

APPENDIX

References

- Acutt, R., Cai, D., Dong, Z., & Bell, D. (2007). The lipid lowering effect of plant sterol ester capsules in hypercholesterolemic subjects. *Lipids Health Dis*, Apr 9;6:11.
- Agency for Healthcare Research and Quality. (2010). *Medical Expenditure Panel Survey (MEPS)*. Retrieved February 2013, from <http://meps.ahrq.gov/mepsweb/>
- Age-Related Eye Disease Study Research Group. (2001). A randomized, placebo-controlled, clinical trial of high-dose supplementation with vitamins C and E and beta carotene for age-related cataract and vision loss: AREDS report no. 9. *Arch Ophthalmol*, 119(10):1439-52.
- Albarracin, C., Fuqua, B., Evans, J., & Goldfine, I. (2008). Chromium picolinate and biotin combination improves glucose metabolism in treated, uncontrolled overweight to obese patients with type 2 diabetes. *Diabetes Metab Res Rev*, 24(1):41-51.
- Albert, C., Cook, N., Gaziano, J., Zaharris, E., MacFadyen, J., Danielson, E., et al., (2008). Effect of folic acid and B vitamins on risk of cardiovascular events and total mortality among women at high risk for cardiovascular disease: a randomized trial. *JAMA*, 299(17):2027-36.
- American Diabetes Association. (2011, January 26). *Diabetes Statistics*. Retrieved March 2013, from Diabetes Basics: <http://www.diabetes.org/diabetes-basics/diabetes-statistics/>
- American Heart Association. (2012, 12 10). *What Your Cholesterol Levels Mean*. Retrieved March 2013, from http://www.heart.org/HEARTORG/Conditions/Cholesterol/AboutCholesterol/What-Your-Cholesterol-Levels-Mean_UCM_305562_Article.jsp
- American Optometric Association. (2013, April). *Lutein & Zeaxanthin*. Retrieved April 2013, from Diet & Nutrition: <http://www.aoa.org/patients-and-public/caring-for-your-vision/diet-and-nutrition/lutein>
- American Public Health Association - Center for Public Health Policy. (2012, June). *The Prevention and Public Health Fund: A critical investment in our nation's physical and fiscal health*. Retrieved March 2013, from http://www.apha.org/NR/rdonlyres/8FA13774-AA47-43F2-838B-1B0757D111C6/0/APHA_PrevFundBrief_June2012.pdf
- Anderson, J., Allgood, L., Turner, J., Oeltgen, P., & Dagg, B. (1999). Effects of psyllium on glucose and serum lipid responses in men with type 2 diabetes and hypercholesterolemia. *Am J Clin Nutr*, 70(4):466-73.
- Anderson, J., Davidson, M., Blonde, L., Brown, W., Howard, W., Ginsberg, H., et al., (2000). Long-term cholesterol-lowering effects of psyllium as an adjunct to diet therapy in the treatment of hypercholesterolemia. *Am J Clin Nutr*, 71(6):1433-8.
- Anderson, J., Floore, T., Geil, P., O'Neal, D., & Balm, T. (1991). Hypocholesterolemic effects of different bulk-forming hydrophilic fibers as adjuncts to dietary therapy in mild to moderate hypercholesterolemia. *Arch Intern Med*, 151(8):1597-602.
- Anderson, R., Cheng, N., Bryden, N., Polansky, M., Cheng, N., Chi, J., et al., (1997). Elevated intakes of supplemental chromium improve glucose and insulin variables in individuals with type 2 diabetes. *Diabetes*, 46(11):1786-91.
- Assisted Living Facilities.org. (2012). *Assisted Living Costs*. Retrieved April 2013, from Assisted Living Facilities.org: <http://www.assistedlivingfacilities.org/articles/assisted-living-costs.php>
- Baigent, C., Blackwell, L., Emberson, J., Holland, L., Reith, C., Bhalra, N., et al., (2010). Cholesterol Treatment Trialists' (CTT) Collaboration - Efficacy and safety of more intensive lowering of LDL cholesterol: a meta-analysis of data from 170,000 participants in 26 randomised trials. *Lancet*, 376(9753):1670-81.
- Blume, S., & Curtis, J. (2011). Medical costs of osteoporosis in the elderly Medicare population. *Osteoporoses Int*, 22(6):1835-44.
- Bønaa, K., Njølstad, I., Ueland, P., Schirmer, H., Tverdal, A., Steigen, T., et al., (2006). NORVIT Trial Investigators. Homocysteine lowering and cardiovascular events after acute myocardial infarction. *N Engl J Med*, 354(15):1578-88.

- Brouwer, I., Zock, P., Camm, A., Böcker, D., Hauer, R., Wever, E., et al., (2006). SOFA Study Group - Effect of fish oil on ventricular tachyarrhythmia and death in patients with implantable cardioverter defibrillators: the Study on Omega-3 Fatty acid and Ventricular Arrhythmia (SOFA) randomized trial. *JAMA* , 295(22): 2613-9.
- Brown, L., Rimm, E., Seddon, J., Giovannucci, E., Chasan-Taber, L., Spiegelman, D., et al., (1999). A prospective study of carotenoid intake and risk of cataract extraction in US men. *Am J Clin Nutr.* , 70(4):517-24.
- Carr, T., Krogstrand, K., Schlegel, V., & Fernandez, M. (2009). Stearate-enriched plant sterol esters lower serum LDL cholesterol concentration in normo- and hypercholesterolemic adults. *J Nutr.* , 139(8):1445-50.
- Center for Evidence Based Medicine. (2012, August 14). *Number Needed to Treat (NNT)*. Retrieved March 2013, from <http://www.cebm.net/index.aspx?o=1044>
- Centers for Disease Control and Prevention. (2011, April 6). *Calcium and Bone Health*. Retrieved 2013 March, from Nutrition for Everyone: <http://www.cdc.gov/nutrition/everyone/basics/vitamins/calcium.html>
- Centers for Disease Control and Prevention. (n.d.). *Heart Disease Facts*. Retrieved March 1, 2013, from <http://www.cdc.gov/heartdisease/facts.htm>
- Centers for Disease Control and Prevention. (2012, April). *NCHS Data Brief - Total and High-density Lipoprotein Cholesterol in Adults: National Health and Nutrition Examination Survey, 2009–2010*. Retrieved February 2013, from CDC/National Center for Health Statistics: <http://www.cdc.gov/nchs/data/databriefs/db92.htm>
- Centers for Disease Control and Prevention. (n.d.). *The Power to Prevent, The Call to Control: At A Glance 2009*. Retrieved March 2013, from Chronic Disease Prevention and Health Promotion: <http://www.cdc.gov/chronicdisease/resources/publications/aag/chronic.htm>
- Chapuy, MC., Arlot, ME., Duboeuf, F., Brun, J., Crouzet, B., Arnaud, S., et al., (1992). Vitamin D3 and calcium to prevent hip fractures in the elderly women. *N Engl J Med.* , 327(23):1637-42.
- Chapuy, MC., Pamphile, R., Paris, E., Kempf, C., Schlichting, M., Arnaud, S., et al., (2002). Combined calcium and vitamin D3 supplementation in elderly women: confirmation of reversal of secondary hyperparathyroidism and hip fracture risk: the Decalys II study. *Osteoporos Int.* , 13(3):257-64.
- Chasan-Taber, L., Willett, W., Seddon, J., Stampfer, M., Rosner, B., Colditz, G., et al., (1999). A Prospective Study of Carotenoid and Vitamin A Intakes and Risk of Cataract Extraction in US Women. *Am. J. Clin. Nutr.* , 70:509-516.
- Chew, E., et al., (2013). Age-Related Eye Disease Study 2 Research Group. Lutein/Zeaxanthin for the Treatment of Age-Related Cataract. *JAMA Ophthalmol.*
- Chew, E., et al., (2013). Age-Related Eye Disease Study 2 Research Group. Lutein + Zeaxanthin and Omega-3 Fatty Acids for Age-Related Macular Degeneration. *J Am. Med. Assoc.* , 309(19).
- Christen, W., Liu, S., Glynn, R., Gaziano, J., & Buring, J. (2008). Dietary carotenoids, vitamins C and E, and risk of cataract in women: a prospective study. *Arch Ophthalmol* , 126(1):102-9.
- Cleveland Clinic. (2011, March). *Heart and Vascular Health & Prevention*. Retrieved March 2013, from <http://my.clevelandclinic.org/heart/prevention/nutrition/phytosterols-sterols-stanols.aspx>
- Cohen, J. T., Neumann, P. J., & Weinstein, M. C. (2008). Does preventive care save money? Health economics and the presidential candidates. *N Engl J Med.* , 358(7):661–3.
- Dawson-Hughes, B., Harris, S., Krall, E., & Dallal, G. (1997). Effect of calcium and vitamin D supplementation on bone density in men and women 65 years of age or older. *N Engl J Med* , 337(10):670-6.
- De Graaf, J., De Sauvage Nolting, P., Van Dam, M., Belsey, E., Kastelein, J., Haydn Pritchard, P., et al., (2002). Consumption of tall oil-derived phytosterols in a chocolate matrix significantly decreases plasma total and low-density lipoprotein-cholesterol levels. *Br J Nutr* , 88(5):479-88.
- DerSimonian, R., & Kacker, R. (2007). Random-effects model for meta-analysis of clinical trials - An update. *Contemporary Clinical Trials* , 28(2): 105-14.
- DerSimonian, R., & Laird, N. (1986). Literature Review in clinical trials. *Control Clinical Trials* , 7(3):177-88.

Division for Heart Disease and Stroke Prevention. (2013, March). *Division for Heart Disease and Stroke Prevention - Centers for Disease Control and Prevention*. Retrieved March 2013, from Division for Heart Disease and Stroke Prevention: <http://www.cdc.gov/dhbsp/>

Everson, G., Daggy, B., McKinley, C., & Story, J. (1992). Effects of psyllium hydrophilic mucilloid on LDL-cholesterol and bile acid synthesis in hypercholesterolemic men. *J Lipid Res*, 33(8):1183-92.

Galan, P., de Bree, A., Mennen, L., Potier de Courcy, G., Preziosi, P., Bertrais, S., et al., (2003). Background and rationale of the SU.FOL.OM3 study: double-blind randomized placebo-controlled secondary prevention trial to test the impact of supplementation with folate, vitamin B6 and B12 and/or omega-3 fatty acids on the prevention of recurrent ischemic. *J Nutr Health Aging*, 7(6):428-35.

Galan, P., Kesse-Guyot, E., Czernichow, S., Briancon, S., Blacher, J., & Hercberg, S. (2010). SU.FOL.OM3 Collaborative Group. Effects of B vitamins and omega 3 fatty acids on cardiovascular diseases: a randomised placebo controlled trial. *BMJ*, 341:c6273.

