Health & Retirement Services Of Illinois

April 2011 Newsletter

OUR NEWS LETTER

# Medicare won't fund MRIs for patients with new MRI-safe pacemakers

By Christopher Snowbeck
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Updated: 02/25/2011 09:34:00 PM CST

Hospitals across the country have been cranking out news releases this week about patients who are among the first to receive a new MRI-safe pacemaker from Medtronic.

But Medicare patients with the devices might get stuck with the bill should they need an MRI, doctors say.

The Centers for Medicare and Medicaid Services on Thursday issued a memorandum saying Medicare still won't pay for MRIs in patients who have pacemakers — including those with devices deemed MRI-safe.

In the memorandum, CMS officials said the health insurance program will start paying for scans in pacemaker patients who participate in certain clinical trials. But government reviewers didn't have time to pass judgment on the new Medtronic product, which is called Revo and was approved by U.S. Food and Drug Administration earlier this month.

For years, Medicare has had a policy denying payment for MRI exams in pacemaker patients due to safety concerns about how the technologies interact. The memo issued this week came in response to a doctor's request for Medicare to reconsider the policy.

"FDA approved the first pacemaker for use during certain MRI exams on Feb. 8," the CMS officials wrote. "This approval ... was too late for CMS to adequately review the evidence to address coverage for MRI for patients that may obtain this device."

On Friday, Medtronic submitted a formal request for Medicare to reconsider the policy once again, said Bob Thompson, the company's senior director

for reimbursement, economics and health policy. CMS must rule on the request within nine months, although Thompson hopes an answer will come sooner.

"We've asked that they consider granting payment for MRIs for people with pacemakers that have been developed specifically for use in the MRI environment

## In Our Newsletter

and labeled as such by the FDA," Thompson said.

MRI is a test that uses a powerful magnetic field and computer to produce detailed pictures inside the body to diagnose ailments. The cost of a test depends on the body part being scanned; in 2009, Medicare paid about $500 for an MRI of the lower back.

Some commercial insurers on Friday said they likely would pay for MRI tests on patients with the new heart device.

"We would not deny payment for an MRI done on a patient with an MRI-safe pacemaker," said Dr. Patrick Courneya, a medical director for Bloomington-based HealthPartners.

Greg Bury, a spokesman for Minnetonka-based Medica, said: "We think the MRI-safe pacemakers are a good thing."

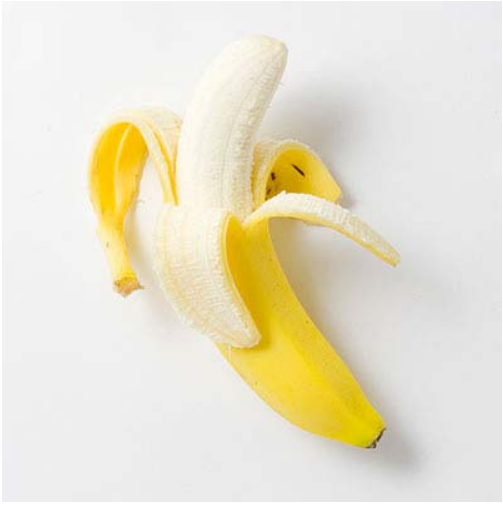
Medtronic estimates that some 200,000 pacemaker patients in the U.S. must go without MRI scans each year because of potential problems between the devices and the scanners. Analysts believe the MRI-safe device — the first such product approved for use in the U.S. — will help Medtronic gain customers in the $4 billion pacemaker market.

Pacemakers with advanced features often sell for close to $6,500, analysts say. Adding MRI-safe technology to the devices could add between 5 percent and 10 percent to the price tag.

# THE BEST FOOD FOR BEATING HUNGER

**Bananas: The ultimate hunger buster**

- by Health.com, on Tue Feb 22, 2011 10:36am PST



*By Shaun Chavis*

Ever grab a snack but then feel hungry again 20 minutes later? Next time, reach for a banana. It's loaded with Resistant Starch (RS), a healthy carb that fills you up *and* helps to boost your metabolism. Slightly underripe medium-sized bananas have 12.5 grams of RS—more than most other foods. Ripe bananas give you 4.7 grams of RS, still enough to keep hunger pangs away. Check out these tasty ways to work in this wonder food.

Health.com: 8 reasons carbs help you lose weight

**Banana "Ice Cream"**
Peel, slice, and freeze 1 small **banana**. Place frozen banana pieces in a blender with 3 tablespoons **1% low-fat milk**; blend until thick. Top with 1 tablespoon **chopped walnuts**.

**Banana Salsa**
Make a quick salsa with 2 **diced peeled bananas**, 2 tablespoons minced **red onion**, 1 tablespoon minced **cilantro**, 1 teaspoon minced **serrano or jalepeno pepper**, juice of 1 **lime**, and **brown sugar** and **salt** to taste. Use it to top fish or pork tacos, jerk chicken, or jerk pork.

Health.com: 8 tasty taco recipes

**Broiled Bananas**
Slice 1 **peeled banana** in half lengthwise. Put banana pieces, cut sides up, on a rimmed baking sheet. Sprinkle the banana pieces with 1 teaspoon **brown sugar**, and broil on high until the sugar bubbles and the bananas brown (about 2–3 minutes). After broiling, sprinkle with **cinnamon**—or drizzle with 1 teaspoon **rum** for an extra-special treat.

Health.com: Surprising health benefits of cinnamon

**Coffee and Banana Smoothie**
Place 1 sliced **peeled banana**, 1 cup **1% low-fat milk**, 1/2 cup **cold black coffee**, 2 teaspoons **sugar**, and 1/2 cup **ice** in a blender. Blend until smooth—and enjoy.

Health.com: 11 healthy milk shakes and smoothies

**Tropical Fruit Salad**
Make a fruit salad with 1 sliced **peeled banana**, 1 sliced peeled **kiwi**, and 1/2 diced peeled ripe **mango**. Squirt juice of 1/4 **lime** over the salad, and serve.

# State employers get nearly $41M for early retiree health

ASSOCIATED PRESS Mar 3, 2011 6:42AM

A federal report shows employers in Illinois received nearly $41 million last year to help them maintain health care coverage for early retirees.

The federal funding comes from a program created by the Affordable Care Act, the national health care law. In Illinois, 337 employers have been accepted into the early retiree program.


It helps pay a portion of health costs for early retirees and their spouses, surviving spouses and dependents.

Illinois-based companies getting subsidies through the program include Abbott Laboratories, McDonald's Corp., Sara Lee Corp. and Deere & Co.

Cities, counties, universities and non-profit groups also are getting help for their early retiree health coverage through the program.

# Pharmacists Fight the Rise of Mail Order

**By REED ABELSON and NATASHA SINGER**

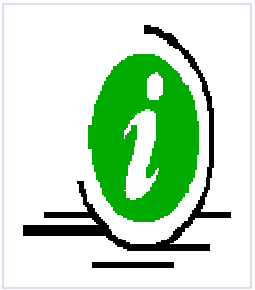
**Published: March 3, 2011**

A fierce battle is being waged between retail pharmacists and mail-order companies over where people should be able to fill their long-term prescriptions.

**Dan Cappellazzo for The New York Times**

Dennis C. Galluzzo, an independent pharmacist, said he had to fight mail-order plans to fill patients' prescriptions at his store.

Community pharmacists in New York are lobbying state lawmakers to pass legislation that would prevent health plans from requiring patients taking medications for chronic ailments to fill their prescriptions through the mail.



While some plans had shifted to mail delivery long ago because it was often cheaper for both employers and consumers, drugstores have been offering more competitive prices and pushing lawmakers to level the playing field by ensuring that people can still visit their local pharmacy for their drugs.

The proposed legislation, which was introduced in both state chambers in late February, would ban mandatory mail-order programs.

It would also forbid plans from demanding that people pay more for drugs if they buy them at the drugstore. “What we are asking is to make mail order an option, not mandatory,” said Craig M. Burridge, the executive director of the Pharmacists Society of the State of New York, whose members traveled to Albany on Wednesday to plead their case. “We are not opposed to mail order as a convenience to the patients. But right now, they don’t have a choice.”

Pennsylvania is considering similar legislation. The federal Medicare program already requires drug benefit plans to allow members the option of filling their prescriptions at the drugstore.

