Health & Retirement Services of Illinois

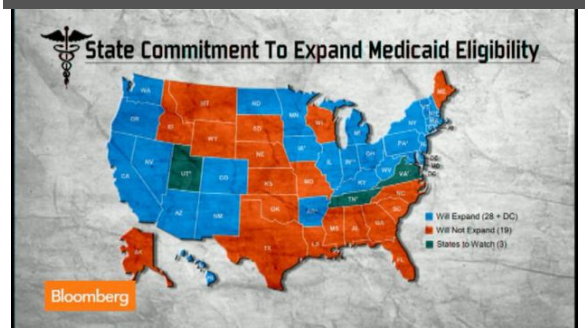
Newsletter August 2014

OUR NEWS LETTER

HRSI

Hobby Lobby Ruling Complicates Obamacare Birth Control

By Alex Wayne Jul 1, 2014



July 1 (Bloomberg) -- Megan Hughes reports on the impact of Supreme Court rulings on Obamacare. Hughes speaks on “In The Loop.” (Source: Bloomberg)

The U.S. **Supreme Court**’s suggested work-around to provide and pay for employees’ birth-control coverage at businesses whose owners have religious objections hasn’t worked in practice, say the companies administering it.

While free birth-control coverage is required under Obamacare, the insurance administrators providing it for workers at religious-affiliated groups say the current solution has left them stuck with the bill.

That may be further exacerbated by the court’s ruling, which exempted for-profit, closely held companies whose owners have religious objections, said Mike Ferguson, chief executive officer at the Self-Insured Institute of America, Inc.

“If that is the accommodation the administration chooses, then it would create the same problems, in our view, that are currently in play for the nonprofit religious organizations,” Ferguson said. His Greenville, **South Carolina**, trade association represents insurance administrators and their clients.

In Our Newsletter

Under the Patient Protection and Affordable Care Act known as Obamacare, insurers and employers offering health benefits are required to cover all U.S.-approved forms of birth control with no out-of-pocket costs. President **Barack Obama**' administration carved out an exemption for religious organizations that object. To make sure women got the coverage, outside companies that administer health plans for religious groups were required to pay for it, with government reimbursement to follow.

Photographer: Chip Somodevilla/Getty Images
Anti-abortion advocates cheer in front of the Supreme Court after the decision in Burwell v. Hobby Lobby Stores was announced on June 30, 2014 in Washington, DC. **Close**

Photographer: Chip Somodevilla/Getty Images
Anti-abortion advocates cheer in front of the Supreme Court after the decision in Burwell v. Hobby Lobby Stores was announced on June 30, 2014 in Washington, DC.

It's a complex solution that hasn't worked in the real world, said the third-party administrators, or TPAs, providing the birth-control benefit, because the government hasn't figured out how to pay them back.

Dropped Clients

Without a solution, the benefits administrators may ultimately choose to drop clients with religious objections to covering birth control, Ferguson said. Nonprofits and businesses with religious owners that refuse to cover the benefit would have to change the way they provide health benefits as a result, adding to disruptions from the health-care law.

Obama's goal of providing free reproductive **health services** to all women has been met repeatedly by objections from religious groups, their affiliated organizations such as hospitals and universities, and now by private companies whose owners have strong religious beliefs.

The court's 5-4 **ruling** June 30 said that closely held, for-profit companies can opt out of providing birth control benefits, the same sort of exemption church-affiliated organizations get. Yet the justices didn't strike down the requirement that American women have access to birth control. That means that while millions of American women are entitled to coverage, it isn't clear who will pay for it.

Religious Freedom

The court held the companies don't have to comply with the requirement because of a 1993 law, the Religious Freedom Restoration Act. Justice **Samuel Alito**, who wrote the majority opinion in the case, said one solution could be extending the same accommodation the government has created for religious nonprofits to closely held for-profit companies.

"That accommodation does not impinge on the plaintiff's religious beliefs that providing insurance coverage for the contraceptives at issue here violates their religion and it still serves HHS's stated interests," Alito wrote.

So far the responsibility of making sure the benefit is provided and paid for has fallen to the TPAs.

No Money

"There was no budget money set aside for this. There's certainly no money that is part of the Affordable Care Act appropriations. I can see why the third-party administrators would be concerned," Amy Gordon, a partner at McDermott, Will and Emery in **Chicago** who works on health benefits for large employers, said in a phone interview.

Third-party administrators handle billing and other administrative tasks for large employers that insure themselves. They aren't insurers, although some TPAs are owned by insurance companies, including **UnitedHealth Group Inc. (UNH)**'s subsidiary United Medical Resources and **Aetna Inc. (AET)**'s Meritain Health.

To make sure women employed by religious organizations enjoy the same access to birth control as women working for secular employers, the administration offered two options: the TPAs for religious groups could find an insurer willing to cover contraception for their nonprofit clients' workers; or the TPAs could pay for birth control themselves and find an insurer as a partner using the federal health exchange.

The government would then rebate user fees to the insurer, which would pass the money on to the TPA to cover the cost of birth control. The **Department of Health** and Human Services has **said** it doesn't know how many religious groups would take advantage of the arrangement or how many TPAs would have to administer it.

'Political Objective'

"This was a political objective that was being put out by the White House that was put on the shoulders of HHS," Ferguson said. "They said, 'You guys figure it out,' essentially."

While the system may work for TPAs that are owned by insurers, Ferguson said that no independent TPA -- there are more than 300 in the U.S. -- has found an insurer willing to join with it. Since the birth-control benefit began Jan. 1, the costs to independent TPAs are potentially in the millions of dollars, he said, with no certainty they'll ever be paid back.

