# THE OTHER RETIREMENT ISSUE

# FACTS

- At age 65 Americans must apply for Medicare health insurance.
- Those with 40 quarters of social security coverage get Part A free and pay for Part B and may opt to pay for Part D
- Those without 40 quarters of coverage must pay for Part A.
- At 65 health insurance to assist with paying for what  Medicare Coverage does not pay is called Medigap.


GRANDMA!
www.yesemails.com

# JUST THE FACTS

- Teachers in Illinois are not covered by Social Security so they do not receive Medicare Part A free unless:
  - Through employment outside of teaching they earned 40 quarters of coverage.
  - A spouse or an eligible ex-spouse earned 40 quarters of coverage.

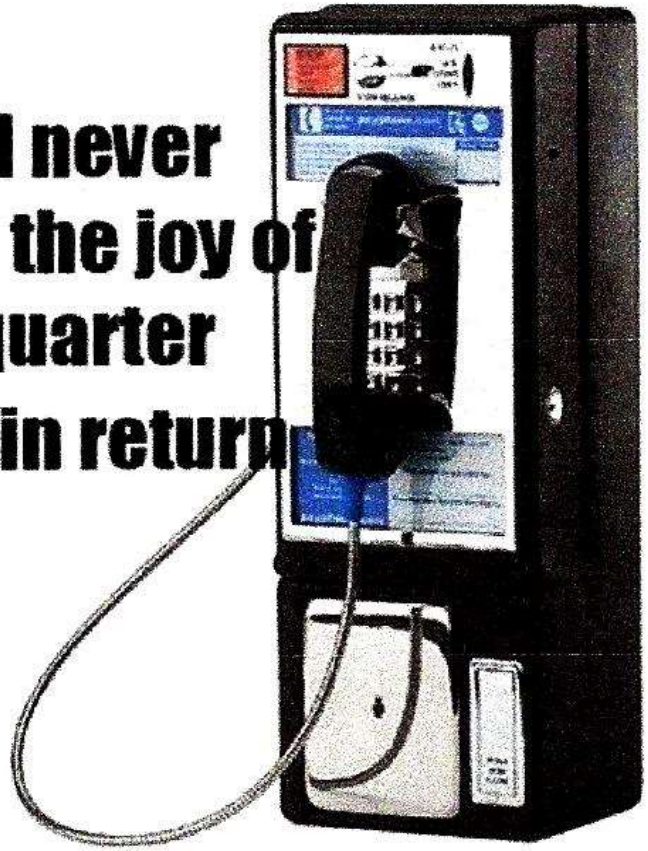
# MORE FACTS

- Since 1986 some school districts are now requiring employees to contribute toward Medicare so that they will be eligible to receive Medicare Part A and be able to pay for Part B.


# LOWER BENEFIT

- Teachers in Illinois who have social security benefits have their benefits reduced by 60% under the Windfall Law.

My kids will never know the joy of finding a quarter in the coin return



# RETIREES UNDER 65

- May have COBRA benefits for 18 months.
- Then need to find a health plan through the pension fund or through a spouse

AHIP
America's Health Insurance Plans

# AGE 65!!

- Three months before age 65 individuals should apply for Medicare. There is a 7 month window. Failing to apply results in penalties for a life time!

# AFFORDABLE CARE ACT

- THE ACA a.k.a. Obama Care impacts all Americans.
- Insurance companies offer plans to meet the law.

# HEALTH INSURANCE PLANS

- Obama Care requires individuals to have health insurance.
- Those who do not have health insurance pay a tax penalty

# ACA INSURES MORE

## Federal report: 7 million fewer uninsured this year

**Laura Ungar**
USA TODAY

The number of Americans without health insurance dropped from 36 million last year to 29 million in the first quarter of this year, according to the latest in a string of reports showing uninsured rates are on the decline.

The newest report, to be released Wednesday by the U.S. Centers for Disease Control and Prevention's National Center for Health Statistics, contains early estimates from the National Health Interview Survey based on data for 26,121 people from across the nation. The estimate of 29 million, which represents 9.2% of Americans, reflects the portion of respondents who reported being uninsured at the time of the interview.

AFP/GETTY IMAGES
**Obama**

"Our report doesn't address any reasons" behind the drop in the uninsured, lead author Robin Cohen says. "We're a policy-neutral research organization."

Research published last month in the *Journal of the American Medical Association* analyzed 2012-15 results of the Gallup-Healthways Well-Being Index and found a 7.9 percentage point drop in the number of people who reported being uninsured since the Affordable Care Act took effect. And a report released in March by the U.S. Department of Health and Human Services said the number of adults without insurance fell 16.5 million from five years ago.

**"Certainly, the biggest thing that's going on is the ACA."**

**Rachel Garfield**, a senior researcher at the Kaiser Family Foundation

"Certainly, the biggest thing that's going on is the ACA," says Rachel Garfield, a senior researcher and expert on the uninsured at the Kaiser Family Foundation. "The reason we know that is that groups being targeted by the ACA are seeing the sharpest declines."

Wednesday's report details insurance gains for various groups in the first quarter of this year:

- Among adults 18-64, 18.1% had public coverage, 70.4% had private coverage and 13% were uninsured. The uninsured rate was down from 16.3% in 2014.
- Among children, 4.6% were uninsured — less than half the 1997 rate of 13.9% — and 40.4% had public coverage. Just over 56% were covered by private plans, up slightly from 2013, reversing a 14-year trend.
- Since 2013, poor and near-poor children and working-age adults saw the biggest drops in their uninsured rates. And working-age adults who live in states that expanded Medicaid under the ACA were less likely to be uninsured than residents of non-expansion states.

# COST OF PLANS

- Individuals with limited means may receive health insurance at no cost.
- Someone has to eventually pay.
- Some may have high deductibles.

# OPTIONS

- Health Market Place
- State Plans
- Private Plans
- Medicaid

# HEALTH CARE IMPACT

- Cost of a Family Health Plan Tops $17,000.
- The individual employer coverage is $6,251.
- Average deductible is $1,318

# LOOKING AT TRENDS


- Health Insurers are merging.
- Less competition
- Market Control
- Lower costs through efficiencies
- More clout with providers

# MERGERS AFFECTING COSTS

- Pharmaceutical companies merging with one another
- Hospitals and pharmacies merging
- Out patient facilities without physicians

# HEALTH INSURERS

- All insurance companies exist to make a profit including health insurance companies.
- ACA meant to ease the risk of insurers—risk corridors


# PARTNERSHIPS TO CONTOL COSTS

## Blue Cross, Advocate Health launch low-cost health plan

BY TINA SFONDELIS
Staff Reporter

Blue Cross and Blue Shield of Illinois and Advocate Health Care are teaming up to create a low-cost health plan in which the neediest patients will be able to access more than 4,000 primary and specialty physicians across five Chicago-area counties.

BlueCare Direct will be the insurer's lowest-cost insurance offering for individuals and families in terms of monthly premiums and out-of-pocket costs, according to Blue Cross and Advocate. It will be offered both on and off the Get Covered Illinois exchange and will also be available for small group customers.

Illinois residents should have been able to window shop for new plans beginning Oct. 1, but that has been delayed because of budget and staffing issues stemming from the lack of a state budget, according to Blue Cross spokesman Mike Deering.

As of Sunday, the BlueCare Direct plan was not listed on the Get Covered Illinois exchange.

Still, Illinois residents will be able to enroll for the new plan beginning on Nov. 1 at getcovered.Illinois.gov or at bcbsil.com.

The BlueCare Direct announcement comes a week after Blue Cross, the state's largest health insurer, said it would eliminate the Blue PPO plan, its most popular individual plan. Members on that plan were switched to the Blue Choice plan.

The BlueCare Direct plan is not meant to replace the Blue PPO plan but to be an additional choice, said Deering, who added the goal of creating the plan was to expand greater access to health care coverage.

Dr. Opella Ernest, chief medical officer at Blue Cross and Blue Shield of Illinois, participates in a panel discussion. | SUN-TIMES FILE PHOTO

The partnership between Downers Grove-based Advocate and Blue Cross stems from an agreement the two reached in 2010 to create the country's biggest Accountable Care Organization.

"We believe it's an opportunity to increase the access across the Chicago and metro area. We've been in the community a long time, and we thought it made sense to partner to provide and to be part of *really* broad, affordable quality care," said Dr. Opella Ernest, chief medical officer for Blue Cross.

BlueCare Direct will offer patients access to more than 4,000 primary care and specialty doctors across Cook, DuPage, Kane, Lake and Will counties. It includes more than 250 sites of care, including nine hospitals and a children's hospital.

Dr. Lee Sacks, chief medical officer and executive vice president for Advocate Health Care, said the partnership helps alleviate some problems patients have reported in terms of not being able to access specialized care within the same hospital network.

That's a key difference from a typical HMO plan, Sacks said.

"The exciting thing for us is about 4,000 physicians in the Advocate network that cover every specialty with multiple physicians. . . . So there's access to everything. We're dedicated to breaking down those barriers," Sacks said.

Sacks said some patients had complained about the need for a referral for specialty care. He said patients won't need a referral within the BlueCare Direct plan, but will still be encouraged to designate a primary care physician.

Patients who use the plan will get the same services all other Advocate patients receive, including same-day evaluations for cardiac risks, mammograms and for primary care visits.

"We think that [the plan] provides the whole of every sub-specialty," Sacks said.

Open enrollment for the plan begins Nov. 1 and ends on Jan 31. In order to be enrolled for 2016, patients must enroll by Dec. 15.

Email: tsfondelis@suntimes.com
Twitter: @TinaSfon

# MARKET CONTROL

## Health insurer to curb sales to small businesses

**By Ameet Sachdev**
Chicago Tribune

Land of Lincoln Health confirmed Monday that the startup insurer will limit the sales of new policies for small employers for the last two months of the year in order to manage its exposure.

The nonprofit insurer said in a statement that it is focused on "responsible growth" after enrolling more than 50,000 members in its health plans in 2015. Land of Lincoln, a nonprofit health insurer spawned by the Affordable Care Act, signed up about 4,000 members in 2014, its first year offering policies.

Land of Lincoln said in a statement that the enrollment was ahead of target.

"As we move toward the end of the year, we are strategically managing our performance, including ensuring we are not surpassing our enrollment targets," the statement said. "Responsible growth ensures that our members have the service and benefits they deserve."

The decision affects businesses with two to 50 employees. The company said it will continue expanding its individual and large group business.