In making their argument, the pharmacists say some people, particularly the elderly who are taking multiple medications, benefit from going into a store and having a pharmacist oversee their prescriptions. They say many customers prefer being able to shop at places where they have longtime relationships with pharmacists.

The large companies that manage prescription drug programs, known as pharmacy benefit managers, say mail order is attractive because it is less expensive and more convenient.

"There's going to be use of more home delivery, not less," said Mark Merritt, the president of the Pharmaceutical Care Management Association, which represents the pharmacy benefit managers. "It saves money and is pretty popular with consumers." He says employers choose mail-order programs because they believe them to be a better alternative, and the legislature should not take away their choice of plans.

But as the business of filling prescriptions also shifts from expensive branded pharmaceuticals to much cheaper generic alternatives, retail pharmacists, particularly large chains like Walgreen's, are having much more success in persuading employers and health plans to allow people the choice of using drugstores for their medications for chronic ailments.

To increase sales at their stores, "retail pharmacies can offer and compete with mail order" by being willing to make less profit on the prescriptions they fill, said Adam J. Fein, an industry consultant in Philadelphia. "They are essentially trying to offer these products at mail-order pricing," he said.

The decision by Wal-Mart several years ago to offer generic drugs for only $4 and the move by retailers to compete aggressively on price has damped the enthusiasm for mail order as the least expensive option, Mr. Fein said. Medicare's insistence on including retail drugstores as an option has also helped slow the growth in prescriptions being filled by mail-order pharmacies, which he said lost market share in 2009.

Mr. Fein also points to Walgreen's new marketing campaign, promoting its ability to fill prescriptions for the 90 days, the same as mail order. Walgreens, which claims many customers do not know their plans allow them to get three months' worth of medicine at a drugstore, says it filled nearly 700,000 more 90-day prescriptions in January than it did at the same time last year.

Some benefit managers say they are now less convinced that mail is always better than retail, even in trying to save money. "I don't know if mail service is a vastly superior cost containment tool today," said David R. Kwasny, the president of Restat, an independent pharmacy benefit manager that does not have a mail delivery service. He says employers and insurers can instead try to steer patients to certain retail pharmacists, including independent stores, that are willing to compete on price.

But he also emphasized the personal touch of a retail pharmacist. "We feel there's a lot of value and underutilization behind the pharmacy counter," he said.

Take the case of an elderly patient who came into Family Medical Pharmacy, an independent drugstore in Williamsville, N.Y., near Buffalo. The patient had run out of Aricept, to treat dementia. She had already been to a chain drugstore where the pharmacists told her they could not help because she had mandatory mail-order prescriptions. Dennis C. Galluzzo, a pharmacist who is the co-owner of Family Medical Pharmacy, said he called her plan to try to get permission to refill her prescription.

"I relentlessly stayed on the phone for hours until we finally get it resolved and had to get an override from two supervisors," he said. Only after he threatened to send the woman to a hospital to get the medication did the plan give the drugstore permission to fill her prescription, he said.

For their part, the prescription benefit managers say mail-order programs are better able to convert a patient to a less expensive generic drug, and that the plans they offer are better equipped to oversee a patient's prescriptions.

Because these companies have invested in sophisticated computer systems to monitor all prescriptions, they argue they can intervene when someone is taking drugs that interact. If a patient has a particular question and needs privacy, they can simply telephone one of the plan's pharmacists. In a drugstore, someone may feel rushed or uneasy about asking a question. "It's just not an optimal environment," said Timothy C. Wentworth, a senior executive at Medco Health Solutions, a large pharmacy benefit manager.

Some companies, however, are trying to develop programs that provide more flexibility. CVS Caremark, for example, has made use of its CVS retail drugstore chain to offer a program called maintenance choice, where people can go to one of their stores or use mail order to fill a long-term prescription. Express Scripts says it has developed a program that allows customers to choose whether to use mail order for all or some of their medications, and many people decide they would rather have their drugs delivered.

And while mandatory programs are still relatively rare, consultants say employers are increasingly likely to use financial incentives to try to steer workers to the least expensive options. In some cases, plans may have programs where customers pay less when they go to a limited network of retail pharmacists that are willing to offer less expensive prices or they may ask customers to pay more when they go to the drugstore.

Edward A. Kaplan, a benefits consultant with the Segal Company, recalls a recent client that instituted a co-payment when any of its employees used a retail pharmacist to fill a long-term prescription. Many of the employees happily paid for the privilege. “They didn’t vote with their wallets,” he said.

# 5 health reasons to not quit coffee

By Kerri-Ann Jennings, M.S., R.D., Associate Nutrition Editor at *EatingWell* Magazine

I really like coffee. The morning ritual of brewing a cup, the smell that perks me up before I take a sip and, of course, the flavor all make it my favorite beverage aside from water (water's delicious!). As a registered dietitian and a nutrition editor for EatingWell Magazine, I know that coffee is fine in moderation. It has lots of antioxidants and is low in calories if you don't load it up with cream and sugar. Nonetheless, I always feel slightly guilty about drinking it—you know, in a "it's so good, it must be bad" kind of way.

**Don't Miss: 5 "Bad" Foods You Should Be Eating**

Which is why I'm always delighted to hear of new reasons that coffee is good for your health...and there are plenty! Over 18,000 studies on coffee have been published in the past few decades, revealing these benefits, many of which Joyce Hendley wrote about in the March/April issue of EatingWell Magazine:

**Recipes to Try: Hot Fudge Pudding Cake and Other Coffee-Infused Recipes**
**Don't Miss: How to Brew a "Greener" Cup of Coffee**

**1. It protects your heart:** Moderate coffee drinkers (1 to 3 cups/day) have lower rates of stroke than noncoffee drinkers, an effect linked to coffee's antioxidants. Coffee has more antioxidants per serving than blueberries, making it the biggest source of antioxidants in American diets. All those antioxidants may help suppress the damaging effect of inflammation on arteries. Immediately after drinking it, coffee raises your blood pressure and heart rate, but over the long term, it actually may lower blood pressure as coffee's antioxidants activate nitric acid, widening blood vessels.

**2. It diverts diabetes**: Those antioxidants (chlorogenic acid and quinides, specifically) play another role: boosting your cells' sensitivity to insulin, which helps regulate blood sugar. In fact, people who drink 4 or more cups of coffee each day may have a lower risk of developing type 2 diabetes, according to some studies. Other studies have shown that caffeine can blunt the insulin-sensitivity boost, so if you do drink several cups a day, try mixing in decaf occasionally.

**Must-Read: 4 Diet-Busting Coffee-Shop Drinks (and What to Drink Instead)**

**3. Your liver loves it**: OK, so the research here is limited, but it looks like the more coffee people drink, the lower their incidence of cirrhosis and other liver diseases. One analysis of nine studies found that every 2-cup increase in daily coffee intake reduced

liver cancer risk by 43 percent. Again, it's those antioxidants—chlorogenic and caffeic acids—and caffeine that might prevent liver inflammation and inhibit cancer cells.

**4. It boosts your brain power**: Drinking between 1 and 5 cups a day (admittedly a big range) may help reduce risk of dementia and Alzheimer's disease, as well as Parkinson's disease, studies suggest. Those antioxidants may ward off brain cell damage and help the neurotransmitters involved in cognitive function to work better.

**5. It helps your headaches**: And not just the withdrawal headaches caused by skipping your daily dose of caffeine! Studies show that 200 milligrams of caffeine—about the amount in 16 ounces of brewed coffee—provides relief from headaches, including migraines. Exactly how caffeine relieves headaches isn't clear. But scientists do know that caffeine boosts the activity of brain cells, causing surrounding blood vessels to constrict. One theory is that this constriction helps to relieve the pressure that causes the pain, says Robert Shapiro, M.D., Ph.D., associate professor of neurology and director of the Headache Clinic at the University of Vermont Medical School.

Now, that's not to say that coffee doesn't have any pitfalls—it does. Some people are super-sensitive to caffeine and get jittery or anxious after drinking coffee; habitual coffee drinkers usually develop a tolerance to caffeine that eliminates this problem (but they then need the caffeine to be alert and ward off withdrawal headaches). Coffee can also disturb sleep, especially as people age. Cutting some of the caffeine and drinking it earlier in the day can curb this effect. Lastly, unfiltered coffee (like that made with a French press) can raise LDL cholesterol, so use a filter for heart health.