Ferguson's association asked the health department in a February letter to pay the TPAs directly; the agency doesn't believe it has legal authority to do that, he said. He said he plans to raise the issue with the government again this week.

Court Decision

Spokesmen for UnitedHealth and Aetna declined to comment. Aaron Albright, a spokesman for the Centers for Medicare and Medicaid Services, which administers the Affordable Care Act, said he wasn't able to immediately comment on the complications Ferguson outlined.

Executives at five independent TPAs contacted for this story didn't return phone messages.

The Supreme Court's decision came on behalf of two companies that had sued over the birth-control requirement, Hobby Lobby Stores Inc. and Conestoga Wood Specialties Corp. While both closely held companies' health plans cover most contraceptives, their owners refuse to pay for **Teva Pharmaceutical Industries Ltd. (TEVA)**'s Plan B One-Step and **Actavis Plc (ACT)**'s Ella, as well as some intrauterine devices, which they believe can cause abortions.

CMS proposes changes to reduce Medicare home payments

By Ferdous Al-Faruque - 07/01/14

The Centers for Medicare and Medicaid Services (CMS) has proposed several new changes to how it pays for Medicare home health services, which the agency says will save it $58 million next year.

The agency is proposing to save money by toughening requirements to be eligible for home health services, setting a minimum requirement on home health agencies to prove their effectiveness and revising how much the CMS pays for certain services.

“CMS projects that Medicare payments to home health agencies in 2015 will be reduced by 0.30 percent, or $58 million, based on the proposed policies,” said the agency.

The proposed rule is also part of the agency's 4-year plan under ObamaCare to gradually reduce costs for home health services by 2017 and require more efficiency from home health providers.

The CMS notes the Affordable Care Act requires it to apply an adjustment to the national standardized 60-day episode rate and other payment amounts to reflect factors, such as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, and the average cost of providing care per episode.

Supply won't meet growing demand for primary care

Kaitlyn Krasselt and Jayne O'Donnell, USA TODAY June 30, 2014

Nurse practitioners Michele Knappe, left, and Julie Zimmer go over a patient's chart at Ingalls Family Care Center in Flossmoor, Ill. Illinois lawmakers this spring rebuffed a variety of proposals that would have given more authority to nurses ahead of a surge of patients newly insured under President Obama's health law.(Photo: M. Spencer Green, AP)

Federally funded programs will add at least 2,300 new primary care practitioners by the end of 2015, but the funding for at least one of those programs is set to expire at the same time, contributing to a massive shortage of doctors available to treat patients — including those newly insured through the Affordable Care Act and Medicare.

The U.S. is expected to need 52,000 more primary care physicians by 2025, according to a study by the Robert Graham Center, which does family medicine policy research. But funding for teaching hospitals that could train thousands more of these doctors expires in late 2015.

Population growth will drive most of the need for family care doctors, accounting for 33,000 additional physicians, the study says. The aging population will require about 10,000 more. The Affordable Care Act is expected to increase the number of family doctors needed by more than 8,000, the study says.

Farzan Bharucha, a health care strategist with consulting firm Kurt Salmon, says the ACA should have focused more on the primary care shortage "because we already knew there was a problem -- and we knew implementation of ACA would potentially make it worse."

Health and Human Services spokeswoman Erin Shields Britt says continuing to build the primary care workforce will take time, but she notes President Obama's budget working its way through Congress has several new ways to expand the primary care workforce, which includes nurse practitioners and pediatricians. The ACA, she says, significantly increases the number of primary care providers in underserved areas and increases Medicare and Medicaid payment for services delivered by primary care practitioners.

ACA funding that added 600 new primary care residencies was part of a five-year investment that expires at the end of 2015, eliminating the chance to produce hundreds more doctors each year.

But many agree far more needs to be done. Among the issues:

• **Other medical residency funding**. More oversight is needed in the distribution of the current $12 billion in federal graduate medical education (GME) funding, which is used for medical residencies, says Bob Phillips with the American Board of Family Medicine. Hospitals can decide the kind of residencies to create and tend to

train and hire specialists who bring in more revenue than primary care doctors, he says. HHS says reform is needed, but that it doesn't have authority to make program changes since the GME formula is determined by Congress.

• **Rising cost of medical school**. For the class of 1992, the median education debt was $50,000. In 2012, it was $170,000, according to a 2012 Association of American Medical Colleges study. Gina Martin, who is finishing her primary care residency and plans to practice in rural Delta, Colo., says she faces $250,000 in medical school debt, which made her choice more difficult.

• **More lucrative specialty care**. Payment rates for Medicare and Medicaid — the largest payers for primary care by far — tend to reward specialty, interventionist care over prevention, primary care and diagnosis, says health care consultant Kip Piper. Family physicians made an average of $175,000 in 2012, the third lowest of any doctor, according to the MedScape annual physician compensation report.

• **Scope of practice laws**. States regulate and license doctors and have been slow to embrace the idea that non-physicians could take over some of the functions. Nurse practitioners and physician assistants should be performing vaccinations and strep tests, Bharucha says.

Despite the challenges, Martin says her intention to pursue the field has never wavered. "I grew up in a system and I'm now training in a system that works toward keeping people as healthy as possible," she says.

$100M in O-Care funds go to local health centers

By Ferdous Al-Faruque - 07/08/14

The Department of Health and Human Services (HHS) is doling out $100 million under ObamaCare to help expand new health centers around the country.

The grant money will be available to 150 new centers next year and is meant to increase access to healthcare for underserved communities and vulnerable populations.

“In communities across the country, Americans turn to their local Community Health Center for vital health care services that help them lead healthy, productive lives,” HHS Secretary Sylvia Burwell said in a statement. “That’s why it’s so important that the Affordable Care Act is supporting the expansion of health centers.”