Ghosh, D., Bhattacharya, B., Mukherjee, B., Manna, B., Sinha, M., Chowdhury, J., et al., (2002). Role of chromium supplementation in Indians with type 2 diabetes mellitus. *J Nutr Biochem*, 13(11):690-697.

Grant, A., Avenell, A., Campbell, M., McDonald, A., MacLennan, G., McPherson, G., et al., (2005). Oral vitamin D3 and calcium for secondary prevention of low-trauma fractures in elderly people (Randomised Evaluation of Calcium or vitamin D, RECORD Group): a randomised placebo-controlled trial. *Lancet*, 365(9471):1621-8.

Grundey, S., Cleeman, J., Merz, C., Brewer, H., Clark, L., Hunninghake, D., et al., (2004). Implications of recent clinical trials for the National Cholesterol Education Program Adult Treatment Panel III guidelines. *Circulation*, 110(2):227-39.

Hallikainen, M., Sarkkinen, E., Wester, I., & Uusitupa, M. (2002). Short-term LDL cholesterol-lowering efficacy of plant stanol esters. *BMC Cardiovasc Disord*, 27; 2:14.

Hankey, G., Ford, A., Yi, Q., Eikelboom, J., Lees, K., Chen, C., et al., (2010). VITATOPS Trial Study Group: B vitamins in patients with recent transient ischaemic attack or stroke in the VITamins TO Prevent Stroke (VITATOPS) trial: a randomised, double-blind, parallel, placebo-controlled trial. *Lancet Neurol*, 9(9):855-65.

Harvard School of Public Health Nutrition Source. (2013, March). *Three of the B Vitamins: Folate, Vitamin B6, and Vitamin B12*. Retrieved March 2013, from <http://www.hsph.harvard.edu/nutritionsource/vitamin-b/>

Institute of Medicine. (2010). *Dietary reference intakes for calcium and vitamin D*. Washington D.C.: National Academy Press.

Institute of Medicine. (1997). *Dietary reference intakes for calcium, phosphorus, magnesium, vitamin D, and fluoride*. Washington D.C.: National Academy Press.

Institute of Medicine. (1998). *Dietary Reference Intakes for Thiamin, Riboflavin, Niacin, Vitamin B6, Folate, Vitamin B12, Pantothenic Acid, Biotin and Choline*. Washington, D.C.: National Academy Press.

Institute of Medicine. (2001). *Dietary Reference Intakes for Vitamin A, Vitamin K, Arsenic, Boron, Chromium, Copper, Iodine, Iron, Manganese, Molybdenum, Nickel, Silicon, Vanadium and Zinc*. Washington D.C.: National Academy Press.

Institute of Medicine. (2000). *Dietary reference intakes for vitamin C, vitamin E, selenium, and carotenoids*. Washington D.C.: National Academy Press.

Institute of Medicine. (2006). *Dietary Reference Intakes: The Essential Guide to Nutrient Requirements*. Washington, D.C.: National Academies Press.

Ipsos Public Affairs. (2012). *2012 Council for Responsible Nutrition Consumer Survey on Dietary Supplements*. Ipsos Public Affairs.

Jackson RD et al., (2006). Women's Health Initiative Investigators: Calcium plus vitamin D supplementation and the risk of fractures. *N Engl J Med*, 354(7):669-83.

Jacques, P., Chylack, L., Hankinson, S., Khu, P., Rogers, G., Friend, J., et al., (2001). Long-term nutrient intake and early age-related nuclear lens opacities. *Arch Ophthalmol*, 119(7):1009-19.

- Kassoff et al., (2001). Age-Related Eye Disease Study Research Group. A Randomized, Placebo-Controlled, Clinical Trial of High Dose Supplementation with Vitamins C and E, Beta Carotene, and Zinc for Age-Related Macular Degeneration and Vision Loss. *Arch. Ophthalmol* , 119: 1417-1436.
- Kris-Etherton, P., Harris, W., & Appel, L. (2002). Fish Consumption, Fish Oil, Omega-3 Fatty Acids, and Cardiovascular Disease. *Circulation* , 106: 2747-2757.
- Larsen, E., Mosekilde, L., & Foldspang, A. (2004). Vitamin D and calcium supplementation prevents osteoporotic fractures in elderly community dwelling residents: a pragmatic population-based 3-year intervention study. *J Bone Miner Res* , 19(3):370-8.
- Lau, V., Journoud, M., & Jones, P. (2005). Plant sterols are efficacious in lowering plasma LDL and non-HDL cholesterol in hypercholesterolemic type 2 diabetic and nondiabetic persons. *Am J Clin Nutr* , 81(6):1351-8.
- Leaf, A. (2006). Prevention of sudden cardiac death by n-3 polyunsaturated fatty acids. *Fundam Clin Pharmacol* , 20(6): 525-38.
- Lonn, E., Yusuf, S., Arnold, M., Sheridan, P., Pogue, J., Micks, M., et al., (2006). Heart Outcomes Prevention Evaluation (HOPE) 2 Investigators. Homocysteine lowering with folic acid and B vitamins in vascular disease. *N Engl J Med* , 354(15):1567-77.
- Maki, K., Lawless, A., Reeves, M., Dicklin, M., Jenks, B., Shneyvas, E., et al., (2012). Lipid-altering effects of a dietary supplement tablet containing free plant sterols and stanols in men and women with primary hypercholesterolaemia: a randomized, placebo-controlled crossover trial. *Int J Food Sci Nutr* , 63(4):476-82.
- Marchioli, R. (1999). GISSI-Prevenzione Investigators. Dietary supplementation with n-3 polyunsaturated fatty acids and vitamin E after myocardial infarctions: results of the GISSI-Prevenzione trial. *Lancet* , 354(8): 447-455.
- McPherson, T., Ostlund, R., Goldberg, A., Bateman, J., Schimmoeller, L., & CA, S. (2005). Phytostanol tablets reduce human LDL-cholesterol. *J Pharm Pharmacol* , 57(7):889-96.
- Memorial Sloan-Kettering Cancer Center. (2013, January). *About Herbs, Botanicals & Other Products - Integrative Medicine*. Retrieved February 2013, from <http://www.mskcc.org/cancer-care/integrative-medicine/about-herbs-botanicals-other-products>
- Mussner, M., Parhofer, K., Von Bergmann, K., Schwandt, P., Broedl, U., & Otto, C. (2002). Effects of phytosterol ester-enriched margarine on plasma lipoproteins in mild to moderate hypercholesterolemia are related to basal cholesterol and fat intake. *Metabolism* , 51(2):189-94.
- National Eye Institute. (2009, September). *Facts About Age-Related Macular Degeneration*. Retrieved March 2013, from National Institutes of Health - National Eye Institute: http://www.nei.nih.gov/health/macularden/armd_facts.asp#1
- National Eye Institute. (2009, September). *Facts About Cataract*. Retrieved March 2013, from National Institutes of Health - National Eye Institute: http://www.nei.nih.gov/health/cataract/cataract_facts.asp
- National Health and Nutrition Examination Survey. (2010). *National Health and Nutrition Examination Survey*. Retrieved March 2013, from Centers for Disease Control and Prevention: <http://www.cdc.gov/nchs/nhanes.htm>
- National Institutes of Health. (2012, August 23). *National Heart, Lung, and Blood Institute - Department of Health and Human Services*. Retrieved March 2013, from What Is Coronary Heart Disease: <http://www.nhlbi.nih.gov/health/health-topics/topics/cad/>
- National Osteoporosis Foundation. (2013). *What is Osteoporosis?* Retrieved March 2013, from <http://www.nof.org/articles/7>
- Nestel, P., Cehun, M., Pomeroy, S., Abbey, M., & Weldon, G. (2001). Cholesterol-lowering effects of plant sterol esters and non-esterified stanols in margarine, butter and low-fat foods. *Eur J Clin Nutr* , 55(12):1084-90.
- NIH MedlinePlus. (2011, Winter). *New Recommended Daily Amounts of Calcium and Vitamin D*. Retrieved March 2013, from NIH MedlinePlus Magazine: <http://www.nlm.nih.gov/medlineplus/magazine/issues/winter11/articles/winter11pg12.html>

Nilsen, D., Albrektsen, G., Landmark, K., Moen, S., Aarsland, T., & Woie, L. (2001). Effects of a high-dose concentrate of n-3 fatty acids or corn oil introduced early after an acute myocardial infarction on serum triacylglycerol and HDL cholesterol. *Am J Clin Nutr.* , 74(1):50-6.

Office of Dietary Supplements. (2005, August 5). *Dietary Supplement Fact Sheet: Chromium*. Retrieved March 2013, from National Institute of Health: <http://ods.od.nih.gov/factsheets/Chromium-HealthProfessional/>

Ostlund, R. (2002). Phytosterols in Human Nutrition. *Annual Review of Nutrition* , 22: 533-549.

Porthouse, J., Cockayne, S., King, C., Saxon, L., Steele, E., Aspray, T., et al., (2005). Randomised controlled trial of calcium and supplementation with cholecalciferol (vitamin D3) for prevention of fractures in primary care. *BMJ* , 330(7498):1003.

Prevent Blindness America. (2007). *The Economic Impact of Vision Problems: The Toll of Major Adult Eye Disorders, Visual Impairment and Blindness on the U.S. Economy*. Chicago: Prevent Blindness America.

PubMed Health. (2012, September 3). *Fact sheet: Preventing osteoporosis*. Retrieved March 2013, from <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0004996/>

Rabinovitz, H., Friedensohn, A., Leibovitz, A., Gabay, G., Rocas, C., & Habot, B. (2004). Effect of chromium supplementation on blood glucose and lipid levels in type 2 diabetes mellitus elderly patients. *Int J Vitam Nutr Res* , 74(3):178-82.

Raitt, M., Connor, W., Morris, C., Kron, J., Halperin, B., Chugh, S., et al., (2005). Fish oil supplementation and risk of ventricular tachycardia and ventricular fibrillation in patients with implantable defibrillators: a randomized controlled trial. *JAMA* , 293(23): 2884-91.

Ray, K., Seshasai, S., Wijesuriya, S., Sivakumaran, R., Nethercott, S., Preiss, D., et al., (2009). Effect of intensive control of glucose on cardiovascular outcomes and death in patients with diabetes mellitus: a meta-analysis of randomised controlled trials. *Lancet* , 373(9677):1765-72.

Roncaglioni, M., Tombesi, M., Avanzini, F., Barlera, S., Caimi, V., Longoni, P., et al., (2013). n-3 fatty acids in patients with multiple cardiovascular risk factors. *N Engl J Med* , 368(19):1800-8.