Land of Lincoln is the only Consumer Oriented and Operated Plan, or CO-OP, in Illinois. The plans were an experiment under the health act to infuse competition and lower prices for consumers shopping for individual and family policies on state and federal exchanges. Land of Lincoln received a $160 million low-interest federal loan to get started.

But many of the 23 plans are struggling to survive amid heavy financial losses. Eight have collapsed or are unwinding operations, including ones in Colorado and Oregon that announced Friday they were folding.

Land of Lincoln's growth came after it lowered its monthly premiums for 2015 by as much as 30 percent from 2014.

The company said it remains "steadfast and committed to providing an alternative health insurance option in Illinois."

asachdev@tribpub.com
Twitter @ameetsachdev

# NEW VENUES FOR INSURANCE

## A changed marketplace for health insurance

### Startup to join fray at time of upheaval

**By Ameet Sachdev**
Chicago Tribune

Chicago-area residents who buy health plans on the federal online insurance marketplace will see some new options for 2016 that are a sign of where health care is headed.

Insurance startup Harken Health will launch in Cook County on Nov. 1, when the Affordable Care Act's third open enrollment season begins, company executives told the Tribune in an exclusive interview. Harken will combine an insurance plan with its own medical clinics in a kind of holistic system that President Barack Obama's health care law encourages.

Harken's entry comes at a time of upheaval in the Illinois individual marketplace. Assurant Health, which was new to the Illinois health insurance exchange this year, is shutting down its financially troubled insurance business and will not sell plans during open enrollment. Blue Cross and Blue Shield of Illinois, the state's largest health insurer, is eliminating its popular individual plan that had the largest network of doctors and hospitals. Blue Cross said on its website that it plans to announce details about a new product for the Chicago area later this month.

Plans and pricing for 2016 are expected to be available as early as Sunday on Healthcare.gov for consumers to begin window shopping.

"There's major flux in the market," said Bill Hallberg, chief enrollment officer at ACAenroll .com. "Carriers are reshuffling the decks on their offerings in order to reach some form of profitability."

Harken is a symbol of the changes. The company is an independently operated subsidiary of UnitedHealth Group, the nation's largest health insurer. UnitedHealth has taken a cautious approach to the Affordable Care Act, also known as Obamacare. It did not participate in the first year of the Illinois exchange in 2014 and this year offered individual plans only in Cook County. A company spokesman said UnitedHealth will offer plans in more Illinois counties in 2016 but declined further comment.

In 2014, UnitedHealth put together a small group of employees, led by Tom Vanderheyden, vice president of business development and innovation, to come up with something new. Acknowledging the frustration of

*Turn to* ***Obamacare, Page 7***

# LIMITING CHOICES



## Rush, Aetna offer joint health plan

### Follows narrow-network trend of lower cost via fewer choices

By Ariket Sachdev
Chicago Tribune

Rush Health has formed a partnership with insurance giant Aetna to create a health insurance plan available to Chicago-area employers starting next month, the two organizations said Thursday.

Called Aetna Whole Health Chicago, the plan will have cheaper premiums than the insurer's PPO plan, but there's a trade-off. The plan will limit consumers' choices to Rush's 1,300 primary care doctors and specialists at its four hospitals. With few exceptions, the plan will not pay for trips to doctors who aren't in the Rush health system.

The plan reflects the rapidly changing U.S. care system, as insurers cozy up with health systems on new payment arrangements and care models, moving away from uncoordinated, volume-driven care to improving the health of populations and paying for value.

One outcome of collaboration has been the creation of so-called narrow provider networks. As the name implies, narrow networks place limits on the doctors and hospitals available to subscribers. Less choice in a health plan typically means lower premiums.

More employers are evaluating narrow network plans in an effort to control health care costs. In the individual market, where insurers are under intense pressure to keep

Health Network in Mesa, Ariz., Bertolini said Banner saw these results in the Aetna co-branded fully insured plan:

- 8 percent medical cost savings.
- 9 percent reduction in radiology services.
- 9 percent decrease in avoidable admissions.

The collaboration with Aetna is a first for Rush. The company will take on financial risk in the cost of care as well as patient outcomes and quality measures, said Brent Estes, the health system's president and CEO.

"We see this as a much deeper collaboration, from how the product is designed and priced to how do we work together to care for patients," Estes said. "We think this will break down some of the historical issues between providers and payers."

Nitin Bhargava, president of Aetna's Illinois operations, said the company partnered with Rush because of its reputation for quality and readiness to take on insurance risk. There's a sig-

> ***"We think this will break down some of the historical issues between providers and payers."***
>
> *— Nitin Bhargava, president of Aetna's Illinois operations*

# DROPPING PLANS

## Biggest insurer dropping top PPO

### Blue Cross of Illinois ending most popular plan due to costliness

**By Ameet Sachdev**
Chicago Tribune

Big changes are coming next year for Blue Cross and Blue Shield of Illinois individual health plans, causing stress among some consumers before open enrollment on the state's health insurance exchange begins Nov. 1.

The state's largest health insurer is eliminating its most popular individual plan, called Blue PPO, which has the largest network of doctors and hospitals of any plan the company offers, because it was too costly for the company. The plan will still be available for employer groups next year.

Tony Schor of Highland Park, who bought Blue Cross insurance for his family of four through a broker, said he was startled when he got a letter from the company a few weeks ago telling him his plan was being discontinued at the end of the year.

"I'll be honest with you, I'm concerned," said Schor, a small-business owner. "I'm truly at the edge of my seat because I don't know what the new plan will look like."

Schor is one of 173,000 members enrolled in the Blue PPO who will have to find a new plan. It's a significant upheaval in the Illinois individual market. Two out of every five Blue Cross customers who buy individual or family plans on the exchange or direct

# WHAT NEXT?

JOHN KONSTANTARAS/FOR THE CHICAGO TRIBUNE

Cheryl Mostowski of Algonquin feels misled by her new insurance company after she found out this month that it's dropping her doctor from its network.

## Sick people caught in the middle

### Health insurers can eliminate providers whenever they deem

BY AMEET SACHDEV
Chicago Tribune

Some Chicago-area consumers were surprised to learn this month that insurance companies can at any time limit their access to doctors and hospitals in health plans.

Land of Lincoln Health announced last week on its website that it will drop the University of Chicago's top-flight medical center from its network as of March 1, after the two sides couldn't agree to terms on reimbursement rates.

The removal blindsided people who began coverage with the Chicago-based insurer Jan. 1. Customers thought their U. of C. doctors would be covered all year because the doctors were listed in Land of Lincoln's network directory when the customers bought plans during open enrollment in the public marketplace under the Affordable Care Act.

Trimming networks after enrollment season ends is not uncommon in Illinois and other states, highlighting glaring holes in state insurance regulations, consumer advocates say. In Illinois, rules don't prohibit health insurers from changing their networks after people enroll in either employer-sponsored or marketplace plans, forcing consumers to find new doctors or pay more of the bill if they receive care outside their network.

"There aren't a lot of standards across the states on how to handle a provider dropping out of a plan," said Claire McAndrew, private insurance program director at Families USA, a national health care consumer advocacy group. "But that doesn't mean states can't put standards in place."

Turn to Options, Page 4

- Choose a network that has your physician
- Network drops your physician
- You are stuck in the plan

# ACA EFFECT

## Obamacare catalyzes health market consolidation

**Rosenthal,** *from Page 1*

The goal has seemed to be to amass enough size and scope to exercise a bit of leverage in trying to push back against government efforts to rein in health costs, which might spare the family budget but threaten to crimp company profits.

On Wednesday's quarterly earnings call with analysts, Stefano Pessina, the 74-year-old Italian billionaire CEO and executive vice chairman who leads Walgreens Boots, itself the product of a fairly recent merger, downplayed the additional bargaining power with benefits managers and insurers the merger would create.

A Rite Aid acquisition was all about synergies and an increased footprint, he insisted.

But Pessina, trained as a nuclear engineer and an academic before taking over his family's drug distribution business and building it into a European and now global retail and health care force, has previously come across like one of James Bond's chattier counterparts on the topic.

SHAUN CURRY/GETTY-AFP 2008

Horizontal consolidation. Vertical consolidation. Whatever's there and makes sense, he has said again and again.

"The American market," Pessina told analysts back in April, is primed for "consolidation because the margins are squeezed everywhere. The government is more and more in charge for the costs of the health care business, and so for sure they will exercise their power to squeeze the cost as much as possible, as we have seen in Europe for decades.

> ***"The American market (is primed for) consolidation because the margins are squeezed everywhere."***
>
> *— Stefano Pessina, Walgreens Boots Alliance CEO and executive vice chairman*

"So the complex structure of delivering the medicines to the patients will have to be rationalized," he said. "And as a consequence, it's easy to believe that we will have additional synergies coming from M&A activities."

Because regulators have yet to dampen enthusiasm for this sort of voraciousness, there's been an orgy of activity in the space with dozens of companies coming together of late, figuring it's eat or get eaten, go big or go home.

Among them: Anthem and Cigna, Aetna and Humana, CVS and Target's pharmacy business, Illinois Health and Science and IBA Molecular North America, National Surgical Healthcare and Optim, UnitedHealth Group and pharmacy benefits manager Catamaran, Navigant and RevenueMed, Alexian Brothers Health System and The Medical Care Group, Pfizer and Hospira, and AbbVie and Pharmacyclics.

To name but a few.

Not only are these companies girding for marketplace changes Obama's health care program brings about, they are also trying to spur growth, innovation, new products or anything else they have had trouble creating on their own.

To be fair, this may be part of what Walgreens Boots is attempting to do, too. If margins are to shrink, Pessina and company will be hard-pressed to give Wall Street the quarterly improvements it demands.

Rite Aid would make it decidedly bigger, though it's not entirely clear just how much bigger. Pessina refused to hazard a guess as to how many of the more than 12,000 o chains have in States he expects regulators to demand the sprawling combo shed.

"It is very difficult for us to make public comments," Pessina said. "When we have public authorities, it is better for us not to interfere at all."

Let the M&A bankers and lawyers work it out, find out what the government prescribes and what it's going to cost.

**Margin call:** A computer programmer at UCLA sent a message to the Stanford Research Institute in the first host-to-host connection on the Advanced Research Projects Agency Network 46 years ago Thursday. Only the first two letters — L and O — were transmitted successfully before the system crashed, but it was a start for today's Internet.