Public and nonprofit private health centers, including Native American, faith-based, and community-based organizations are eligible to request funding up to $650,000 from the New Access Point (NAP) grant.

According to HHS, 550 new health centers have sprouted around the country since the Affordable Care Act went into effect three years ago.

Besides providing medical care, they also play a role in teaching the public about health insurance coverage available through ObamaCare.

“Since last fall, health centers have provided enrollment assistance to more than 4.7 million people across the country,” said Mary Wakefield, administrator of the Health resources and Service Administration. “We are pleased that the Affordable Care Act is supporting the establishment of additional health center sites to provide expanded opportunities for the newly insured to receive care.”

The Obama administration announced the new funding a month after it separately offered $300 million to community health centers to increase service hours, hire more healthcare providers, and add oral health, behavioral health, pharmacy, and vision services.

More Than 750 Hospitals Face Medicare Crackdown On Patient Injuries

By JORDAN RAU KHN Staff Writer **JUN 22, 2014**

During a hernia operation, Dorothea Handron's surgeon unknowingly pierced her bowel. It took five days for doctors to determine she had an infection. By the time they operated on her again, she was so weakened that she was placed in a medically induced coma at Vidant Medical Center in Greenville, North Carolina.

Comatose and on a respirator for six weeks, she contracted pneumonia. "When they stopped the sedation and I woke up, I had no idea what had happened to me," said Handron, 60. "I kind of felt like Rip Van Winkle."

Dorothea Handron was so weakened by complications from a hernia operation that she was placed in a medically induced coma at Vidant Medical Center (Photo by Jim R. Bounds/AP Images for KHN)

Because of complications like Handron's, Vidant, an academic medical center in eastern North Carolina, is likely to have its Medicare payments docked this fall through the government's toughest effort yet to crack down on infections and other patient injuries, federal records show.

A quarter of the nation's hospitals – those with the worst rates – will lose 1 percent of every Medicare payment for a year starting in October. In April, federal officials released a preliminary analysis of which hospitals would be assessed, identifying 761. When Medicare sets final penalties later this year, that list may change because the government will be looking at performance over a longer period than it used to calculate the draft penalties. Vidant, for instance, says it lowered patient injury rates over the course of 2013, and Handron praises their efforts.

The sanctions, estimated to total $330 million over a year, kick in at a time when most infections measured in hospitals are on the decline, but still too common. In 2012, one out of every eight patients nationally suffered a potentially avoidable complication during a hospital stay, the government estimates. Even infections that are waning are not decreasing fast enough to meet targets set by the government. Meanwhile new strains of antibiotic-resistant bacteria are making infections much harder to cure.

Dr. Clifford McDonald, a senior adviser at the federal Centers for Disease Control and Prevention, said the worst performers "still have a lot of room to move in a positive direction."

Are The Metrics Right?

Medicare's penalties are going to hit some types of hospitals harder than others, according to an analysis of the preliminary penalties conducted for Kaiser Health News by Dr. Ashish Jha, a professor at the Harvard School of Public Health. Publicly owned hospitals and those that treat large portions of low-income patients are more likely to be assessed penalties. So are large hospitals, hospitals in cities and those in the West and Northeast. Preliminary penalties were assigned to more than a third of hospitals in Alaska, Colorado, Connecticut, the District of Columbia, Nevada, Oregon, Utah, Wisconsin and Wyoming, Medicare records show.

Hospital-Acquired Conditions

- More Than 750 Hospitals Face Medicare Crackdown On Patient Injuries
- Analysis: Medicare's Primary Penalties For Hospitals
- Methodology: How Hospital-Acquired Conditions Are Calculated
- Hospitals Most Likely To Be Penalized By Medicare
- Downloadable Spreadsheet Of Preliminary Scores (CSV)

"We want hospitals focused on patient safety and we want them laser-focused on eliminating patient harm," said Dr. Patrick Conway, chief medical officer of the Centers for Medicare & Medicaid Services.

The biggest impact may be on the nation's major teaching hospitals: 54 percent were marked for preliminary penalties, Jha found. The reasons for such high rates of complications in these elite hospitals are being intensely debated. Leah Binder, CEO of The Leapfrog Group, a patient safety organization, said academic medical centers have such a diverse mix of specialists and competing priorities of research and training residents that safety is not always at the forefront. Nearly half of the teaching hospitals — 123 out of 266 in Jha's analysis —had low enough rates to avoid penalties.

The government takes into account the size of hospital, the location where the patient was treated and whether it is affiliated with a medical school when calculating infection rates. But the Association of American Medical Colleges and some experts question whether those measures are precise enough. "Do we really believe that large academic medical centers are providing such drastically worse care, or is it that we just haven't gotten our metrics right?" Jha said. "I suspect it's the latter."

Medicare assigned a preliminary penalty to Northwestern Memorial Hospital in Chicago, for instance, but Dr. Gary Noskin, the chief medical officer, said hospitals that are more vigilant in catching problems end up looking worse. "If you don't look for the clot, you're never going to find it," he said.

Another concern is there may be little difference in the performance between hospitals that narrowly draw penalties and those that barely escape them. That is because the health law requires Medicare to punish the worst-performing quarter of the nation's hospitals each year, even if they have been improving.

