Health & Retirement Services of Illinois
Newsletter September 2016

OUR NEWS LETTER

Disabled Veterans Get 30 Wheelchairs Built by BCBSIL Volunteers

August 10, 2016

Earlier this summer, Blue Cross and Blue Shield of Illinois (BCBSIL) employee volunteers, 150 strong, built 30 wheelchairs. They were turned over, free of charge, to the Edward Hines, Jr. Veterans Administration Hospital west of Chicago.

The wheelchairs will have a huge impact.

Dan Bracker heads the Hines VA Hospital “escort” team, made up of 31 employees and volunteers. They move hundreds of veterans every day in wheelchairs across the 147-acre Hines campus. Bracker is a 20-year Army sergeant first class veteran who “wanted to do something really meaningful when I retired from the military. That’s why I work at Hines.

“We have 200 wheelchairs now. So these 30 more will make a big difference. We can lower or even avoid time our vets now spend waiting for chairs to free up so we can get them where they need to go.”

Veterans live in the communities that BCBSIL serves, and many of its own employees are veterans. So events like this are very meaningful. They provide an opportunity to show appreciation for the service and sacrifice veterans have given.

Wheelchair Gift ‘Thrilling’
Mitra Gobin is the Hines Chief of Voluntary Services. He was at Chicago BCBSIL headquarters on June 28 when the wheelchairs were built. He offered thanks there and later spoke at the hospital when the chairs were dropped off.

“We’re always thrilled when we get tangible donations. When I told colleagues at Hines I was going to BCBSIL to say a few words of thanks, everybody in my office applauded.” Gobin also oversees cash gifts and the volunteers who donate their time doing things like maintaining the hospital grounds.

The truck driver who delivered the wheelchairs is Mike Dolan. He got caught up in the moment. “My dad, Robert, was in the Navy Reserves. As a veteran, he would have been proud of what’s happening today.” Mike’s eyes teared up ever so slightly.

BCBSIL Marine Veteran Helps
James Keathley was among the 150 volunteers who assembled the wheelchairs, helped load them on the delivery truck, and then hopped onto the truck to unload them at the Hines VA Hospital. Keathley is BCBSIL’s senior supervisor of protection and security, and a Marine Corps veteran.

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“I’m very proud we have this opportunity to be involved in an event supporting veterans’ needs,” Keathley said. “Delivering these chairs as a veteran and as an employee of the company just makes me feel good because I know this is a good thing for veterans here at Hines VA Hospital. It’s something giving back to the veterans.”

Our company’s “Supporters of Military Veterans” leadership group, along with Human Resources Vice President Ron Balsewich, arranged the event. Balsewich runs the “In-Abled” group at Blue Cross and Blue Shield.

The Blue Cross and Blue Shield veterans group is committed to reaching out in practical ways. For example, the Fisher House at Hines gets BCBSIL help. It’s a free “home away from home” for families, caregivers and patients’ loved ones. Its motto: “Because a Family’s Love is Good Medicine.”

Likewise, there’s a commitment to all people working at Blue Cross and Blue Shield with physical and other challenges. Such challenges must not get in the way of vital daily contributions they make. Thus, all Blue Cross and Blue Shield Plans care not only for those who protect America, but also for those working here.

Why Are Rotisserie Chickens Cheaper Than Raw Chicken?

Rheanna O'Neil Bellomo,Delish August 2016

Picking up a rotisserie chicken-that slow-roasted, perfectly herbed bird-is one of our favorite quick dinner tricks. You can use it in casseroles, skillet dinners, tacos, soups, pot pies, and more. But is simply picking up a pre-cooked roast also the cheapest option?

It would seem that taking home a whole bird for about $7 is a total deal, especially when the store has done all the work of seasoning, brining and/or marinating, and slow cooking it. But the real answer is a little tricky. In most supermarkets, rotisserie chickens aren't any less expensive, they just seem it. That's because the "per chicken" price looks better at the deli counter while the per pound price is best in the meat aisle, Priceonomics reports.

The data-driven site decided to run an experiment and test seven rotisserie birds against seven raw chickens that they dressed and cooked-all from seven different grocery stores. They then weighed the roasts against one another, and the results were staggering: After being prepared and cooked, the bird from the refrigerated case almost always weighed more than its prepared counterpart. And that includes the cost of oil and seasonings you'd be using at home.

Is Rotisserie Chicken a Bargain?

Store	Rotisserie price per pound	Home-cooked price per pound*	Savings from home cooking
Albertson	$4.21	$1.32	$2.89
Wholesome Choice (halal)	$4.37	$1.71	$2.66
Stater Bros.	$3.88	$2.26	$1.63
Ralphs	$3.80	$2.84	$0.96
Whole Foods (organic)	$5.83	$4.96	$0.87
Costco	$1.61	$1.76	-$0.15
Smart & Final	$1.82	$1.99	-$0.17

*The prices for home-cooked chicken include 52 cents for salt, pepper, olive oil, heat, and washup.