# MEDICARE COSTS IN 2015

- Medicare Part A costs $411 a month if you do not have coverage.
- Part B costs are based on your annual income and start at $121.80 a month

# NO COLA

# NO BENEFIT BOOST FOR ELDERLY

## Social Security won't adjust for cost of living

**Robert Powell**
Special for USA TODAY

It could be belt-tightening time for the nation's 65 million seniors. For just the third time in four decades, Social Security recipients won't get an annual cost-of-living adjustment.

The announcement Thursday by the Social Security Administration means many older Americans may see a reduced standard of living, particularly 30% of Medicare beneficiaries — about 17 million Americans — who could see their Part B premium and deductible rise 52% because of provisions in the Social Security law.

The decision introduces a $12 billion complication into contentious budget talks between Congress and the White House.

The price tag for Congress to protect seniors from the higher Part B premiums and deductibles could be about $10 billion. Plus, states are likely to ask Congress for $2 billion to cover the extra cost of Part B premiums for the 10 million dual Medicare-Medicaid beneficiaries whose premiums are paid by state Medicaid programs.

Seniors won't get a cost-of-living adjustment, known as a COLA, in 2016 because such increases are tied to the general rate of inflation — no inflation, no increase. In the past year, prices for the goods and services used to calculate inflation fell, mostly because of a dip in fuel prices.

Though prices on paper may have dropped, the cost of living for Social Security beneficiaries is rising, and their quality of life is falling. Social Security recipients have lost nearly a fourth of their buying power over the past 15 years, according to the Senior Citizens League. Consider: The cost of housing, often a retiree's greatest expense, rose 44% since 2000; heating oil, 159%; eggs, 117%; and gasoline, 76%. In contrast, Social Security COLAs averaged just 2.2% per year since 2000, or 36.3% overall.

"Since the goods retirees consume have actually increased in price over the last year, it means that retirees are going to be slightly worse off next year vs. this year, since their Social Security retirement benefits aren't going to be increasing, but their expenses have been," said David Blanchett, head of retirement research at Morningstar Investment Management in Chicago.

The difference will be especially pronounced for retirees who spend more on medical care, because that expenditure group had the largest inflation rate over the past year, Blanchett said. "The impact isn't huge, but it will likely mean retirees will have to cut back a little bit going into 2016," he said.

**'How do I pay my bills?'**
Many rely on Social Security for most of income. **IN MONEY**

# 2016 CHANGES CURRENTLY

- There will be no COLA in 2016.
- Hold Harmless will take effect for 70% of the population.
- The other 30% are on the hook for a premium increase that would be shared by all.
  - 2.8 million new beneficiaries
  - 1.6 million whose premiums aren't deducted from social security payments.
  - 3.1 million people with incomes above $85,000 annually

# WHY YOUR COSTS MAY RISE

**Will Your Medicare Premiums Rise?**
It depends on your current income and Social Security status.

| Your situation now | Will you pay higher premiums with a zero COLA? |
|---|---|
| You pay standard Part B premiums and have them deducted from your Social Security checks. | **No**, you would be held harmless under the law. |
| You pay higher-income Part B premiums. | **Yes**, even if you receive Social Security benefits. |
| You're enrolled in Part B but pay your premiums directly to Medicare. | **Yes**, because your premiums are not deducted from Social Security benefits. |
| Your Part B premiums are paid by your state. | **No**, because your state will continue to pay your premium. |
| You pay permanent penalties because you signed up late for Part B. | **Yes**, you'll pay more than you do now, because the penalties will be calculated as a percentage of the higher standard premium for 2016. |
| You are not yet enrolled in Part B but will sign up in 2016. | **Yes**, since you are new to the program. |

# PART B NEW COSTS

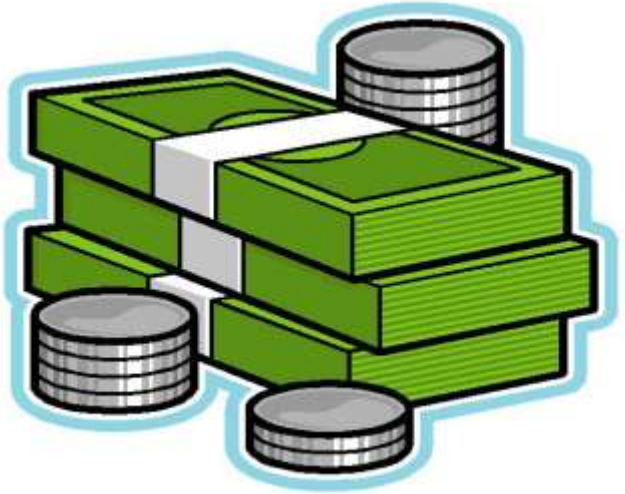
- The monthly rate increases would be:
- $104.90 to $121.80 for up to $85,000
- $146.90 to $170.50 up to $107,000
- $335.70 to $509.80  over $214,000

# BUDGET ACT PASSED AWAITING SIGNING

- The monthly rate increases would be:
- $104.90 to $123.70 for up to $85,000
- $146.90 to $226.00 up to $107,000
- $335.70 to $389.80 over $214,000
- 15% increase instead of 52 per cent increase.
- Also includes a $3.00 surcharge

# ESCALATING COSTS

- 2015 Medicare deductible was $147.00
- 2016 Medicare deductible will be $166.00



# IMPACT ON RETIREES

- With limited social security amounts and the rise of costs, soon more retirees will receive no check and will have to send in money for Medicare coverage


# MEDICARE COSTS


- Part D is the prescription cost. This is covered by your Medigap policy which you must purchase at additional cost. If your annual income is above $85,000 you pay an additional premium to Medicare

# PRESCRIPTION COSTS

- Prescription Costs are expected to increase by 17% next year
- Certain drugs have seen dramatic increases


# DRUG PRICE HIKE WHY?

# Adverse reaction to drug price hike

## Company raising $13.50 pill to $750 sparks outrage, call for industry probe

**By John Russell**
Chicago Tribune

U.S. Rep. Jan Schakowsky, a longtime pharmaceutical industry critic, is calling for a congressional inquiry into why a small drug company sharply raised the price of a drug that treats life-threatening infections.

The Illinois Democrat called the move by Turing Pharmaceuticals to raise the price of Daraprim, a 62-year-old medicine, from $13.50 per tablet to $750 last month a "particularly outrageous example" of how the pharmaceutical industry sets drug prices, sometimes making them unaffordable.

"It is a clear signal there is big trouble out there for anyone who needs or might need medication," Schakowsky said at a news conference Tuesday morning in front of a Walgreens store at the Wrigley Building downtown. "It also goes to show there is hardly any lengths that some of these big pharmaceutical companies won't go to in order to keep the price of drugs high."

Americans have a low opinion of pharmaceutical companies, according to polls. As far back as 1991, 73 percent of Americans said they considered the high cost of prescription drugs an important reason for rising health care costs, Gallup Inc. said. People surveyed last month by Gallup ranked the pharmaceutical industry 23rd out of 25 industries.

MICHAEL GRAAE/NEW YORK DAILY NEWS

Turing CEO Martin Shkreli now says he'll cut back on the price increase.

Now drug prices could become an issue in the presidential campaign. Hillary Clinton, a Democratic candidate and longtime supporter of the Affordable Care Act, laid out a plan Tuesday to rein in the rising cost of prescription drugs.

Clinton's plan would cap monthly and annual out-of-pocket costs for prescription drugs to help patients with chronic or serious health conditions. It would also seek to increase competition for traditional generic versions of specialty drugs to drive down prices and offer more choices to consumers.

Clinton's main challenger for

*Turn to **Drug, Page 5***

# CONTROL OF DRUG COSTS

MATT DOLKINGER/AP 2015

High-priced drugs seem to be making the public view the drug industry unfavorably.

## Americans want government to curb drug costs, poll finds

By Ricardo Alonso-Zaldivar
Associated Press

WASHINGTON — A new poll finds Americans are worried about medication costs and broadly support government action to curb drug prescription prices.

Overall, 72 percent said the costs of prescription medications are unreasonable, according to a poll released Thursday by the nonpartisan Kaiser Family Foundation.

Regardless of party affiliation, large majorities support requiring pharmaceutical companies to disclose how they set prices (86 percent); allowing Medicare to negotiate drug prices on behalf of beneficiaries (83 percent); limiting what drug companies can charge for medications to treat serious illnesses (76 percent); and allowing consumers to get prescriptions filled by pharmacies in Canada (72 percent).

The 2016 presidential candidates continue to debate President Barack Obama's 5-year-old law expanding coverage for the uninsured, but the survey suggests the public has other priorities.

"The public is more focused on consumer issues like the price of drugs and out-of-pocket costs than the continuing political battles over the health care law," said Drew Altman, president of the foundation, a clearinghouse for information on the health care system.

The Pharmaceutical Research and Manufacturers of America argues that government price controls would stifle an innovative industry that is delivering cures for life-threatening illnesses and allowing many people with chronic disease to lead productive lives.

But high-priced new drugs, including a $1,000 pill for hepatitis C, have alarmed the public.

Insurers are complaining and so are state Medicaid programs and the Department of Veterans Affairs, which are legally entitled to lower prices.

Insurers and employers often require patients with private coverage to pay a bigger share of the cost of new drugs. At the same time, prices for some of the old generic standby medications have soared.

As a result, the drug industry seems to be taking a beating when it comes to public opinion. Only about 4 in 10 in the poll viewed pharmaceutical companies favorably, about the same share that holds a positive opinion of oil companies.

