couple of years, your earnings statement should give you a pretty good

sense of what to expect from Social Security. And that should, in turn, help you finalize your retirement planning.

There's no need for a guessing game

The formula used to calculate Social Security benefits is a bit complex. But the good news is that you don't need to rack your brain trying to figure it out. All you need to do is take a look at your most recent earnings statement to get a sense of what Social Security will pay you down the line. And even though that estimate may not be all that accurate when you're only halfway through your career, it can at least serve as a starting point so you don't end up landing on a totally random number.

Does your Medicare Advantage plan deny care frequently? Who knows

Robins Fields reports for **Pro Publica** on the serious challenge facing anyone, including people with Medicare, trying to choose health insurance. There is no way for them to know which health plans deny care frequently, and some of these health plans have super high denial rates that can put the health and well-being of their enrollees at risk. So, if you're choosing among Medicare Advantage plans, the corporate health plan alternative to the government-administered traditional Medicare option, beware.

As Fields explains in her story, people need to know about health plan denial rates in order to make an informed choice. After all,

you're buying insurance to ensure that when you need care, you can get it and, when you need care urgently, you can get it swiftly, without worry about the cost. But, even though there are health plans that deny one in three requests for coverage, making it challenging for people in those plans to get the care they need, you can't know which ones those are.

The problem of not knowing about Medicare Advantage plan denial rates is most acute when you are diagnosed with a complex and costly condition and need a lot of care. Will you get to the oncologist before your cancer spreads? Will your health plan



even cover the tests you need to see whether you have cancer?

Fields tried to get the information on health plan denial rates without any success. What's so troubling is that this information should be easily accessible but neither the federal government nor state governments have tried to correct it. Pro Publica has already exposed how top insurers deny claims speedily and even in bulk in some cases. So, it's clear that people need protection from these insurers.

Of note, the Affordable Care Act legislation gives federal regulators authority to force insurers to turn over denial

information. But, more than ten years later the federal government has not collected much information at all.

In 2010, federal regulators were granted expansive authority through the Affordable Care Act to require that insurers provide information on their denials. This data could have meant a sea change in transparency for consumers. But more than a decade later, the federal government has collected only a fraction of what it's entitled to. And what information it has released, experts say, is so crude, inconsistent and confusing that it's essentially meaningless....**Read More**

Congress urges administration to address delays of care in Medicare Advantage

Last week, 294 members of Congress sent **a letter** to Secretary of Health and Human Services, Xavier Becerra and the Centers for Medicare and Medicaid Services (CMS) seeking greater protections for people in Medicare Advantage plans. The letter focuses on the need to speed up the prior authorization process in Medicare Advantage and alludes to the risk to Medicare Advantage enrollees from delays and denials of care. Congress wants the Centers for Medicare and Medicaid Services

to help ensure that people in Medicare Advantage get timely access to care, which people cannot count on today.

CMS has proposed a rule that is designed to help ensure people in Medicare Advantage are not waiting to get the care they need. But, a bipartisan majority of members of Congress correctly appreciate that the rule does not go far enough. They want to help ensure that the Medicare Advantage plans use an electronic prior



authorization system and that they are transparent about what they are doing. They know full well that right now, people in some Medicare Advantage plans are dying or being harmed needlessly because their Medicare Advantage plans are not providing them the care they need when they need it.

The problem, as many see it, is that the government pays the Medicare Advantage plans upfront for their services, with too little regard as to whether the

Medicare Advantage plans are providing their enrollees with the Medicare benefits they are due. The Medicare Advantage plans have a powerful incentive to delay and deny care in order to maximize profits. CMS does not have the resources to undertake annual audits of these plans to ensure they are complying with their contractual obligations. And, CMS does not have the political will to penalize them appropriately for their bad acts when it uncovers them...**Read More**

Reversing a Trend, Sicker Americans Are Staying With Medicare Managed Care Plans

A new study shows that older Americans with health issues are now staying with their Medicare Advantage managed plans, rather than swapping them for traditional plans through a health insurer.

Although Medicare Advantage has been criticized in the past for "cherry-picking" healthy patients, that's no longer the case, according to the research.

"This is not what a lot of people would expect, based on what we've seen with Medicare managed care plans historically," said senior study author **Wendy Xu**, an associate professor at Ohio State University's College of Public Health.

The study doesn't seem to support the premise that people become unhappy with care access in the managed plans when they become sicker, Xu noted.

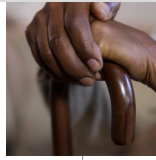
"Twenty or 30 years ago, it used to be that people who develop chronic conditions switch back to traditional

Medicare like crazy -- but in our study, the switch-back rate was very low," she said in a university news release.