The only exception was at Costco and Smart & Final, where it appears you can get a pre-cooked bird for less than cash per pound than doing all the work yourself. So save yourself some cash and shop smarter for poultry. Though, if you're lazy or in a rush, the ready-to-eat version will always win, right?

‘Simple Choice Plans’ To Debut In 2017 Marketplace Enrollment

By **Michelle Andrews** September 2, 2016

Despite much hand-wringing about health insurers exiting the marketplaces where people buy individual coverage, in many areas consumers will likely still have a choice of plans when the 2017 open enrollment starts in November. Aiming to make picking a plan easier, the federal government, which runs the marketplaces in roughly two-thirds of states, is encouraging insurers to offer “simple choice plans” as an option this fall.

The six new standardized plan designs will eliminate many of the moving parts that have bedeviled consumers trying to make apples-to-apples comparisons between plans. The government is providing guidelines for a simple choice plan at each of the bronze, silver and gold levels, and three more silver options for people who qualify for cost-sharing reductions based on their income.

In these plans, the deductibles and annual limits on out-of-pocket spending will be standardized, as will many of the consumer payments for medical services.

Insuring Your Health

KHN contributing columnist Michelle Andrews writes the series**Insuring Your Health**, which explores health care coverage and costs.

To contact Michelle with a question or comment, click here.

In the simple choice silver plan, for example, the deductible will be $3,500 and the maximum amount that someone will owe out-of-pocket for the year will be $7,100. For many specific services, consumers will have flat dollar copayments for services up front rather than having to meet their deductible before the plan picks up any of the tab. Some of these include primary care visits ($30), specialist visits ($65), urgent care ($75) and generic drugs ($15).

Insurers won’t be required to offer standardized plans on the federal marketplace, just as they aren’t required to do so in most of the state-based marketplaces that offer such plans.

Offering both standardized and non-standardized plans can present a challenge for consumers, say experts. Both need to be clearly differentiated online or consumers will have no easier time comparison shopping than before, said Sabrina Corlette, research professor at Georgetown University’s Center on Health Insurance Reforms who coauthored a recent report examining state efforts to offer standardized plans.

“It’s really important to get the consumer shopping experience right, otherwise you might as well not bother” with standardized plans, she said.

When the administration announced the simple choice plans in April, Kevin Counihan, CEO of the healthcare.gov marketplace,said the plans would “display prominently” on the website and have “clear visual cues” that would distinguish the simple choice plans from others.

A CMS official said there was no further information available at this time about how the plans will be displayed this fall.

In addition to potentially helping consumers wade through a bewildering array of options, standardized plans make it harder for insurers to design plans to be less attractive to people with expensive health care conditions, said Corlette. Insurers may be limited in their ability to make certain types of specialist care or drugs more expensive, for example.

Behavioral economics research tells us that simplifying consumer choices helps people make better ones. It makes sense that it will work with marketplace plans, too, but at this time that’s an unknown.

“We don’t yet know that standardized benefit design will help people make better choices and get into the plan that’s right for them,” Corlette said.

How PBMs make the drug price problem worse

By David Balto, contributor August 31, 2016

Recent price increases on the lifesaving allergy drug EpiPen have spawned a conversation about how drug pricing works in this country. Unfortunately the focus on this one product by a one-note media and headline chasing polls has obscured a far bigger issue — the corrosive role of Pharmacy Benefit Managers (PBMs) who oversee drug prescription plans in driving up consumer prices.

Mylan, the manufacturer of EpiPen, for example, receives less than half the list price for an EpiPen 2-Pak. PBMs — who do not research, develop, create or manufacture any new treatments or drugs generally claim 40 to 50 percent of a medicine's list price via an obscure and complex system of mandatory rebates — not to be confused with "kickbacks," "collusion' or other recognized improprieties.

On a $600 EpiPen, the PBM is likely receiving close to $300 on each prescription.

The role of the PBM is to aggregate drug purchasing power from payers (insurance companies, small businesses, and consumers) and supposedly negotiate the lowest price from drug manufacturers and the lowest dispensing fee from pharmacies.

Their revenue mainly comes from rebates paid by drug manufacturers in order to be carried on a PBM's system, creating perverse incentives toward PBMs dispensing more, not less, expensive drugs.

But instead of lowering costs, the largest PBMs, Express Scripts, CVS Caremark and Optum Rx, are incentivized to inflate drug prices. The higher the price, the higher the rebate — and walk away with a bigger slice of the pie.

Large employers who have some negotiating power may claw back some of that money — that's the idea of aggregating drug plans through a PBM — but small employers and consumers can't.