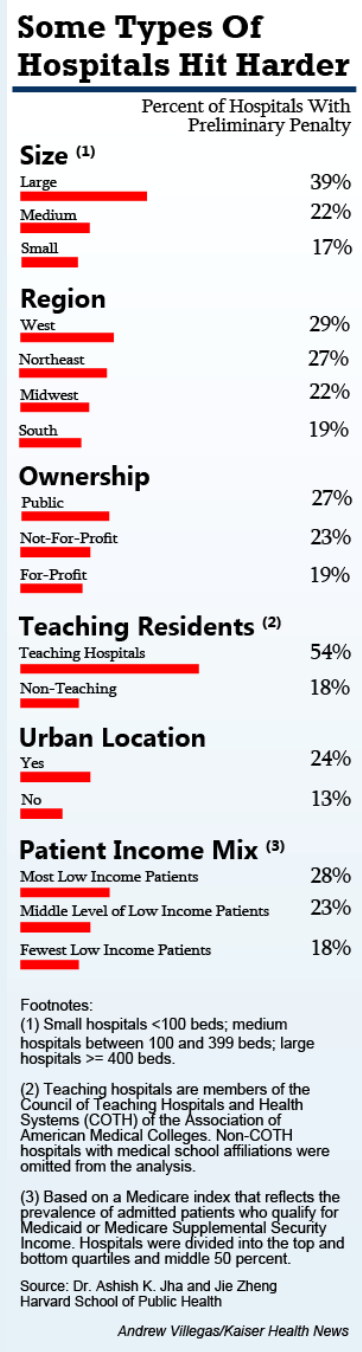
"Hospitals that have been working hard to reduce infections may end up in the penalty box," said Nancy Foster, vice president for quality and public safety at the American Hospital Association.

Third Leg Of Medicare's Pay-For-Performance

The Hospital-Acquired Condition (HAC) Reduction Program, created by the 2010 health law, is the third of the federal health law's major mandatory pay-for-performance programs for hospitals. The first levies penalties against hospitals with high readmission rates and the second awards bonuses or penalties based on two dozen quality measures. Both are in their second year. When all three programs are in place this fall, hospitals will be at risk of losing up to 5.4 percent of their Medicare payments.

Medicare's Primary Penalties For Hospitals

Medicare's upcoming penalties for hospitals with high rates of infections and other patient injuries will fall harder on some types of institutions than for others. This analysis shows the disparate effect of the preliminary penalties.



In the first year of the HAC penalties, Medicare will look at three measures. One is the frequency of bloodstream infections in patients with catheters inserted into a major vein to deliver antibiotics, nutrients, chemotherapy or other treatments. The second is the rates of infections from catheters inserted into the bladder to drain urine. Both those assessments will be based on infections during 2012 and 2013.

Finally, Medicare will examine a variety of avoidable safety problems in patients that occurred from July 2011 through June 2013, including bedsores, hip fractures, blood clots and accidental lung punctures. Over the next few years, Medicare will also factor in surgical site infections and infection rates from two germs that are resistant to antibiotic treatments: *Clostridium difficile*, known as C. diff, and Methicillin-resistant *Staphylococcus aureus*, known as MRSA.

Vidant is worse than average in catheter-associated urinary tract infections and serious complications from surgery in the latest statistics Medicare published on its Hospital Compare website. But in more recent data the medical center voluntarily reports on its website, the number of catheter and urinary tract infections dropped

during 2013. Joan Wynn, Vidant Health's chief quality and safety officer, said complications rates are dropping this year as well.

The prospect of penalties is "difficult when you know how much your performance is improved," said Wynn. She said Vidant has taken many steps to reduce complications, added patients to internal committees and now reveals on its website the number of infections, patient falls, medication errors and bed sores.

Vidant asked Handron, a retired nursing professor injured in 2009, to tell her experience to the trustees and make a video for the medical staff talking about it. She continues to advise the hospital. "I know they're going in the very right direction," Handron said. "I would have absolutely zero concern about myself or a family member going to Vidant for anything now."

Nationally, rates of some infections are decreasing. Catheter-related infections, for instance, dropped 44 percent between 2008 and 2012. Still, the CDC estimates that in 2011, about 648,000 patients—1 in 25—picked up an infection while in the hospital, and 75,000 died.

Rates of urinary tract infections have not dropped despite efforts. These infections are more likely the longer a line is left in, but sometimes they are not removed promptly out of convenience for the nurse or patient or simply institutional lethargy. Swedish Medical Center in Seattle, which has higher urinary catheter infection rates than do most hospitals, has given nurses more authority to remove catheters so long as they follow guidelines for when removal is appropriate, said Dr. Michael Myint, Swedish's vice president for quality and patient safety. "Historically, they would just wait for the physician's order to come through," Myint said.

Medicare has been pressuring hospitals for several years to lower rates of injuries to patients. In 2008 Medicare started refusing to reimburse hospitals for the extra cost of treating patients for avoidable complications. A subsequent study by Harvard researchers found no evidence that the change led to lower infection rates.

"With infections, we are moving in the right direction," said Lisa McGiffert, who directs the patient safety program at Consumers Union, "but I would not say we are anywhere near where we need to be."

Patient Advocates Praise Move

Patient advocates say the financial penalties are long overdue, given how little accountability there has been. Gerald Guske discovered that in 2012 when he went into Martha Jefferson Hospital in Charlottesville, Virginia, for an artificial hip implant. Doctors later had to reopen the incision and wash out Guske's implant. Guske, a retired electronic technician, was laid up for a month in a rehabilitation facility while strong antibiotics were pumped directly into a vein.

Martha Jefferson told Guske it had followed proper protocols. "Unfortunately, infection is a known risk of any surgery, and even when everything is performed correctly and conditions are ideal, they can occur," the hospital wrote him afterward. "Infection does not necessarily indicate that something went wrong."