The managed care plans for those 65 and up are run by private insurance companies. An approved network of health care providers negotiate service rates with the companies, which is different from the traditional Medicare model where someone can see any caregiver who participates in Medicare.

"These plans work with providers to get better rates for their members, so it's a little more controlled and it also allows for other benefits that you can't get through traditional Medicare, such as dental care," said lead study author **Eli Raver**, a doctoral student at Ohio State's College of Public Health.

"It tends to have lower premiums and be a bit more coordinated, with an emphasis on the role of primary care, and one



of the extra benefits is disease management for multiple conditions, an approach that benefits many aging Americans," Raver said in the release.

In the study, the researchers examined Medicare enrollment data from almost 45,000 enrollees from 2009-2019, when an increasing number of people were opting for Medicare Advantage's managed care options.

The study found that about half of Medicare beneficiaries are covered under Medicare Advantage plans. That percentage is growing, Xu added.

"When this model was first created, there was a clear incentive for providers to skimp on health services, and gravitate toward healthier, younger patients. So, the 'cherry-picking' criticism was valid," Xu said.

But changes to the system have led to better compensation for providers who care for those with complex, chronic conditions.

"These plans have started to enroll a larger proportion of lower-income and minority groups and even people with multiple chronic conditions, and the Medicare program gives them incentives to do that," Xu explained.

Lower-income Americans, a vulnerable population, were seen to be an exception.

"We found that they do have a higher rate of switching from Medicare Advantage to traditional Medicare than non-dual-eligible enrollees," Raver said.

"These plans appear to serve older Americans reasonably well based on our study, but for those with multiple chronic conditions who are also poor, and for those with disabilities, there could be some concerns about whether Medicare Advantage is providing enough access to care," Raver noted.

I'm a Social Security Expert: Here's What Your Benefit Should Be in 5 Years

Anyone planning to rely on Social Security in retirement probably knows the program is on thin financial ice.

While your benefits are safe for now, they **won't be for long without action**. A simmering crisis will boil over in the 2030s if Congress doesn't shore up the program before then, but **what's in store for your benefits in the nearer term over the next half-decade?**

GOBankingRates asked the experts.

There's Not Much To Fear in the Next Five Years

Barring something unforeseen, Social Security will exist as we know it throughout the 2020s. There will be tweaks and modifications, but those are built into the program's existing legal framework. For example, the law has required annual cost-of-living adjustments (COLAs) since 1975 to ensure that benefits keep pace with inflation. But there's no reason to expect a



radical change this decade.

"Social Security is very much safe in the near term," said Nicholas B. Creel, Ph.D., assistant professor of business law and director of the **Center for Innovation at Georgia College and State University**. "It's going to be paying out promised benefits in full until at least the early to mid-2030s, even if the government doesn't do anything to shore it up in the meantime."

The average monthly benefit in 2023 is \$1,694 — an amount that varies based on retirement age and Social Security contributions during work life. The benefit changes each year based on cost of living. The 2022 average was about \$1,550. The 2024 average is expected to be 2.4% to 3.1% higher. The typical COLA bump is no more than 2% though, so in five years the average benefit is likely to be between \$1,800 and \$1,900....**Read More**

Language barrier? Your smartphone can help

Jason Rich writes for the AARP Bulletin on four amazing ways your smartphone can help you communicate. The technology is amazing. With an iPhone or Android phone 1. you can communicate with people who speak a different language 2. you can listen to the text on your phone's screen so you don't need to read it; 3. you can read what someone is saying to you on a video call 4. you can hear sounds you need to hear.

1. **Your cellphone can help you understand someone who does not speak English.** It

can translate what that person is saying. And, it can do so in real-time. You do not need to Google each word the person is speaking. All you need to do is set up your phone to translate by activating an app that's already installed on your phone. The app both allows you to understand what that person is saying, and it will translate what you say into that person's language.

2. **Your cellphone can read you anything that is written on**



your phone's screen. You can even set the pace at which it reads out loud to you. You can even choose the voice that speaks to you. If you have an

iPhone, go to the VoiceOver option in settings. If you have an Android phone, go to the Select to Speak option.

3. **Your cellphone can put in writing on your screen the words someone is speaking on a video call.** It can do automatic close-captioning. To activate this feature, go to settings on your phone and

activate the live captions option.

4. **Your cellphone can help you hear things you might not otherwise be able to hear.** For example, if you need help hearing the doorbell, or a child crying, or a dog barking, you can set your phone to detect those particular sounds and let you know when it hears them. Go to the accessibility menu on your phone and look for sound recognition or sound notifications.