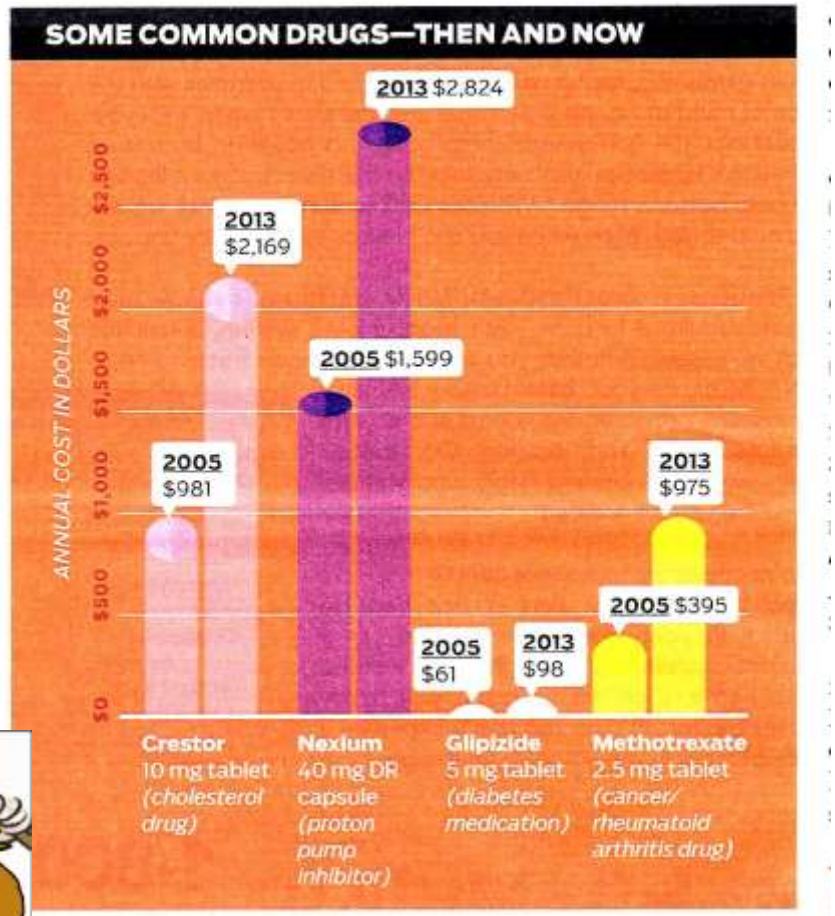
Overall, 73 percent said drug companies make too much profit.

"It's clear that drug companies have overreached and their pricing is not sustainable," said Topher Spiro, the top health policy expert at the Center for American Progress, a think tank often aligned with the White House.

But it won't be easy to translate public sentiment into government policies that don't spawn new problems.

"To arbitrarily limit the price of drugs without regard to benefit or value would not be wise," said Spiro. More transparency is needed about how pharmaceutical companies price their products, and more research is needed to establish which drugs work best, he added.

# DRUG PRICES RISE




# RE-ADMISSION ISSUE

Illinois hospitals suffering from pain of READMISSIONS

By John Russell | Chicago Tribune

At Presence Saint Joseph Medical Center in Joliet, administrators were so concerned about the number of discharged patients being readmitted for treatment that they took extra steps.

In the past few years they set up several ...inics for those with chronic diseases to ... care. Nurses reminded patients to take ...ations and see their doctors. The ...hasized a healthy lifestyle to avoid the ...a serious flare-up.

...ps, at least for now, are still not enough. ...ns are still too high, the federal

# RE-ADMISSION HOSPITALS

## High readmissions, high fines

More than 100 hospitals in Illinois are being penalized for having too many patients return within a month of discharge. Those hospitals will see their Medicare reimbursements reduced by up to 3 percent this year. (The national average penalty is 0.61 percent.)

**CHICAGO-AREA HOSPITALS FACING THE LARGEST PENALTIES**

*Twenty-five hospitals in metropolitan Chicago will be fined for high readmissions, although many have improved from last year. Here are the top 10, with each hospital's percentage reduction in Medicare reimbursements this year and last year, in parentheses.*

1. Presence Saint Joseph, Joliet 2.79% this year (2.66% last year)
2. Louis A Weiss Memorial, Chicago 1.52% (1.54%)
3. St. Bernard, Chicago 1.36% (1.43%)
4. Advocate Trinity, Chicago 1.2% (1.13%)
5. Roseland Community, Chicago 1.19% (1.54%)
6. Presence Saint Joseph, Chicago 1.12% (same)
7. Holy Cross, Chicago 1.09% (1.14%)
8. Rush University, Chicago 1.06% (1.17%)
9. Northwestern Memorial, Chicago 1.03% (1.98%)
10. Advocate Illinois Masonic, Chicago 0.78% (1.02%)

# WAYS TO OFFSET REDUCTIONS

# Northwestern's far-out plans

## The teaching hospital seeks growth from a DeKalb care network

BY KRISTEN SCHORSCH

When Northwestern Memorial HealthCare beat out Advocate Health Care for the chance to scoop up far west suburban KishHealth System, it signaled [illegible]minant health [illegible]g to go to bulk

KishHealth, a two-hospital system based in DeKalb, almost 70 miles west of the Loop, has 123 hospital beds. Northwestern has 1,601, 13 times as many. KishHealth's $221.7 million in annual revenue amounts to just 6 percent of Northwestern's $3.71 billion.

The pairing might not seem to give Northwestern much, but in the evolving world of hospital economics, it makes sense, experts say. "I think it's a market

See NORTHWESTERN on Page 15

### A SNAPSHOT OF KISHHEALTH

KishHealth System would give Northwestern Memorial HealthCare a new outpost nearly 70 miles west of Chicago, in DeKalb.

**Footprint:** Kishwaukee Hospital (98 beds), Valley West Hospital (25 beds) and more than a dozen outpatient facilities

**Revenue** $221.7 million*

**Who pays the bills***


**Number of physicians:** 313

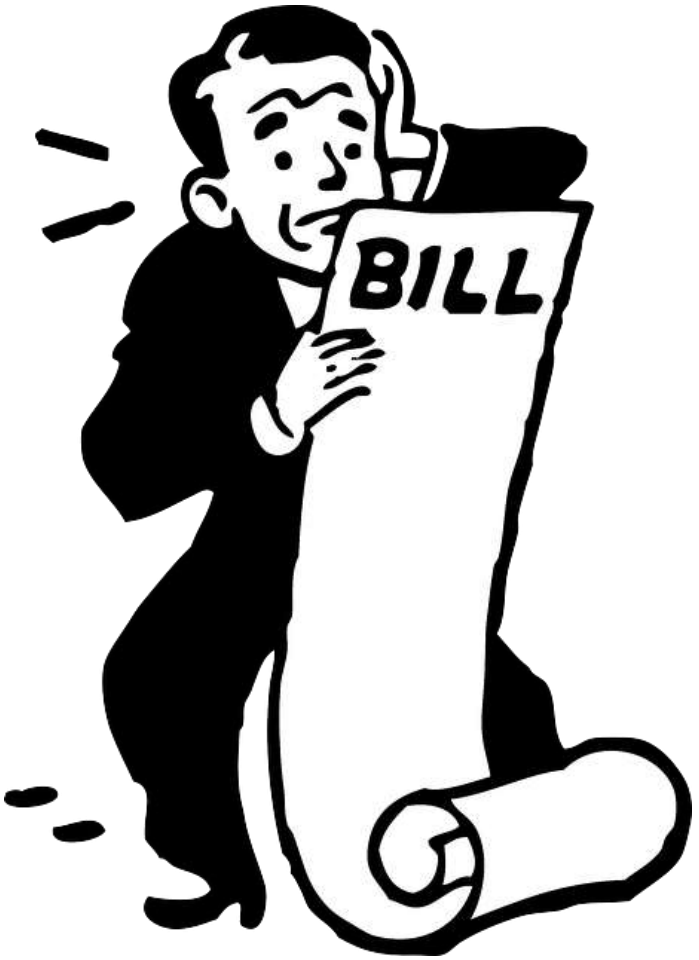
**Inpatient admissions:** 6,947

**Outpatient visits:** 190,865

*Fiscal 2014. Otherwise information is for fiscal 2015.
Sources: KishHealth System, KishHealth System 2014 financial statement

# MEDICAL BILL ERRORS

- Reports indicate that up to 80 percent of bills contain errors.
- APPS to help you navigate bills
- Yes, there is a cost




# ADDING TO THE ISSUE

# New coding system could lead to longer doctor waits

## Change meant to help identify trends, outbreaks

BY DIANA NOVAK JONES
Staff Reporter

Doctors and hospitals will soon have to be far more specific in detailing diagnoses and treatments when they submit bills to insurers for payment.

So patients shouldn't be surprised if it takes longer than usual to be billed for their portion once the new medical coding system, required by federal law, takes effect Oct. 1, experts say. It might even add to waits at doctor's offices, some say.

"It's like learning another language," Karen Zupko, a consultant in Chicago who has been working with doctors and hospitals around the country, says of the changes.

Before a bill can go to an insurance company, medical practices and hospitals have to indicate the diagnosis and treatment using billing codes. The number of these codes will increase dramatically, from around 14,000 to about 68,000.

The change is meant to help the government collect more specific data on health trends and outbreaks. Its implementation has been delayed twice since 2012 over concerns medical offices weren't prepared.

Under the new system, doctors will need to have more specific notes from their patient visits to help with the billing code selection, Zupko says. In many doctor's offices, the codes are chosen even before the patient leaves.

"While you are waiting in your office for your appointment, in order to check you out, I have to close that record, and the only way is to have diagnosis codes," Zupko says. "So it may take them longer to identify these codes. You may be at the doctor for a bit longer."

While some hospitals and medical practices have been preparing for years for the new coding system, others have left that to nearly the last minute, according to Zupko, who says some have scheduled training for only the day before the changes go into effect.

Orthopedic surgeons face the biggest challenge. They have more codes than any other surgical specialty.

Illinois Bone and Joint Institute — which has about 100 doctors at 17 locations around Chicago — spent about $600,000 over the past year and a half to prepare for the Oct. 1 rollout, according to David Wold, the group specialty practice's chief operations officer. That includes the cost of training and making the necessary technology updates, says Wold, who doesn't anticipate patients will notice any slowdown in the billing process.

Dr. Lees S. Benson demonstrates a new medical coding system using computers that will be used in all doctors' offices across the country starting Oct. 1, at Illinois Bone & Joint Institute in Glenview on Friday.
TIM BOYLE/FOR THE SUN-TIMES

"I think we are ready to handle this potential challenge — but you should call me in the middle of October and ask how we are doing," Wold says.

The Cook County Health and Hospitals System, which has more than 900 doctors who see about 300,000 patients a year, began preparing in 2011, says Donna Hart, county agency's chief information officer.

**"IT'S LIKE LEARNING ANOTHER LANGUAGE."**

**Karen Zupko**, Chicago consultant working with doctors and hospitals on medical coding changes

"We had a full assessment with every department in the hospital," Hart says, covering *every* aspect of the process, from patient registration to when a claim is sent to an insurer.

Still, Hart says seeing patients might take a little longer as the county health system's staff adjusts to the new system.

Alicia Waletzko, a consultant who has been helping Northwestern Memorial Hospital prepare, says the hospital has taken steps to try to ensure doctors take the right notes and that bills go out properly.