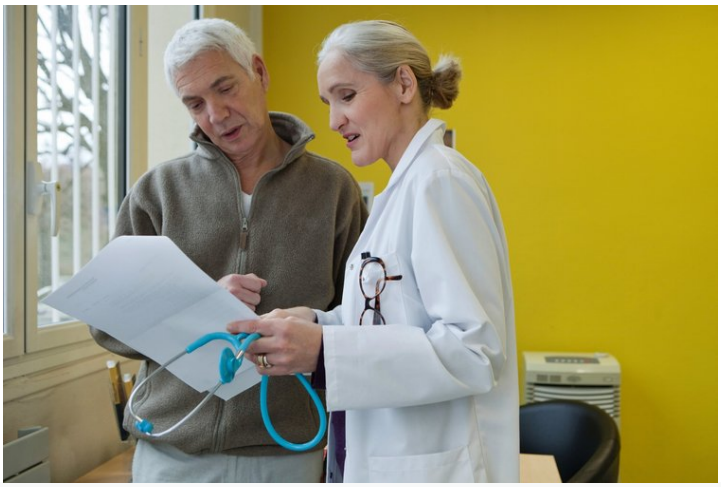
Martha Jefferson Hospital said it could not discuss the case because of patient privacy laws. The hospital's infection control specialist, Dr. Keri Hall, said infection rates have been dropping and "we are every day doing what we can to hopefully bring our rates down to zero."

Guske said he has fully recovered, "other than taking six weeks out of my life," but he attributes the stress around his complications to a minor stroke his wife suffered. He said state regulators told him they could not take any action because the hospital followed proper procedures. The fear of a financial penalty against a hospital, Guske said, is "the only thing that's really going to change matters."

Friday, July 11, 2014 HEALTH CARE

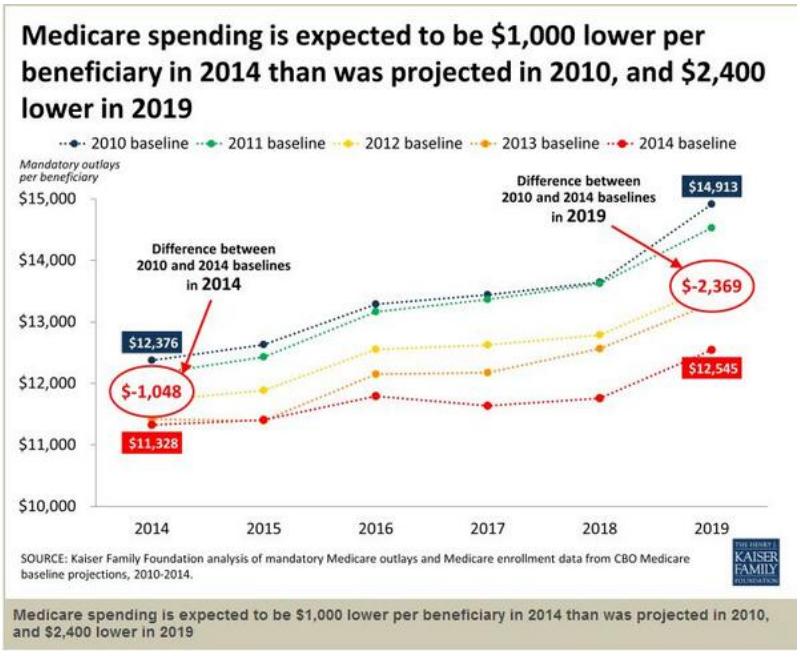
The amazing, mysterious decline in Medicare's price tag

Updated by Sarah Kliff on July 9, 2014, @sarahkliff sarah@vox.com



DON'T MISS STORIES. FOLLOW VOX!

This simple, four-line chart is amazing news for the federal budget. It shows that the government is expected to spend about $50 billion less paying for the Medicare program this year than it had expected to just four years ago.



Medicare spending is expected to be $1,000 lower per beneficiary in 2014 than was projected in 2010, and $2,400 lower in 2019

What this chart shows is how much the Congressional Budget Office expects we'll need to pay for each and every Medicare beneficiary. And over the past four years, the forecasting agency has consistently downgraded the price of covering one senior's health care costs.

Saving $1,000 per patient adds up quickly in a program that covers about 50 million people. More precisely, it adds up to about $50 billion in savings this year. The reduction in expected costs grows to $2,369 in 2019. With an expected 60 million seniors enrolled in Medicare that year, it would work out to more than **$120 billion** shaved off the total cost of the program.

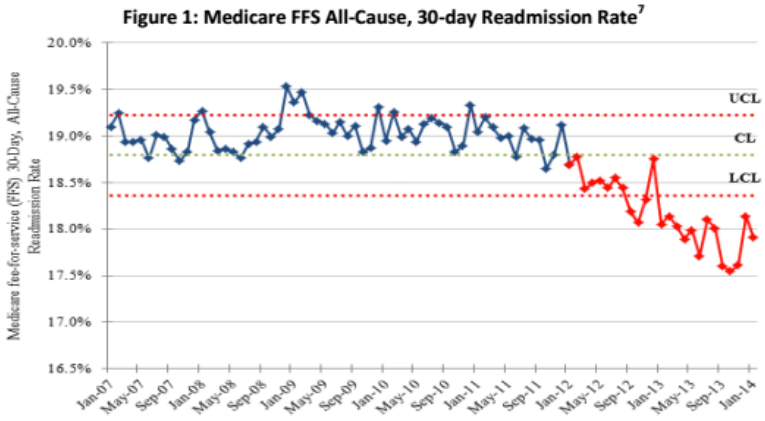
"The numbers are impressive, and the consecutive year-to-year reductions in projected Medicare spending are unprecedented," Kaiser Family Foundation's Tricia Neuman and Juliette Cubanski, who drew up the above chart, write. "The unexpected $1,000 per beneficiary reduction in spending this year may ease short-term budgetary pressures on Medicare and could provide an opportunity for thoughtful consideration of ways to bolster the program for an aging population."

