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Drug Legislation Running Out of Time as Part D Costs Set to Soar

Medicare Part D's True Out-of-Pocket-Cost (TrOOP) spending requirements which are unusually high as it is, are poised to make a stunning and unprecedented jump in 2020. Unless Congress takes action, the Part D doughnut hole coverage gap will swell by 25% next year, from $5,100 in 2019, to $6,350 in 2020 ($1,250 increase) before the catastrophic phase of coverage kicks in. This would be the largest increase in Part D's required out–of–pocket spending ever, since the start of the program in 2006.

In counting out-of-pocket spending, Medicare does not include the cost of monthly Part D premiums or the cost of any drugs that aren't listed on your drug plan's formulary. And, even after hitting $6,350, out-of-pocket spending would not end there, because Part D has no annual out-of-pocket maximum. The TrOOP cost is the amount you must spend before you qualify for the catastrophic stage of Part D coverage, when Medicare steps in and co-insurance goes down. But you still are required to pay a minimum of $3.60 for generic drugs or a 5% coinsurance for brand drugs.

Now, as we draw close to the end of the year, the window for Congress to take major action to lower prescription drug prices is beginning to close. Concern is growing that the prospects of a substantial drug price reduction bill may get lost in the politics surrounding the 2020 election. Legislation that would allow Medicare to negotiate the cost of prescription drugs is in the House, and a bipartisan bill that would cap out-of-pocket Part D costs at $3,100 a year is stalled in the Senate. The whole effort is fiercely being fought by the pharmaceutical industry, and the outcome remains unclear.

Nearly 20% of participants in TSCL's Senior Survey say they spent $3,100 or more out-of-pocket on prescription drugs in 2018. And, as we age, all of us face the grim potential that a new health problem could increase our spending on prescription drugs to this level. Doing nothing to lower drug prices for Medicare beneficiaries is not a good option.

President Trump has said that he wants to deliver on his promise to lower drug costs, but bipartisan legislation is required to cap costs and provide real cost savings for older Americans. If Congress fails to take action, older Americans will bear the increasing burden of higher drug spending through depleted savings, higher taxes, and a lower standard of living.

Your contact with Members of Congress is important now and could help clear the legislative path for this important legislation. Call your Member of Congress now toll free at 1-844-455-0045.

TAKE ACTION HERE

Prescription Drugs

Add Your Name

Target Congress

Analysis Finds Record 3,148 Medicare Advantage Plans Will be Available in 2020

Most Offer Additional Benefits, Including Some Fitness, Dental and Vision, though Few Offer Telemonitoring, In-Home and Caregiver Support

A record 3,148 Medicare Advantage plans will be available across the country as alternatives to traditional Medicare, a **new KFF analysis** finds. That's up 15% from last year's 2,734 plans and results in a typical beneficiary having 28 plans available to them in their local market for the 2020 Medicare open enrollment period, which began Oct. 15 and runs until Dec. 7.

About 22 million Medicare beneficiaries – a third of all beneficiaries – are currently in Medicare Advantage plans, which are mostly HMOs and PPOs offered by private insurers that are paid to provide Medicare benefits to enrollees.

Most plans also offer benefits beyond what traditional Medicare covers, including fitness (93%), dental (88%), eye exams and glasses (87%), and hearing aids (83%). Nearly half (46%) provide a meal benefit, such as a cooking class, nutrition education or meal delivery, and one-third (33%) provide some transportation benefit. Far fewer offer other benefits related to social and residential needs that can affect health, such as bathroom safety devices, handrails (6%), telemonitoring (4%), in-home support (4%), and support for caregivers (2%).

The number of 2020 plans available varies greatly across the country, with 31 plans, on average, in metropolitan counties and 16 plans, on average, in non-metropolitan counties. Six counties in Ohio and Pennsylvania have more than 60 plans, while no plans will be available in 77 mostly rural counties nationwide.

Most Medicare Advantage plans (90%) include prescription drug coverage. Similar to last year, about 49% of these plans do not charge any additional premium beyond Medicare's standard Part B premium.

KFF has also updated its collection **of frequently asked questions** about Medicare Open Enrollment to help beneficiaries understand their options during the annual open enrollment period, including the private stand-alone Part D plans that provide Medicare's drug benefit and Medicare supplement (Medigap) plans, in addition to Medicare Advantage plans.

Medicare Advantage 2020 Spotlight: First Look

Medicare Advantage plans have taken a large and growing role in the Medicare program over the past decade, with more than **22 million Medicare beneficiaries (34%)** enrolled in Medicare Advantage plans in 2019, a private plan alternative to the traditional Medicare program. This brief provides an overview of the Medicare Advantage plans that will be available for 2020, based on an analysis of data from the Centers for Medicare and Medicaid Services (CMS). Findings include:

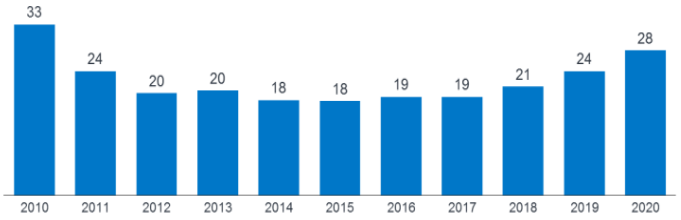
Number of Plans. Nationwide, 3,148 Medicare Advantage plans will be available for individual enrollment for the 2020 plan year – an increase of 414 plans since 2019. The average beneficiary will be able to choose among 28 plans in 2020, up from 24 in 2019 (ES Figure). The number of Special Needs Plans (SNPs) will also increase from 717 plans in 2019 to 855 plans in 2020.