Meanwhile local pharmacies, which are the front lines of delivering health care and are the most trusted and accessible health care providers see their margins cut to the bone. On EpiPen they might get 4 percent, or $24, pennies compared to the PBM's profits, which can be to ten times greater. It's no wonder communities are seeing their local pharmacies disappear as PBMs rake in more and more of the available cash.

No other country has a private system of intermediaries to handle drug reimbursement in this way. And for good reason.

For a market to work effectively you need three things: choice, transparency and a lack of conflicts of interest. But on all three accounts the PBM market receives a failing grade.

Choice

The PBM market is dominated by three mega-companies that capture over 70 percent of the market. New entry is extremely difficult due to the massive economies of scale enjoyed by these giants and their ability to demand unreasonably favorable "discounts" from manufacturers unavailable to upstarts and new players.

Transparency

A large portion of PBM profits are derived from rebates they receive from drug manufacturers, but don't pass on to their consumers. How big is the difference? Unfortunately, we don't know because the information has not been disclosed to the public.

PBMs fight tooth and nail to prevent anything that might exposure the true origins of their massive profits. Transparency is considered essential for other health care markets to work. Yet when **state legislatures**, the **White House**, **consumer groups**, **unions** and **major employers** have sought to secure transparency, the PBMs have objected; like the Wizard of Oz they cry out, "don't look behind the curtain!"

If there was transparency when prices increase employers could "follow the money" – they could figure out what rebates are being paid and who received them. Giving them that information would enable employers to bargain effectively and secure lower prices. That's the way markets are supposed to work.

Conflicts

PBMs own and operate mail order and specialty pharmacies, but considering their purpose is to control drug dispensing costs, it's hard to believe the fox can guard the henhouse. In a PBM's perfect world, there would be no independent pharmacy and no local pharmacist advocating to make sure patients do not overpay for drugs.

Little choice, no transparency, conflicts of interest — so what's the result? Rapidly escalating profits for PBMs and high drug prices for the consumer. Since 2003 Express Scripts has seen its profit per prescription increased over 500 percent per adjusted script. Often PBMs are making more on prescriptions than the pharmacy, crushing small businesses and driving up health care costs across the board.

A system that rewards middle men over those who develop new treatments and manufacture real products makes no sense. It imposes unnecessary costs on the system and interferes with delivering the best health care for the lowest price.

When Congress looks at EpiPen or any other drug pricing crisis, it must look at the entire vertical supply chain. Transparency and choice at all levels of the supply chain are vital for consumers to be protected against escalating drug costs. It's time to make the PBM market work for consumers.

Medicare changes fiercely resisted

By Peter Sullivan - 08/12/16

The Obama administration is hitting resistance from industry groups as it tries to change Medicare payments before leaving office.

The administration argues its Medicare proposals will make payments smarter, save money and incentivize quality care. Opposition to the plans, it says, is mainly coming from entrenched interests that are seeking to protect their profits.

But opponents say administration officials are overstepping their authority and rushing to make changes before the clock runs out.

The Centers for Medicare and Medicaid Services (CMS) has put forward several proposals that would change how Medicare pays for care. The plans move away from the old system of paying for individual tests and procedures, instead seeking to reward doctors for delivering healthy outcomes.

The most controversial of these proposals would change how Medicare Part B pays for drugs. While Medicare now pays doctors a percentage of the cost of a drug, the administration wants to shift toward paying a flat fee.

Industry groups, including the Pharmaceutical Research and Manufacturers of America (PhRMA) and the group representing cancer doctors, have strongly objected, arguing the payment cuts would harm patients' access to drugs. Members of Congress in both parties have echoed those concerns.

"The health and well-being of seniors is nothing to be experimented with," Rep. Joe Pitts (R-Pa.) said at a hearing on the proposal in May.

Less controversially, the administration is making changes so that hospitals are paid a set amount, known as a bundled payment, for an entire episode of care, like a hip replacement or heart surgery, rather than getting paid individually for each test and procedure. If providers' costs are below the target and meet quality goals, they get to keep some of the money that is saved.

The American Hospital Association says the administration is making changes too fast; an expansion of the hip and knee program, for example, was announced just three months after it started.

"We are nowhere near having any lessons learned, but CMS is already proposing to expand it," said Joanna Hiatt Kim, a vice president at the American Hospital Association.

Proponents of the payment changes dismiss such critiques, arguing industries stand to lose money in a more efficient system.

"No shit, Sherlock," said Dr. Zeke Emanuel, a former Obama administration health adviser and professor at the University of Pennsylvania, when asked about industry objections. "Who are you taking the money from? You're taking the money from many of these organizations. They're going to be resistant. It's like, duh."