As to what is driving the lower than expected spending, that's not completely clear. But Neuman and Cubanski have a few guesses.

Unnecessary readmissions are dropping

Unnecessary readmissions — when someone turns up at the hospital a second time because something went wrong on the first visit — are bad for patients and for budgets.

The good news on unnecessary readmissions is they're becoming less frequent among Medicare patients, a drop that started at just about the same time as CBO began revising downward the cost of covering a Medicare patient.



When there are fewer trips to the hospital, insurance coverage becomes, unsurprisingly, less expensive — and that could be part of the explanation for the downward changes.

Obamacare changed the way doctors get paid

The health care law included lots of **changes** to the way that doctors get paid within the Medicare program, all aimed at getting doctors to provide better care at lower costs. That's true, for example, with **readmissions**: Obamacare now penalizes hospitals when their patient shows up for a second visit that didn't need to happen, if everything had gone right the first time.

There are dozens of changes like this that could be playing a role in explaining why Medicare may cost significantly less than initially expected. This theory, as Neuman and Cubanksi acknowledge, is still somewhat speculative. Some of these programs didn't start until 2012, which makes it difficult to attribute the revised estimates in 2010 and 2011 to health reform.

The sequester cut Medicare doctor payments

The Budget Control Act of 2011 included a 2 percent cut to Medicare doctor payments. This was significantly less than the across-the-board spending reductions of 8.6 percent that other federal agencies saw, but it might have played a role in the downward revision between 2010 and 2011.

Again though, its not a full explanation: CBO knew about the sequester in every forecast after 2011. So the agency thinks something else is going on that would drive down Medicare costs even further than the BCA can explain.

Without any clear explanation of why expected Medicare cost growth has slowed so much, Neuman and Cubanksi dub it a bit of a "mystery" — one that has incredibly good implications for the budget.

"Whatever the causes may be, the slowdown in spending is good news for Medicare, the federal budget and for beneficiaries-at least for now, and as long as it does not adversely affect access to or quality of care," they write. "Lower costs lead directly to lower Medicare premiums and cost sharing."

Obamacare still crippled by technical problems, customer service: survey

The Washington Times Thursday, July 10, 2014

Many Americans remain uninsured or underserved by Obamacare because of technical problems or a lack of information from insurers and the new health exchanges, instead of typical obstacles such as cost, according to J.D. Power's first shopper-satisfaction survey on the overhaul.

Surveyed shoppers said they had trouble completing their enrollment during the law's first sign-up period due to three main reasons — a combination of technical problems (40 percent), the application taking too long (19 percent) and the website not providing sufficient information about plans (18 percent).

Nearly half (49 percent) of shoppers who did not finish their enrollment did not choose a plan because they had not yet decided which one they wanted.

"No doubt that ensuring a technologically error-free experience, along with streamlining the online enrollment process will be most impactful to future Marketplace shoppers," said Rick Johnson, senior director of the health care practice at J.D. Power. "While the uninsured are now a smaller group, they continue to be underserved, just as they were prior to the exchanges, and continue to need more information delivered in an easy-to-understand and personal way."

He said the new exchanges have benefited from intense media coverage, but looking ahead the marketplaces "will need to retool their marketing, information and enrollment efforts toward a new generation of uninsured to serve their needs."

J.D. Power surveyed 1,632 consumers who shopped for health insurance under the Affordable Care Act between November and April.

Technical problems on the web-based exchanges were a major headache for the Obama administration last fall. The federal exchange, HealthCare.gov, had well-documented problems and several of the 15 state-based exchanges struggled throughout the sign-up period.

J.D. Power found no significant difference in satisfaction among people who enrolled the federal exchange and those who used the state exchanges.

The foremost reason shoppers tried to enroll was to comply with the law's individual mandate — 50 percent — while 40 percent shopped because they have wanted insurance but could not get it in the past.

More than half of shoppers (55 percent) said they first heard about the marketplace through the news media, while only 4 percent learned of it through a state or federal agency.

"With media coverage of the health exchanges expected to decrease over time, the insurance industry will need to develop effective communication to reach the uninsured to help fill that that information vacuum," according to the survey.

POSSIBLE BENEFITS OF PROBIOTICS

July 23, 2014

Share the Wellness: Bacteria with Benefits

Products containing probiotics — often called “good” or “friendly” bacteria — are becoming increasingly popular. You can find probiotics in supplements (such as capsules, tablets and powders) and foods (including yogurt, milk, juice and soy beverages). Look for yogurt that says it has “live active cultures.” Fermented foods like aged cheeses, sauerkraut, miso and tempeh also contain good bacteria.

Examples of probiotics include Lactobacillus, Bifidobacteria and Saccharomyces boulardi.

Are these good bacteria a good investment — or a waste of money? Experts say that more research is needed, but studies conducted so far suggest that probiotics offer some health benefits.

In clinical studies, probiotics have been shown to improve digestive problems such as:

- Diarrhea
- Ulcerative colitis
- Irritable bowel disease
- Constipation
- Food allergies, including lactose intolerance

Probiotics are generally considered safe. However, they may not be appropriate for everyone, including older adults or people with certain medical conditions. It’s best to talk with your doctor before “making friends” with this type of bacteria.

Sources: The Mayo Clinic; California Dairy Research Foundation

Well

A Sleep Apnea Test Without a Night in the Hospital

By DONALD G. MCNEIL JR. July 21, 2014 : July 22, 2014

Donald G. McNeil Jr., given a diagnosis of mild apnea10 years ago, found a test at home less cumbersome than one in a lab.Credit Michael Nagle for The New York Times

Where was I?

Sorry — must have nodded off for a decade.