- **Variation in Number of Plans.** The number of Medicare Advantage plans will vary greatly across counties in 2020, from 31 plans, on average, in metropolitan counties to 16 plans, on average, in non-metropolitan counties. More than 60 plans will be available in six counties (in OH and PA), while no plans will be offered in 77 counties (accounting for less than 1% of beneficiaries) in 2020.
- **Number of Firms.** The average beneficiary will be able to choose from plans offered by seven firms in 2020, similar to 2019. Four percent of all Medicare beneficiaries will have a choice of plans offered by two or fewer firms while 24 percent will be able to choose from plans offered by 10 or more firms.
- **Market Entrants and Exits.** Thirteen insurers will be entering the Medicare Advantage market for the first time, and one insurer will be exiting in 2020. In all, well over 100 firms will offer Medicare Advantage plans in 2020.
- **Extra Benefits.** Nearly all beneficiaries (97%) have access to a Medicare Advantage plan that provides dental, fitness, vision, and hearing benefits, which are not covered by traditional Medicare. Many beneficiaries also have access to some transportation assistance (92%) and a meal benefit (96%), but some benefits are less frequently available, such as in-home support (54%), bathroom safety (49%), telemonitoring services (29%), and support for caregivers of enrollees (12%).

ES Figure

The average Medicare beneficiary has access to 28 Medicare Advantage plans in 2020, an increase from prior years

Average Number of Medicare Advantage Plans Available to Beneficiaries, 2010-2020



NOTE: Excludes SNPs, EGHPs, HCPPs, and PACE plans.
SOURCE: Kaiser Family Foundation analysis of CMS's Landscape files for 2010 – 2020.

KFF

Do you need care? Why should your health insurer decide

In a **Washington Post op-ed**, William E. Bennett Jr., a gastroenterologist and associate professor of pediatrics at the Indiana University School of Medicine, makes the case that health insurers should not be allowed to practice medicine. They **too often deny medically necessary care** unless and until your doctor is willing to go through hoops with their medical staff. But, medical staff who work for health insurers have no clue whether you need care.

Bennett appreciates our need for health insurance. He also recognizes that having health insurance is necessary but not sufficient for our well-being. To get his patients needed medicines and tests, he must request prior authorization from his patients' insurers, which can needlessly delay their access to care for weeks. And, still, the insurers may deny needed care. Only if Bennett appeals to a doctor who works for the insurer, someone who is unqualified to know whether the treatment or medicine is needed, will the insurer reverse the denial. Most of the time, the doctor in the employ of the health insurer has little accurate information about the patient; the doctor has never had any contact with the patient.

There is nothing beneficial about this process for the doctor or the patient. It does not assure the patient gets the proper treatment. In fact, it keeps many patients from getting needed care. And, it burdens the doctor excessively and unreasonably.

Bennett experiences the system from the patient's side as well because his daughter has a serious health condition, and he has had to deal with an insurer that has limited her access to needed treatment. Appealing is a challenging process that requires Bennett to rely on the advocacy of his daughter's doctors. It takes time and does not always work. In the meantime, his daughter suffers even though his daughter's treating physicians all know she would benefit from the treatment.

In short, when health insurer denials are based on the insurer's claim of lack of medical necessity, the system breaks down, and the most vulnerable patients are harmed. **One study** revealed that one health insurer denied claims for emergency visits that met a "prudent layperson" emergency coverage standard in more than 85 percent of cases. Patients can appeal the denials with a high likelihood of success on appeal. But, only a tiny number know they can appeal and have the wherewithal to do so.

Bennet concludes that health insurers should not be able to decide the care people need: "When an insurance company reflexively denies care and then makes it difficult to appeal that denial, it is making health-care decisions for patients. In other words, insurance officials are practicing medicine without accepting the professional, personal or legal liability that comes with the territory."

Several states wary of $48 billion opioid settlement proposal

Several U.S. states that have been ravaged by the opioid epidemic are pushing back on a proposed $48 billion settlement framework that would resolve thousands of lawsuits against five drug companies accused of fueling the addiction crisis.

The proposal would bring an end to all opioid litigation against AmerisourceBergen Corp(ABC.N), Cardinal Health Inc(CAH.N) and McKesson Corp(MCK.N), drugmaker Teva Pharmaceutical Industries Inc(TEVA.TA)(TEVA.N), and Johnson & JohnsonJNJ.J.

The companies have proposed paying $22.25 billion cash mostly over 18 years, while services and drugs to treat addiction valued at $26 billion by the companies would be provided over the coming decade, mostly by Teva.

Officials in states such as Ohio, New Hampshire and West Virginia — all hard hit by the deadly drug addition crisis — voiced concerns about the proposal.

James Boffetti, the associate attorney general for New Hampshire, said in an interview he was troubled that payments were stretched over many years.

"The concern is, I think, the states need money now to create the infrastructure for treatment," he said.

Small states fear the money will be divvied up by population rather than need.

"Any global opioid settlement that doesn't reflect the unique and unprecedented damage imposed on West Virginia through the opioid epidemic should be DOA," West Virginia Attorney General Patrick Morrisey said on Twitter on Tuesday.

Some 400,000 U.S. overdose deaths between 1997 and 2017 were linked to opioids, according to government data. Roughly 2,600 lawsuits have been brought nationwide by states, local and tribal governments.

The three distributors in a joint statement said they were committed to finalizing a global settlement and would continue working with the other parties on the details of the framework. Teva declined to comment.

J&J said in a securities filing on Wednesday the deal would lower third quarter profit by $3 billion.

The proposal, announced on Monday, was hammered out by the companies and attorneys general in North Carolina, Pennsylvania, Tennessee and Texas.

It will need broad support among state attorneys general and will have to overcome opposition from the lawyers representing local governments that sued. Those lawyers declined to sign on when presented the proposal last week.

Under the settlement framework, money for each state would be divvied up, with 15% going to the state treasury, 15% for local governments that filed lawsuits and 70% going to a proposed state fund aimed at addressing the crisis.

Boffetti predicted it would takes weeks for states to determine whether they back the settlement framework.

North Carolina's attorney general, Josh Stein, acknowledged that a detailed term sheet needs to be developed.

"There are a lot of details and mechanics that need to be added to it," Stein told Reuters in an interview. "That will happen in the coming weeks."

The proposal did win a major supporter on Tuesday. Tom Miller of Iowa, the longest-serving attorney general, publicly backed the proposal, calling the framework "an important step in addressing the crisis."

Colorado's attorney general, Phil Weiser, called it a "very promising development."