Will the Doctor See You Now? The Health System's Changing Landscape

Lucia Agajanian, a 25-year-old freelance film producer in Chicago, doesn't have a specific primary care doctor, preferring the convenience of visiting a local clinic for flu shots or going online for video visits. "You say what you need, and there's a 15-minute wait time," she said, explaining how her appointments usually work. "I really liked that." But Olga Lucia Torres, a 52-year-old who teaches narrative medicine classes at Columbia University in New York, misses her longtime primary care doctor, who kept tabs for two decades on her conditions, including lupus and rheumatoid arthritis, and made sure she was up to date on vaccines and screening tests. Two years ago, Torres received a letter informing her that he was changing to a "boutique practice" and would charge a retainer fee of \$10,000 for her to stay on as a patient.

"I felt really sad and abandoned," Torres said. "This was my PCP. I was like, 'Dude, I

thought we were in this together!'"

The two women reflect an ongoing reality: The primary care landscape is changing in ways that could shape patients' access and quality of care now and for decades to come. A solid and enduring relationship with a primary care doctor — who knows a patient's history and can monitor new problems — has long been regarded as the bedrock of a quality health care system. But investment in primary care in the U.S. lags that of other high-income countries, and America has a smaller share of primary care physicians than most of its European counterparts.

An estimated one-third of all physicians in the U.S. are primary care doctors — who include family medicine physicians, general internists, and pediatricians — according to the Robert Graham Center, a research and analysis organization that studies primary care. Other



researchers say the numbers are lower, with the **Peterson-KFF Health System Tracker** reporting only 12% of U.S. doctors are generalists, compared with 23% in Germany and as many as 45% in the Netherlands.

That means it's often hard to find a doctor and make an appointment that's not weeks or months away.

"This is a problem that has been simmering and now beginning to erupt in some communities at a boil. It's hard to find that front door of the health system," said Ann Greiner, president and CEO of the **Primary Care Collaborative**, a nonprofit membership organization.

Today, a smaller percentage of physicians are entering the field than are practicing, suggesting that **shortages will worsen over time**.

Interest has waned partly because, in the U.S., primary care yields lower salaries than other

medical and surgical specialties.

Some doctors now in practice also say they are burned out, facing cumbersome electronic health record systems and limits on appointment times, making it harder to get to know a patient and establish a relationship. Others are retiring or selling their practices. Hospitals, insurers like Aetna-CVS Health, and other corporate entities like Amazon **are on a buying spree**, snapping up primary care practices, furthering a move away from the "**Marcus Welby, M.D.**"-style neighborhood doctor. About 48% of primary care physicians currently work in practices they do not own. Two-thirds of those doctors don't work for other physicians but are employed by private equity investors or other corporate entities, according to data in the "**Primary Care Chartbook**," which is collected and published by the Graham Center....**Read More**

How to Spend Down Your Assets for Medicaid

Demystify the Medicaid spend down process and gain insights into how it works. Understand the intricacies of asset reduction to qualify for Medicaid coverage.

Everyone knows that **health care is expensive**, and many people worry that they will lose everything when they get ill or older and need long-term care.

You may have heard about the concept of a Medicaid spend down, which requires you to "spend" away your own assets to become eligible for the social program. But it may not be as scary or devastating as you think.

The key is to start planning now for the future and the possibility that you, or a loved one, will need some type of long-term care services. It will save you a tremendous amount of grief, anxiety and confusion, and it will help ensure that there will still be an inheritance left for the family.

Medicare Isn't Long-Term Care

A common misunderstanding people have is that if they have **Medicare**, everything,

including **long-term care**, is covered and they'll never have to worry about Medicaid. Medicare is the federal program that provides health care insurance for people aged 65 and older, as well as some younger individuals with disabilities or other conditions. **Medicaid**, on the other hand, is a federal-state hybrid that provides health care coverage to individuals who have limited income and resources.

In truth, **Medicare generally doesn't cover long-term care**. It only covers some medical services in this setting, such as the price of **physical therapy** or the changing of sterile dressings. Basic Medicare, or **Medicare Part A**, does pay for some short-term stays in a skilled nursing facility, but only if you come from the hospital after a three-day stay there. Medicaid to the Rescue

If you don't have enough savings to cover the cost of a nursing home, you can become eligible for assistance from Medicaid. State-run Medicaid programs are required to



cover **skilled nursing home care**, according to the American Health Care Association.

To qualify for these services, you will have to meet a state's level of care criteria and financial eligibility requirements. These requirements can be tricky because there is more than one avenue to qualify. Plus, each state has its own specific rules. Ultimately, depending on your assets and a variety of factors, you may be required to contribute to the cost of your care.

Buck Up for Spending Down

The truth is that Medicaid is needs-based, so you will need to show you have **insufficient assets to pay for your own care**. A single individual aged 65 years or older can't have an income of more than \$2,742 per month. Asset limits — the value of your assets like investments and some possessions that help determine your Medicaid eligibility — are a little more complicated and determined by state rules.