Ten years ago, I spent two nights in a sleep lab at SUNY Downstate Medical Center, taking the test for sleep apnea, and wrote about it for Science Times.

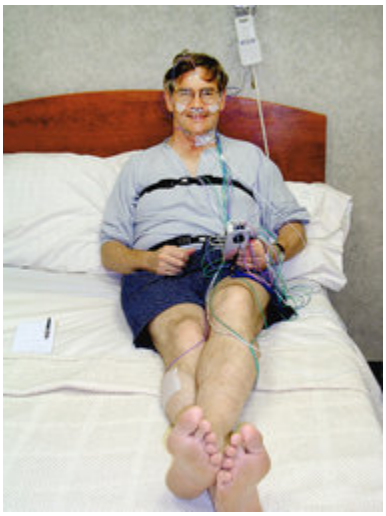
Back then, “sleep technicians” wired me up like the Bride of Frankenstein: 15 sensors glued or clamped to my scalp, lip, eye sockets, jaw, index finger, chest and legs, two belts around my torso, and a “snore mike” on my neck.

As I slept, an infrared camera watched over me. And I ended up spending 23 hours in that hospital bed because the test wasn’t over until you could lie in a dark room for 20 minutes without dozing off. I had such a sleep deficit that I kept conking out, not just all night, but all the next day.

So this year, when a company called NovaSom offered to let me try out a new home sleep-test kit that promises to streamline the process, I said yes.

In the decade since my ordeal, the pendulum has swung sharply in the direction of the home test, said Dr. M. Safwan Badr, past president of the American Academy of Sleep Medicine, which first recognized home testing for apnea in 2007. Insurers prefer it because it costs only about $300, about one-tenth that of a hospital test, and many patients like it, too.

Photo



Donald G. McNeil Jr. preparing to take a sleep test 10 years ago.Credit Downstate Medical Center

“Lots of people are reluctant to let a stranger watch them sleep,” said Dr. Michael Coppola, a former president of the American Sleep Apnea Association who is now the chief medical officer at NovaSom.

Doctors estimate that 18 million Americans have moderate to severe apnea and 75 percent of them do not know it.

Home testing is not recommended for those with heart failure, emphysema, seizures and a few other conditions. And because it does not record brain waves as a hospital lab does, a home test can be fooled by someone who just lies awake all night staring at the ceiling. But it’s useful for many people who exhibit the warning signs of apnea, such as waking up exhausted after a full night’s sleep or dozing off at the wheel in bright daylight. And severe apnea can be lethal: starving the brain of oxygen all night quadruples the risk of stroke.

Ten years ago, after my long lab night, I was given a diagnosis of mild apnea.

The likely culprits were that I was overweight, had some bad habits — coffee-fueled evenings at work followed by late wine-fueled dinners at home — and that I had a “crowded airway.” (The doctor looking down my throat said “Wow!” My uvula apparently resembles not a punching bag but a stalactite.)

The Downstate doctors made me abstain from coffee and alcohol for 24 hours and be tucked in just after 9 p.m. I protested that my life was not like that. But it had been years since I had negotiated bedtime with an authority figure. I lost.

After my diagnosis, they offered three options: I could lose weight, drink less and go to bed earlier. I could have airway surgery. Or I could sleep with a CPAP (continuous positive airway pressure) machine blowing air into my lungs.

For me, surgery was out. A cousin said it was the most painful thing he had ever endured, changed the way he spoke and didn't cure his apnea. I tried the CPAP and hated it: Although for many people it is a lifesaver, I felt as if I were sleeping inside Darth Vader's helmet. So I joined Weight Watchers and lost 35 pounds.

Ten years later, my habits are still imperfect — I still drink a bit more than I should, and I've gained back 15 pounds. In bad weeks, my BMI is 25, right on the border of normal and overweight. As for my snoring, depending on the audience, it has been described as "pretty awful" and "some of the least offensive I've heard."

The home test is done over three nights, and I made them as true-to-life as possible: I did the first with no alcohol or caffeine, then one with my typical amount, then one with too much. On Night 2, to add to the challenge, I invited over a friend and her dog.

The device arrived by mail (and is mailed back later). I was able to wire myself up without help in 15 minutes: a belt clipped around my chest, a finger poked into a blood-oxygen sensor and a breath sensor hooked over my ears and taped beneath my nose. All three plugged into a box the size of a computer modem strapped on my arm.

The best part: By shifting the box or laying it on the pillow, I could sleep almost normally. At the hospital, my 15 wires had felt like marionette strings keeping me on my back. At home, I could flip from side to side, as usual.

The first night was during a major snowstorm. I ate dinner early and drank only water, tired myself out by shoveling a foot of snow and was soon so bored that I went to bed at 8:30. I slept 10 hours and even had dreams. (The usual: Trapped in a giant men's room. Sounds kinky, but even Freud would agree that its deeper meaning is: "Hey, stupid! You need to go! Wake up!")

On the second night, my friend and I had dinner with wine and talked till midnight. She said the tape mustache holding the sensor under my nose was not as dashing as Errol Flynn's. That night was fitful — the house furnace ran too hot, the dog yipped unpredictably. I finally put in my radio earbuds to block the noise, so I didn't notice that a wire had come loose and the device was telling me off, intoning, "Check finger sensor!" over and over.

On the third night, I met another friend to hash out his marital woes over about five beers, walked home and went to bed woozy. I dropped off fast but woke up soaked in sweat at 3 a.m.

Each morning, as I plugged the device in to recharge, it beamed the night's data to NovaSom.

A few days later, I got my results in a phone call from Dr. Coppola.

They were better than I had expected.

"It's plenty of data," he said. "We got 21 hours of recording time. And you're all good."