Waletzko says that, while big hospitals have the money to spend to prepare for the massive changes in the billing system, many smaller medical operations might find the shift more trying.

"These smaller practices, they just don't have the resources," Waletzko says.

In practices where doctors do their own coding and billing, they might need time to take more notes while seeing patients and then figuring out the right codes.

"If you are a patient, you are going to need to be patient," Zupko says. "It's likely to take them a little longer the first couple weeks of October pulling these codes."

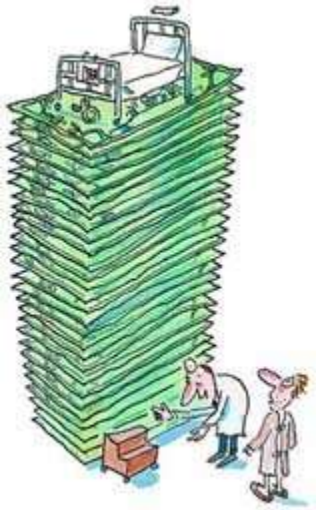
Email: dnovak@suntimes.com
Twitter: @dnovak

# ACA TRENDS

- Number of uninsured is down
- Health care spending will climb
- More highly deductible plans
- Health options
- Cover gender reassignment

# HEALTH PLAN CHANGES

- Consolidation of drug stores impacts where you obtain your prescriptions
- Moving to outpost clinics
- Encouraging healthy practices



# DRUG COSTS & DISTRIBUTION

# MASSIVE DRUG CHAIN IN MAKING

## $17.2B deal unites Walgreens, Rite Aid

**Nathan Bomey**
USA TODAY

Walgreens said Tuesday that it will buy drug-store chain rival Rite Aid in a $17.2 billion deal that would whittle the nation's one-time mom-and-pop drug-story industry into two massive competitors.

The deal would combine the second and third largest drug-store operators, and if it gets regulatory approval, intensify the already fierce competition between Walgreens and CVS Health.

The tectonic shift in the market comes as pharmacies are grappling with the rapidly changing health-care industry, seeking negotiating leverage against drug companies and increasingly offering clinical services.

Walgreens Boots Alliance, which operates the namesake drug store chain, said it is paying $9 per share in cash in a valuation that includes the assumption of debt. That reflects a 48% premium above Rite Aid's value at the close of trading Monday.

Walgreens said Rite Aid would keep its name for now. The company expects to save more than $1 billion in "synergies," which could come in the form of combined purchasing power and cost cuts.

CVS has 58% market share in the pharmacy and drug store business, Walgreens controls 31% and Rite Aid has 10%, research firm IBISWorld says. The industry has $263 billion in annual revenue and $10.3 billion in profit.

But pharmacies are fending off competition from mail-order prescription discounters, online pharmacies, wholesale retailers and health clinics, among others. Consolidation gives the drug-store companies more leverage to negotiate with drug companies.

"It is to get leverage against not only drug companies but also other competitors in the marketplace," Edwards Jones senior equity analyst John Boylan said in an interview.

Rite Aid shares (RAD) soared 43% to close at $8.67 after the *Wall Street Journal* reported mid-day that the deal was close. The shares relinquished some of their gains after the market closed, trading around $8.

Walgreens Boot Alliance (WBA) stock rose 6% on the day to $95.16 and jumped an additional 1% in aftermarket trading.

CVS Health stock (CVS) was up 2% to $105.29 for the day. It was relatively flat in after-market trading.

Walgreens executives will discuss the deal with investors when they reveal the company's fourth-quarter earnings Wednesday.

# NEW AVENUES TO CARE


PHIL VELASQUEZ/CHICAGO TRIBUNE

Suburban Seattle-based Providence Health & Services will run clinics in the Northwest.

## Walgreens, hospital to partner on new clinics

BY AMEET SACHDEV
Chicago Tribune

Walgreens is teaming up with a large hospital network for the first time to open a handful of new in-store clinics, as the drugstore chain looks for a more cost-effective and collaborative approach to expand its health care services.

The partner is Providence Health & Services, a nonprofit Catholic health system based in suburban Seattle that operates 34 hospitals and 475 doctor's offices in the Northwest and California. Providence plans to open as many as 25 clinics inside Walgreens stores in Seattle and Portland over the next few years, the two companies said Thursday.

Financial terms were not disclosed.

Walgreens is taking a closer look at its in-store clinic business under its new management team put in place after the merger with European druggist Alliance Boots. In May, the company closed 38 clinics around the country, including two in the Chicago area, as part of a larger cost-cutting program, spokesman Jim Cohn said.

The cuts represented about 8 percent of Walgreens' retail clinics, leaving it with slightly more than 400 locations.

Walgreens, CVS Health, Target, Wal-Mart and other retailers have opened hundreds of walk-in clinics in recent years run by nurses to treat ear infections and other routine illnesses, administer vaccines and increasingly help people with chronic diseases.

But some doctor groups have bristled at the concept. They worry patients will substitute retail care for primary medical care by internists, pediatricians and family doctors. They also say the clinics further fragment the health care system because patients often don't inform their doctors of their clinic visits.

Some retailers have addressed critics' concerns by setting up arrangements with health systems to coordinate patient care. Walgreens' partnership with Providence takes the collaboration one step further.

"This is a reflection of our efforts to develop deeper and more strategic relationships with our health system partners," Jeff Koziel, a Walgreens group vice president, said in a statement. "Collaboration among providers is key in today's health care environment, to help ensure continuity of patient care and to provide greater convenience and access for patients."

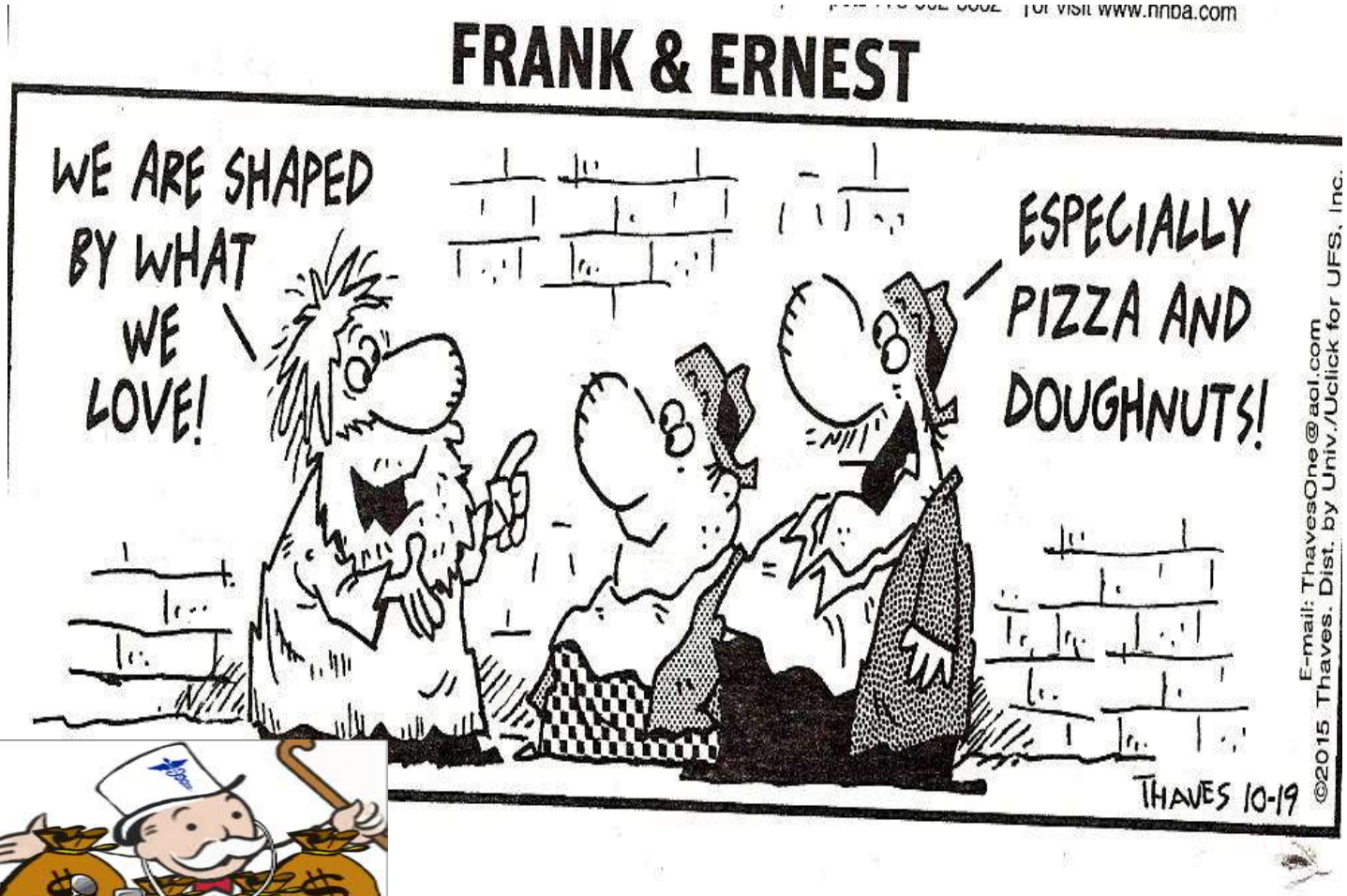
Cohn said the company is talking with other prospective partners to develop deeper relationships with other health care systems.

Providence will staff the new clinics with nurse practitioners who will be available, often with no appointment, seven days a week. It plans to open six clinics early next year.

asachdev@tribpub.com
Twitter @ameetsachdev

# ON-LINE EYE TESTS

- For $40 a computer and a smart phone you can have your eyes tested.
- Part of telehealth and telemedicine
- Issues, of course


FRANK & ERNEST
WE ARE SHAPED BY WHAT WE LOVE!
ESPECIALLY PIZZA AND DOUGHNUTS!
THAVES 10-19
E-mail: ThavesOne@aol.com
©2015 Thaves. Dist. by Univ./Uclick for UFS, Inc.

# TARGET EMPLOYEES

JEFF CHIU/AP 2012

Target is launching programs to encourage shoppers and employees to try healthier living.

## Target stores aim to instill healthier habits

By Anne D'Innocenzio
Associated Press

MINNEAPOLIS — Target is going on a health kick, aimed at its customers and employees.