But if you like coffee and you can tolerate it well, enjoy it...without the guilt.

# NAHU's TRAUTWEIN SAYS INSURANCE BROKERS MAKE HEALTHCRE MARKETPLACE MORE EFFICIENT

## Confused by your health options? Reform could make it worse

- Nicole Brochu
- 


Nicole Brochu Sun Sentinel Columnist

March 8, 2011

*Health care reform has a lot of people in the health care industry on edge, worried about how the changes will affect their livelihoods and bottom line. Below, the head of the association of health underwriters gives her pitch, and it's a convincing one, for why insurance agents are essential in helping consumers navigate a complicated system of care. Give it a read and add your perspective in the comment section under the column. If you have an opinion to share on a topical health-related issue, e-mail it to nbrochu@tribune.com. — Nicole Brochu*

**By Janet Trautwein**

Proponents of the new health care law claim to have seen the future of American health care — and they say it's a lot like air travel.

According to some, come January 2014, choosing a health insurance plan in the new exchanges will be as easy as shopping on Orbitz. By cutting insurance agents from the transaction and forcing consumers and employers to buy policies direct, advocates claim that the exchanges will trim costs.

Of course, these folks seem to overlook that selecting a health insurance policy is a tad more complicated than buying a plane ticket. Many consumers rely on agents and brokers to help them make informed insurance choices and take advantage of cost saving opportunities — and should be allowed to consult with them if they so choose.

Most of the products consumers buy online are simple commodities. For instance, to buy a plane ticket through a Web portal, all a traveler needs to know is where he's from, where's he going, and when he'd like to leave. The amount of legroom, the quality of the food and the reputation of the airline may factor into his decision, but most folks are just looking for the lowest possible fare.

When it comes to health insurance, consumers are looking for more than just the lowest price — they're also searching for the best value. For some folks, that may be the cheapest available plan. But other individuals and small businesses may have more specific needs in navigating the system, requiring help when problems arise and information when new products and changes are introduced that may impact them.

Imagine if buying airline tickets were as complicated as picking a health insurance policy. Travelers wouldn't have to simply select their destination and date of departure. They may not even know anything

about their future destination or journey toward it. They'd have to select the thickness of their seat cushions. And tell the airline whether they planned to use the bathroom during flight. And whether they'd have chili or Indian food before boarding the plane.

And if you're an employer, the number of workers could change product offerings and cost. Each answer could change the price of their seat — or perhaps bar them from traveling altogether.

The consequences for purchasing the wrong plane ticket are minor — loss of money and time. But buying the wrong health insurance can jeopardize a person's health and financial security. And for small business owners that provide health benefits to their workers, the risks are magnified across many families and lives.

That's where licensed professional agents and brokers come in. Few things are more important than our health — and expert agents can ensure that individuals and businesses find the plans that best suit their needs.

Unlike travel agents, insurance brokers are more than salespeople. They can assist their customers by helping them appeal denied claims and correct administrative errors.

For small businesses, outside brokers frequently serve as virtual human resources departments, providing administrative savings by assisting in compliance, completing enrollment forms, answering questions about benefits, and ensuring that enrollees have the documentation they need to access medical care.

According to the nonpartisan Center for Studying Health System Change, at least half of all small firms in the United States obtain their health benefits through a broker or agent. These companies appreciate the services brokers provide. A survey commissioned by IBM found that three-quarters of small-business owners were very satisfied with their agents' work.

The health reform law claims to offer some help to confused consumers by establishing so-called "navigators" to conduct public education activities, distribute information about enrollment and premium credits, and provide enrollment assistance.

Unfortunately, the law does not specify what training or certification navigators must receive to advise customers — unlike professional agents who are state-licensed and accountable. Consumers may thus be at risk of encountering sham operators who could give them faulty advice or information.

By empowering consumers with useful information, brokers make the health care marketplace more — not less — efficient.

*Janet Trautwein is CEO of the National Association of Health Underwriters.*

# Gas prices are about more than just oil

Associated Press


*AP – A woman gets gas at a Shell station in San Francisco, Monday, March 7, 2011. (AP Photo/Jeff Chiu)*
*By JONATHAN FAHEY, AP Energy Writer Jonathan Fahey, Ap Energy Writer* – Mon Mar 7, 6:17 pm ET

When Jay Ricker, owner of the BP gas station off Interstate 70 in Plainfield, Ind., set the price of unleaded gasoline at $3.44 per gallon on Monday of last week, it was 4 cents higher than the Friday before.

That alone might have been irritating to drivers paying the highest gas prices in more than two years. It was even more so because it happened on a day when the price of crude oil, which is used to make gasoline, fell almost $1 a barrel.

"It's up 20 cents one day, down 10 cents the next day," says Oscar Elmore, a courier who was filling up his Ford Taurus at a RaceTrac service station in Dallas recently. "It sounds kinda fishy to me."

Gas prices rise when oil prices rise, and fall when oil prices fall — except when they don't. What you pay at your gas station depends on an array of factors, from what happens on an exchange in New York to what the competition is charging.

This can rankle drivers, especially these days. Gas reached a national average of $3.51 a gallon on Monday. That's up 14 cents, or 4 percent, over the past week. The week before, the average rose 20 cents, the steepest increase since September 2008.

A year ago, the price was $2.75. The average is the highest it's ever been this time of year, and analysts expect it to climb higher in the coming weeks.

Unlike an iPhone or a pair of jeans or a Big Mac, oil and gas are commodities, and their prices can change every second at the New York Mercantile Exchange and other trading hubs. Those far-off changes affect the cost of the next day's commute.

Sellers of commodities, like gas station owners and refineries, price their product based not on what it costs to produce it, but on what it costs to replace it. Stations like the Plainfield BP, which gets shipments of gas several times a week, must constantly adjust their prices to keep up with the changing costs of their shipments.

Oil is the biggest factor in gas prices. It accounts for 50 to 70 percent of the cost. Recent upheaval in the Middle East and strong demand for oil around the world have pushed oil prices over $100 a barrel for only the second time in history. But the price of a gallon of gas at the pump rises â€” and, yes, falls â€” for a number of other reasons.

Oil prices can be moved by geopolitics, the value of the dollar, extreme weather or Chinese demand. Gas prices can be moved by oil prices, refinery problems or even weather that might keep drivers at home.

In the next few weeks, gas prices are expected to rise as refiners switch to a more expensive blend of gasoline designed to help protect against evaporation during the warmer summer months.

"We have to pay whatever the market says we do. It's an instantaneous world," says Joe Petrowski, CEO of Gulf Oil, a big gasoline wholesaler.

Whether the gas at the Plainfield BP was made from a barrel of oil pumped a month ago 1,000 miles away in Williston, N.D., or three months ago and 7,000 miles away in Kuwait, its price is set by buyers and sellers in New York hours before Ricker buys it.

There's no way to know exactly where the oil used to make the gasoline sold at the Plainfield BP came from, or even where the gas was refined. Oils from many sources are mixed together on their way to a refinery, and gasolines from many refineries are mixed together on their way to a fuel terminal, where gas is stored before trucks take it to gas stations.

But here's a plausible route: Oil is pumped by a company with wells in Texas or Louisiana and piped to a major oil hub in Cushing, Okla. From there, it is sold to an energy trader who may store it or trade it a few times.

Then BP buys it to feed its Whiting, Ind., refinery. After a two-week pipeline trip to Whiting, the oil is cooked into gasoline and piped to BP's fuel terminal in Indianapolis.

There, BP blends it with ethanol and a few special BP-branded additives and sets a final wholesale price, known as the rack price. It's this rack price that leads to the final pump price for most station owners.

A wholesaler like BP or Gulf each has its own formula for setting the rack price. In an attempt to smooth out the spikes and dips of the market, a wholesaler usually buys some of his fuel through long-term contracts. The rest is bought on the so-called spot market, priced at a given moment by a benchmark like the New York Harbor gasoline price.

Every day at 5 p.m., BP tells Ricker what the rack price will be starting at 6 p.m. That price is good for 24 hours.

Ricker hires a trucker to go to the terminal a short drive away in Indianapolis, fill 'er up with 10,000 gallons and bring it to his station. Then Ricker decides what price to charge customers based on his ultimate concerns: the Speedway and Circle K stations that share an intersection with him.