Many individuals who apply for Medicaid realize they have

too many assets to qualify for the program's benefits. The process of reducing an individual's assets to qualify for Medicaid is referred to as "spending down."

The good news is that spending down doesn't have to mean that you will eventually lose everything and have nothing left to leave to your heirs.

Some assets are exempt from the spend down. These are called "non-countable assets" and can, for example, include your home, one car, household furnishings and pre-paid funeral and burial arrangements. It is important to note that each state's Medicaid program has individual laws that govern aspects of how to spend down. So, individuals should consult their respective state laws with a Medicaid planner or estate planning attorney before they apply.

IRAs and 401(k) accounts are often considered countable assets, unless they are currently paying out — that is, you are getting money from them. Investments including stocks and mutual funds are also considered countable assets....**Read More**

Infectious Disease Experts Update Rules on 'Superbug' Spread in Hospitals

"Superbug" infections are increasing in U.S. hospitals, and a coalition of medical groups has now issued a set of updated recommendations to protect patients.

These guidelines are meant to prevent the spread of methicillin-resistant *Staphylococcus aureus*, also known as MRSA, the authors of the recommendations argue.

MRSA causes about 10% of hospital-associated infections in the United States, and these infections are associated with an increased risk of death because the bug is resistant to common antibiotics.

Some infections caused by MRSA rose by as much as 41% during the pandemic, after falling in preceding years, researchers said.

"The enormous strain put on health care during the pandemic may have contributed to the observed increase in some hospital infections. We have data that show MRSA infections rose," said senior guidelines

author **Dr. David Calfee**, a professor of medicine at Weill Cornell Medical College in New York City.

The updated guidelines, published June 27 in the journal *Infection Control & Hospital Epidemiology*, are intended to counter that increase, Calfee added.

"The evidence that informs these recommendations shows that we can be successful in preventing transmission and infection," Calfee said in a news release from the Society for Healthcare Epidemiology. "We can get back to the pre-2020 rates and then do even better."

Hospital MRSA infections often follow invasive procedures like surgeries, the authors said, or the use of devices like needles or catheters that are inserted into the body. MRSA can spread throughout a hospital on the hands of health care personnel or through contact with contaminated surfaces and



equipment.

The new recommendations place more emphasis on antimicrobial stewardship, which involves tight oversight over how antibiotics are prescribed and used.

Antimicrobial stewardship had been suggested as an "additional practice," but the new guidelines call it an "essential practice" that all hospitals should perform.

A patient colonized with MRSA who is treated with antibiotics for another infection is more likely to develop a full-blown case of MRSA, the authors said. They then have a higher risk of transmitting their MRSA to others.

Another essential practice is the use of a gown and gloves when treating a patient colonized or infected with MRSA, the guidelines say, as well as hand hygiene and cleaning of surfaces.

"Basic infection prevention practices, such as hand hygiene and cleaning and disinfection of

the health care environment and equipment, remain foundational for preventing MRSA," Calfee said. "These fundamental practices help to prevent the spread of other pathogens as well."

The guidance also promotes surveillance to detect MRSA carriers who haven't developed symptoms, as well as treatment to eradicate or reduce the burden of MRSA among people who are colonized with the antibiotic-resistant bug.

This guidance updates a 2014 strategy paper aimed at preventing MRSA transmission and infection in hospitals.

Five medical organizations collaborated to produce the new recommendations, including the Society for Healthcare Epidemiology, the Infectious Diseases Society of America, the Association for Professionals in Infection Control and Epidemiology, the American Hospital Association, and The Joint Commission.

Taking Ozempic, Wegovy? Stop Before Surgery, Anesthesiologists Say

The trendy weight-loss drug Ozempic could be dangerous for a patient undergoing anesthesia for an operation, according to a new warning from the American Society of Anesthesiologists.

Semaglutide (Ozempic, Wegovy) and other drugs of their class known as GLP-1 receptor agonists cause digestion to slow down, which decreases hunger and reduces how much people eat.

That food left in the stomach increases the risk you will vomit while under anesthesia, said ASA President **Dr. Michael Champeau**.

"We've had reports of people vomiting immediately preoperatively when there shouldn't be any food in their stomach," Champeau said. "As soon as we started hearing anecdotal reports and case reports, the mind immediately goes to how the drug works and what it does."

The ASA is recommending that people on a GLP-1 agonist like

Ozempic stop taking it prior to surgery.

If you take such a drug once a day, you should not take your daily dose the morning of surgery, Champeau said.

If you take the drug once a week, you should hold off on your dose until after surgery.