The lawsuits accuse distributors of failing to flag and halt a rising tide of suspicious orders and drugmakers of overstating the benefits of opioids while downplaying the risks…**Read More**

Courts Stop Harmful "Public Charge" Rule from Taking Effect

This month, five federal courts temporarily blocked a Trump administration final rule that would greatly harm families and prevent people with Medicare from accessing the services and supports they need to thrive. The new "public charge" policy was set to become effective on October 15, 2019, but the recently-issued nationwide injunctions will prohibit the rule from taking effect—for now.

The courts found that the administration was trying to change the public charge test in ways that Congress has rejected in the past. They also found that the new rule departed both from Congressional intent and from long-standing precedent, and that the rule would violate a law forbidding discrimination about people with disabilities.

Part of federal immigration law for over a hundred years, the public charge inadmissibility test was designed to identify people who may depend on the government as their main source of support. If the government finds that a person is "likely to become a public charge," it can deny that person admission to the United States or lawful permanent resident status.

Since the 1990s, the test only affected legal immigrants who use cash benefits or publicly funded long-term care. This has meant only an extremely small number of immigrants were affected by the public charge test. The new rule would greatly expand the ways immigrants could fall afoul of the test. Advocates, including Medicare Rights, were deeply concerned that this extension of the test would seriously harm older adults, people with disabilities, and their families, and would cause a chilling effect where people would avoid using needed benefits out of fear that they or a loved one might be barred from pursuing citizenship.

This fear has, unfortunately, been well founded. One survey, taken before the rule was even final, found that one in seven adults in immigrant families were already avoiding benefits due to concerns about the forthcoming changes, even when they were not at risk because they already had green cards or were already naturalized. This was especially prevalent in families with children in the household and families with low incomes.

The public charge test must not be allowed to interfere with access to health programs or family unification. At Medicare Rights, we urge the Trump administration to pursue policies that will make health care and other essential services more accessible, affordable, and available to those in need—not less so. We must not force immigrants to choose between citizenship or their health.

Getting Started With the New Medicare Plan Finder

The Centers for Medicare & Medicaid Services (CMS) recently launched a redesigned version of the Medicare Plan Finder. Many of the functions are the same, but the look and feel has been updated, and the way you access a personalized or basic search has changed.

Here are some highlights of the changes and a few tips and tricks to navigate the updated tool to search for Medicare Advantage and stand-alone Part D plans that work with Original Medicare.

Update 10/10/19: Medicare Plan Finder now gives you the option to sort plan search results by the combined lowest drug and premium costs. This is a helpful feature for estimating some of your out-of-pocket expenses for the year.

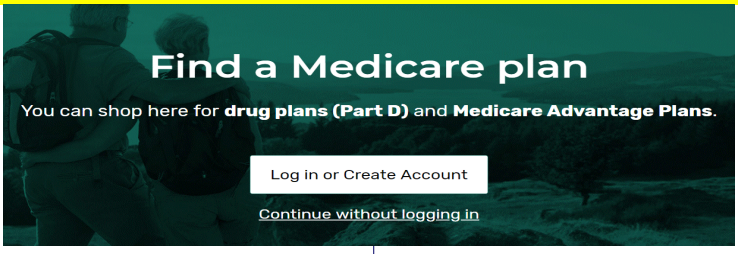
Original post 10/3/19: On the first page of Plan Finder, you have the option to do a personalized search by creating a new account or logging into your existing **www.MyMedicare.gov** account. You can also continue without logging in.

If you log in to your **www.MyMedicare.gov** acc ount, Plan Finder will use your prior claims history to put prescription drugs on your drug list and save any changes that you make.

If you continue without logging in, you will have to manually input your drugs into your drug list, and your drug list will not be saved.

If you are a professional working on behalf of a Medicare beneficiary, this type of search is useful because you do not need a beneficiary's personal health care information. Note, however, that unlike the old Plan Finder, you will not get a drug list ID that allows you or the beneficiary to access their drug list later. Drug lists are only saved if you do a personalized search.

If you are a professional working on behalf of a beneficiary, visit **CMS's National Training Program** website for more information about how to use the new Medicare Plan Finder. You will have to create an account or log in to view a recording of the September 2019 Plan Finder webinar.



CMS has also released Plan Finder tutorial videos: **Medicare Plan Finder** and **Overview and Medicare Plan Finder Pointers: Plan Results**.

Getting started: Find a Medicare plan

Let's take a look at how to do a basic Plan Finder search. To begin, click on the link that says, "Continue without logging in." This brings you to the page, shown below, that asks you what type of coverage you are looking for.

Choose a coverage option, and the page will expand with more questions to answer. You have to answer all the questions on the screen before more questions will appear. You'll have the option to search for Medicare Advantage Plans, stand-alone Part D plans, and Medigap policies (searching for Medigap policies takes you outside the Medicare Plan Finder).

Additional questions ask for your zip code, Medicare number (which is needed if you want to enroll in a plan online), and date of birth. If it is not currently Fall Open Enrollment and/or you are not in your Initial Enrollment Period (IEP), Plan Finder will let you know that you may not be able to change plans at this time. You can still continue and search for plans, though, regardless of whether there is an available enrollment period.

Next, Plan Finder asks if you receive any cost assistance. The purpose of this question is to find out whether you have **Extra Help**. If you have Extra Help, Plan Finder displays different drug costs. Answer the cost assistance question, and click "Next" to continue.

Lastly, Plan Finder asks if you want to see drug costs as part of the plan results. If you answer yes, it asks how you normally fill your prescriptions. You can choose retail pharmacy, mail-order pharmacy, or both.

Adding prescriptions to drug list

After completing the introductory questions, Plan Finder gives you the option to add prescription drugs to the search. Adding drugs will allow you to see which plans cover the your drugs and how much they might cost.

Enter the name of a drug, choose whether it is brand-name or generic, set the dosage, and add the drug to the list. After adding a drug, choose whether you want to add more drugs or click on "Done" to continue.

Tip: Before beginning a Plan Finder search, create a list of all the drugs you take, whether they are generic or brand-name, and what their dosages are.