President Obama, in a journal article he wrote on ObamaCare in July, expressed his frustration with opposition to the changes, specifically citing the Medicare Part B drug proposal. He wrote that despite being able to work with some health groups, "others, like the pharmaceutical industry, oppose any change to drug pricing, no matter how justifiable and modest, because they believe it threatens their profits."

Even supporters of the changes acknowledge that there is a sense of urgency to act before Obama leaves office.

“The last few years they've been working on them and they're finally ready for prime-time and there is I think some sense that, you know, we've got to push it out now because if we don't push it out now our work may well go for naught,” Emanuel said.

The drug-pricing proposal has encountered widespread opposition in Congress, including from Democrats.

Every Democrat on the Senate Finance Committee signed a letter to the administration in April expressing reservations about the proposal. They warned that patient access to drugs could be harmed if Medicare payments fall below what it costs to acquire the drug. They called for changes when the rule is finalized, while Republicans have called for the proposal to be scrapped.

Lobbyists expect that the administration will go forward with the proposal, finalizing it in September or October, but make changes to address the issues raised by Democrats. Those changes are expected to include reducing the geographic area that the program affects to exempt rural providers and exempting drugs for which there is no good alternative treatment.

Rep. **Larry Bucshon** (R-Ind.) has introduced a bill to block the drug-pricing proposal, and lobbyists expect it could move forward in the lame-duck session after the election.

A Senate Democratic aide said that Democrats are waiting to see what changes the administration makes in the final rule. It is too early to say whether Democrats would support a bill to block the program after the election, the aide said.

“They kind of want to keep their powder dry,” the aide said.

In an interview, Dr. Patrick Conway, the No. 2 official at CMS, said he is working with Congress on the drug-pricing plan.

“I think we have engaged with members of Congress on the Part B model,” he said. “We’re listening to those members on both sides of the aisle.”

Rep. Lloyd Doggett (D-Texas), one of the few lawmakers to express support for the proposal, said he is disappointed in his Democratic colleagues who have objected.

“I've been disappointed, and there's no doubt that PhRMA’s influence here in Congress is not limited to the influence it exercises over Republicans,” Doggett said.

He added that PhRMA has been lobbying lawmakers “vigorously,” both directly and through “every group of individuals with given diseases that they’ve ever contributed to.”

Kelsey Lang, a senior director at PhRMA, countered criticism of her group by noting that opposition to the model is “very broad” and includes provider groups and others as well.

While controversy has been swirling around some specific proposals, the broader idea of changing the incentives from Medicare payments has bipartisan support.

The bipartisan “doc fix” bill that Congress passed last year put forward a new system of rewarding doctors for healthy outcomes in patients. CMS has won praise from Republicans for its outreach and openness in implementing that law.

And Dr. Bill Frist, a former Republican Senate majority leader from Tennessee, has praised the administration's new "bundled payments" and called for more to be implemented.

"Anytime you are asking people to focus on a broader episode of care, there's going be a cohort of people that may push back on that," Conway said. But he said bundled payments have a "long history of success" and expanding them and making participation mandatory is "a very natural next stage."

He said that payment reforms like these are "a bipartisan issue, and we need to keep it that way."

Aetna reverses course on ObamaCare outlook

By Sarah Ferris - 08/02/16

The nation's third-largest health insurer is casting doubt on its future in the ObamaCare marketplace, offering a stark reversal from its relatively optimistic outlook last fall.

Aetna Inc. on Tuesday became the last of the nation's five largest insurers to predict that it will lose money next year through the ObamaCare exchanges.

Aetna CEO Mark Bertolini told investors that the company is expected to lose more than $300 million this year. He said the company is now backing off its previous expansion plans and is undertaking a "complete reevaluation" of its participation in the ObamaCare marketplace.

The company currently sells plans in 17 state exchanges and was planning to expand to five more next year.

"We believe it is only prudent to reassess our level of participation on the public exchanges," Bertolini told investors Tuesday.

The grim prediction from Aetna is the latest blow to the Obama administration as it looks to stabilize the three-year-old marketplace. Federal health officials had previously touted Aetna's commitment to the marketplace last November, after UnitedHealthGroup announced it planned to exit the exchanges entirely.

Aetna reported a "poor performance" for its ObamaCare plans, as well as "disappointing" expectations for the upcoming year, despite better-than-expected profits in the most recent quarter.

It's a major shift in tone from the insurer, which previously said it would remain in the exchanges. In October, Bertolini told investors he believed the exchanges were "a big opportunity."

Aetna's decision to pull back its ObamaCare expansion plans comes just one week after Anthem also announced it was reexamining its participation in the exchanges. Anthem, one of the top players in the exchanges, said it was expecting mid-single-digit losses next year, after previously predicting slight gains.

The other three top insurers — UnitedHealth, Cigna and Humana — have all also projected losses on ObamaCare in the upcoming year.