"If you take it every Sunday and you're having surgery on a Wednesday, you can't take it the Sunday before the surgery," Champeau said. "You've got to stop it at least a week in advance, if you're taking the once-a-week dose."

There's a reason patients are told to not eat the night before surgery, and it's the same reason they need to hold off on Ozempic.

"When anesthesia was first discovered back in the 1840s, nobody knew about this and it happened a lot. You'd be putting someone to sleep with ether and they would vomit and they would suck it in their lungs and they



would have a terrible, terrible pneumonia or die," Champeau said.

"And so it became clear very early to us that this is a major complication of anesthesia and we have to find ways of reducing the likelihood of that as best we can."

That's why anesthesiologists are such sticklers for how long patients need to fast prior to surgery.

"We annoy people all the time. We annoy patients and we annoy surgeons, when a patient doesn't follow the guidance that they're given and they have a sandwich or toast or an egg or whatever on the morning of their surgery and then show up," Champeau said. "We basically will not do the surgery at that point, and make people wait the prescribed amount of time."

GLP-1 agonists like Ozempic were originally developed to treat people with diabetes. They mimic a hormone called GLP-1 that prompts the pancreas to produce

more insulin after meals, according to Johns Hopkins Medicine.

But they also keep food in the stomach longer so patients feel full sooner when eating, and they suppress the appetite -- the reasons why Ozempic has become renowned for aiding in weight loss.

Other GLP-1 agonists include dulaglutide (Trulicity), exenatide (Byetta), liraglutide (Victoza) and lixisenatide (Adlyxin), according to Johns Hopkins.

Patients can resume taking their GLP-1 agonist the next day after surgery, Champeau said.

Those taking the drugs to control diabetes might need to briefly switch to another drug, he added.

"They're going to need to go to whichever doctor is managing their diabetes because they're going to need to change to another antidiabetic therapy to keep their diabetes under control during those days that they're not getting their Ozempic," he said.

New Competitor to Wegovy Shows Promise in Clinical Trials

An experimental drug appears to outperform the trendy medications Wegovy and Ozempic for both weight loss and diabetes control, a pair of early clinical trials shows.

Retatrutide helped people with obesity drop about one-quarter of their starting weight, on average, during 48 weeks taking the drug, according to phase 2 trial results published online June 26 in the *New England Journal of Medicine*.

"What is clear is that 24% weight loss from a single drug has not been seen before," said co-researcher **Dr. Lee Kaplan**, an associate professor with Harvard Medical School. "And the subjects in the trial were still losing weight at the end."

The best comparable results come from last year's clinical trial results for the diabetes drug Mounjaro (tirzepatide), which after 72 weeks had produced an average weight loss of more than 22%, Kaplan said.

Retatrutide also helped patients establish better control over their blood sugar levels, according to a second phase 2 trial published online June 26 in *The Lancet*.

Retatrutide works by targeting three different gut hormones that are stimulated by food intake, explained **Dr. Ania Jastreboff**, director of the Yale Obesity Research Center, in New Haven, Conn. Jastreboff led the obesity trial and was a co-author for the diabetes management trial.



The hormones include one targeted by Ozempic and two targeted by Mounjaro, Jastreboff and Kaplan said. "These are all involved in the regulation of

metabolism," Kaplan said. "They're complex, they work together to coordinate the body's response to eating, the body's response to the need for sugar management, and the like. They're involved in appetite. They're involved in energy expenditure. This is a complicated system, and the three in normal life tend to collaborate in various ways."

In the obesity trial, researchers tested retatrutide in 338 obese people, randomly assigning them to different weekly doses of the

injectable drug or a placebo.

People on the highest dose of retatrutide dropped more than 17% of their body weight, on average, after 24 weeks, and progressed to an average 24% weight loss by the end of 48 weeks, the researchers found.

"That translated to an average absolute weight reduction of 58 pounds, so nearly 60 pounds in the 11 months of the study," Jastreboff said.

The drug worked even better for some. "Two-thirds lost at least 20%, nearly half lost 25% or more, and a quarter lost 30% or more," Jastreboff said.... **[Read More](#)**

Fasting Diets vs. Cutting Calories: Which Works Best?

A trendy form of intermittent fasting does seem to help people lose some weight — though it may be no better than old-fashioned calorie counting, a new clinical trial suggests.

Researchers found that the tactic — called time-restricted eating — helped people with obesity drop around 8 pounds, on average, over one year. That was right on par with a second study group who went the traditional route of calorie counting and portion control.

Time-restricted eating is a form of intermittent fasting where people limit themselves to eating within a certain time window each day. Outside that window, they swear off everything other than calorie-free drinks.