The discount store chain will push granola bars over candy bars at the checkout and hand out free basic activity trackers from Fitbit to its more than 300,000 employees as part of the effort.

Target will also give employees extra discounts on fruits and vegetables, said Jodee Kozlak, Target's chief human resources officer. It will also feature healthy grab-and-go snacks near the cash registers, downplaying items that are high in fat and sugar.

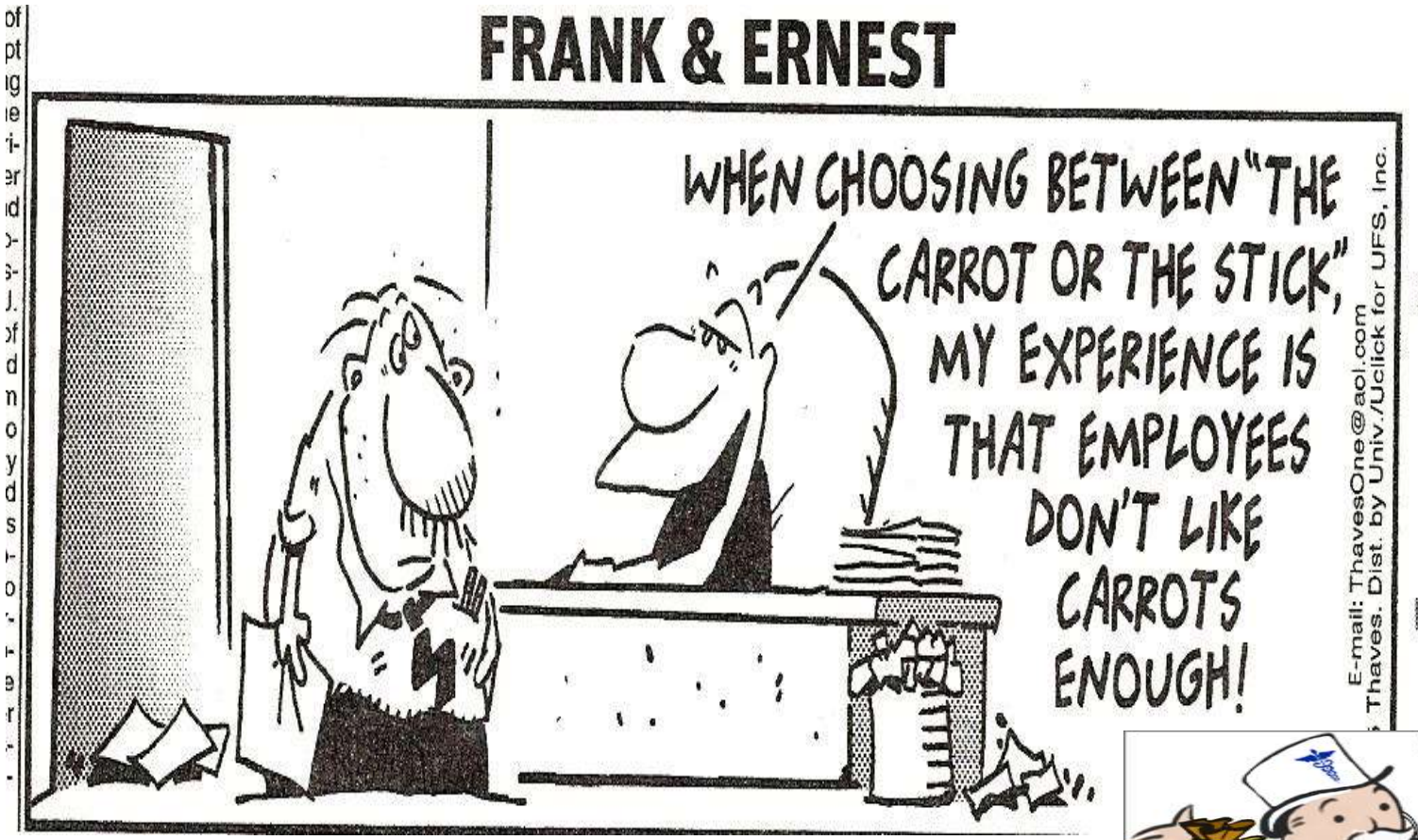
Target's partnership with Fitbit is one of its biggest corporate accounts for the activity tracker company, Kozlak said. Target employees will get the Fitbit Zip, which retails for $59.95.

Target is trying to reinvent its image as a promoter of wellness for employees and customers under CEO Brian Cornell, who came onboard in August 2014. The move mirrors a similar strategy adopted by drugstore chain CVS, which stopped selling cigarettes and changed its corporate name to CVS Health as part of a plan to become known as a health brand.

As part of Target's Fitbit program, employees who participate will be grouped into teams for a monthlong challenge. The winning team will get $1 million to funnel into a charity of their choice, Kozlak said.

Wellness is one of the key areas for Cornell, along with such areas as baby products and fashion. Target is adding more organic and natural food as it revamps its grocery aisles.

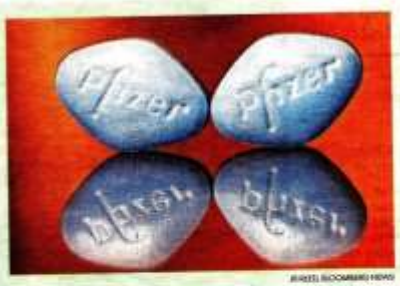
Candy bar fans shouldn't fret, though. They're not going away. In tests in 30 stores, the chain is trying to get the balance right, so that its health push isn't too pushy. "They don't want us to be too preachy," said Christina Hennington, Target's senior vice president of merchandising.


FRANK & ERNEST
WHEN CHOOSING BETWEEN "THE CARROT OR THE STICK", MY EXPERIENCE IS THAT EMPLOYEES DON'T LIKE CARROTS ENOUGH!
E-mail: ThavesOne@aol.com
Thaves. Dist. by Univ./Uclick for UFS, Inc.

# DRUG COMPANIES MERGE

PFIZER, ALLERGAN IN 'FRIENDLY' MERGER TALKS TO CREATE

## PHARMA GIANT





**PFIZER**

**Headquarters:** New York City
**No. of employees:** 78,300
**Market cap:** $218B

**TOP FIVE PRODUCTS**
**Prevnar** (pneumonia): $2.8B
**Lyrica** (nerve and muscle pain): $2.4B
**Enbrel** (arthritis, psoriasis): $1.6B
**Lipitor** (cholesterol): $950M
**Viagra** (erectile dysfunction): $843M

**ALLERGAN**

**Headquarters:** Dublin (legally); Parsippany, N.J. (administratively)
**No. of employees:** 32,100
**Market cap:** $113B

**TOP FIVE PRODUCTS**
**Botox** (wrinkles): $751M
**Namenda IR** (Alzheimer's, immediate release): $478M
**Namenda XR** (Alzheimer's, extended release): $355M
**Restasis** (dry eye): $355M
**Bystolic** (high blood pressure): $321M

NOTES: MARKET CAPS ARE BEFORE THE MERGER TALKS WERE REVEALED. ALLERGAN EMPLOYEES FIGURE INCLUDES ALLERGAN (BLABS) AND ACTAVIS (LABS) AS OF DEC. 31, BEFORE THEY MERGED IN 2015.
SOURCES: 10-K ANNUAL REPORTS, CREDIT SUISSE ANALYST REPORT

### Tax policy could come into play in what would be the largest merger/acquisition of year

**Nathan Bomey**
@NathanBomey
USA TODAY

Drug giants Pfizer and Allergan are weighing a massive merger in a deal that would deliver a sharp jolt to an industry accustomed to shakeups and could stir up political division over U.S. tax policy.

The potential combination would easily qualify as the largest merger or acquisition of the year in business, with both pharmaceutical companies combining for a market capitalization of nearly one-third of a trillion dollars.

But it could provoke political dissension if it's structured as a corporate inversion — a tax maneuver in which a company strategically acquires a foreign entity and then legally changes its headquarters to the target's foreign base to save on its U.S. tax bill.

Pfizer CEO Ian Read has publicly blasted the U.S. tax code for putting American companies at a disadvantage.

"This fits nicely for a tax inversion deal," S&P Capital IQ analyst Jeffrey Loo said in an interview. "Clearly that's a goal of theirs."

Dublin-based Botox maker Allergan said in a statement that New York-based Pfizer approached it about a possible deal and they are engaging in "preliminary friendly discussions" about a combination. Pfizer distributed a similar statement.

"No agreement has been reached and there can be no certainty that these discussions will lead to a transaction, or as to the

▶ CONTINUES ON NEXT PAGE

# CADILLAC TAX DELAYED

- In 2018 a 40% levy on employer-sponsored health plans whose value exceeds $12,500 for individuals and $27,000 for family plans


# TAX CONTINUED


- Employers shrink the value of employee health plans with a reduction in benefits such as Flexible spending accounts, wellness programs, etc.

# WHY THE TAX?

- Purpose of tax is to cover costs of expanding health coverage.
- Tax applies to plans above the thresholds