Choosing pharmacies

After adding prescription drugs, you will have a list of pharmacies to choose from depending on the zip code you entered at the beginning of the search. Choose two pharmacies, then click "Done" to continue. If you indicated that you would like to view mail-order pharmacies as well, you will see mail-order pharmacy in the pharmacy list along with the two retail pharmacies you select.

Comparing plan options

After choosing pharmacies, Plan Finder will display available Medicare Advantage or Part D plans, depending on what you chose to search for at the beginning.

Here's what you need to know:

- Each search result displays a plan summary, such as the premium, deductible, and cost estimates. Click on the Plan Details button for each entry to learn more, like health and drug coverage specifics.
- You can compare up to three plans at a time.
- Plan details are presented all on one page. Use the menu on the left-hand side to jump to the section you want, or keep scrolling.
- Part D plan details include information about which drugs are on the plan's formulary (list of covered drugs) and which pharmacies are in-network. It also shows if there are any restrictions on the drugs, such as quantity limits. However, a beneficiary must contact a plan directly for more specific information about those coverage restrictions.
- Medicare Advantage plan details include information about covered health care services, from basic benefits like primary care visits to extra benefits such as dental cleanings or eyeglasses.

Doing sample searches is the best way to familiarize yourself with the new Plan Finder. Although the design and search process have changed, the tool still provides a lot of information about Medicare Advantage and Part D plans that you can use to guide your enrollment decisions during Fall Open Enrollment.

We will periodically update this blog post with tips and advice throughout Fall Open Enrollment.

MEDICARE RIGHTS CENTER
Getting Medicare right
Blog

H.R.3, No Republican House members have signed on to the bill

Reducing the cost of prescription drugs has become a major focus of both President Trump and Speaker of the House Nancy Pelosi (D-Calif.). We have written about the Pelosi bill (H.R.3) that is currently making its way through the House of Representatives.

The bill is controversial and as a result no Republican House members have signed on to the bill and Senate Majority Leader Mitch McConnell (R- Ky.) has indicated he will not bring the bill up for debate in the Senate even if the House passes it.

President Trump has not taken a position on the bill and in fact White House officials have met with personnel from the Speaker's office to discuss the bill. There is hope in the House leadership that the President will either support the Pelosi bill or something close to it.

However, the pharmaceutical industry has launched an all-out multi-million dollar advertising and lobbying campaign to defeat the Pelosi bill, as well as other bills now in Congress that do some of the same things the Pelosi's bill would do. You may well have seen or heard some of those ads.

There is even a fear among the big drug companies that the President will act on his own to rein in drug prices for seniors. Trump has said that he's working on a "most-favored nation" approach that also assures that Medicare Part D beneficiaries don't pay more than in European countries. The Trump administration also has worked on a pilot program that would set some drug prices based on an index reflecting prices paid in other advanced economies.

According to Investor's Business Daily, "Generally, the GOP has opposed price controls. Republicans have tended to side with Big Pharma. Both have argued that government price controls will harm private incentives to develop new cures at a high cost. Yet Trump apparently has an America First view of the issue. That's because high drug prices for Americans essentially subsidize the cost paid in other countries."

According to the Chief Executive Officer of Pharma, the big drug companies' large lobbying organization, the Pelosi bill "... creates a windfall for the government and insurance companies without providing any guarantee that patients can get the medicines they need."

He also points out that the bi-partisan Congressional Budget Office (CBO) said the plan "would result in lower spending on research and development and thus reduce the introduction of new drugs."

At the same time, however, the CBO also said the Pelosi bill could save Medicare $345 billion over a six year period.

However, Dr. Peter B. Bach, the director of the Drug Pricing Lab at Memorial Sloan Kettering Cancer Center in New York City disagrees. According to Dr. Bach, six of the largest drug companies are based in other countries, including such familiar companies as Novartis, Glaxo Smith Kline, and Astra Zeneca.

He addresses the talking points being made by Pharma, including the argument that, in his words, "U.S. patients, taxpayers, and employers must pay higher prices for medications than citizens of other countries because that is why the U.S. has successful pharmaceutical companies."

He also points out, "That Roche and Novartis are dominant players and based in Switzerland exposes the false logic of this point, as drug prices are 75% lower in Switzerland than in the U.S., according to the House Ways and Means Committee. Drug prices in France, the United Kingdom, and Japan are lower, too. The pharmaceutical industry is global, and our overpaying for medications in the U.S. explains no more of New Jersey-based Merck's successes than it does of Takeda's, half a world away."

Dr. Bach goes on to say, "Given that the countries in the Speaker's bill have longer life expectancies than the U.S., better health system performance by nearly every measure, offer all their residents health insurance, and pay less per capita for health care, that might not be a bad outcome. But, it does make me wonder what other attributes of these countries might slip across our borders. Will looking at French prices improve our wines and our men's soccer team? That would certainly be nice."

He then concludes this way: "In Washington, talking points are generally not intended to persuade anyone. Instead, they mostly serve to backfill rationales into minds that are already made up. But for prescription drugs we need serious reform of both pricing and insurance coverage. It's not just one or the other. There will be tradeoffs too, but if you want to know what they are, don't read PhRMA's talking points."

The health care system in the United States is extremely complicated and difficult to understand, much less try to explain. The arguments on both sides of the Pelosi bill, or any legislation that involves the government negotiating and/or trying to lower drug prices, are important to understand.

Medicare Rights Education Staff Present on Medicare and the Opioid Crisis

Staff from the Medicare Rights Center presented on the opioid crisis and Medicare coverage of substance use disorder treatment at the 2019 Senior Medicare Patrol (SMP) and State Health Insurance Assistance Program (SHIP) National Conference. SMPs and SHIPs are state-based agencies that assist people with Medicare and their caregivers. SMPs empower people with Medicare to prevent, detect, and report health care fraud, while SHIPs provide local and unbiased Medicare counseling. As a partner of the SHIP Technical Assistance Center, Medicare Rights provides ongoing technical assistance and training for SHIP counselors throughout the nation.