The main selling point of time-restricted eating is its simplicity:

Instead of laboriously counting calories, people only have to watch the clock. And small studies have shown that limited eating windows — 6 hours being a popular one — can help people eat less and shed some pounds.

The new trial adds to the story because it aimed to be as real-world as possible, said senior researcher **Krista Varady**, a professor of nutrition at the University of Illinois Chicago.

Participants were allowed to eat across an 8-hour time span, from noon to 8 p.m., which let them have dinner with family or go out to a restaurant with friends. And they merely stuck with that time window, without having to cut out particular foods or measure strict portion sizes.

Past studies of time restriction



have had people take additional steps, like tracking calories.

But that misses the point, Varady said, since people try time-restricted eating to keep things easy.

"I think it became so popular because it's simple, it's accessible and it's free," she said.

So, for their trial, Varady and her colleagues recruited 90 adults with obesity who were looking to lose weight. The majority were Black or Hispanic — two groups often underrepresented in clinical trials.

Each participant was randomly assigned to one of three groups: One started the time-restriction plan, a second committed to calorie-counting, and the third made no changes and served as a control group.

The calorie counters aimed to trim their daily calories by 25% and met with a dietitian to come up with healthy food choices.

The time-restriction group, meanwhile, went by the clock: For the first six months, they limited their eating window to noon to 8 p.m.; for the next six months, they were allowed to expand it to 10 a.m. to 8 p.m.

Both diet groups also had periodic phone or video calls with a dietitian to talk about generally healthy eating.

In the end, the two groups fared similarly. After one year, people in the control group had gained weight — about 2.5 pounds, on average. But those in the diet groups had lost an average of about 8 to 9.5 pounds.

.... **[Read More](#)**

A Little Drinking Won't Help Prevent Obesity, Diabetes

Having a couple of drinks a day won't protect you from obesity or diabetes, a new study suggests.

Everybody knows that heavy drinking isn't good for your health, but whether moderate alcohol consumption is protective or harmful is still open for debate, researchers say.

"Some research has indicated that moderate drinkers may be less likely to develop obesity or diabetes compared to non-drinkers and heavy drinkers. However, our study shows that

even light-to-moderate alcohol consumption (no more than one standard drink per day) does not protect against obesity and type 2 diabetes in the general population," said lead researcher **Tianyuan Lu**, of McGill University in Montreal, Canada.

"We confirmed that heavy drinking could lead to increased measures of obesity (body mass index, waist-to-hip ratio, fat mass, etc.) as well as increased risk of type 2 diabetes," Lu added



in a news release from the Endocrine Society.

For **the study**, Lu's team collected data on alcohol use from nearly 409,000 men and women in the UK Biobank (a large-scale biomedical database and research resource). The researchers found that people who had more than 14 drinks per week had higher fat mass and a higher risk of obesity and type 2 diabetes.

The links were greater among women than men, the researchers noted. They found no association

between moderate drinking and better health in people consuming up to seven drinks per week.

"We hope our research helps people understand the risks associated with drinking alcohol and that it informs future public health guidelines and recommendations related to alcohol use," Lu said. "We want our work to encourage the general population to choose alternative healthier behaviors over drinking."

Hepatitis C Can Kill, But Too Many Can't Access the Cure

More than 2 million people in the United States have hepatitis C, but most are not getting the safe treatment that can cure the disease, public health officials said Thursday.

A new U.S. Centers for Disease Control and Prevention report details this problem and highlights the need for a proposed national program to expand access to the cure, in the form of antiviral pills.

Left untreated, hepatitis C can lead to liver scarring (cirrhosis), end-stage liver disease and cancer.

"Tens of thousands of Americans with hepatitis C are getting liver cancer, suffering liver failure, or dying because they can't access lifesaving medicine," said **Dr. Jonathan Mermin**, director of CDC's National Center for HIV, Viral

Hepatitis, STD, and TB Prevention.

"In our nation, no one should have to live knowing a cure for their potentially deadly disease is available, but out of reach," he said in an agency news release.

More than 14,800 Americans died in 2020 from conditions associated with hepatitis C.

An announcement about the new CDC report described the number of people cured of known hepatitis C infections as "jarringly low."

This was true across all age and insurance groups. The rate was especially low among those without health insurance or Medicaid coverage.

While adults under age 40 had the highest rates of new infections, they were also least likely to get the highly effective



medication.

Although cure rates were highest in patients who were 60 and up with Medicare or commercial insurance, fewer than half of them received the treatment.

"The development of a safe and highly effective cure for hepatitis C is one of the most stunning medical achievements of the past 20 years," said the U.S. National Institutes of Health's **Dr. Francis Collins**, who leads the White House National Hepatitis C Elimination Program. "But unfortunately, too many people in our country still face insurmountable barriers to accessing this treatment -- which means we must work harder."