# WHEN CHOSING A PLAN READ ALL THE DETAILS

COSTS

COVERAGE

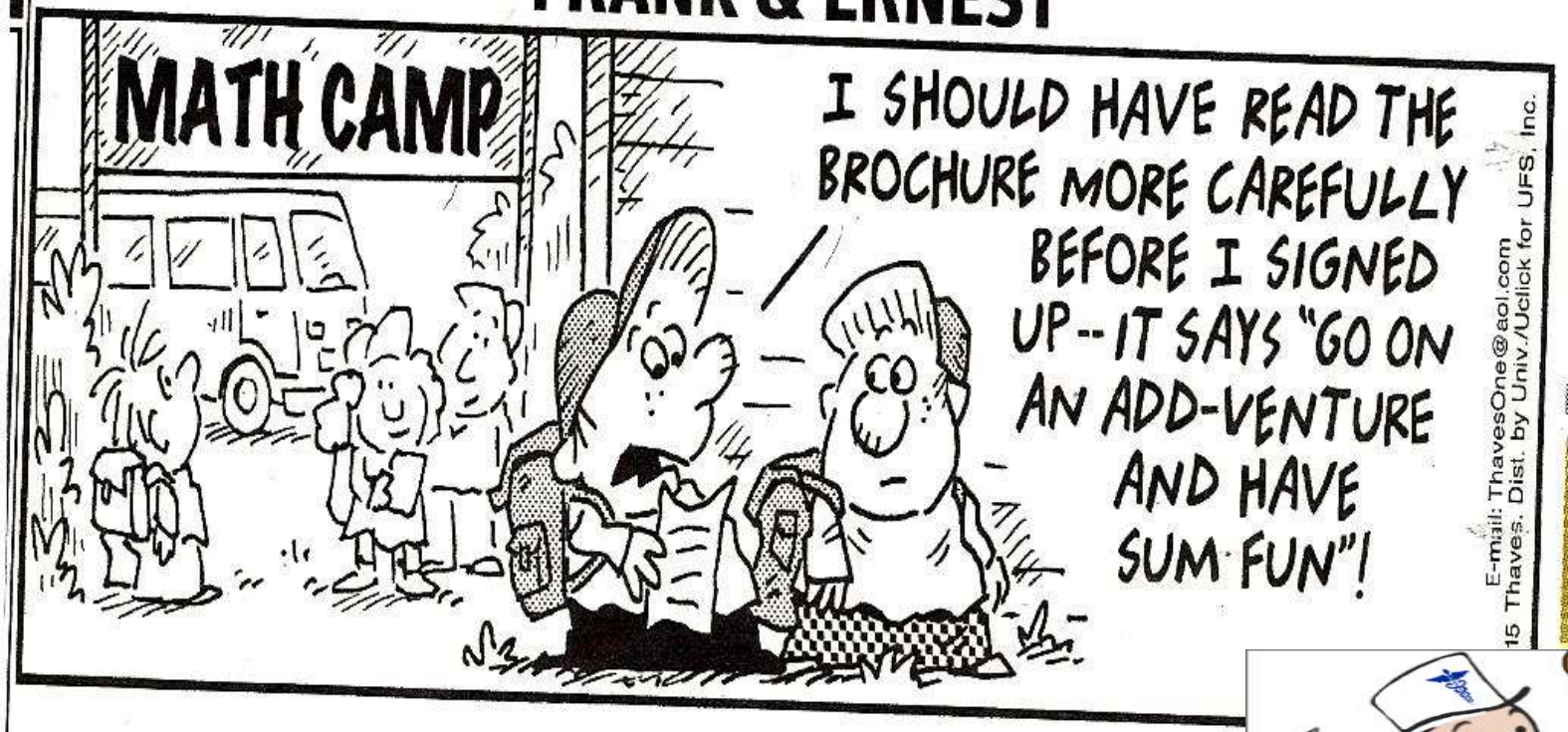
DEDUCTIONS

DOCTOR CHOICE

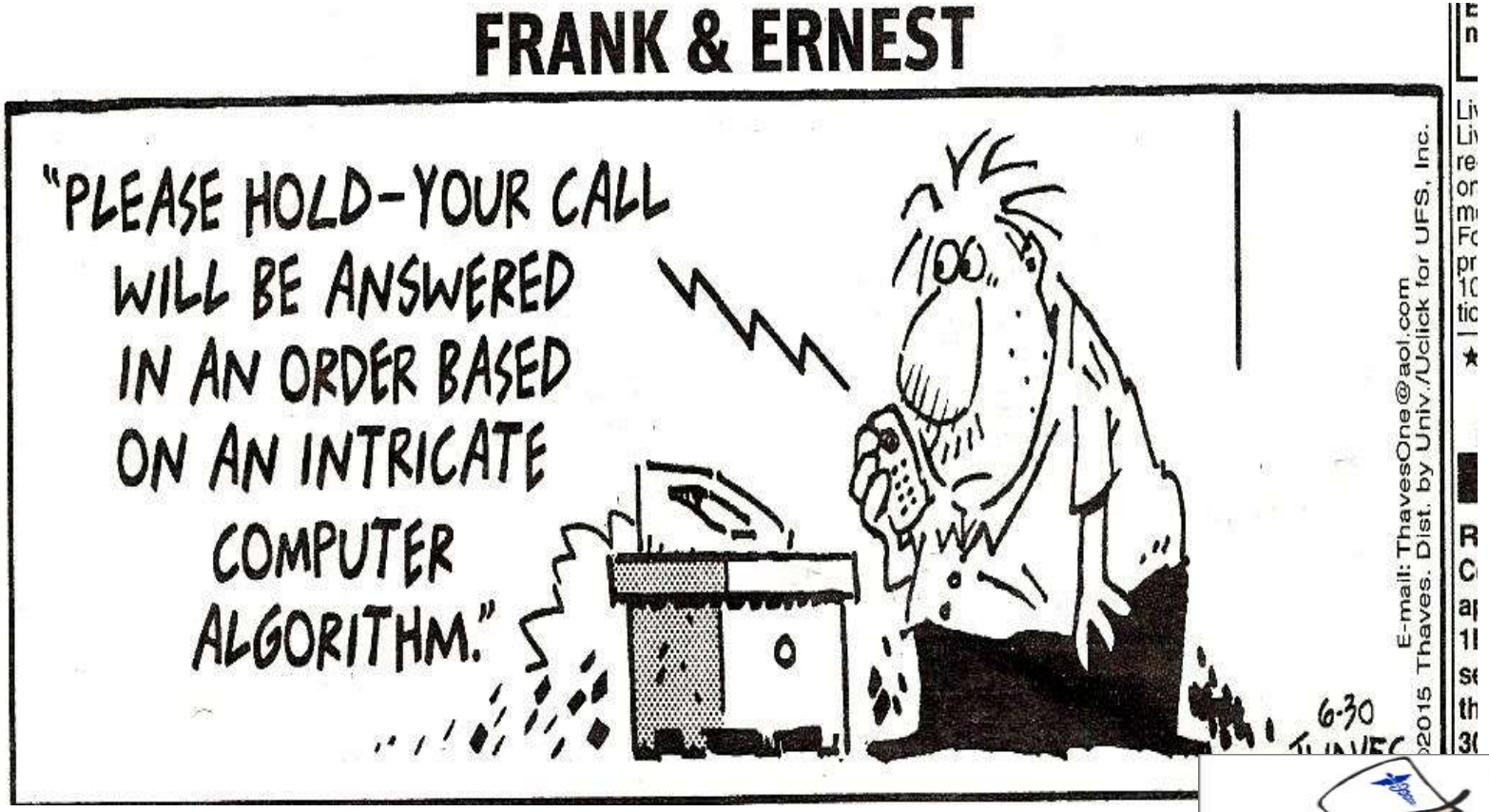
HOSPITAL CHOICE


Ziggy
HOTEL
8/1
...YOUR ADS SAY THAT YOU HAVE A BREAKFAST BAR!
YEAH, OVER THERE!
BREAKFAST BARS
75¢
Friends, Inc./Dist. by Universal Uclick

# FRANK & ERNEST

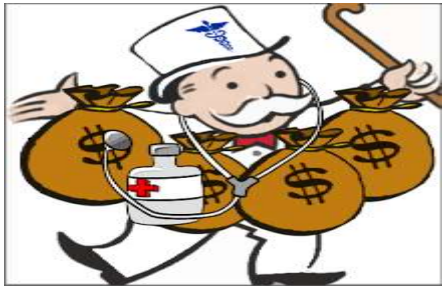


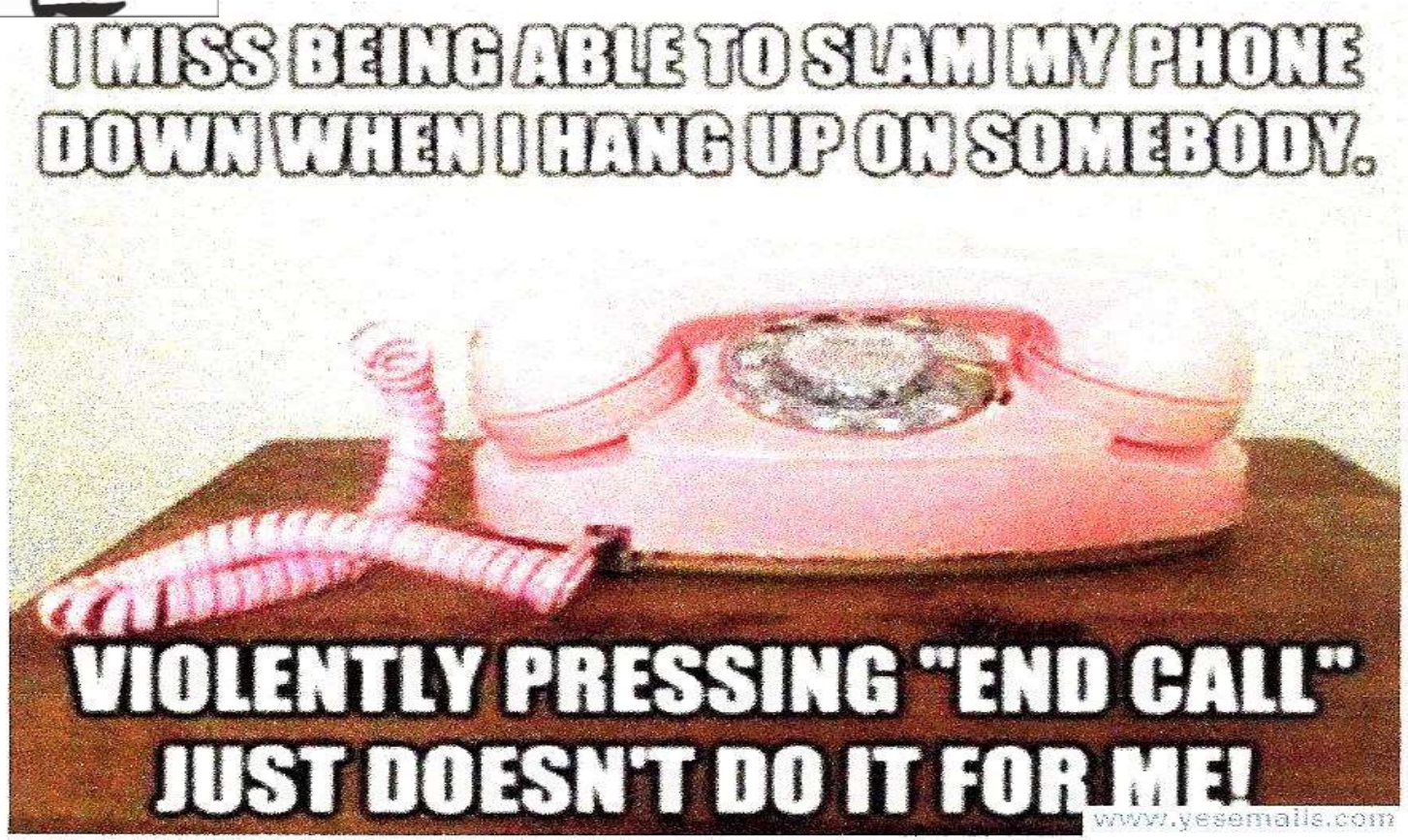

# CALL FOR:
# INFORMATION
# ASSISTANCE
# CLARIFICATION
# ASK SPECIFIC QUESTIONS
# DON'T GIVE UP!


FRANK & ERNEST
"PLEASE HOLD-YOUR CALL WILL BE ANSWERED IN AN ORDER BASED ON AN INTRICATE COMPUTER ALGORITHM."
6-30
E-mail: ThavesOne@aol.com
©2015 Thaves. Dist. by Univ./Uclick for UFS, Inc.