At this year's conference, Medicare Rights Senior Counsel for Education and Federal Policy Casey Schwarz and Education Coordinator Emily Whicheloe co-led a training session with the National Council on Aging (NCOA) and the West Virginia SHIP about the opioid crisis. NCOA and West Virginia SHIP representatives presented survey data and stories from the field that demonstrate how people with Medicare are affected by the opioid crisis. Schwarz and Whicheloe then explained what services Medicare covers—and does not cover—to treat substance use disorders. They outlined policies that Medicare has put in place to address potential opioid misuse, including safety checks at the pharmacy and drug management programs for certain at-risk beneficiaries. Schwarz also spoke about possible policy changes, such as expanded Medicare coverage for medication-assisted treatment for substance use disorders.

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

For Seniors, Financial Woes Can Be Forerunner to Alzheimer's

Unpaid bills, overdrawn accounts, dwindling investments: When seniors begin experiencing fiscal troubles, early dementia or Alzheimer's disease could be an underlying cause, researchers say.

In the early stages of the disease, people with undiagnosed Alzheimer's are at high risk of making foolish and dangerous decisions about their finances, mostly because families may not know they need help, researchers say.

"Individuals often aren't diagnosed early enough, and it's a perfect storm," said study author Carole Gresenz, a professor of health systems administration at Georgetown University in Washington, D.C.

"They're vulnerable to large reductions in liquid assets because they're not making wise decisions about their finances, savings and checking accounts.

This can also reduce net wealth," added Gresenz.

Ruth Drew, director of information and support services for the Alzheimer's Association, pointed out that Alzheimer's destroys the brain.

"As the disease progresses, everyone with Alzheimer's will reach a point where they need help with their finances and ultimately assistance with daily tasks and around-the-clock care. We have certainly spoken to people whose finances were significantly affected," she said.

In some cases, people responsible for making major financial decisions, either at work or at home, were unaware of their own mental decline, added Drew, who wasn't involved with the study.

"Others around them either did not notice or did not feel they could alert the family until there was already significant financial impact," she said. "By the time we met them, family members were facing the challenges of caring for a person with far fewer financial resources than expected."

The new study linked Medicare fee-for-service claims data and the national Health and Retirement Study of Americans over the age of 50 for the years 1992 to 2014. The health and retirement study included questions about households' financial assets and liabilities.

The sample included nearly 8,900 U.S. households, of which nearly 2,800 included someone with Alzheimer's or related dementia. In these households, the financial "head of the household" had the thinking disorder in 73% of them.

Gresenz said declining financial skills associated with Alzheimer's may mean unpaid bills, overspending on credit cards or paying too little attention to investments and other forms of wealth. Impaired money sense also makes the elderly more vulnerable to fraud and scams.

The bottom line: "Living in a house with early-stage AD puts both the patient and family members at heightened risk of a large reduction in liquid assets -- money that's easily accessible, like checking, savings, money markets, bonds and stocks," Gresenz explained. "One reason this is so concerning is that these core financial outcomes are occurring just prior to a time when they will have substantial costs placed on them."...**Read More**

Too Many Seniors Back in Hospital for Infections Treated During First Stay

The rate of hospital readmissions for seniors with infections that were first treated during their initial hospital stay is too high, researchers report.

"We found that as many as 5% of patients leaving the hospital with an infection have a readmission for that pre-existing infection -- that's bad," said Geoffrey Hoffman, an assistant professor in the University of Michigan's School of Nursing, in Ann Arbor.

Hoffman led a team that analyzed Medicare data on more than 318,000 hospital discharges for patients aged 65 and older. Overall, 2.5% of them were readmitted for a pre-existing infection.

The most common type of pre-existing infection in the patients was *C. difficile* (about a 5% readmission rate) -- which causes diarrhea and colitis, and is potentially deadly -- followed by urinary tract infections (2.4% readmission rate).

While it may seem small, the overall 2.5% readmission rate for pre-existing infections is too high when you consider that hospitals know how to treat these infections and knew patients had the infections at discharge, Hoffman explained.

"Presumably they've been treated for the infection since the hospital has already billed Medicare," he said in a university news release. "Readmissions shouldn't be zero, but they should be much closer to zero."

The researchers were surprised to find that patients discharged to home care (with home care provided by an agency) or discharged home (without home health care) were 38% more likely to return with a linked infection than those discharged to skilled nursing facilities.

"This is somewhat conflated with the conventional wisdom, which is that skilled nursing facilities are warehouses for infection transmission," Hoffman said.

However, while infections spread at high rates in skilled nursing homes, they're also adept at treating them, according to the researchers.

"There are probably some gaps in self-care for patients going home with an infection from the hospital," Hoffman said. "This suggests home health care agencies aren't up to snuff with infection control, and patients going home without home health care probably need better training, as do their caregivers."

Of the patients in the study, 50% were discharged to a skilled nursing facility, 26% to home health care and 24% to home.

The study was published online Oct. 23 in the *Journal of the American Geriatrics Society*.

To reduce the risk of hospital readmission, patients and family members should keep asking questions until they fully understand discharge instructions, Hoffman advised.

More information

The Family Caregiver Alliance offers a **hospital discharge planning guide**.

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Meet SCAD, a Major Cause of Heart Attacks in Women 50 and Under

If someone asked you to picture a heart attack patient, you might imagine an older man clutching his chest. In reality, every year an estimated 445,000 U.S. women 35 and older will experience a new heart attack, recurrent heart attack, or fatal outcome of coronary heart disease (which, in addition to heart attack, can cause issues like heart failure). A major cause of heart attacks in women is SCAD, or spontaneous coronary artery dissection. And the strangest thing about SCAD: It most commonly affects otherwise healthy women in their 40s and 50s.

In this article, we'll be discussing how SCAD is known to be more prevalent in people who were assigned female at birth. We do not have data on whether or not hormonal or surgical transitioning has any effect on SCAD risk, but it is likely that this elevated risk also extends to trans men. While we refer to women throughout this article (particularly because gender bias is a known factor when it comes to diagnosing and treating heart attacks), it's important to remember that you do not necessarily need to identify as a woman to be at a greater risk of SCAD.