He said the proposed National Hepatitis C Elimination Program would overcome many of these barriers, potentially saving tens

of thousands of lives and tens of billions of health care dollars. That is "compassionate care that also contributes to deficit reduction," Collins said in the release.

Barriers to treatment include cost, restrictive treatment coverage policies and challenges diagnosing the condition, the CDC said.

The medication can cost tens of thousands of dollars. The CDC said an innovative national delivery model would make hepatitis C treatment attainable for all.

The CDC said the White House has requested substantial funding to make this happen, potentially saving billions in health care costs within 10 years....[Read More](#)

Exercise + Weight Loss Perfect Combo to Fight Diabetes

Pairing exercise with a 10% weight loss can make a major health improvement in people living with obesity and prediabetes, a new study says.

Building in regular exercise more than doubled sensitivity to insulin compared to just weight loss alone. This has the potential to prevent or delay prediabetes from progressing into type 2 diabetes while also decreasing the risk of heart disease, researchers said.

"Insulin resistance is a major factor that causes type 2 diabetes, nonalcoholic fatty liver disease and abnormal blood

lipids in people with obesity," said senior investigator **Dr. Samuel Klein**, director of the Center for Human Nutrition at Washington University School of Medicine in St. Louis.

"We've shown that combining exercise with weight loss causes a marked improvement in whole-body insulin sensitivity, thereby lowering the risk of developing diabetes and treating obesity-related metabolic diseases to a much greater degree than is possible with weight loss alone," he said in a university news



release.

Obesity makes the body resistant to insulin, leading to an increase in blood sugar concentration, Klein explained.

The 16 study volunteers were obese, with a body mass index ranging from 30 (the threshold for obesity) to 49. They also had prediabetes, with medical evidence of insulin resistance.

Eight of the volunteers were put in a diet-only group and lost 10% of their body weight. The other eight also dieted and lost 10% of their body weight but

added a supervised exercise program several days each week.

"The data from most studies show that exercise has very little effect on body weight in people with obesity," said Klein. "Our study involved detailed analyses of metabolic changes in muscle and body fat before and after a 10% weight loss in people who lost weight with diet therapy alone and in those who lost the same amount of weight with diet therapy plus supervised exercise training. The results demonstrate that the benefits of combining exercise with weight loss are considerable."[Read More](#)

Will Medicare cover a new cancer screening test

Word's out. Medicare has a lot of money to spend on medical services, and every corporation with something to sell wants in. Jonathan Wosen reports for **Stat News** on the latest lobbying efforts by Grail to have Medicare pay for its blood-based cancer screening test. Grail sees the dollar signs from getting Medicare coverage of the test, while Medicare's approval could drive up Medicare spending for a test that might offer only limited benefits.

Grail's cancer screening test allegedly can identify 50

different cancers in people with no symptoms. The test detects bits of DNA. But, how would that help people? How often would people need the test for it to be useful and what would happen after cancer DNA were detected?

If approved by the Food and Drug Administration, Medicare might cover the Galleri test, which costs \$949. The Food and Drug Administration has not yet approved it. In the last quarter, with the hope of imminent FDA approval, Grail spent \$1.07 million pushing members of



Congress to support Medicare coverage of this test.

Medicare is not required to cover all preventive care services, as these services are not considered "medically reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." However, the government has chosen to have Medicare cover a growing list of **preventive care services**, because preventive services could help bring down

people's health care costs down the road and save lives. If Medicare covered the Galleri test, it would be as a preventive care service.

No one yet knows whether multi-cancer screening tests offer benefits to people without cancer symptoms. Sometimes, cancer lives in your body for decades doing no harm. And, sometimes cancer cells grow so quickly that they are not possible to treat effectively. For sure, the test could very well save lives, and that's a benefit. but at what price?

CDC Gives Full Approval to RSV Shots for People Over 60; Vaccines Available This Fall

Americans ages 60 and up can get their vaccine for respiratory syncytial virus (RSV) this fall, the U.S. Centers for Disease Control and Prevention announced Thursday.

On Thursday, Dr. Rochelle Walensky, the outgoing CDC director, gave her signature to a recommendation made last week by an advisory panel of outside experts for a single dose of the vaccines made by Pfizer and GSK. The FDA sanctioned the shots last month for adults 60 and

older.

The CDC added in a **statement** that it is advising seniors to first consult with their doctors to determine if the vaccine is right for them.

These higher-risk adults can get a single dose of either the Pfizer or GSK vaccine, both of which have already been approved by the U.S. Food and Drug Administration.

While some, including **Robert Blancato**, executive director of



the National Association of Nutrition and Aging Services Programs, wanted the CDC to give a stronger vaccine recommendation for those ages 65 and up, the advisory panel offered the weaker endorsement after raising questions, the *AP* reported.