Russell, L. B. (2007, October). *Prevention's Potential for Slowing the Growth of Medical Spending*. Retrieved March 2013, from <http://www.ihcpar.rutgers.edu/downloads/RussellNCHC2007.pdf>

Ryder, K., Shorr, R., Bush, A., Kritchevsky, S., Harris, T., Stone, K., et al., (2005). Magnesium intake from food and supplements is associated with bone mineral density in healthy older white subjects. *J Am Geriatr Soc* , 53(11):1875-80.

SanGiovanni, J., Chew, E., Clemons, T., Ferris, F., Gensler, G., Lindblad, A., et al., (2007). Age-Related Eye Disease Study Research Group: The relationship of dietary carotenoid and vitamin A, E, and C intake with age-related macular degeneration in a case-control study: AREDS Report No. 22. *Arch Ophthalmol* , 125(9):1225-32.

Schnyder, G., Roffi, M., Flammer, Y., Pin, R., & Hess, O. (2002). Effect of homocysteine-lowering therapy with folic acid, vitamin B12, and vitamin B6 on clinical outcome after percutaneous coronary intervention: the Swiss Heart study: a randomized controlled trial. *JAMA* , 288(8):973-9.

Seddon, J., Ajani, U., Sperduto, R., Hiller, R., Blair, N., Burton, T., et al., (1994). Dietary carotenoids, vitamins A, C, and E, and advanced age-related macular degeneration. Eye Disease Case-Control Study Group. *JAMA* , 272(18):1413-20.

Seddon, J., Reynolds, R., & Rosner, B. (2010). Associations of smoking, body mass index, dietary lutein, and the LIPC gene variant rs10468017 with advanced age-related macular degeneration. *Mol Vis* , 16:2412-24.

Svensson, M., Schmidt, E., Jørgensen, K., & Christensen, J. (2006). OPACH Study Group. N-3 fatty acids as secondary prevention against cardiovascular events in patients who undergo chronic hemodialysis: a randomized, placebo-controlled intervention trial. *Clin J Am Soc Nephrol* , 1(4): 780-6.

Tan, J., Wang, J., Flood, V., Rochtchina, E., Smith, W., & Mitchell, P. (2008). Dietary Antioxidants and the Long-Term Incidence of Age-Related Macular Degeneration. *Ophthalmol* , 115:334-341.

Tavazzi, L. (2008). GISSI-HF Investigators. Effect of n-3 polyunsaturated fatty acids in patients with chronic heart failure (the GISSI-HF trial): a randomized, double-blind, placebo-controlled trial. *Lancet* , 372(10): 1223-1230.

The American Society of Health-System Pharmacists, Inc and the U.S. National Library of Medicine. (2010, 9 1). *Calcitriol*. Retrieved March 2013, from MedlinePlus: <http://www.nlm.nih.gov/medlineplus/druginfo/meds/a682335.html>

Toole, J., Malinow, M., Chambless, L., Spence, J., Pettigrew, L., Howard, V., et al., (2004). Lowering homocysteine in patients with ischemic stroke to prevent recurrent stroke, myocardial infarction, and death: the Vitamin Intervention for Stroke Prevention (VISP) randomized controlled trial. *JAMA* , 291(5):565-75.

Tucker, K., Hannan, M., Chen, H., Cupples, L., Wilson, P., & Kiel, D. (1999). Potassium, magnesium, and fruit and vegetable intakes are associated with greater bone mineral density in elderly men and women. *Am J Clin Nutr* , 69(4):727-36.

U.S. Food & Drug Administration. (2012, April 1). *CFR - Code of Federal Regulations Title 21*. Retrieved March 2013, from <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcr/CFRSearch.cfm?fr=101.81>

U.S. Food and Drug Administration. (2013, May). *Q&A on Dietary Supplements*. Retrieved May 2013

University of Maryland Medical Center. (2013, May). *Psyllium*. Retrieved May 2013, from Complementary and Alternative Medicine Guide: <http://umm.edu/health/medical/altmed/supplement/psyllium#ixzz2XEKQw1r7>

Vu, H., Robman, L., Hodge, A., McCarty, C., & Taylor, H. (2006). Lutein and Zeaxanthin and the Risk of Cataract: The Melbourne Visual Impairment Project. *Investigative Ophthalmology & Visual Science* , 47(9): 3783-3786.

World Health Organization Collaborating Centre for Metabolic Bone Diseases. (2013). *Calculation Tool*. Retrieved March 2013, from FRAX® WHO Fracture Risk Assessment Tool: <http://www.shef.ac.uk/FRAX/tool.jsp>

World Health Organization. (2008). *WHO guide for standardization of economic evaluations of immunization programmes*. Retrieved March 2013, from http://whqlibdoc.who.int/hq/2008/WHO_IVB_08.14_eng.pdf

Yokoyama, M., Origasa, H., Matsuzaki, M., Matsuzawa, Y., Saito, Y., Ishikawa, Y., et al., (2007). Japan EPA lipid intervention study (JELIS) Investigators. Effects of eicosapentaenoic acid on major coronary events in hypercholesterolaemic patients (JELIS): a randomized open-label, blinded endpoint analysis. *Lancet* , 369(9567): 1090-8.

Literature Review Methodology

DerSimonian and Laird (D-L) Random-effects Literature Review Methodology

For this study, a random-effects literature review model was adopted for use in cases where the dietary supplement in question had a significant number of scientific/clinical studies that explored the specific question this study aims to address: What is the impact on the odds of a disease event occurring, given the use of the dietary supplement in question? This question is in the same mold of many questions that pharmaco-economic/clinical studies aim to address, which is the determination of an overall treatment effect on a given event outcome when a treatment regimen is applied to one group versus a control group. From these type of analyses, risk—and, subsequently, risk reduction—of an event can be calculated and applied into a cost-effectiveness model, which helps key decision makers (including physicians, patients, governments, insurance companies, and employers) determine whether it is worth the increased cost of treatment for the potential savings derived from avoided events.

However, the key problem is how one properly assesses the results of a set of studies, which we define as K , that address the same research question, when each study (element of set $K = \text{study } i$) varies significantly in terms of sample size, study protocol, the research team, and a host of other study qualities. Researchers, specifically DerSimonian and Laird (DerSimonian & Laird, 1986, DerSimonian & Kacker, 2007), have addressed this critical issue over the last several decades, and the research consensus has determined that the random-effects model is one of the best approaches available to researchers when key quality variables are unknown.

The random-effects model assumes that the observed effect of a treatment in a given study i , Y_i is a function of two components, the overall effect of treatment, Y_i^* , and a sampling error in study i , ε_i . It is assumed that the functional relationship is linear, or

- $Y_i = Y_i^* + \varepsilon_i$.

Sampling error can be caused by many factors internal to the given study, such as inadvertently selecting a biased sample from the population, but it is mostly due to the relative size of the study sample, N_i . The sampling error also provides insight into the precision of the findings—the larger the error, the more likely the findings are less precise and, consequently, the lower the confidence one should have in the results when compared with another study's results, if that study has a smaller sampling error.

Sampling error is not the only variance that must be considered when assessing a set of studies. The true effect of treatment, Y_i^* , can also vary based on many factors, such as the dosage size of treatment, the demographics of the population receiving the treatment, the study's methodology, and/or protocol that impacts the treatment's effect. All of these true treatment effects vary by study and must be accounted for in order to understand the true treatment effect on the total population. Thus, equation (1) must be transformed to account for intra-study variance, thus

- $Y_i = \mu^* + \delta_i + \varepsilon_i$

Where μ^* is the true treatment's effect on a given population independent of the studies and δ_i is the difference in study i 's observed effect from the true treatment's effect on a given population, or intra-study error.

Thus, the goal is to provide an estimate of μ^* , by controlling for δ_i and ε_i , which is done through a weighting process where the weights are functions of the variance in inter-study error (ε_i), defined as s_i^2 , and the variance in intra-study error (δ_i), defined as τ^2 . In other words, each study's observed treatment effect is adjusted using the following equation:

- $X = (\sum_i w_i * Y_i) / \sum_i w_i$
- $w_i = (s_i^2 + \tau^2)^{1/2}$

Where X is the deduced treatment effect that is used in the cost-saving calculations and w_i is the variance weight applied to each study to control for inter-study and intra-study variance in the observed treatment effect of each study i .

Various approaches to calculating s_i^2 and τ^2 which are sufficiently outlined by many prior studies, including the work of DerSimonian and Kacker (2007); however, for the purposes of this study, the two-step DerSimonian and Laird was adopted to calculate s_i^2 , τ^2 , and X .

Center for Evidence Based Medicine (CEBM) Approach—Estimated Number needed to be Treated Function Calculation

In cases where the use of the random effects model is not appropriate, such as the case when the number of qualified studies is small or when the relationship between the supplement intervention's effect and the utilization of costly treatment services is indirect, a much simpler, though less accurate, estimation function that determines the number needed to be treated was used. In these cases, all that is needed for the function is an average relative risk reduction or the odds ratio and the current disease incidence rate (Center for Evidence Based Medicine, 2012).

As stated, the number needed to treat (NNT) is the total number of people that would have to undergo a treatment intervention to realize one avoided undesired event. For example, if it was found that a given dietary supplement had a NNT of 100, this would mean that 100 people would have to be treated in order to avoid one undesired event from occurring in the same population. In order to calculate an estimate of the NNT from just knowing the current incidence rate and the expected odds ratio and/or relative risk reduction metric, the following function should be calculated:

- $NNT = (1 - (ER * (1 - RRR))) / ((1 - ER) * ER * (1 - RRR))$

Where ER is the event or disease event incident rate among the high-risk population and the RRR is the estimated relative risk reduction and/or the odds ratio.