- **How SCAD causes a heart attack**
- **Symptoms of heart attacks caused by SCAD**
- **How hormones and pregnancy play a role in SCAD**
- **How stress and mental health play a role in SCAD**
- **Other known risk factors for SCAD**
- **Taking SCAD symptoms seriously**

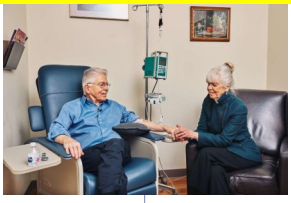
Read More on each of the above

How Biogen's Experimental Alzheimer's Drug Was Resurrected From the Dead

"My first reaction was to be angry," says JoAnn Wooding. "I've gotten over that, and frustration is more the word right now."

Wooding's husband, Peter, who was diagnosed with Alzheimer's in 2016, was among the more than 3,200 people with the disease **who volunteered to tes**t a promising drug called aducanumab. Made by **Biogen,** a U.S. biotech company, and Eisai, a Japanese pharmaceutical manufacturer, the drug seemed, **in early studies** released the same year, to be the first to both shrink deposits of the protein amyloid accumulating in the brains of patients with Alzheimer's, and to slow the cognitive decline resulting from their buildup. The study in which Peter was participating was one of two trials designed to confirm that early promise, and, patients and doctors hoped, lead to the first approved treatment that could actually halt the neurodegenerative disease.

But last March, Biogen, after an early review of its data involving half of the patients, decided that the results were not promising enough to continue the trial, and **terminated it.** Peter and the other volunteers stopped taking the experimental drug and the company began an in-depth analysis of the data it had collected so far.



Its **full report**, which included all 3,285 patients, revealed a rosier picture. After 18 months of taking aducanumab, participants in one of the studies showed anywhere from 15% to 27% less cognitive decline, as measured by standard tests of memory and cognitive ability, compared to those receiving a placebo. The cognitive protection was most pronounced in those getting the highest dose of the drug. Based on the latest analysis, the company is now asking the Food and Drug Administration to approve aducanumab for the treatment of early Alzheimer's disease.

"In retrospect, the…analysis [last spring] was incorrect," says Dr. Alfred Sandrock, chief medical officer at Biogen. "But based on the data we had at the time, we followed the science and made the decision to terminate the studies. With the additional data and the additional analysis, we now know the drug has efficacy."

The news is bittersweet for the Woodings, who now feel they have lost precious time in holding off the disease ravaging Peter's brain. After being randomly assigned to receive either aducanumab or a placebo once a month for 18 months, all of the volunteers were then given the opportunity to receive the drug for at least a year. Peter had completed his 18-month test period and had received his fifth infusion of the active drug when Biogen pulled the plug.

"When he was off the drug, there were some changes that came rather quickly, with his short-term memory being the most affected," says JoAnn. "Over time I could see a difference without the drug."

How could the two different reviews of the data lead to such startlingly different conclusions? After all, the early phase study of aducanumab was encouraging enough to prompt the company to launch the large, late-stage studies in 350 sites in 20 countries in which Peter participated. The drug seemed to have a unique way of finding and sticking to clumps of amyloid protein, and signaling the body's immune cells to destroy them.

The conclusion of the data from the first half of patients that emerged in March 2019 was undeniable. There was no statistically significant difference between the cognitive test results from those who had received monthly infusions of aducanumab for 18 months and those who received a placebo. And the drug did have side effects, the most worrisome one being brain inflammation that could be life-threatening. Rather than risk exposing people to the risk of side effects with no perceivable benefit, Biogen CEO Michel Vounatsos decided to terminate the studies.

"The decision was driven by the interests of the patients—to not expose them to a product that the data deemed to be ineffective," Vounatsos says.

For Sandrock, who had been working with aducanumab since 2007, "The first few weeks after that decision were pretty tough for me. I would meet with the team weekly and say, 'Are we sure the drug doesn't work?' And they said, 'Look at the data. Face facts.'"

Samantha Budd Haeberlein, head of Biogen's late-stage clinical development for Alzheimer's Disease, was equally dumbfounded, even annoyed. "As a scientist, I was completely confused," she says. "How could it be, when we had such clear data form the [early] clinical trial, such compelling data? How could this have happened? The scientist in me was really irritated—what the hell happened?" ...**Read More**

More Patients With Heart Disease Die at Home Than in Hospital

Nearly a third of U.S. heart patients die at home, which is more than the number who die in the hospital, according to a new study.

Researchers examined data on more than 12 million heart disease patients who died between 2003 and 2017. They looked at whether the deaths occurred in a hospital, home, nursing or long-term care facility, inpatient hospice, or elsewhere (outpatient medical facility, emergency department, or dead-on-arrival at the hospital).

The number of heart disease deaths in the hospital fell from nearly 331,000 in 2003 to nearly 235,000 in 2017. Home deaths, meanwhile, rose from almost 193,000 to over 265,000, accounting for about 31% of heart disease deaths in 2017.

"When I talk to my patients about what's most important to them as they begin to reach the end of life, so many of them tell me they want to spend their last moments surrounded by the familiarity of home," said study author Dr. Haider Warraich, a cardiologist at Brigham and Women's Hospital in Boston.

Patients in underserved racial and ethnic groups were more likely to die in the hospital and less likely to die at home, according to the findings. Heart disease is the leading cause of death worldwide, but little is known about where patients die, according to the researchers.

"Understanding where patients die can help us determine how we can deliver care to them and what services they'll require in those settings," Warraich explained in a hospital news release.

While the data show where patients died, it doesn't reveal what their last days or weeks of life were like, their wishes and whether their place of death reflected those wishes, Warraich noted.

"Cardiology has lagged behind other specialties in focusing on end-of-life care, but we're now seeing more interest in this important area," he said.

"We're seeing that more people are dying at home than at any other location, but we need to better understand what that experience is like so that we can focus our energy on the needs of our patients," Warraich said.

The study was recently published in the *Journal of the American College of Cardiology*.

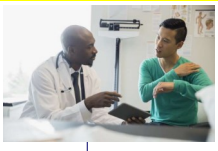
The U.S. Centers for Disease Control and Prevention outlines **heart disease risk factors**.