There are only two or three pennies per gallon in profit selling gas for most station owners. What Ricker really wants is to attract customers to sell the truly precious liquids: Not the gasoline and diesel outside, but the water and soft drinks inside.

Three times a day, his station manager, Debbie Sennett, records his competitors' prices. When the competition lowered prices on Tuesday, so did Ricker, to $3.24 per gallon.

"Gasoline is the only product in this country that if you're a penny different people will go out of their way to go somewhere else," Ricker says.

Wholesale gasoline prices have risen 38 cents per gallon, or 15 percent, since the first uprising in Libya on Feb. 15. When wholesale gas prices rise fast, filling station owners get squeezed or even lose money because competition prevents them from raising retail prices as fast as costs are rising.

So if it seems that station owners take their time lowering prices when oil and wholesale gas get cheaper, it's because that's exactly what they do.

"If gasoline prices drop a dime, a station will only pass along one or two pennies a day," says Patrick DeHaan, an analyst at GasBuddy.com, a website that collects and publishes retail gas prices. "They are slower to pass along the discount because they need to make up for money they lost when prices went up."

Through the first eight weeks of 2011, average gross profit for gas stations was 4.9 percent, according to the Oil Price Information Service. In 2010, it was 6 percent.

That doesn't draw much sympathy from those who have to pay more at the pump, though. "To me it seems like a money game," says Steve Armonett of Indianapolis, who pulled into Ricker's BP to fill up his Buick LeSabre recently. "They're just worried about how much money they can make."

# Walgreen to sell pharmacy benefits business

By Bruce Japsen
Posted today at 7:19 a.m.


A Walgreens on Michigan Avenue. (Bonnie Trafelet/Chicago Tribune)

Walgreen Co. said Wednesday it will sell its pharmacy benefit management business, which increasingly has conflicted with the drugstore giant's push to get consumers to fill their prescriptions at the pharmacy counter.

The Deerfield-based company will sell Walgreens Health Initiatives for $525 million in cash to Catalyst Health Solutions Inc. of Rockville, Md. The deal is expected to close in June.

"With nearly 7,700 drugstores as our center of gravity, we are focused more than ever on delivering convenient, affordable, high quality pharmacy, health and wellness solutions, and on enhancing our full scope of services to become America's first choice for health and daily living needs," Walgreen Chief Executive Greg Wasson said.

Pharmacy benefit managers — middlemen who buy from drugmakers and provide prescription coverage to employers — have been known to encourage consumers to bypass retail pharmacies and purchase their drugs through the mail, typically in three-month supplies.

Walgreens had a pharmacy benefit unit and pushed it in recent years to employers as more companies and insurers encouraged employees to get more of their prescriptions by mail. Employers saw mail order as less expensive and popular with consumers because it saved money.

But consumers these days are getting better buys from retailers and therefore are becoming more educated about the benefits of cheaper generic copies so analysts question the savings of mail order. Employers increasingly offer employees generics for chronic conditions for free and retailers like Wal-Mart have popularized generic prescriptions for just $4.

Meanwhile, Walgreens has aggressively pushed an alternative to the convenience of the mail order by allowing its customers to fill 90-day prescriptions.

Walgreens Health Initiatives was considered small by comparison to larger players like Medco Health Solutions and Express Scripts with just 10 million health plan members. The larger business with Rockville, Md.-based Catalyst will bring its combined pharmacy business more than 18 million health plan members.

As part of the deal, Walgreen says it will provide some services to help patients transition to Catalyst. The company said it expects those costs to Walgreens to be around $40 million.

Still, Walgreens expects to "record a gain on the sale" of Walgreens Health Initiatives upon the sale's closing that will offset any one-time costs of the transaction in the company's fiscal year, which ends Aug. 31.

"We believe (Walgreens Health Initiative's) clients and members will benefit from our sole focus on excelling in providing pharmacy benefit management services," said Catalyst chief executive officer David Blair. "We are gaining … talented employees who have been integral to the growth and success of the business and are pleased to welcome them to the Catalyst team."

The companies did not mention whether there would be potential layoffs as a result of the transaction. Catalyst, however, said it plans to "maintain a significant presence in the Chicago area."

# Illinois enacts Internet sales tax law

## *Gov. Pat Quinn signs bill into law, prompting Amazon.com, Overstock.com to say they will cut ties with affiliates in state*

ın on Thursday signed into a law a bill that imposes state sales tax on goods sold online. The move prompted Amazon.com verstock.com to tell Illinois affiliates that they would be dropped. (Abel Uribe, Chicago Tribune / February 24, 2011)

By Sandra M. Jones, Tribune reporter

*9:17 p.m. CST, March 10, 2011*

Gov. Pat Quinn stepped into the Internet tax fray Thursday, signing into law a bill designed to collect a sales tax for certain online purchases, a move that Amazon.com Inc. said it would blunt by severing ties with Illinois affiliates.

The controversial law, which takes effect immediately, makes it tougher for online merchants such as Amazon and Overstock.com Inc. to claim they have no physical presence in a state — something they must do in order to avoid charging their customers sales tax.

"Amazon has basically a 10 percent pricing advantage, and they're fighting like the dickens to keep it," said Fiona Dias, executive vice president of strategy at GSI Commerce, a Pennsylvania-based digital marketing firm.

The move is expected to have little effect on consumers but deals a blow to small Web businesses that count Internet retail giant Amazon and other online merchants as a major source of ad revenue.

Under the new law, called the Main Street Fairness Act, online retailers must collect and remit sales taxes on purchases made by Illinois residents if the online retailer has a physical presence in the state. The new law expands the meaning of "physical presence" beyond a warehouse, factory or office to include affiliate companies, typically deal and coupon website operators that earn commissions for directing shopping traffic to an online store.

The average combined sales tax on goods purchased in the U.S. jumped to a record high of 9.64 percent in 2010, from 8.63 percent in 2009, according to Vertex Inc., as cash-strapped city, county and state governments sought new revenue. The average state sales tax rose to 5.52 percent in 2010 from 5.48 percent in 2009. The state sales tax in Illinois is 6.25 percent.

Amazon and Overstock said they would avoid the sales-tax issue by dropping their affiliates in Illinois. Amazon declined to

disclose how many of its affiliates are in Illinois, but Overstock said it did business with "well over 100." Amazon and Overstock have relationships with thousands of affiliates across the country.

Illinois is among a handful of states — including New York, Rhode Island and North Carolina — that have instituted similar laws to extract sales taxes from online merchants and boost depleted state coffers.

"Illinois' Main Street businesses are critical to ensuring our long-term economic stability, which is why they must be able to compete with every company doing business online in Illinois," Quinn said. "This law will put Illinois-based businesses on a level playing field, protect and create jobs, and help us continue to grow in the global marketplace."

The Illinois Department of Revenue estimates it misses out on $153 million to $170 million in uncollected sales taxes each year from online purchases. The uncollected taxes of goods sold online and through catalogs totaled $8.6 billion in 2010 nationwide, according to a Wall Street Journal report citing the National Conference of State Legislatures.

The U.S. Supreme Court ruled in 1992 that companies without a physical presence in a state aren't required to collect state sales taxes.

Amazon, based in Seattle, sent a letter to its affiliates in Illinois on Thursday telling them that the company will terminate their contracts April 15. Its affiliates will no longer receive advertising fees for sales referred to Amazon.com, Endless.com or SmallParts.com, the letter said.

Overstock also sent a letter to its Illinois affiliates Thursday, saying it will sever its ties with them as of May 1 unless the law is repealed or the affiliates move to another state where no such law exists.

"We think that states that do this are making a mistake," said Jonathan E. Johnson, president of Salt Lake City-based Overstock. "We think this kind of law doesn't really hurt Overstock that much. The affiliate business can be borderless. If a Web shopper is looking for a coupon, they don't care if they get it from an Illinois-based affiliate or an Indiana-based affiliate."

Scott Kluth, founder and CEO of Chicago-based CouponCabin.com, called the new law "deeply disappointing" and said his company is "actively exploring" moving to Indiana.

"It's a shame we have to consider leaving our longtime home in Illinois, but we will do what is best for our business," Kluth said.

Brad Wilson, founder of BradsDeals.com, is staying in Chicago for now but predicted the new law will stunt the growth of the deal-site industry that has sprouted in Illinois.