List of Common Variables and Equations Health Economics Research

- Total sample size per study = **N**
- Number of events occurring in the treatment group per study = **EE**
- Number of events occurring in the control group per study = **CE**
- Observed event rate (observed disease prevalence in the target population) = **ER**
- Treatment group event rate—**TER = EE / N**
- Control group event rate—**CER = CE / N**
- Relative risk—**RR = TER/CER**
- Absolute risk reduction—**ARR = CER – TER**
- Relative risk reduction—**RRR = ARR/CER**
- Number needed to treat—**NNT = 1/ARR = CER/RRR**
- Number needed to treat using the CEBM approach (only requires the use of the observed event rate and the deduced relative risk reduction) = **$(1-(ER*(1-RRR))) / ((1-ER)*(ER)*(1-RRR))$**

List of Abbreviations

AMD	Age-related macular degeneration
AOA	American Optometric Association
ARED	Age-related eye disease
B	billion
B12	Vitamin B - cyanocobalamin
B6	Vitamin B - pyridoxine
B9	Vitamin B - folate
BMD	Bone mineral density
CBA	Cost-benefit analysis
CDC	Center of Disease Control and Prevention
CHD	Coronary heart disease
CI	Confidence interval
CTT	Cholesterol Treatment Trialists
DHA	Docosahexaenoic acid
DPA	Dual photon absorptiometry
DSHEA	Dietary Supplement Health and Education Act
DXA	Dual energy X-ray absorptiometry
EPA	Eicosapentaenoic acid
ER	Event or disease event incident rate among the high-risk population
FNB	Food and Nutrition Board
FRAX	Fracture Risk Assessment Tool
g	gram
HbA1c	Glycated hemoglobin
IOM	The Institute of Medicine
IU	International unit
LDL	Low-density lipoprotein
M	million
mcg	microgram
MEPS	Medical Expenditure Panel Survey
mg	milligram
mg/dL	milligrams per deciliter
MI	Myocardial infarction
mmol/L	millimoles per liter
NAS	National Academy of Sciences
NCEP	National Cholesterol Education Program
NNT	Number needed to treat
OR	Odds ratio
PUFA	Polyunsaturated fatty acids
RCT	Randomized controlled trials
RRR	Relative risk reduction
UL	Tolerable Upper Intake Level

Detailed Figures

Omega-3 and CHD Analysis

Figure 8.1—Omega-3 and Coronary Heart Disease Cost Analysis for All U.S. Adults over the Age of 55, 2013–2020

Year	Number of adults over the age of 55 with CHD (people)	Expected number of adults over the age of 55 with CHD who will experience a new CHD-related hospitalization event (people)	Mean CHD expenditure per person experiencing a CHD event (\$)	Total CHD event expenditure among all U.S. adults over the age of 55* (\$)	Total CHD event expenditure among all U.S. adults over the age of 55 given omega-3 intervention at preventive daily intake levels* (\$)	Change in CHD expenditure among all U.S. adults over the age of 55 given omega-3 intervention at preventive daily intake levels (avoided costs = benefits)* (\$)
2013	17,256,590	4,899,840	\$13,982.49	\$68,511,963,964	\$66,702,608,126	\$1,809,355,838
2014	17,515,439	4,973,338	\$14,681.61	\$70,889,927,762	\$69,017,771,467	\$1,872,156,295
2015	17,789,118	5,051,046	\$15,415.69	\$73,395,594,202	\$71,457,264,906	\$1,938,329,296
2016	18,089,309	5,136,283	\$16,186.48	\$76,083,351,550	\$74,074,040,353	\$2,009,311,197
2017	18,405,872	5,226,168	\$16,995.80	\$78,918,010,400	\$76,833,837,731	\$2,084,172,669
2018	18,739,479	5,320,892	\$17,845.59	\$81,908,562,433	\$79,745,411,254	\$2,163,151,179
2019	19,102,556	5,423,984	\$18,737.87	\$85,116,813,467	\$82,868,934,492	\$2,247,878,975
2020	19,484,607	5,532,464	\$19,674.77	\$88,504,958,469	\$86,167,600,816	\$2,337,357,653
Cumulative, 2013–2020	--	--	--	\$623,329,182,248	\$606,867,469,145	\$16,461,713,103
Average, 2013–2020	18,297,871	5,195,502	\$16,690	\$77,916,147,781	\$75,858,433,643	\$2,057,714,138

* Discounted at a 3% rate to show present value

Source: Summary Health Statistics for U.S. Adults: National Health Interview Survey 2011, Centers for Disease Control and Prevention and Frost & Sullivan

Figure 8.2—Omega-3 and Coronary Heart Disease, Number of Avoided CHD Events Given Use of Omega-3 for All U.S. Adults over the Age of 55, 2013–2020

Year	Number of avoided events (events)
2013	129,402
2014	131,343
2015	133,395
2016	135,646
2017	138,020
2018	140,521
2019	143,244
2020	146,109
Cumulative, 2013–2020	1,097,678
Average, 2013–2020	137,210

Source: Summary Health Statistics for U.S. Adults: National Health Interview Survey 2011, Centers for Disease Control and Prevention and Frost & Sullivan

Figure 8.3—Omega-3 Retail Prices of Best-selling Brands, 2013

Best-selling brands	Number of caps per daily intake (1000 mg of EPA + DHA)	Price per daily dose (\$)	Annual cost of supplement utilization per person (\$)
GNC Triple Strength Fish Oil 1500	1	\$0.38	\$139.95
Now Foods, Omega-3, Cardiovascular Support, 200 Softgel	2	\$0.08	\$30.24
Natural Factors, RxOmega-3 Factors, EPA 400 mg/DHA 200 mg, 240 Softgels	2	\$0.25	\$91.22
Madre Labs, Omega-3 Premium Fish Oil, 180 mg EPA/120 mg DHA, 100 Softgels	2	\$0.10	\$36.16
Carlson Labs, Super Omega-3 Gems, Fish Oil Concentrate, 1000 mg, 100 Soft Gels + 30 Free Soft Gels	2	\$0.27	\$100.30
Nordic Naturals, Ultimate Omega, Lemon Flavor, 1000 mg, 180 Soft Gels	2	\$0.66	\$241.31
Puritan's Pride - Double Strength Omega-3 Fish Oil 1200mg	2	\$0.17	\$60.83
Vitamin Shoppe - Omega 3 Fish Oil 600 EPA / 240 DHA	1	\$0.09	\$33.47
Carlson Laboratories - Super Omega-3 Fish Oil	3	\$0.12	\$43.79
Carlson Laboratories - The Very Finest Fish Oil Lemon Flavor	2	\$0.47	\$170.33
Nordic Naturals - Ultimate Omega	1	\$0.17	\$60.81
the Vitamin Shoppe - Omega 3 Fish Oil 300 EPA / 200 DHA	2	\$0.36	\$130.39
Barlean's Organic Oils - Fish Oil	1	\$0.34	\$124.15
Country Life - Omega-3 Fish Body Oils	1	\$0.33	\$120.65
Twinlab - Mega Twin EPA	2	\$0.32	\$116.81
Vitacost Mega EFA® Omega-3 EPA & DHA Fish Oil -- 2,126 mg per serving - 240 Softgels	2	\$0.17	\$62.79
Omega-3 Fish Oil 1000 mg., 250 Softgels	3	\$0.22	\$82.13
Triple Strength Omega-3 Fish Oil 1360 mg, 180 Softgels	1	\$0.26	\$94.30
Nature Made Ultra Omega-3 Mini Fish Oil 500 mg Liquid Softgels	3	\$0.25	\$93.08
Windmill Natural Omega 3 EPA+DHA Fish Oil Concentrate 1000mg Dietary Supplement Softgels	1	\$0.16	\$59.84
GNC Triple Strength Fish Oil 1500	1	\$0.38	\$139.95
	Median Price	\$0.25	\$92.15

Note: All figures are rounded. Source: Frost & Sullivan

Figure 8.4—Omega-3 and Coronary Heart Disease Cost Analysis for All U.S. Adults over the Age of 55, 2013–2020

Year	Change in CHD expenditure among all U.S. adults over the age of 55 given omega-3 intervention at preventive daily intake levels (avoided costs = benefits)* (\$)	Expected per person cost of omega-3 at preventive annual intake levels (\$)	Expected cost of dietary supplementation of among all U.S. adults over the age of 55 with CHD at preventive daily intake levels* (supplement utilization costs) (\$)	Net cost savings derived from avoided CHD events given required omega-3 dietary supplement expenditures among all U.S. adults over the age of 55, 2013–2020 (\$)
2013	\$1,809,355,838	\$92.15	\$1,590,186,704	\$219,169,133
2014	\$1,872,156,295	\$93.07	\$1,582,698,932	\$289,457,364
2015	\$1,938,329,296	\$94.00	\$1,576,216,397	\$362,112,899
2016	\$2,009,311,197	\$94.94	\$1,571,692,426	\$437,618,771
2017	\$2,084,172,669	\$95.89	\$1,568,144,674	\$516,027,996
2018	\$2,163,151,179	\$96.85	\$1,565,565,989	\$597,585,190
2019	\$2,247,878,975	\$97.82	\$1,564,910,503	\$682,968,472
2020	\$2,337,357,653	\$98.80	\$1,565,214,370	\$772,143,283
Cumulative, 2013–2020	\$16,461,713,103	--	\$12,584,629,995	\$3,877,083,108
Average, 2013–2020	\$2,057,714,138	--	\$1,573,078,749	\$484,635,389

* Discounted at a 3% rate to show present value

Source: Summary Health Statistics for U.S. Adults: National Health Interview Survey 2011—Centers for Disease Control and Prevention, Center for Financing, Access and Cost Trends—Agency for Healthcare Research and Quality; Medical Expenditure Panel Survey, 2010 and Frost & Sullivan

B vitamins and CHD Analysis

Figure 8.5—B Vitamins and Coronary Heart Disease Cost Analysis for All U.S. Adults over the Age of 55, 2013–2020

Year	Number of adults over the age of 55 with CHD (people)	Expected number of adults over the age of 55 with CHD who will experience a new CHD-related hospitalization event (people)	Mean CHD expenditure per person experiencing a CHD event (\$)	Total CHD event expenditure among all U.S. adults over the age of 55* (\$)	Total CHD event expenditure among all U.S. adults over the age of 55 given B vitamin intervention at preventive daily intake levels* (\$)	Change in CHD event expenditure among all U.S. adults over the age of 55 given B vitamin intervention at preventive daily intake levels (avoided costs = benefits)* (\$)
2013	17,256,590	4,899,840	\$13,982.49	\$68,511,963,964	\$67,179,727,997	\$1,332,235,968
2014	17,515,439	4,973,338	\$14,681.61	\$70,889,927,762	\$69,511,451,565	\$1,378,476,197
2015	17,789,118	5,051,046	\$15,415.69	\$73,395,594,202	\$71,968,394,559	\$1,427,199,643
2016	18,089,309	5,136,283	\$16,186.48	\$76,083,351,550	\$74,603,887,649	\$1,479,463,901
2017	18,405,872	5,226,168	\$16,995.80	\$78,918,010,400	\$77,383,425,696	\$1,534,584,704
2018	18,739,479	5,320,892	\$17,845.59	\$81,908,562,433	\$80,315,825,535	\$1,592,736,898
2019	19,102,556	5,423,984	\$18,737.87	\$85,116,813,467	\$83,461,691,153	\$1,655,122,315
2020	19,484,607	5,532,464	\$19,674.77	\$88,504,958,469	\$86,783,952,645	\$1,721,005,824
Cumulative, 2013–2020	--	--	--	\$623,329,182,248	\$611,208,356,798	\$12,120,825,450
Average, 2013–2020	18,297,871	5,195,502	\$16,690	\$77,916,147,781	\$76,401,044,600	\$1,515,103,181

* Discounted at a 3% rate to show present value

Source: Summary Health Statistics for U.S. Adults: National Health Interview Survey 2011, Centers for Disease Control and Prevention and Frost & Sullivan

Figure 8.6—B Vitamins and Coronary Heart Disease, Number of Avoided CHD Events Given Use of B Vitamins for All U.S. Adults over the Age of 55, 2013–2020