Those included how well the vaccine worked in those who were most frail, whether there might be a need for boosters and costs, the *AP* reported.

Pfizer has not revealed their

pricing plan. GSK plans to charge between \$200 and \$295 a shot.

RSV can appear like the common cold, but can be dangerous for infants, children and the elderly, the *AP* reported. Those adults considered most at risk have chronic heart or lung disease, a weakened immune system or live in a long-term care facility.

New RSV vaccines may soon be approved for pregnant women, to help prevent their infants from becoming sick.

Mixed Results on Vitamin D's Benefit for Aging Hearts

Vitamin D supplements might lower the risk of heart attack and other cardiac ills for people over 60 -- especially if they're already taking heart meds, a new study suggests.

"Our results suggest that further exploration of the possible benefit of vitamin D on cardiovascular events, particularly in those at higher risk of having an event, might be warranted," said senior researcher Rachel Neale.

Evidence of benefit was strongest for folks taking cholesterol-lowering statins or

other heart medications, said Neale, deputy coordinator of the population health program at the QIMR Berghofer Medical Research Institute in Queensland, Australia.

The large trial found "some evidence of benefit for people who were taking drugs to treat cardiovascular conditions or high cholesterol at baseline, and vitamin D reduced the rate of heart attack," she said.

Other studies have not found a benefit of vitamin D for major cardiovascular events, "but the



results of [our] D-Health Trial suggest that it might be beneficial," Neale said.

Still, the findings aren't conclusive. "Overall, we found no statistically significant effect of vitamin D on major cardiovascular events, such as stroke, myocardial infarction [heart attack], or treatment of blocked vessels in the heart," she added.

While not whole-heartedly endorsing D supplementation, Neale said older adults might give it some thought.

"Taking a modest dose of

vitamin D is unlikely to be harmful," she said. "People at increased risk of cardiovascular events may like to take vitamin D even if they are not vitamin D-deficient, but they should be informed that the evidence for such a recommendation is relatively weak so that they can make an informed choice about whether they choose to spend money on vitamin D supplements."

WHO Experts Take Another Look at Aspartame's Safety

The artificial sweetener **aspartame** is in the hot seat once more.

Two separate committees made up of health experts from around the world will soon offer advice on consuming aspartame, a popular sugar substitute that is added to sodas, cough drops, desserts and gum.

The World Health Organization's International Agency for Research on Cancer (IARC) is **analyzing** whether the

ingredient is a carcinogen. Meanwhile, the WHO's Joint Expert Committee on Food Additives will offer guidance on an acceptable daily intake of aspartame.

Both are expected to issue their reports on July 14, according to leaked WHO documents, *CNN* reported.

Aspartame continues to have approval from the U.S. Food and Drug Administration as a safe product.



Not only that, but U.S. health officials are concerned that doing simultaneous, potentially conflicting, reviews will "seriously undermine"

confidence in the scientific process and "inflame the current climate of public skepticism about the validity of science and scientific process," according to a **letter** sent to the WHO last summer by the U.S. Department of Health and Human Services.

The WHO's cancer research committee considers a broad range of items carcinogens, including mobile devices, **Qi Sun**, an associate professor of nutrition and epidemiology at Harvard's T.H. Chan School of Public Health, told *CNN*.

For aspartame to be ruled a carcinogen "boils down to what kind of evidence we have," he added....**Read More**

AHA News: Are You Getting Enough Omega-3 Fatty Acids?

Omega-3 fatty acids play an important role in heart and brain health. They've been linked to a stronger immune system, reduced inflammation and lower blood pressure and triglycerides, reducing the risk for heart disease and cognitive decline.

But most people in the U.S. don't include enough omega-3s in their diets.

"Intakes in the U.S. are abysmally low," said Ann Skulas

-Ray, an assistant professor in the School of Nutritional Sciences and Wellness at the University of Arizona in Tucson.

There are three main types of omega-3 fatty acids: alpha-linolenic acid, or ALA; docosahexaenoic acid, or DHA; and eicosapentaenoic acid, or EPA. The human body can convert small amounts of ALA



into EPA and DHA, but the main way people increase levels is to consume foods and supplements that contain omega-3s. Yet survey data suggests U.S. adults typically consume very little EPA and DHA, with average intake about 0.1 gram per day.

U.S. health agencies offer no guidelines for how much EPA and DHA a person should

include in their daily diet. However, there are recommendations for daily consumption of ALA, based on age and gender. The National Academy of Medicine recommends men consume 1.6 grams of ALA daily and 1.1 grams per day for women. Individuals who are pregnant or breastfeeding need more....**Read More**