Questions to Ask a Pain Management Doctor

Pain management specialists are doctors who can diagnose and treat chronic pain. This is pain that you may have for more than three months that isn't getting better. Although you may try some self-care at home or see your primary care doctor for pain when it first develops, you usually would see a **pain management physician** for pain that doesn't go away.

Here are a few examples of the types of pain managed by **pain management** specialists:

- **Back pain**.
- Neck pain.
- **Headaches**/migraines.
- Arm or leg pain.
- Abdominal pain.
- Pelvic pain.
- Nonspecific **joint pain**.
- Pain related to a failed surgery.
- Pain related to cancer.



"The most common pain syndrome is probably back and neck pain," says Dr. Edward M. Ellison, co-CEO of The Permanente Federation, LLC, which is the national leadership organization for the eight Permanente Medical Groups across the U.S.

- Preparing for a pain management appointment
- Keep a pain diary.
- Other ways to prepare for your appointment
- Have you seen this before in other patients?
- What's causing my pain?
- What are my treatment options?
- Who else will be involved with my care?
- Are there any red flags with this type of pain?
- What can I do for self-care and to improve my pain?

Click through the slide show to learn more.

What you should know about ayahuasca, a psychedelic drug

Casey Schwartz reports for the **New York Times** that many Americans, including many older adults, are taking ayahuasca, a psychedelic drug, native to the Amazon, that is illegal in the United States. Indeed, ayahuasca, pronounced aa·yuh-waa-skuh, which you take as a drink, has become popular across the globe.

Ayahuasca is not a new drug. People have taken it for many hundreds of years as part of religious traditions in Central and South America. It's active ingredient is N-Dimethyltryptamine or DMT. But, there is little data about its effects on older adults.

Today, people from around the world travel to Peru, Mexico and other faraway places to find ayahuasca. That said, it sounds like a challenging drug, which causes hallucinations and excretions of many types, including vomiting and diarrhea.

Michael Pollan provides a history of psychedelics and his experiences using them in his bestselling new book, "How To Change Your Mind." He believes that psychedelics may offer especial value to older adults. "[P]sychedelics seem to be particularly good for … jogging us out of our grooves of habit and allowing us to acquire a fresh perspective on familiar things. And as you get older, you get mired in habits."

Pollan further believes that ayahuasca allows people to work through their feelings about death. "And with ayahuasca in particular, which can sponsor some pretty dark journeys, people often come back with insights about death." Others say that ayahuasca helps older adults find their purpose and combat mental angst and depression.

But, ayahuasca also has risks. People with heart problems such as arrhythmia likely should stay clear of it. So should people on SSRI anti-depressants.

If you are considering taking ayahuasca, keep in mind that you should not expect it to bring you joy; it can be extremely painful emotionally as well as physically.

FDA investigating whether Zantac causes carcinogens to form in users

The U.S. Food and Drug Administration is investigating whether the popular heartburn drug Zantac causes carcinogens to form in the bodies of users, in an effort to fully understand the risks posed by the already recalled drug, the agency's spokesman said on Thursday.

The issue of whether ranitidine, commonly known as Zantac, causes levels of the probable carcinogen N-nitrosodimethylamine (NDMA) to rise in users' bodies has been raised previously by Valisure, an online pharmacy that originally flagged the potential contamination of ranitidine to the FDA.

Zantac, sold over-the-counter in the United States by French drugmaker Sanofi SA (SASY.PA), and some of its generic versions, have been recalled due to possible NDMA contamination of pills that had not yet been consumed. The FDA said earlier this month it found unacceptable levels of NDMA in drugs containing ranitidine.

But FDA spokesman Jeremy Kahn said the regulator is now "working to understand what happens to NDMA levels in the body, after ranitidine has been exposed to acid in the stomach."

Zantac has been on the market for more than 35 years and was originally sold by Glaxo Holdings Ltd, now a part of GlaxoSmithKline PLC. (GSK.L) At one point it was the top-selling drug in the world.

Representatives of GSK and Sanofi were not immediately available for comment.

Valisure's Chief Executive David Light said it was important that the FDA is investigating the issue because the company's data suggests the NDMA levels that can be formed in the body "are many magnitudes of order higher than what's been talked about in the contamination."

"This is one of the main red flags we've raised the whole time — not just contamination but the fact that this is happening in the human body," Light said.

Sanofi said last week it would recall the drug in the United States and Canada. Other drugmakers including GlaxoSmithKline and Novartis (NOVN.S) have recalled or halted distribution of their versions of the drug.

Retailers including Walmart Inc (WMT.N), CVS Health Corp (CVS.N), Walgreens Boots Alliance Inc (WBA.O) and Rite Aid Corp (RAD.N) have stopped selling ranitidine.

The FDA said on Wednesday that early tests of alternatives to Zantac such as Pepcid, Tagamet, Nexium, Prevacid and Prilosec have not been found to contain NDMA.

NDMA had previously been found in some blood pressure medicines from a class of drugs known as angiotensin II receptor blockers. Those impurities are believed to have been introduced by recent changes in the manufacturing process.

Does Medicare cover dental care?

Dear Marci,
I'm new to Medicare and would like to know about what benefits are covered. Does Medicare cover dental care?
-Anthony (Providence, RI).

Dear Marci

Medicare does not cover dental services that you need primarily for the health of your teeth, including but not limited to:

- Routine checkups
- Cleanings
- Fillings
- Dentures (complete or partial/bridge)
- Tooth extractions (having your teeth pulled) in most cases

If you receive dental services, you will be responsible for the full cost of your care unless you have private dental coverage or are utilizing a **low-cost dental resource**. Again, Medicare will not pay for or reimburse you for dental services you receive primarily for the health of your teeth.

Note: Some **Medicare Advantage Plans** cover routine dental services, such as checkups or cleanings. If you have a Medicare Advantage Plan, contact your plan to learn about dental services that may be covered.