Year	Number of avoided events (events)
2013	95,279
2014	96,708
2015	98,219
2016	99,877
2017	101,624
2018	103,466
2019	105,471
2020	107,580
Cumulative, 2013–2020	808,225
Average, 2013–2020	101,028

Source: Summary Health Statistics for U.S. Adults: National Health Interview Survey 2011, Centers for Disease Control and Prevention and Frost & Sullivan

Figure 8.7—B Vitamins Retail Prices of Best-selling Brands, 2013

Best-selling brand	Price per daily dose (\$)	Annual cost of supplement utilization per person (\$)
Source Naturals, Homocysteine Defense, 120 Tablets	\$0.17	\$61.30
Nutricology, Homocysteine, 90 Veggie Caps	\$0.14	\$50.45
Superior Source - Vitamin B12 1,000 mcg with Vitamin B6 2 mg & Folic Acid 400 mcg Microlingual	\$0.17	\$60.81
Carlson Laboratories - Tri-B	\$0.07	\$24.32
The Vitamin Shoppe - Homocysteine Blocker	\$0.07	\$26.46
Solgar - Homocysteine Modulators	\$0.16	\$58.32
Country Life - Homocysteine Shield	\$0.22	\$79.08
KAL - B6 B12 Folic Acid Lozenge Berry	\$0.12	\$44.38
Source Naturals - Homocysteine Defense	\$0.13	\$46.54
Source Naturals Homocysteine Defense™	\$0.33	\$119.32
Mason Natural Folic Acid B6 & B12 Tablets	\$0.04	\$15.38
Median price	\$0.14	\$50.45

Note: All figures are rounded. Source: Frost & Sullivan

Figure 8.8—B Vitamins and Coronary Heart Disease Cost Analysis for All U.S. Adults over the Age of 55, 2013–2020

Year	Change in CHD event expenditure among all U.S. adults over the age of 55 given B vitamin intervention at preventive daily intake levels (avoided costs = benefits)* (\$)	Expected per person cost of B vitamin at preventive annual intake levels (\$)	Expected cost of B vitamin supplementation of people with CHD at preventive daily intake levels among all U.S. adults over the age of 55* (supplement utilization costs) (\$)	Net cost savings derived from avoided CHD events given required B vitamin supplement expenditures among all U.S. adults over the age of 55, 2013–2020 (\$)
2013	\$1,332,235,968	\$50.45	\$870,510,134	\$461,725,834
2014	\$1,378,476,197	\$46.98	\$866,411,130	\$512,065,067
2015	\$1,427,199,643	\$47.45	\$862,862,419	\$564,337,223
2016	\$1,479,463,901	\$47.93	\$860,385,879	\$619,078,023
2017	\$1,534,584,704	\$48.40	\$858,443,745	\$676,140,959
2018	\$1,592,736,898	\$48.89	\$857,032,106	\$735,704,792
2019	\$1,655,122,315	\$49.38	\$856,673,275	\$798,449,039
2020	\$1,721,005,824	\$49.87	\$856,839,620	\$864,166,205
Cumulative, 2013–2020	\$12,120,825,450	--	\$6,889,158,308	\$5,231,667,142
Average, 2013–2020	\$1,515,103,181	--	\$861,144,789	\$653,958,393

* Discounted at a 3% rate to show present value

Source: Summary Health Statistics for U.S. Adults: National Health Interview Survey 2011—Centers for Disease Control and Prevention, Center for Financing, Access and Cost Trends—Agency for Healthcare Research and Quality; Medical Expenditure Panel Survey, 2010 and Frost & Sullivan

Phytosterols and CHD Analysis

Figure 8.9—Phytosterols and Coronary Heart Disease Cost Analysis for All U.S. Adults over the Age of 55, 2013–2020

Year	Number of adults over the age of 55 with CHD (people)	Expected number of adults over the age of 55 with CHD who will experience a new CHD-related hospitalization event (people)	Mean CHD expenditure per person experiencing a CHD event (\$)	Total CHD event expenditure among all U.S. adults over the age of 55* (\$)	Total CHD event expenditure among all U.S. adults over the age of 55 given phytosterol intervention at preventive daily intake levels* (\$)	Change in CHD event expenditure among all U.S. adults over the age of 55 given phytosterol intervention at preventive daily intake levels (avoided costs = benefits)* (\$)
2013	17,256,590	4,899,840	\$13,982.49	\$68,511,963,964	\$64,774,976,543	\$3,736,987,421
2014	17,515,439	4,973,338	\$14,681.61	\$70,889,927,762	\$67,023,234,224	\$3,866,693,538
2015	17,789,118	5,051,046	\$15,415.69	\$73,395,594,202	\$69,392,229,002	\$4,003,365,200
2016	18,089,309	5,136,283	\$16,186.48	\$76,083,351,550	\$71,933,382,534	\$4,149,969,016
2017	18,405,872	5,226,168	\$16,995.80	\$78,918,010,400	\$74,613,424,820	\$4,304,585,580
2018	18,739,479	5,320,892	\$17,845.59	\$81,908,562,433	\$77,440,857,089	\$4,467,705,343
2019	19,102,556	5,423,984	\$18,737.87	\$85,116,813,467	\$80,474,113,961	\$4,642,699,506
2020	19,484,607	5,532,464	\$19,674.77	\$88,504,958,469	\$83,677,452,478	\$4,827,505,991
Cumulative, 2013–2020	--	--	--	\$623,329,182,248	\$589,329,670,652	\$33,999,511,596
Average, 2013–2020	18,297,871	5,195,502	\$16,690	\$77,916,147,781	\$73,666,208,832	\$4,249,938,949

* Discounted at a 3% rate to show present value

Source: Summary Health Statistics for U.S. Adults: National Health Interview Survey 2011, Centers for Disease Control and Prevention and Frost & Sullivan

Figure 8.10—Phytosterols and Coronary Heart Disease, Number of Avoided CHD Events Given Use of Phytosterols for All U.S. Adults over the Age of 55, 2013–2020

Year	Number of avoided events (events)
2013	267,262
2014	271,271
2015	275,509
2016	280,159
2017	285,061
2018	290,228
2019	295,851
2020	301,768
Cumulative, 2013–2020	2,267,111
Average, 2013–2020	283,389

Source: Summary Health Statistics for U.S. Adults: National Health Interview Survey 2011, Centers for Disease Control and Prevention and Frost & Sullivan

Figure 8.11—Phytosterol Retail Prices of Best-selling Brands, 2013

Best-selling brand	Price per daily dose (\$)	Annual cost of supplement utilization per person (\$)
Source Naturals Mega Strength Beta Sitosterol	\$0.20	\$74.6
Source Naturals, Phytosterol Complex, with Beta-Sitosterol, 113 mg, 180 Tablets	\$0.15	\$54.5
Phytosterol Complex 1000 mg (Per Serving)	\$0.14	\$51.1
Phytosterol Complex (650 MG) (60 Tablets , \$0.20/serving)	\$0.20	\$73.0
Vitacost Phytosterol Complex with Beta-sitosterol -- 240 Tablets	\$0.08	\$28.4
Phytosterol Complex 1000mg w/ Beta Sitosterol, 100 Softgels	\$0.12	\$43.8
Nature Made CholestOff Complete Dietary Supplement Softgels	\$0.70	\$255.6
Median Price	\$0.15	\$54.48

Note: All figures are rounded. Source: Frost & Sullivan

Figure 8.12—Phytosterols and Coronary Heart Disease Cost Analysis for All U.S. Adults over the Age of 55, 2013–2020

Year	Change in CHD expenditure among all U.S. adults over the age of 55 given phytosterol intervention at preventive daily intake levels (avoided costs = benefits)* (\$)	Expected per person cost of phytosterol at preventive annual intake levels (\$)	Expected cost of phytosterol supplementation of people with CHD at preventive daily intake levels among all U.S. adults over the age of 55* (supplement utilization costs) (\$)	Net cost savings derived from avoided CHD events given required phytosterol supplement expenditures among all U.S. adults over the age of 55, 2013–2020 (\$)
2013	\$3,736,987,421	\$54.48	\$882,156,894	\$2,796,794,456
2014	\$3,866,693,538	\$51.63	\$877,982,643	\$2,930,927,695
2015	\$4,003,365,200	\$52.15	\$874,448,578	\$3,071,432,136
2016	\$4,149,969,016	\$52.67	\$871,913,952	\$3,220,710,736
2017	\$4,304,585,580	\$53.20	\$869,999,763	\$3,377,424,898
2018	\$4,467,705,343	\$53.73	\$868,536,790	\$3,542,069,300
2019	\$4,642,699,506	\$54.27	\$868,216,338	\$3,717,451,017
2020	\$4,827,505,991	\$54.81	\$868,342,148	\$3,902,077,842
Cumulative, 2013–2020	\$33,999,511,596	--	\$6,981,597,105	\$26,558,888,081
Average, 2013–2020	\$4,249,938,949	--	\$872,699,638	\$3,319,861,010

* Discounted at a 3% rate to show present value

Source: Summary Health Statistics for U.S. Adults: National Health Interview Survey 2011—Centers for Disease Control and Prevention, Center for Financing, Access and Cost Trends—Agency for Healthcare Research and Quality; Medical Expenditure Panel Survey, 2010 and Frost & Sullivan

Psyllium Dietary Fiber and CHD Analysis

Figure 8.13—Psyllium Dietary Fiber and Coronary Heart Disease Cost Analysis for All U.S. Adults over the Age of 55, 2013–2020

Year	Number of adults over the age of 55 with CHD (people)	Expected number of adults over the age of 55 with CHD who will experience a new CHD-related hospitalization event (people)	Mean CHD expenditure per person experiencing a CHD event (\$)	Total CHD event expenditure among all U.S. adults over the age of 55* (\$)	Total CHD event expenditure among all U.S. adults over the age of 55 given psyllium dietary fiber intervention at preventive daily intake levels* (\$)	Change in CHD event expenditure among all U.S. adults over the age of 55 given psyllium dietary fiber intervention at preventive daily intake levels (avoided costs = benefits)* (\$)
2013	17,256,590	4,899,840	\$13,982.49	\$68,511,963,964	\$64,659,250,924	\$3,852,713,041
2014	17,515,439	4,973,338	\$14,681.61	\$70,889,927,762	\$66,903,491,914	\$3,986,435,848
2015	17,789,118	5,051,046	\$15,415.69	\$73,395,594,202	\$69,268,254,295	\$4,127,339,906
2016	18,089,309	5,136,283	\$16,186.48	\$76,083,351,550	\$71,804,867,855	\$4,278,483,695
2017	18,405,872	5,226,168	\$16,995.80	\$78,918,010,400	\$74,480,122,034	\$4,437,888,366
2018	18,739,479	5,320,892	\$17,845.59	\$81,908,562,433	\$77,302,502,872	\$4,606,059,561
2019	19,102,556	5,423,984	\$18,737.87	\$85,116,813,467	\$80,330,340,591	\$4,786,472,877
2020	19,484,607	5,532,464	\$19,674.77	\$88,504,958,469	\$83,527,956,090	\$4,977,002,379
Cumulative, 2013–2020	--	--	--	\$623,329,182,248	\$588,276,786,575	\$35,052,395,672
Average, 2013–2020	18,297,871	5,195,502	\$16,690	\$77,916,147,781	\$73,534,598,322	\$4,381,549,459