"Chicago doesn't lead on the Internet in many things, but this space is one of the things that we do, and the state should cherish that and foster that," Wilson said. "These are modern business models. They don't require factories or fixed investments. They require smart people. And you can find smart people anywhere. They're legislating (this industry) out of the state."

Rival retailers saddled with brick-and-mortar stores, for their part, cheered the new law.

As the biggest online retail company, Amazon's ability to avoid collecting and remitting state sales taxes has been the envy of brick-and-mortar retailers. Retail margins are so slim, typically less than 5 percent, that not charging sales tax amounts to a price advantage.

In the past few weeks, Sears Holdings Corp., Best Buy Co., Barnes & Noble and Wal-Mart Stores Inc., among others, launched an effort to poach disgruntled Amazon affiliates in states the online retailer has threatened to leave.

Wal-Mart said in a statement Thursday that the new law "will help create a level playing field between online-only retailers and brick-and-mortar retailers."

# WHEN TO TAKE SOCIAL SECURITY

## Should You Take Social Security Early?

*by Jilian Mincer*

*Monday, March 14, 2011* SmartMoney

Leave it boomers to flout one of the long-held rules of retirement planning. Afraid lawmakers will soon lift the retirement age of Social Security or shrink benefits, many are ignoring the traditional advice of financial planners and retirement experts everywhere and taking their benefits as soon as possible. Are they right to rebel?

The number of Americans opting to take Social Security at 62 -- currently the youngest age allowed -- is on the rise. In 2009, 42% of 62-year-olds claimed benefits, up from 38% in 2007, according to economists at the Brookings Institution in Washington, D.C. And while more recent data is not yet available, financial planners and industry experts say the ranks of early claimers are still growing. This, despite the fact that by delaying benefits individuals stand to boost their payments by 7% to 8% each year until age 70. "The mentality is that getting something now is better than nothing later," says Richard Rosso, an adviser with Charles Schwab Corp. in Houston, who says he's been "begging" many of his clients to delay claiming Social Security -- often to no avail.

While some boomers have been driven to tap Social Security early out of necessity after losing jobs or savings during the downturn, many are reacting to the growing chorus of politicians calling for Social Security reform, says Gary Burtless, an economist at the Brookings Institution. Last month, New Jersey Gov. Chris Christie urged lawmakers to increase the retirement age of Social Security, while Senators Lindsey Graham and Rand Paul have proposed reducing payments to wealthier Americans. More than half of Americans support both initiatives, as long as they take effect in the distant future, according to a new Wall Street Journal/NBC News poll. As a result of all the political rhetoric, fears about Social Security, once at a hum, "have risen to a crescendo in the last six weeks," Rosso says.

Are all those fears realistic? Most advisers and retirement planning pros say no. "It's so off the mark," says Alicia H. Munnell, director of the Center for Retirement Research at Boston College. "There is no question the benefits will be paid. The worst that could happen is that the system would be able to provide only 80% of the benefits under current law." The Social Security Administration has estimated that beginning in 2037 benefits could be reduced by 22% and could continue to decline, barring any changes to the system.

But even these shortfalls are a ways out, and do little to explain why boomers are scrambling now to claim benefits. Likewise, the proposals being floated in Washington seem to target younger generations of Americans, say advisers. "When we look at the proposals, very few would impact those in or near retirement," says Chad Terry, director of retirement solutions at the Principal Financial Group. He says longevity and inflation could be more of a risk to portfolios, but "there are some who will take it [Social Security benefit] no matter what," he says. "They feel I've contributed, I'm eligible, I'm going to take it."

Another explanation: Advisers say the average pre-retiree typically underestimates the impact of taking benefits early. For example, a top-earner retiring at 62 would get $1,803 a month. By waiting until 66, he'd increase that amount to $2,442, and delaying until 70 would bump the monthly payment to $3,256, according to Rande Spiegelman, vice president of financial planning at the Schwab Center for Financial Research. Another way to look at it: someone who delays taking Social Security until 66 rather 62 will collect more money over time if they live until at least age 77.

That could have an enormous impact on retirement income, says Christine Fahlund, senior financial planner at T. Rowe Price. She says, for example, a couple who earns $100,000 a year and has $500,000 saved could expect to receive about $50,000 a year in Social Security payments and other income if they claim at 62; that same couple would get almost twice as much a year in Social Security benefits ($96,000) if they wait until 70, says Fahlund.

In specific situations, the decision to claim does make sense, say advisers, like if you're in poor health or unemployed. Otherwise, they recommend delaying retirement (and social security payments) in order to boost their retirement savings, which likely took a serious hit during in 2008. A February report by the non-profit Employee Benefit Research Institute found that nearly half of the early boomers -- those 56 to 62 -- are at risk of not having enough retirement income for "basic" costs in retirement such as food, transportation and housing. And taking social security early won't help as much as it seems.

# HUMANA CEO DISCUSSES THE IMPACT OF HEALTHCARE LAW ON INDUSTRY

## The business of Obamacare


Interview by Geoff Colvin, senior editor at largeMarch 17, 2011: 9:39 AM ET

FORTUNE -- Running one of America's largest health insurers was never easy, but now it's a strategic challenge that will be studied in business schools for years. That's because the industry is about to be revolutionized by the new health care reform law. Yet no one is sure exactly how. At least Humana CEO Michael McCallister has the comfort of knowing his company has remade itself before. Launched 50 years ago as a nursing home operator, it later abandoned that business and became America's largest hospital company before bailing out of that industry in 1993 to focus on insurance. Humana's biggest business now is Medicare Advantage insurance -- essentially enhanced Medicare offered through private companies.

McCallister, 58, has a short résumé, having joined Humana as a finance specialist straight out of Louisiana Tech in 1974. He spent much of his career running hospitals around the country and became CEO in 2000. He talked recently with *Fortune's* Geoff Colvin about why Humana (HUM, Fortune 500) is getting back into the health care delivery business, why the new health care reform law won't keep costs down, what he has learned from providing coverage for Humana's own employees, and much else. Edited excerpts:

**It's rare to see an entire industry get whaled on by government leaders as health insurance has been. President Obama said, "Americans are being held hostage by health insurance companies." Nancy Pelosi said health insurers are "villains" who "have been immoral all along." How do you feel when you hear that kind of thing from the leaders of the nation?**

A: Personally I look at it as politics, and I don't get too bothered by it. But I hate it because it's such a downer for all our employees who wake up every day trying to do good things for people, help people get through illnesses, protect them from financial disaster, from being sick. We have a good, higher purpose to what we do, and our people feel that. So it can be hurtful when they say that. Some of it comes from a misunderstanding of what we actually do, and it sets us up to be a pretty good target.

## Public misperception of health care

That gets to a larger issue, which is how the public perceives the whole health care industry. In most industries, rising revenues are seen as good news -- growth and opportunity. Why is it that in this one industry, rising revenues are seen as a grave national problem?

I think it's a lack of understanding of what actually drives health care costs. Health care costs become premiums, which are our revenues. I can show you a historical chart showing that our premiums have tracked health cost increases pretty closely for many, many years. So why would health care costs be going up? And then you enter a whole new space -- the aging population, new technology and new drugs, and wonderful things we can do medically that we all want but are very expensive. It takes us into the space of our own health and wellness as individuals. We're not taking care of ourselves. We're becoming an obese nation, leading to diabetes and other chronic illnesses. A lot of medical spending is tied to five chronic illnesses [diabetes, stroke, heart disease, pulmonary conditions, and hypertension], all of which are preventable. People don't really connect the dots when they think about why in the world health care costs are going up.

**What specifically can be done about those five illnesses?**

Let's talk about a couple of them. Heart disease is obvious. It gets a lot of publicity, and people know a lot about it, but have we changed our diets? Are we really taking care of ourselves? Obesity leads to all these things. Diabetes is becoming an epidemic across this country. We have kids, 30% of whom are overweight or obese already, so we have another tranche of folks coming along who are going to suffer the same thing. We haven't brought the public to a point where they realize that they actually control their health and ultimately the cost of their health care. It's just tough to get people to focus on it in the short term.

**There's an argument that people don't focus on it because they don't feel they're spending their own money when they get health care. Is that right, and is it going to change?**

The third-party payment system does set up incentives that are driving much of what happens. Historically, if people had insurance, they had very little out-of-pocket as they used the health care system, so the power of consumers was not showing up. In the rest of the economy, consumers are very, very powerful. We do not tolerate bad services or bad products. In health care, we not only tolerate them, we pay for them every single day without knowing any better. We've got a third-party payment system where the payer's in a different room from the seller and the buyer, and it sets up a perfect storm for inflation.