While Medicare does not pay for dental care needed primarily for the health of your teeth, it does offer very limited coverage for dental care needed to protect your general health, or for dental care needed in order for another Medicare-covered health service to be successful. For instance, Medicare may cover:

An oral examination in the hospital before a kidney transplant

An oral examination in a rural clinic or Federally Qualified Health Center (FQHC) before a heart valve replacement

Dental services needed for radiation treatment for certain jaw-related diseases (like oral cancer)

Ridge reconstruction (reconstruction of part of the jaw) performed when a facial tumor is removed

Surgery to treat fractures of the jaw or face

Dental splints and wiring needed after jaw surgery

It is important to know that while Medicare may cover these initial dental services, Medicare will not pay for any follow-up dental care after the underlying health condition has been treated. For example, if you were in a car accident and needed a tooth extraction as part of surgery to repair a facial injury, Medicare may cover your tooth extraction—but it will not pay for any other dental care you may need later because you had the tooth removed.

Medicare also covers some dental-related hospitalizations. For example, Medicare may cover:

Observation you require during a dental procedure because you have a health-threatening condition

In these cases, Medicare will cover the costs of hospitalization (including room and board, anesthesia, and x-rays). It will not cover the dentist fee for treatment or fees for other physicians, such as radiologists or anesthesiologists. Further, while Medicare may cover inpatient hospital care in these cases, it never covers dental services specifically excluded from **Original Medicare** (like dentures), even if you are in the hospital.

If you need dental care, look into resources or other forms of insurance that may help pay for dental services. You can also use **FAIR Health's consumer cost lookup tool** to get an estimate for the amounts dental professionals usually charge in your area for different services.

-Marci

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Family Can Help Keep Delirium at Bay After Surgery

Many older hospital patients suffer delirium after surgery, but a new program that involves the patient's family in recovery may help, a new study suggests.

Called the Tailored, Family-Involved Hospital Elder Life Program (t-HELP), it appears to help lessen the burden of postoperative delirium while maintaining or improving physical and thinking functions, and shortening the time patients spend in the hospital.

"Family involvement through t-HELP may be cost-effective, by providing psychological and emotional support to older patients undergoing treatment in hospitals without adding extra costs," said researcher Yanyan Wang, a post-doctorate fellow at the University of Texas at Austin.

Postoperative delirium is a common problem after an operation, especially among older patients. Patients suffering from it may have problems understanding what is happening to them. They may say things that don't make sense or have hallucinations. They may also be afraid or anxious.

That's where the t-HELP program comes in. The program adds family members to a team of nurses and volunteers who help patients recover after an operation.

Having family members with the patient most of the time helps relieve the patient's anxiety and confusion about being in a strange place. They can also help the patient understand delusions that might crop up in dreams, the researchers explained.

Bringing familiar things from home like blankets, photos or a clock can help patients re-orient themselves. Also, being sure they have their glasses or hearing aids can help reduce confusion about what's happening to them, the study authors said.

In addition, family members can help the patient eat and walk, and get on the road to recovery. They can also intervene if they feel special help is needed, and act as an advocate for their relative.

The program is tailored to each patient's risk factor profile so that each patient has a customized menu of interventions, Wang said.

For the study, Wang and colleagues randomly assigned patients in West China Hospital in Chengdu, China, to t-HELP (152 patients) or regular care (129 patients) after surgery from August 2015 through February 2016. Patients had a variety of operations including on the stomach, colon, pancreas, chest and thyroid.

In all, four patients in the t-HELP group developed postoperative delirium compared with 25 in the usual care group. Patients in the t-HELP group also showed less decline in physical and mental function, and spent less time in the hospital than those who didn't receive the special help, the findings showed.

The report was published online Oct. 21 in *JAMA Internal Medicine*.

Dr. Teresa Amato is chair of emergency medicine at Northwell Health's Long Island Jewish Forest Hills, in Forest Hills, N.Y. Commenting on the study, she said, "The elderly postoperative patient faces many challenges during recovery and more than 10% will experience an acute episode of delirium."

Delirium can pose hazards, such as increased risk of falls, and psychological stress for the patient and the family, she added.

"This study is exciting in that the intervention included not only medical personnel, but also had family and caregivers as an essential part of the care," Amato said.

More information

For more on how family members can help patients, head to the **Hospital Elder Life Program**

Choose below to learn more:

- **About Delirium**
- **What You Can Do**
- **Resources**

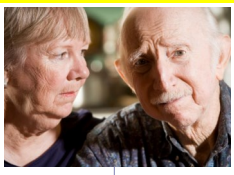
Banned Trans Fats Linked to Higher Dementia Risk: Study

A diet high in trans fats could put you at increased risk for dementia, a new study suggests.

Most trans fats were banned in the United States last year. But foods with less than a half-gram of trans fats can be labeled as containing zero, so some foods still contain them.

The new study included over 1,600 people in Japan without dementia. Their average age was 70, and they were followed for an average of 10 years. During that time, 377 of them developed dementia.

Of the 407 who started the study with the highest levels of trans fats in their blood, 104 developed dementia, a rate of 29.8 per 1,000 person-years. (A "person-year" is a formula that accounts for the number of people in a study and how long they were followed.)



Among those with the second-highest level of trans fats, the rate was 27.6 per 1,000 person-years. The rate was 21.3 among those with the lowest trans fat levels in their blood.

After adjusting for other dementia risk factors -- such as high blood pressure, diabetes and smoking -- the researchers concluded that compared to study participants with the lowest levels of trans fats, dementia risk was 52% more likely among those with the highest levels.

Foods that contributed the most to high blood levels of trans fats included sweet pastries, margarine, candies and caramels, croissants, non-dairy creamers, ice cream and rice crackers, according to the study published online Oct. 23 in the journal *Neurology*.

"These results give us even more reason to avoid trans fats," said lead author Toshiharu Ninomiya, a professor of epidemiology and public health at Kyushu University in Japan. "In the United States, the small amounts still allowed in foods can really add up if people eat multiple servings of these foods, and trans fats are still allowed in many other countries."

Ninomiya noted in a journal news release that the World Health Organization has called for trans fats to be eliminated worldwide by 2023.

"These public health efforts have the potential to help prevent dementia cases around the world, not to mention the decrease in heart disease and other conditions related to trans fats," Ninomiya said.

More information

The American Heart Association has more on **trans fats**.