* Discounted at a 3% rate to show present value

Source: Summary Health Statistics for U.S. Adults: National Health Interview Survey 2011, Centers for Disease Control and Prevention and Frost & Sullivan

Figure 8.14—Psyllium Dietary Fiber and Coronary Heart Disease, Number of Avoided CHD Events Given Use of Dietary fibers for All U.S. Adults over the Age of 55, 2013–2020

Year	Number of avoided events (events)
2013	275,538
2014	279,671
2015	284,041
2016	288,835
2017	293,889
2018	299,216
2019	305,013
2020	311,113
Cumulative, 2013–2020	2,337,318
Average, 2013–2020	292,165

Source: Summary Health Statistics for U.S. Adults: National Health Interview Survey 2011, Centers for Disease Control and Prevention and Frost & Sullivan

Figure 8.15—Psyllium Dietary Fiber Retail Prices of Best-selling Brands, 2013

Best-selling brand	Price per daily dose (\$) (at 10 grams per day)	Annual cost of supplement utilization per person (\$)
Health Plus Inc. THE ORIGINAL Colon Cleanse®	\$0.19	\$68.41
Psyllium Husk Seed 100% Natural	\$0.44	\$159.66
Organic India USA - Psyllium Organic Whole Husk	\$0.36	\$133.05
Yerba Prima Psyllium Husks Powder -- 12 oz	\$0.21	\$78.07
100% Natural Psyllium Husk Seed, 8 oz. Powder	\$0.15	\$53.19
Metamucil Fiber Supplement Smooth Texture, Orange, 114 doses	\$0.47	\$171.67
Now Foods, Psyllium Husk Fiber, Orange-Flavored, 12 oz (340 g)	\$0.33	\$119.53
Source Naturals Psyllium Husk Powder -- 12 oz	\$0.18	\$64.19
Psyllium Whole Husk	\$0.33	\$119.71
Equate Fiber Original Texture (NBE) to Metamucil Fiber Powder	\$0.28	\$103.08
Median price	\$0.30	\$111.31

Note: All figures are rounded. Source: Frost & Sullivan

Figure 8.16—Psyllium Dietary Fiber and Coronary Heart Disease Cost Analysis for All U.S. Adults over the Age of 55, 2013–2020

Year	Change in CHD event expenditure among all U.S. adults over the age of 55 given psyllium dietary fiber intervention at preventive daily intake levels (avoided costs = benefits)* (\$)	Expected per person cost of psyllium dietary fiber at preventive annual intake levels (\$)	Expected cost of psyllium dietary fiber supplementation of people with CHD at preventive daily intake levels among all U.S. adults over the age of 55* (supplement utilization costs) (\$)	Net cost savings derived from avoided CHD events given required psyllium dietary fiber supplement expenditures among all U.S. adults over the age of 55, 2013–2020 (\$)
2013	\$3,852,713,041	\$111.31	\$1,920,822,260	\$1,931,890,781
2014	\$3,986,435,848	\$112.42	\$1,911,777,611	\$2,074,658,236
2015	\$4,127,339,906	\$113.55	\$1,903,947,212	\$2,223,392,695
2016	\$4,278,483,695	\$114.68	\$1,898,482,606	\$2,380,001,089
2017	\$4,437,888,366	\$115.83	\$1,894,197,196	\$2,543,691,170
2018	\$4,606,059,561	\$116.99	\$1,891,082,345	\$2,714,977,216
2019	\$4,786,472,877	\$118.16	\$1,890,290,569	\$2,896,182,308
2020	\$4,977,002,379	\$119.34	\$1,890,657,616	\$3,086,344,764
Cumulative, 2013–2020	\$35,052,395,672	--	\$15,201,257,415	\$19,851,138,258
Average, 2013–2020	\$4,381,549,459	--	\$1,900,157,177	\$2,481,392,282

* Discounted at a 3% rate to show present value

Source: Summary Health Statistics for U.S. Adults: National Health Interview Survey 2011—Centers for Disease Control and Prevention, Center for Financing, Access and Cost Trends—Agency for Healthcare Research and Quality; Medical Expenditure Panel Survey, 2010 and Frost & Sullivan

Chromium Picolinate and Diabetes Analysis

Figure 8.17—Chromium Picolinate and Diabetes Cost Analysis for All Diabetic Adults over the Age of 55 Diagnosed with CHD, 2013–2020

Year	Number of diabetic adults over the age of 55 diagnosed with CHD (people)	Expected number of diabetic people with CHD who will experience a new CHD-related hospitalization event (people)	Mean CHD expenditure per person experiencing a CHD event (\$)	Total CHD event expenditure among all diabetics over the age of 55* (\$)	Total CHD event expenditure among all diabetics over the age of 55 given chromium picolinate intervention at preventive daily intake levels* (\$)	Change in CHD event expenditure among all diabetics over the age of 55 given chromium picolinate intervention at preventive daily intake levels (avoided costs = benefits)* (\$)
2013	7,254,786	2,059,926	\$13,982.49	\$28,802,888,195	\$27,731,554,231	\$1,071,333,964
2014	7,363,608	2,090,825	\$14,681.61	\$29,802,600,091	\$28,694,081,478	\$1,108,518,614
2015	7,478,664	2,123,494	\$15,415.69	\$30,855,999,033	\$29,708,298,860	\$1,147,700,173
2016	7,604,867	2,159,328	\$16,186.48	\$31,985,950,211	\$30,796,221,091	\$1,189,729,120
2017	7,737,952	2,197,116	\$16,995.80	\$33,177,659,764	\$31,943,604,571	\$1,234,055,193
2018	7,878,202	2,236,939	\$17,845.59	\$34,434,907,854	\$33,154,088,858	\$1,280,818,995
2019	8,030,842	2,280,279	\$18,737.87	\$35,783,678,061	\$34,452,691,064	\$1,330,986,997
2020	8,191,459	2,325,885	\$19,674.77	\$37,208,076,896	\$35,824,108,864	\$1,383,968,033
Cumulative, 2013–2020	--	--	--	\$262,051,760,105	\$252,304,649,017	\$9,747,111,087
Average, 2013–2020	7,692,548	2,184,224	\$16,690.00	\$32,756,470,013	\$31,538,081,127	\$1,218,388,886

* Discounted at a 3% rate to show present value

Source: Summary Health Statistics for U.S. Adults: National Health Interview Survey 2011, Centers for Disease Control and Prevention and Frost & Sullivan

Figure 8.18—Chromium Picolinate and Diabetes, Number of Avoided Diabetes Events Given Use of Chromium Picolinate for All Diabetic Adults over the Age of 55 Diagnosed with CHD, 2013–2020

Year	Number of avoided events (events)
2013	76,620
2014	77,769
2015	78,984
2016	80,317
2017	81,723
2018	83,204
2019	84,816
2020	86,512
Cumulative, 2013–2020	649,944
Average, 2013–2020	81,243

Source: Summary Health Statistics for U.S. Adults: National Health Interview Survey 2011, Centers for Disease Control and Prevention and Frost & Sullivan

Figure 8.19—Chromium Picolinate Retail Prices of Best-selling Brands, 2013

Best-selling brand	Price per daily dose (\$)	Annual cost of supplement utilization per person (\$)
GNC Chromium Picolinate 200	\$0.11	\$40.5
Metagenics, Chromium Picolinate, 60 Tablets	\$0.18	\$65.4
Chromium Picolinate 500 mcg Yeast Free	\$0.03	\$10.9
Solgar - Chromium Picolinate	\$0.09	\$32.8
Vitacost Chromium Picolinate -- 500 mcg - 300 Capsules	\$0.03	\$12.2
Chromium Picolinate 500 mcg. Tablets, 250 Tablets	\$0.08	\$30.7
Nature's Bounty Ultra Chromium Picolinate 500 mcg Dietary Supplement Tablets	\$0.10	\$36.5
Finest Nutrition Chromium Picolinate 400 mcg Dietary Supplement Tablets	\$0.10	\$36.5
Median Price	\$0.09	\$31.75

Note: All figures are rounded. Source: Frost & Sullivan

Figure 8.20—Chromium Picolinate and Diabetes Cost Analysis for All Diabetic Adults over the Age of 55 Diagnosed with CHD, 2013–2020

Year	Change in CHD event expenditure among all diabetics over the age of 55 given chromium picolinate intervention at preventive daily intake levels (avoided costs = benefits)* (\$)	Expected per person cost of chromium picolinate at preventive annual intake levels (\$)	Expected cost of chromium picolinate supplementation at preventive daily intake levels among diabetics over the age of 55* (supplement utilization costs) (\$)	Net cost savings derived from avoided CHD events given required chromium picolinate supplement utilization among diabetics over the age of 55 (\$)
2013	\$1,071,333,964	\$34.67	\$251,489,108	\$819,844,856
2014	\$1,108,518,614	\$35.01	\$250,304,912	\$858,213,702
2015	\$1,147,700,173	\$35.36	\$249,279,694	\$898,420,478
2016	\$1,189,729,120	\$35.72	\$248,564,225	\$941,164,895
2017	\$1,234,055,193	\$36.07	\$248,003,146	\$986,052,047
2018	\$1,280,818,995	\$36.43	\$247,595,325	\$1,033,223,670
2019	\$1,330,986,997	\$36.80	\$247,491,660	\$1,083,495,337
2020	\$1,383,968,033	\$37.17	\$247,539,716	\$1,136,428,316
Cumulative, 2013–2020	\$9,747,111,087	--	\$1,990,267,786	\$7,756,843,301
Average, 2013–2020	\$1,218,388,886	--	\$248,783,473	\$969,605,413

* Discounted at a 3% rate to show present value

Source: Summary Health Statistics for U.S. Adults: National Health Interview Survey 2011—Centers for Disease Control and Prevention, Center for Financing, Access and Cost Trends—Agency for Healthcare Research and Quality; Medical Expenditure Panel Survey, 2010 and Frost & Sullivan

Lutein and Zeaxanthin and ARED Analysis

Figure 8.21—Lutein and Zeaxanthin and Age-related Eye Disease Cost Analysis for All U.S. Adults over the Age of 55, 2013–2020