**Under the new health care reform act, it's the law of the land that everybody in America who can afford it has to buy what you sell. Is that fundamentally a good thing for you and for your competitors?**

I would describe the bill as a mixed bag. It does some good things. You can make the policy argument that getting 30 million more people covered is a good thing -- none of us want people outside the system. The issue of preexisting conditions does scare people; the No. 1 concern of most Americans is that they'll fall through the cracks. Do we want to keep our kids on our policies until they're 26? Sure. Would you like to be able to get preventive care without having to pay for that? Why not? But all these things cost money, so the bill is loaded up with all sorts of things that set bad incentives. The biggest takeaway from the bill is, it doesn't do much fundamentally to help with the underlying problem, which is that costs are too high and are rising too fast. This turned into more of an insurance market reform bill than health care reform.

**What's your bottom-line prediction of what will happen to health care costs in the next five to 10 years?**

They're going to rise because we have not addressed the drivers. Nothing in this bill has done that. We have a system where we're insulated from real-world cost and quality measures, and we as consumers can't behave in the way we normally do, and we're not taking care of ourselves in an appropriate way. At our company we've focused our future on the idea of health, wellness, and well-being because we know that's where this has to go next. As large employers sit down and think about their health costs, they've run out of room from the standpoint of moving benefits around. They're really going to have to step up and address the underlying health of their employees, not only because of health care costs but also from the standpoint of productivity and absenteeism.

**So what's the future of employer-funded health insurance?**

Smaller employers will continue to do what they were doing, which is struggling with this. They're likely to send their people to the exchanges [that will be established under the new health care law]. All the businesspeople I know have done the math on the future. They'll have to confront decisions based on the culture of their company and the importance of this benefit to their employees. But I can tell you the pressure and the bias will be to drop it.

## Humana's approach to innovation

**The law not only requires people to have health insurance but also imposes many requirements on the features of that insurance. Some analysts have concluded that the effect will be to turn health insurers into the equivalent of public utilities. Will it?**

It's a shame that we're not going to have a lot of opportunity for innovation and variation. If we try to commoditize this, we're going to end up in a situation where we drive out innovation and good thinking. It's something we can probably live with, and we will find ways to differentiate ourselves, but as a policy matter and as a solution to the problem, I don't think that's it.

**What's Humana's strategy now?**

We have a very straightforward strategy to deal with the individual consumer in those lines of business where we're talking to an individual. So we love Medicare Advantage because it's a retail business where you talk to people directly. We love the individual health insurance market in concept -- we'll see how it plays out relative to exchanges. It will get bigger, so there's potentially an opportunity. We like that relationship with the individual. But this idea around helping people get to a better spot from the standpoint of well-being is what's going to drive us, and we think that's a business for us. We're even trying to change the language -- instead of ROI, return on well-being. We're trying to find ways to motivate behavior change. We're going to bring in incentives and rewards and a lot of things from the rest of the economy to get people to think differently -- about their interaction with the system and the way they take care of themselves.

**That strategy opens up almost anything in the health care world, not just insurance. Where do you see it leading?**

Clearly the core health insurance product is critical to everyone. You want to be protected. But there are other things we think we can do, whether they're going to be fitness programs or other products. If I think about my senior population, I can think about a much longer relationship relative to home health support, for example -- people are always better off in their homes than they are institutionalized. So you're right, it's very broad and leaves us a lot of opportunity.

Recently we bought a company, Concentra, which has us reentering the provider space, which we left many years ago. So now we find ourselves in work-site wellness at 200 and some locations, in urgent care, some primary care. We're beginning to think about the full integration of the relationship and how you can organize the financing and the delivery a little differently, wrap up some new economic ideas that would come from elsewhere, and get to a better place. It's a much broader way to think about it.

**Many companies with so many customers have a tremendous amount of customer data, and they know they're not using it as effectively as they could be. You're doing something you call strategic analytics. What's the goal?**

From our spot as a payer, we have the best view of individuals as they move around health care that exists today. There may be a day when there's an electronic health care system where everything is connected, and that would be great, and there's money in the stimulus bill to try to move that ball. But as we sit here today, I know every doctor people visit, all the drugs they take, because we're paying for all this stuff. We have a pretty good idea of what people are suffering from, whether they're taking their medications, whether they're compliant with the treatments, whether they've had eye exams and things, whether they're diabetic. So we have a wonderful opportunity to add value.

We're in the middle innings around gathering that data and making it actionable. That's the key -- it needs to be actionable for the individual and for us. We're a little late as a company and as an industry in drawing value from that, but we're in a good position to do it. So we're investing in it heavily.

**Humana changed the way it handles health coverage for its own employees about a decade ago. What did you learn from that experience?**

We knew that if we couldn't effectively work with our associates to get a better handle on their health and their health care spending, then we weren't going to have much of a value proposition to our customers. So we took it upon ourselves to be early utilizers of virtually everything we would innovate around. We were early adopters of everything from health savings accounts to higher deductible health plans to elimination of paper. A lot of that stuff's out there broadly today, but we started doing it in 2000 and 2001. In those days eliminating all paper from purchasing health insurance was unknown.

It's a combination of process, technology, benefit structures, information, funding mechanisms, and feedback. Virtually all Humana associates are at a computer, and they are not bashful. So if we ask them, "Tell us about this," we will get a huge percentage of people who will give us feedback. It's a great laboratory.

## How to be a health care CEO

**It sounds as if one of the themes of what you did was give individuals more control and more incentive to exercise control. Is that right?**

I'll give you the principle that started the whole thing. I basically said to the associates of Humana a decade ago, "Listen, I can't solve this problem for you. You're going to have to get engaged here. We're in this together. This is not something that Humana as an employer is going to just take care of forever, because that's not sustainable."

Every business has that problem. So you start by treating everyone like they're adults, and you say, "This is the problem." We laid out everything that was going on with cost trends and said, "We are going to work on this together." They had some accountability and responsibility, and we had some. We've been very transparent about what's happened all along the way, what's working and what's not. We changed things; we stopped things we started; we tested a lot.

When it comes to this subject I would argue I probably have one of the most engaged populations you'd find anywhere in the country in a big business. And yet we still have a lot of work to do. I study my own population in terms of their body mass index, their weight, smoking rates, and all that. We still have a lot of work to do. This is hard work because it really, fundamentally, requires a change in how people think

# ALMOST 50% OF DENIED HEALTH INSURANCE CLAIMS ARE REVERSED ON APPEAL

## GAO report shows success in health insurer appeals

By The Associated Press
The Associated Press
Wednesday, March 16, 2011; 5:15 PM

-- Don't take no for a final answer when a health insurer rejects a claim and leaves behind an unpaid medical bill.

As many as 50 percent of some appeals prompt insurers to reverse their decisions, according to a report from the Government Accountability Office.

Insurers frequently deny claims due to billing errors, missing information or judgments on whether the care or service is appropriate, the investigative arm of Congress said in a report released Wednesday.

These denials can be based on mistakes like an incorrect code on a claim submitted by a doctor's office, said Nancy Davenport-Ennis, CEO of Patient Advocate Foundation, a not-for-profit that helps people appeal claims denials.

"You've got a lot of people in America who are ultimately paying a bill they don't owe because they don't realize it's an incorrect code," said Davenport-Ennis, who wasn't involved in the government study.

The GAO studied health insurer rejection rates at the request of Congress, which wanted a better picture of the issue as part of the health care overhaul it passed last year. The overhaul aims to cover millions of uninsured people after it unfolds over the next few years.

The GAO studied data collected from a handful of states and reports done by other agencies. It found that as many as 50 percent of appeals to insurers in Maryland in 2009 led to coverage decision reversals.

In Ohio, 48 percent of appeals to insurers led to reversals last year.

Appeals to a third party can fare decently, too. The GAO cited a report from America's Health Insurance Plans, which studied 37 state external review programs a few years ago and found that about 40 percent of external appeals led to the reversal of a claim denial.

These figures do not mean patients have nearly a 50 percent shot at success if they appeal a denial. The statistics are based on cases appealed, and only a small portion of denials are challenged, said John Dicken, a GAO health care director.