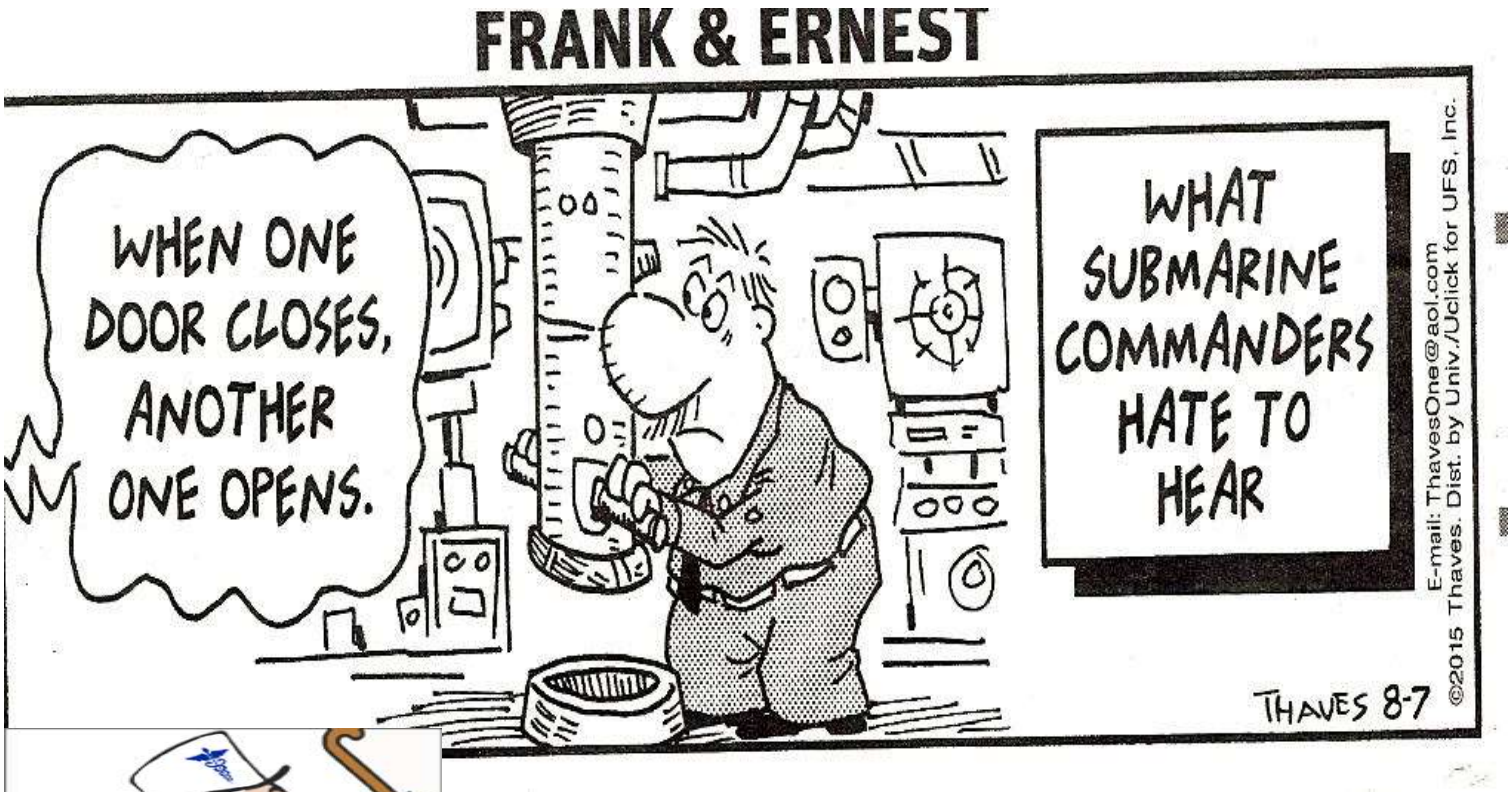
# TIPS FOR CALLING

- Avoid calling on Mondays
- Have insurance card and EOB ready
- Ask to be transferred to a nurse
- If calling for someone else have them present to give permission.
- Get any promises in writing
- Take careful notes: date, time of the call, name of person and what they said
- Consider a follow-up email if possible

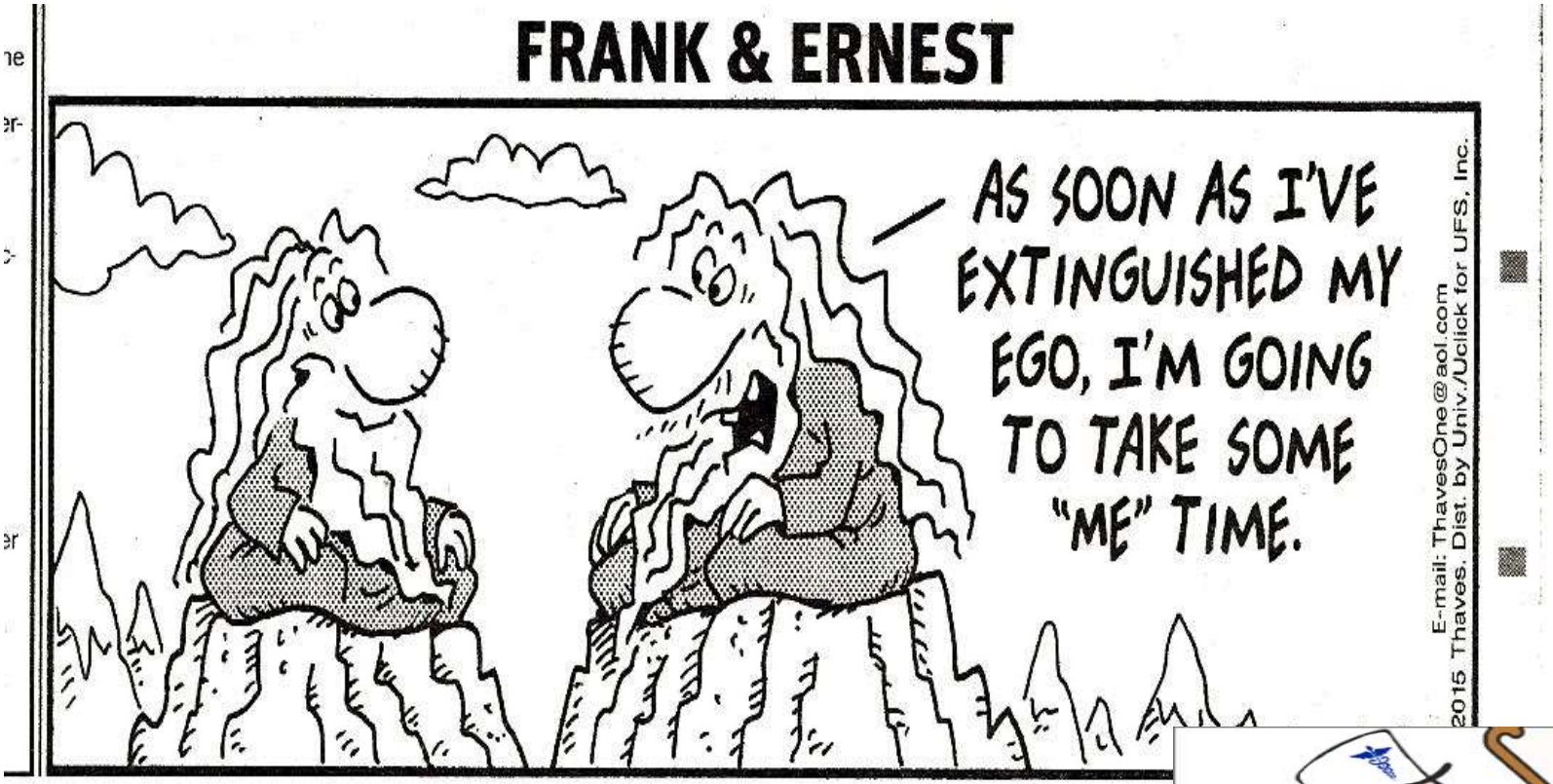



I MISS BEING ABLE TO SLAM MY PHONE DOWN WHEN I HANG UP ON SOMEBODY.
VIOLENTLY PRESSING "END CALL" JUST DOESN'T DO IT FOR ME!
www.yeseemails.com

# DOORS WILL OPEN




# NETWORK WITH OTHERS




# GOOD ADVICE


known as 1925 KINGSTON LANE,
Schaumburg, IL 60193 Property In-
FRANK & ERNEST
NATIONAL SECURITY AGENCY
"THE UNEXAMINED LIFE IS NOT WORTH LIVING."
ENTRANCE
I DOUBT THEY MEAN THAT IN THE SAME WAY SOCRATES DID!
7-28
THAVES
E-mail: ThavesOne@aol.com
©2015 Thaves. Dist. by Univ./Uclick for UFS, Inc.

I'm going to retire and live off my savings. What I'll do the second day, I have no idea.

# SOME THINGS THAT I HAVE PONDERED


Ziggy
©2015 Ziggy and Friends, Inc./Dist. by Universal Uclick
8/17
ONE GOOD THING ABOUT BEING SHORT IS THAT YOU'RE NEVER LACKING FOR OCCASIONS TO RISE TO!!


DON'T TELL ME NOT TO BURN THE CANDLE AT BOTH ENDS... TELL ME WHERE TO GET MORE WAX!
9-16
THAVES
E-mail: ThavesOne@aol.com
©2010 Thaves. Dist. by Univ./Uclick for UFS, Inc.


"That's
all
folks!"