Year	Number of people with age-related macular degeneration (people)	Expected number of people with age-related macular degeneration that will experience a new event (people)	Number of people with cataracts (people)	Expected number of people with cataracts that will experience a new cataracts-related event (people)	Mean age-related eye disease expenditure per person (\$)
2013	2,155,514	1,077,757	25,391,784	3,790,874	\$3,712
2014	2,187,846	1,093,923	25,772,660	3,847,737	\$3,898
2015	2,222,031	1,111,016	26,175,358	3,907,858	\$4,093
2016	2,259,528	1,129,764	26,617,067	3,973,803	\$4,297
2017	2,299,070	1,149,535	27,082,866	4,043,345	\$4,512
2018	2,340,741	1,170,370	27,573,743	4,116,631	\$4,738
2019	2,386,092	1,193,046	28,107,984	4,196,390	\$4,975
2020	2,433,814	1,216,907	28,670,144	4,280,318	\$5,223
Cumulative, 2013–2020	--	--	--	--	--
Average, 2013–2020	2,285,580	1,142,790	26,923,951	4,019,620	\$4,431

* Discounted at a 3% rate to show present value

Source: Summary Health Statistics for U.S. Adults: National Health Interview Survey 2011, Centers for Disease Control and Prevention and Frost & Sullivan

Figure 8.22—Lutein and Zeaxanthin and Age-related Eye Disease Cost Analysis for All U.S. Adults over the Age of 55, 2013–2020 (continued)

Year	Total age-related macular degeneration event expenditure among all U.S. adults over the age of 55* (\$)	Total age-related macular degeneration event expenditure given lutein and zeaxanthin supplement intervention at preventive daily intake levels among all U.S. adults over the age of 55* (\$)	Change in age-related macular degeneration event expenditure given lutein and zeaxanthin supplement intervention at preventive daily intake levels among all U.S. adults over the age of 55 (avoided costs = benefits)* (\$)	Total cataracts event expenditure among all U.S. adults over the age of 55* (\$)	Total cataract event expenditure given lutein and zeaxanthin supplement intervention at preventive daily intake levels among all U.S. adults over the age of 55* (\$)	Change in cataract event expenditure given lutein and zeaxanthin supplement intervention at preventive daily intake levels among all U.S. adults over the age of 55 (avoided costs = benefits)* (\$)
2013	\$4,000,760,135	\$3,950,326,584	\$50,433,551	\$14,072,171,747	\$10,720,724,847	\$3,351,446,900
2014	\$4,139,621,469	\$4,087,437,434	\$52,184,036	\$14,560,599,068	\$11,092,827,675	\$3,467,771,392
2015	\$4,285,940,007	\$4,231,911,481	\$54,028,526	\$15,075,256,165	\$11,484,913,362	\$3,590,342,802
2016	\$4,442,891,755	\$4,386,884,696	\$56,007,058	\$15,627,314,241	\$11,905,492,562	\$3,721,821,679
2017	\$4,608,421,824	\$4,550,328,094	\$58,093,729	\$16,209,545,487	\$12,349,058,851	\$3,860,486,637
2018	\$4,783,055,284	\$4,722,760,127	\$60,295,157	\$16,823,796,771	\$12,817,019,242	\$4,006,777,529
2019	\$4,970,401,290	\$4,907,744,451	\$62,656,839	\$17,482,762,840	\$13,319,045,087	\$4,163,717,753
2020	\$5,168,252,216	\$5,103,101,269	\$65,150,947	\$18,178,678,643	\$13,849,220,668	\$4,329,457,974
Cumulative, 2013–2020	\$36,399,343,979	\$35,940,494,136	\$458,849,843	\$128,030,124,962	\$97,538,302,295	\$30,491,822,667
Average, 2013–2020	\$4,549,917,997	\$4,492,561,767	\$57,356,230	\$16,003,765,620	\$12,192,287,787	\$3,811,477,833

* Discounted at a 3% rate to show present value

Source: Summary Health Statistics for U.S. Adults: National Health Interview Survey 2011, Centers for Disease Control and Prevention and Frost & Sullivan

Figure 8.23—Lutein and Zeaxanthin and Age-related Eye Disease, Number of Avoided Age-related Eye Disease Events Given Use of Lutein and Zeaxanthin for All U.S. Adults over the Age of 55, 2013–2020

Year	Number of avoided age-related macular disease events	Number of avoided cataract events
2013	13,586	902,840
2014	13,790	916,382
2015	14,005	930,701
2016	14,242	946,406
2017	14,491	962,968
2018	14,754	980,422
2019	15,040	999,418
2020	15,340	1,019,406
Cumulative, 2013–2020	115,248	7,658,543
Average, 2013–2020	14,406	957,318

Source: Summary Health Statistics for U.S. Adults: National Health Interview Survey 2011, Centers for Disease Control and Prevention and Frost & Sullivan

Figure 8.24—Lutein and Zeaxanthin Retail Prices of Best-selling Brands, 2013

Best-selling brands	Price per daily dose (\$)	Annual cost of supplement utilization per person (\$)
Nature Made Lutein 20 mg Dietary Supplement Liquid Softgels	\$0.57	\$206.85
Source Naturals® Zeaxanthin With Lutein	\$0.38	\$136.97
Jarrow Formulas, Lutein, 20 mg, 60 Softgels	\$0.19	\$71.04
Source Naturals, Lutein, 20 mg, 60 Capsules	\$0.30	\$110.79
Puritan's Pride Lutein 20 mg	\$0.11	\$38.78
Jarrow's Formula - Lutein + ZEAXANTHIN	\$0.28	\$102.21
	Median Price	\$0.29

Note: All figures are rounded. Source: Frost & Sullivan

Figure 8.25—Lutein and Zeaxanthin and Age-related Eye Disease Cost Analysis for All U.S. Adults over the Age of 55, 2013–2020

Year	Total change in ARED event expenditure given lutein and zeaxanthin supplement intervention at preventive daily intake levels among all U.S. adults over the age of 55 (avoided costs = benefits)* (\$)	Expected per person cost of lutein and zeaxanthin at preventive annual intake levels (\$)	Expected cost of lutein and zeaxanthin supplementation among people with age-related eye disease at preventive daily intake levels among all U.S. adults over the age of 55* (supplement utilization costs) (\$)	Net total cost savings derived from avoided ARED events given required lutein and zeaxanthin supplement expenditures (\$)
2013	\$3,401,880,451	\$106.50	\$2,933,809,533	\$468,070,918
2014	\$3,519,955,428	\$107.57	\$2,919,994,993	\$599,960,435
2015	\$3,644,371,328	\$108.64	\$2,908,035,062	\$736,336,266
2016	\$3,777,828,737	\$109.73	\$2,899,688,578	\$878,140,159
2017	\$3,918,580,366	\$110.83	\$2,893,143,164	\$1,025,437,202
2018	\$4,067,072,686	\$111.93	\$2,888,385,629	\$1,178,687,057
2019	\$4,226,374,593	\$113.05	\$2,887,176,293	\$1,339,198,300
2020	\$4,394,608,921	\$114.18	\$2,887,736,910	\$1,506,872,011
Cumulative, 2013–2020	\$30,950,672,510	--	\$23,217,970,163	\$7,732,702,347
Average, 2013–2020	\$3,868,834,064	--	\$2,902,246,270	\$966,587,794

* Discounted at a 3% rate to show present value

Source: Summary Health Statistics for U.S. Adults: National Health Interview Survey 2011—Centers for Disease Control and Prevention, Center for Financing, Access and Cost Trends—Agency for Healthcare Research and Quality; Medical Expenditure Panel Survey, 2010 and Frost & Sullivan

Calcium and Vitamin D and Osteoporosis Analysis

Figure 8.26—Calcium and Vitamin D and Osteoporosis Cost Analysis for All U.S. Women over the Age of 55, 2013–2020

Year	Number of women over the age of 55 with osteoporosis (people)	Expected number of women with osteoporosis that will experience a new osteoporosis-attributed fracture (people)	Mean osteoporosis expenditure per person experiencing a osteoporosis-attributed fracture (\$)	Total expenditure on osteoporosis-attributed fracture treatment for all U.S. women over the age of 55* (\$)	Total osteoporosis-attributed fracture expenditure given calcium and vitamin D supplement intervention at preventive daily intake levels among all U.S. women over the age of 55* (\$)	Change in expenditure on osteoporosis-attributed fracture treatment for all U.S. women over the age of 55 given calcium and vitamin D supplement intervention at preventive daily intake levels (avoided costs = benefits)* (\$)
2013	8,322,446	1,289,979	\$11,571.62	\$14,927,148,160	\$13,278,693,236	\$1,648,454,924
2014	8,447,283	1,309,329	\$12,150.20	\$15,445,250,633	\$13,739,579,918	\$1,705,670,714
2015	8,579,272	1,329,787	\$12,757.71	\$15,991,176,512	\$14,225,217,376	\$1,765,959,136
2016	8,724,047	1,352,227	\$13,395.60	\$16,576,775,725	\$14,746,146,908	\$1,830,628,817
2017	8,876,718	1,375,891	\$14,065.38	\$17,194,381,325	\$15,295,548,255	\$1,898,833,070
2018	9,037,608	1,400,829	\$14,768.64	\$17,845,952,389	\$15,875,164,146	\$1,970,788,243
2019	9,212,712	1,427,970	\$15,507.08	\$18,544,954,954	\$16,496,973,519	\$2,047,981,436
2020	9,396,966	1,456,530	\$16,282.43	\$19,283,152,190	\$17,153,649,163	\$2,129,503,027
Cumulative, 2013–2020	--	--	--	\$135,808,791,888	\$120,810,972,521	\$14,997,819,367
Average, 2013–2020	8,824,632	1,367,818	\$13,812.00	\$16,976,098,986	\$15,101,371,565	\$1,874,727,421

* Discounted at a 3% rate to show present value

Source: Summary Health Statistics for U.S. Adults: National Health Interview Survey 2011, Centers for Disease Control and Prevention and Frost & Sullivan

Figure 8.27—Calcium and Vitamin D and Osteoporosis, Number of Avoided Osteoporosis Events Given Use of Calcium and Vitamin D for All U.S. Women over the Age of 55, 2013–2020

Year	Number of avoided osteoporosis-attributed fractures (events)
2013	142,457
2014	144,594
2015	146,853
2016	149,331
2017	151,944
2018	154,698
2019	157,696
2020	160,849
Cumulative, 2013–2020	1,208,422
Average, 2013–2020	151,053

Source: Summary Health Statistics for U.S. Adults: National Health Interview Survey 2011, Centers for Disease Control and Prevention and Frost & Sullivan