Patient Advocate Foundation, which works in all 50 states, helped more than 17,000 people deal with insurance claims denials last year. A benefit not covered by a health plan is the most frequent reason they see for claim denials.

Davenport-Ennis said coverage parameters can vary widely, and they are often determined by the insurer and the employer that provides group health coverage. For instance, some company plans may not cover Autism treatments or clinical trial enrollments.

Davenport-Ennis also said they've seen insurers tighten restrictions on prescription drug coverage in recent years and add cost-control wrinkles like limits on the number of surgeries covered in a year.

That means a breast cancer patient in some cases may have her biopsy and lumpectomy covered but not the reconstructive surgery that follows.

Patient Advocate Foundation also deals with claims that are denied even though they involve a benefit covered by the insurance plan.

"There are many times the claim is denied the first go-round to see if you come back and appeal," Davenport-Ennis said.

# CHICAGO SHRINKING BUT STILL NO. 3

## Second City still 3rd largest despite losing 200,000 residents

The Chicago skyline photographed from the Adler Planetarium. (Michael Tercha/Chicago Tribune)

By William Mullen, Tribune Reporter

*8:21 p.m. CDT, March 24, 2011*

While still the country's third largest city, Chicago was the only one among the top 10 cities in 2010 to have lost population over the previous decade, according to the U.S. Census Bureau.

Likewise, Cook County, the nation's second most populous county after Los Angeles, is the only one of 2010's 10 largest counties to have lost population since the 2000 census. Chicago lost about 200,000 residents in the past 10 years and Cook County was down by 182,000.

The Census Bureau on Thursday released newly generated analyses garnered from the April 2010 tally of the nation's population, reflecting on general national population distribution and trends.

Census chief Robert Groves said at a news briefing in Washington that so far the data have backed general trends that his staff had predicted during the past several years based on the bureau's ongoing community survey counts.

As expected, Western and Southern states continued to grow faster than the Midwest and Northeast.

But Kendall County was the fastest-growing county in the country, more than doubling its population to 114,736 during the past decade, a 110 percent boost. And Plainfield was the sixth fastest-growing town with a population of more than 10,000, tripling its population to 39,581.

Despite Chicago's population drain during the decade, with 2,695,598 residents the city is in little danger of dropping to become the fourth city — Houston has that distinction with a population of 2,099,451. New York and Los Angeles remain No. 1 and No. 2, respectively, on the top 10 population list.

Detroit, which lost a quarter of its population in the past 10 years, fell off the top 10 list, replaced by San Jose, Calif.

# U.S. Postal Service cutting 7,500 managers

By Dow Jones Newswires-Wall Street Journal
Posted today at 6:26 a.m.


(Paul J. Richards/AFP/Getty Images)

The U.S. Postal Service will cut 7,500 managers and shut the Carol Stream and six other district offices, responding to record losses and declining mail volume as more people communicate by e-mail and texts and pay bills online. The reduction in postmasters, supervisors and other employees represents a 20 percent cut in middle-management jobs — people not involved in actual physical moving of mail.

The cuts come as part of the agency's previously disclosed plan to close as many as 2,000 post offices and consolidate regional mail-processing centers in the next 12 months.

Besides the fundamental changes in the way the public communicates, the Postal Service is overwhelmed by burdensome retiree health-benefit costs, according to U.S. Postmaster General Patrick Donahoe.

"It's critical that we adjust our work force to match America's changing communication trends, as mail volumes continue to decline," he said in a statement. "At every step and with every change, our focus remains on our customers and continuing to provide outstanding customer service."

District offices, which oversee and provide services to groups of post offices, will close in Columbus, Ohio; Albuquerque, N.M.; Billings, Mont.; Macon, Ga.; Providence, R.I.; Troy, Mich.; and Carol Stream, Ill., the Postal Service said.

The agency has not yet identified post offices that will be closing, but has said previously that it was focusing on rural areas where post offices are losing money, and where residents may have access to services in another town.

Still, postmasters play important roles in small communities, said the National League of Postmasters of the U.S.

"Especially in rural areas, the post office is the only face of the federal government in the community," and the postmaster is "an integral part" of daily life, said John Jameson III, executive vice president of the group, in an interview.

Of the 7,500 jobs to be lost over the next year, 2,500 are supervisors, 2,000 are postmasters, and the rest are in administrative roles.

Slashing managers and closing district offices will save $750 million annually, postal officials said. The plan is the latest attempt by the Postal Service to right itself after losses of $8.5 billion in fiscal 2010; the agency projects it will be $6.4 billion in the red this year.

In addition to the 2,000 post offices it expects to start closing in coming months, the Postal Service is reviewing another 16,000 — half of the nation's post offices — that are operating at a deficit. It also has been lobbying Congress to make it easier to close money-losing facilities.

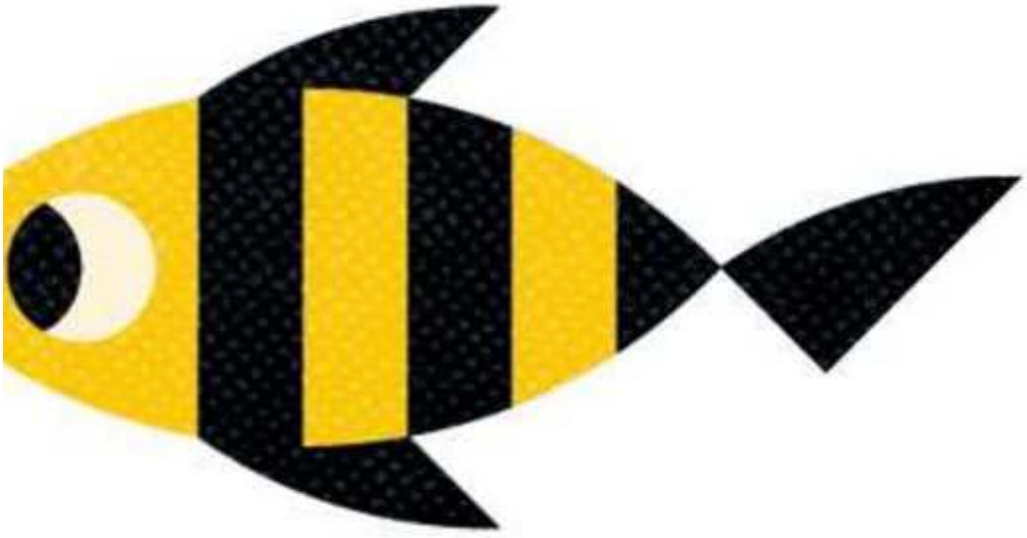
The agency is also seeking to drop to five from six-day delivery. That move would need congressional approval, however, and faces wariness from the Postal Regulatory Commission, which said in an opinion Thursday that cutting Saturday delivery would disproportionately affect people in rural and remote areas.

The Postal Service, an independent government entity supported mostly by postal fees, has had to borrow from the federal government to meet shortfalls and expects to max out its $15 billion federal line of credit by the fall.

Since 2007, U.S. law has required the Postal Service to prefund retiree health benefits at $5.5 billion a year — a law that the Postal Service is now seeking to change.

Donahoe testified to a congressional subcommittee in early March that the Postal Service "will not survive as a self-financing entity without significant changes to current law."

# No link between mercury in fish and heart disease found in study



ew study examines the effect of mercury exposure via fish consumption. (Illustration by Bob Daly / For The Times)

By Mary Forgione, Tribune Health

*1:32 p.m. CDT, March 24, 2011*

Eat fish. And don't stress -- overly much -- about the potential effect of its mercury level on your risk of cardiovascular disease. That ultimately might be the lesson from a new study assessing the effect of mercury exposure via fish consumption.

Researchers examined toenail clippings of 3,427 men and women with cardiovascular disease, comparing them with the clippings of 3,427 people without cardiovascular disease. They then measured the amount of mercury and selenium concentrations in the toenail samples of those who had heart disease. (Selenium appears to offer some protection against mercury poisoning, so they figured they'd better measure that too.)

Their conclusion, as presented in the abstract that was released Wednesday in the New England Journal of Medicine: "We found no evidence of any clinically relevant adverse effects of mercury exposure on coronary heart disease, stroke, or total cardiovascular disease in U.S. adults at the exposure levels seen in this study."

But, the researchers pointed out in a discussion of their work, it's possible that mercury can affect cardiovascular disease risk at higher levels than they found or when there's a lack of selenium (rare in this country).
So keep trying to reduce mercury contamination in fish and the environment overall, they said, adding that such contamination "could still have the potential to offset, at least in part, the net cardiovascular benefits of fish consumption."

Fish, of course, has been touted as heart-healthy food for the omega-3 fatty acids contained in fish oil. (Specifically, that¿s DHA (docosahexaenoic acid), ALA (alpha-linolenic acid) or EPA (eicosapentaenoic acid). This Los Angeles Times story explains the benefits derived from fish oil in protecting your heart.

But chances are you already know that. A ConsumerLab.com survey earlier this year suggests that fish oil supplements are the most popular dietary supplements in America.

# AARP FACES INQUIRY OVER ITS SUPPORT OF HEALTHCARE REFORM

March 28, 2011, *12:37 pm*

## This Week's Health Industry News

*By DUFF WILSON*

The government is expected to introduce two significant new policies this week in emerging areas of health care, one on whether Medicare will pay for a $93,000 cancer drug treatment, and the other on rules that may affect hospitals, insurers, doctors and patients in accountable care organizations set up under the new health care law.

The cancer drug in question is Provenge, from Dendreon, a vaccine that stimulates the body's immune system to attack cancer cells. It was proven to extend the lives of some advanced prostate cancer patients by a median of 4.1 months, to 25.8 months.

Dendreon has priced the drug at $93,000 for three infusions, which it says is in line with other cancer drugs per month of added life. The Centers for Medicare and Medicaid Services is scheduled to announce by Wednesday its coverage.

Medicare could limit uses of Provenge to only those patients that the company has proved would benefit and refuse to pay for broader, so-called off-label uses. The drug is proven in men with advanced prostate cancer who do not respond to hormone treatment but who have minimal or no symptoms.

Medicare is due to reveal its proposed decision by Wednesday, with a final ruling to come by June 30. Some private insurers have already agreed to pay for the vaccine, which was approved by the Food and Drug Administration in April, 2010.

This decision has broader implications as Medicare decides how to pay for very high priced drugs for older Americans, and also because Provenge is the first in a new class of drugs known as active cellular immunotherapies.

The rules for Medicare accountable care organizations, or A.C.O.'s, have no definite deadline. They have been delayed since January.

But on March 11, Kathleen Sebelius, secretary of health and human services, told reporters the draft rules would be announced within two weeks — a period that ended Friday.

A.C.O.'s would provide joint responsibility for patient health to teams of doctors and hospitals and share the financial benefits of good treatment. But those incentives pose complex issues. The government may have to revise fraud and antitrust laws to allow hospitals, insurers and doctors some pricing flexibility. There will be a long period for public comment after draft rules are published.

And there is some possibility the budget battle on Capitol Hill will delay the rules further.

Congress returns to work this week amid talk of wars and spending cuts. Medicare and Medicaid are being discussed in closed-door negotiations between Democrats and Republicans as Congress faces the threat of an April 8 government shutdown if a spending plan is not agreed by then.

In other political news, the health and oversight subcommittees of the House Ways and Means Committee have scheduled a hearing Friday over AARP's insurance business. AARP, formerly known as the American Association of Retired Persons, plays a big role lobbying over government policies and also obtains much of its budget from insurance it recommends to older Americans.

"This hearing is about getting to the bottom of how AARP's financial interests affect their self-stated mission of enhancing seniors' quality of life," Wally Herger, the California Republican who chairs the health subcommittee, said in a statement. "It is important to better understand how AARP's insurance business overlaps with its advocacy efforts and whether such overlap is appropriate."

Wednesday marks the start of the annual meeting of the European Association for the Study of the Liver, in Berlin. The investment house Leerink Swann said in a note to investors on Monday that important results are expected for Bristol-Myers Squibb's interferon-free and ribavirin-free direct antiviral agent, which "could greatly expand the market for agents for hepatitis C. "

There are no F.D.A. advisory committee meetings this week related to drugs or medical devices. There is a meeting on Wednesday and Thursday on the effect of food color additives on children's behavior.

Let us know anything important we may have missed for the week ahead.

# NEW MEDICARE RULE MAY MAKE IT MORE DIFFICULT FOR SENIORS TO PROCURE HOME CARE SERVICES

## Agencies slam new Medicare rule on home care

### By PHIL GALEWITZ

### Kaiser Health News

Home health agencies, hospitals and consumer groups are complaining that a new rule intended to curb unnecessary Medicare spending will make it harder for senior citizens to get home care services.

Under the requirement, which is to take effect Friday, Medicare beneficiaries will have to see doctors 90 days before or 30 days after starting home health services in order for the home health agencies to be reimbursed. Those face-to-face visits may be a burden for some home-bound frail seniors, as well as those who live in rural areas, the industry says.

Some Medicare experts have little sympathy for industry complaints.

"Home health is a benefit that is out of control," said Dr. Robert Berenson, a health policy expert at the Urban Institute.

Medicare home health care typically consists of services such as skilled nursing, physical therapy and speech therapy. Unlike most services in Medicare, patients don't have co-payments or deductibles. The services can be prescribed for 60 days at a time, although there's no limit on the number of times they can be renewed.

Medicare home health costs doubled to $19 billion from 2002 to 2009. Cases of Medicare fraud also have been rising, and federal officials have launched a crackdown that includes prosecuting home health agencies that bill for services that weren't provided.

Under current law, doctors must prescribe home health care for patients to receive services, but the physicians don't have to see the patients to make that determination.

Medicare advisers to Congress say the regulation doesn't go far enough to reduce waste and fraud because it allows patients to start getting home health services before first seeing doctors to ensure that they need it.

"Such a large window ... does not ensure that beneficiaries receive an examination in a timely manner before home health care is delivered," the Medicare Payment Advisory Commission wrote in a report to Congress this month. Berenson is a member of the commission.

The doctor-visit rule, which was included in the health care overhaul, initially was to take effect Jan. 1 and was to require providers to see patients within 30 days before or two weeks after the start of home care. In December, the Centers for Medicare and Medicaid Services delayed implementation until April because of complaints from providers, who claimed that the rule was too stringent and most doctors were unaware of the change. At that time, the CMS also announced that it was expanding the time frame for patients to meet with doctors.

Now a coalition of home health industry, hospital and doctor groups and the AARP is pushing for another three-month extension.

CMS spokesman Tony Salters said the agency was listening to concerns, but he refused to say whether another extension will be granted. Salters said the agency didn't have any data to show what percentage of Medicare patients now got home care services without having recent visits with their doctors.

"There is a lot of confusion out there, and patients may lose access to their care," said Nora Super, an AARP lobbyist.

Dr. Roland Goertz, the president of the American Academy of Family Physicians, said the new rule added documentation requirements for physicians. "It makes our paperwork burden even more onerous," he said.

Under the rule, doctors would have to fill out forms that certify that they or other health care providers such as nurse practitioners had seen patients for the specific purpose of determining the patients' needs for home care. This would be in addition to doctors' current duties of prescribing home health care and signing off on care plans, which the home health agencies typically develop.

"A home health face-to-face encounter contradicts the purpose of home health care," Hoosier Uplands Home Health Care & Hospice in Mitchell, Ind., a rural area about 85 miles south of Indianapolis, wrote the CMS last year. "This would impose on the patient the need to leave home for increased and unnecessary physician visits."

But the home health agency voluntarily has tried out the new rule over the past three months and found only minor problems, such as doctors not filling out forms correctly, said Melissa Jeremiah, the director of operations for Hoosier Uplands.

Rochelle Archuleta, a policy expert at the American Hospital Association, said her organization was "hearing concerns from providers ... and that tells us this policy is not ready for enforcement." Hospitals are worried that patients who are discharged may not be able to get home health services immediately and hospital-owned home health agencies may have trouble complying with the law.

Home health agency groups said they understood Medicare's need to reduce unnecessary care but that the new rule was too onerous.

"We want to make sure beneficiaries who really need the services are not denied it," said Peter Notarstefano, the director of home and community-based services at Leading Age, which represents nonprofit home health agencies.

(Kaiser Health News is an editorially independent news service of the Kaiser Family Foundation, a nonpartisan health care policy organization that isn't affiliated with Kaiser Permanente.)