Figure 8.28—Calcium and Vitamin D Retail Prices of Best-selling Brands, 2013

Best-selling brand	Price per daily dose (\$)	Annual cost of supplement utilization per person (\$)
GNC Calcium 600 with Vitamin D-3	\$0.06	\$21.3
Twinlab, Calcium 1000 Tabs, with Vitamin D3, 120 Tablets	\$0.12	\$43.2
Puritan's Pride - Calcium 600 + Vitamin D3, 250 Servings	\$0.07	\$26.3
Puritan's Pride - Calcium 600 + Vitamin D3, 500 Servings	\$0.07	\$24.8
Calcium Citrate + Vitamin D	\$0.28	\$103.4
Schiff Super Calcium Magnesium With Vitamin D	\$0.20	\$72.9
Calcium 600 mg + Vitamin D3, 500 Caplet	\$0.07	\$24.1
Nature Made Calcium 600 mg with Vitamin D Dietary Supplement Liquid Softgels	\$0.32	\$116.8
Nature's Bounty Coral Calcium 1000 mg Plus Vitamin D & Magnesium Capsules	\$0.23	\$85.2
	Median Price	\$57.55

Note: All figures are rounded. Source: Frost & Sullivan

Figure 8.29—Calcium and Vitamin D and Osteoporosis Cost Analysis for All U.S. Women over the Age of 55, 2013–2020

Year	Change in expenditure on osteoporosis-attributed fracture treatment for all U.S. women over the age of 55 given calcium and vitamin D supplement intervention at preventive daily intake levels (avoided costs = benefits)* (\$)	Expected per person cost of calcium and vitamin D at preventive annual intake levels (\$)	Expected cost of calcium and vitamin D among people with osteoporosis at preventive daily intake levels among all U.S. women over the age of 55* (supplement utilization costs) (\$)	Net cost savings derived from avoided osteoporosis-attributed fractures given required calcium and vitamin D dietary supplement expenditures among all U.S. women over the age of 55, 2013–2020
2013	\$1,648,454,924	\$43.22	\$359,706,531	\$1,288,748,393
2014	\$1,705,670,714	\$43.65	\$358,012,768	\$1,347,657,947
2015	\$1,765,959,136	\$44.09	\$356,546,392	\$1,409,412,744
2016	\$1,830,628,817	\$44.53	\$355,523,052	\$1,475,105,764
2017	\$1,898,833,070	\$44.98	\$354,720,537	\$1,544,112,533
2018	\$1,970,788,243	\$45.43	\$354,137,228	\$1,616,651,015
2019	\$2,047,981,436	\$45.88	\$353,988,955	\$1,693,992,481
2020	\$2,129,503,027	\$46.34	\$354,057,690	\$1,775,445,336
Cumulative, 2013–2020	\$14,997,819,367	--	\$2,846,693,154	\$12,151,126,213
Average, 2013–2020	\$1,874,727,421	--	\$355,836,644	\$1,518,890,777

* Discounted at a 3% rate to show present value

Source: Summary Health Statistics for U.S. Adults: National Health Interview Survey 2011—Centers for Disease Control and Prevention, Center for Financing, Access and Cost Trends—Agency for Healthcare Research and Quality; Medical Expenditure Panel Survey, 2010 and Frost & Sullivan

Magnesium and Osteoporosis Analysis

Figure 8.30—Magnesium and Osteoporosis Cost Analysis for All U.S. Women over the Age of 55, 2013–2020

Year	Number of women over the age of 55 with osteoporosis (people)	Expected number of women with osteoporosis that will experience a new osteoporosis-attributed fracture (people)	Mean osteoporosis expenditure per person experiencing a osteoporosis-attributed fracture (\$)	Total expenditure on osteoporosis-attributed fracture treatment for all U.S. women over the age of 55* (\$)	Total osteoporosis-attributed fracture expenditure given magnesium supplement intervention at preventive daily intake levels among all U.S. women over the age of 55* (\$)	Change in expenditure on osteoporosis-attributed fracture treatment for all U.S. women over the age of 55 given magnesium supplement intervention at preventive daily intake levels (avoided costs = benefits)* (\$)
2013	8,322,446	1,289,979	\$11,571.62	\$14,927,148,160	\$14,179,212,251	\$747,935,909
2014	8,447,283	1,309,329	\$12,150.20	\$15,445,250,633	\$14,671,354,812	\$773,895,820
2015	8,579,272	1,329,787	\$12,757.71	\$15,991,176,512	\$15,189,926,668	\$801,249,844
2016	8,724,047	1,352,227	\$13,395.60	\$16,576,775,725	\$15,746,183,994	\$830,591,730
2017	8,876,718	1,375,891	\$14,065.38	\$17,194,381,325	\$16,332,844,005	\$861,537,320
2018	9,037,608	1,400,829	\$14,768.64	\$17,845,952,389	\$16,951,767,614	\$894,184,775
2019	9,212,712	1,427,970	\$15,507.08	\$18,544,954,954	\$17,615,746,133	\$929,208,821
2020	9,396,966	1,456,530	\$16,282.43	\$19,283,152,190	\$18,316,955,445	\$966,196,745
Cumulative, 2013–2020	--	--	--	\$135,808,791,888	\$129,003,990,923	\$6,804,800,966
Average, 2013–2020	8,824,632	1,367,818	\$13,812.00	\$16,976,098,986	\$16,125,498,865	\$850,600,121

* Discounted at a 3% rate to show present value

Source: Summary Health Statistics for U.S. Adults: National Health Interview Survey 2011, Centers for Disease Control and Prevention and Frost & Sullivan

Figure 8.31—Magnesium and Osteoporosis, Number of Avoided Osteoporosis Events Given Use of Magnesium for All U.S. Women over the Age of 55, 2013–2020

Year	Number of avoided events (events)
2013	64,635
2014	65,605
2015	66,630
2016	67,754
2017	68,940
2018	70,190
2019	71,550
2020	72,981
Cumulative, 2013–2020	548,284
Average, 2013–2020	68,536

Source: Summary Health Statistics for U.S. Adults: National Health Interview Survey 2011, Centers for Disease Control and Prevention and Frost & Sullivan

Figure 8.32—Magnesium Retail Prices of Best-selling Brands, 2013

Best-selling brand	Price per daily dose (\$)	Annual cost of supplement utilization per person (\$)
GNC Super Magnesium	\$0.33	\$121.67
Solaray, Magnesium Asporotate, 120 Capsules	\$0.18	\$66.60
Solgar, Chelated Magnesium, 250 Tablets	\$0.34	\$122.42
Magnesium 250 mg	\$0.02	\$8.93
TwinLab Magnesium Caps	\$0.04	\$14.59
Vitacost Magnesium -- 400 mg - 200 Capsules	\$0.03	\$11.85
Nature Made Magnesium 250 mg Dietary Supplement Tablets	\$0.08	\$29.18
Nature's Bounty Magnesium 500 mg Dietary Supplement Tablets	\$0.09	\$32.84
	Median Price	\$31.01

Note: All figures are rounded. Source: Frost & Sullivan

Figure 8.33—Magnesium and Osteoporosis Cost Analysis for All U.S. Women over the Age of 55, 2013–2020

Year	Change in expenditure on osteoporosis-attributed fracture treatment for all U.S. women over the age of 55 given magnesium intervention at preventive daily intake levels (avoided costs = benefits)* (\$)	Expected per person cost of magnesium at preventive annual intake levels (\$)	Expected cost of magnesium among people with osteoporosis at preventive daily intake levels among all U.S. women over the age of 55* (supplement utilization costs) (\$)	Net cost savings derived from avoided osteoporosis-attributed fractures given required magnesium dietary supplement expenditures among all U.S. women over the age of 55, 2013–2020
2013	\$747,935,909	\$31.01	\$258,076,771	\$489,859,138
2014	\$773,895,820	\$31.32	\$256,861,555	\$517,034,266
2015	\$801,249,844	\$31.63	\$255,809,482	\$545,440,362
2016	\$830,591,730	\$31.95	\$255,075,272	\$575,516,459
2017	\$861,537,320	\$32.27	\$254,499,495	\$607,037,825
2018	\$894,184,775	\$32.59	\$254,080,992	\$640,103,784
2019	\$929,208,821	\$32.92	\$253,974,611	\$675,234,210
2020	\$966,196,745	\$33.25	\$254,023,926	\$712,172,819
Cumulative, 2013–2020	\$6,804,800,966	--	\$2,042,402,102	\$4,762,398,863
Average, 2013–2020	\$850,600,121	--	\$255,300,263	\$595,299,858

* Discounted at a 3% rate to show present value

Source: Summary Health Statistics for U.S. Adults: National Health Interview Survey 2011—Centers for Disease Control and Prevention, Center for Financing, Access and Cost Trends—Agency for Healthcare Research and Quality; Medical Expenditure Panel Survey, 2010 and Frost & Sullivan



This report was funded through a grant from the CRN Foundation.

The CRN Foundation is a non-profit 501(c)(3) educational foundation of the Council for Responsible Nutrition (CRN), the leading trade association for the dietary supplement industry. The CRN Foundation provides consumers with information about responsible use of dietary supplements, and provides researchers and healthcare practitioners with education on the proper role of supplements in a healthy lifestyle.



www.crnusa.org/CRNfoundation

Disclaimer

Frost & Sullivan will strive always to provide first-rate and accurate work. However, there is no guarantee of certainty, express or implied, by Frost & Sullivan regarding the information contained within this document and any related supplemental material. This is because the market dynamics and trends we study have varying degrees of fragmentation and uncertainty. Frost & Sullivan, its employees, and agents disclaim liability to actual, consequential, or punitive damages that may arise as a result of anyone relying on the information contained within this document and any related supplemental material.

©2013 Frost & Sullivan

All rights reserved. Selected passages and figures may be reproduced for the purposes of research, media reporting, and review given acknowledgement of the source is included. Permission for any extensive reproduction must be obtained with the written approval of Frost & Sullivan. For information regarding use permission, write to:

Frost & Sullivan
331 E. Evelyn Ave. Suite 100
Mountain View, CA 94041
myfrost@frost.com

About Frost & Sullivan

Frost & Sullivan, the Growth Partnership Company, works in collaboration with clients to leverage visionary innovation that addresses the global challenges and related growth opportunities that will make or break today's market participants. For more than 50 years, we have been developing growth strategies for the Global 1000, emerging businesses, the public sector and the investment community. Is your organization prepared for the next profound wave of industry convergence, disruptive technologies, increasing competitive intensity, Mega Trends, breakthrough best practices, changing customer dynamics and emerging economies? Contact Us: Start the Discussion.

Silicon Valley

331 E. Evelyn Ave. Suite 100
Mountain View, CA 94041
Tel 650.475.4500
Fax 650.475.1570

San Antonio

7550 West Interstate 10, Suite 400,
San Antonio, Texas 78229-5616
Tel 210.348.1000
Fax 210.348.1003

London

4, Grosvenor Gardens,
London SW1W 0DH, UK
Tel 44(0)20 7730 3438
Fax 44(0)20 7730 3343