Apnea is measured on the apnea/hypopnea index — how many times an hour a person stops or nearly stops breathing for at least 10 seconds. Below five times is minimal, five to 15 is mild, 15 to 30 is moderate, more than 30 is severe.

My three nights were 1.5, 0.7 and 2.4. So, even on the third, alcohol-heavy night, I was in the "minimal" range, though I'd had a 10-minute cluster of apneas at 2 a.m. that dropped my oxygen level to 78 percent — the normal is 90 percent or higher. "Probably you were sleeping on your back at that moment," Dr. Coppola said.

One thing did trouble me, I told him: "This says I snored 98 percent of the time? That's impossible. I have witnesses."

"That's not really snoring," he said. "It's any loud breathing. The mike is sensitive."

My previous apnea diagnosis, Dr. Coppola said, was probably a result of the big trail of brain-wave sensor wires forcing me to sleep on my back, which closed my already narrow airway. Lab monitoring, he said, "creates false sleep scenarios."

"The good news," he added, "is that your lifestyle changes made a big difference. So keep the weight off, don't drink more, and you should be O.K."

Maybe easier said than done. But we'll see.

Some seniors win Medicare exemptions for nursing-home coverage in pilot program

By Susan Jaffe | Kaiser Health News July 20

Medicare is exempting some patients at dozens of hospitals from the controversial requirement that seniors be admitted to the hospital for at least three days to qualify for follow-up skilled nursing home care.

The exemptions are at hospitals participating in Affordable Care Act pilot projects meant to test ways to improve Medicare service while reducing costs or holding them steady.

The pilot projects are conducted under a provision of the ACA that created the Center for Medicare and Medicaid Innovation to develop ways of improving Medicare.

“We’re testing whether it leads to better care and lower costs,” said Medicare’s deputy administrator Sean Cavanaugh. “And if those are successful, the secretary [of Health and Human Services] has the authority to expand those tests.”

The health law allows the government to extend successful pilot projects nationwide.

If the experiment is successful, “we should be able to make an argument to Medicare that there is a way to do it for all our patients,” said Eric M. Weil, associate chief for clinical affairs in the general internal medicine division at Massachusetts General Hospital in Boston. The hospital is one of five in the Partners HealthCare system that began offering the waiver in April after testing a limited version.

“It gets patients to the care they need much quicker and prevents them from clinically declining at home,” Weil said. If patients can spend less time in the hospital, he said, that frees up resources for sicker patients and saves money for Medicare because nursing-home care or home-health care is cheaper than a hospital stay.

Medicare’s three-day rule has frustrated seniors who don’t qualify for nursing-home coverage because they were in the hospital under observation care rather than being admitted. The number of observation patients ineligible for Medicare-covered nursing-home care has shot up by 88 percent in just six years, to 1.8 million in 2012.

Officials have said that only Congress can change the rule.

Diane Paulson, the senior attorney at Greater Boston Legal Services who is handling observation care appeals for several seniors, said Medicare should get rid of the requirement without waiting for any experiment results.

“Nursing-home care and other benefits are supposed to be covered if medically necessary and are not based on alleged cost savings,” she said.

One of the payment experiments involves about 600,000 seniors at more than 170 hospitals participating in what Medicare calls Pioneer Accountable Care Organizations. Under this pilot, which includes the Partners Health hospitals, patients who spend little or no time in the hospital can still qualify for Medicare’s nursing-home benefit. Medicare makes a set payment for a patient, which is shared by the patient’s health-care providers, including the nursing home.

This waiver of the three-day rule applies even to patients kept for observation, which is considered an outpatient service. No matter how long these patients stay, observation care normally doesn’t count toward Medicare’s requirement for short-term nursing- home coverage.

Medicare assigns patients to a program and does not accept volunteers.

Another experiment involves a “bundled payment care initiative” that also moves hospitals away from Medicare’s traditional fee-for-service model and instead pays a set fee for any of 48 specific procedures chosen by the hospital. The list includes hip or knee replacements. Patients admitted to about 70 participating hospitals may be eligible for the waiver for nursing-home coverage. Hospitals, doctors, nursing homes and other providers share Medicare’s discounted reimbursement for a patient receiving one of the eligible procedures. Medicare patients can check with their hospitals ahead of time to see if they are participating in the initiative.

“Even if patients are here 24 hours, they would still qualify for a skilled-nursing facility and are not penalized for getting well sooner,” said Joe Harrington, president of Lodi Memorial Hospital in Lodi, Calif., which provides the waiver to knee and hip replacement patients.

Hospital officials participating in the pilot programs say the waiver should be used conservatively to ensure that patients don’t leave the hospital prematurely, are not kept

longer than necessary and enter a nursing home only if they have the potential for short-term rehabilitation.

“It’s been a long-standing Medicare policy, so if you want to change it, it’s important to make sure it’s safe to change it,” said Mark Froimson, an orthopedic surgeon and president of the Cleveland Clinic system’s Euclid Hospital. The hospital is in the bundled payment pilot project and offers the waiver to seniors who need nursing-home care after undergoing a knee or hip replacement. The Cleveland Clinic has asked Medicare for permission to expand the waiver to more procedures and additional hospitals.

“This is one example where Medicare, to their credit, is saying ‘we are willing to waive our rules and evaluate whether it is better care,’ ” he said.

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Capsules THE KHN BLOG

Advocacy Groups Say Medicare Should Negotiate With Drugmakers

By Julie Apple by M **JULY 24TH, 2014**

Medicare could save billions if Congress overcame its reluctance to anger the drug industry and allowed the program to demand rebates or negotiate prices, Rep. Henry Waxman, D-Calif., said Wednesday. He added that's something polls show many Americans support.

Rep. Waxman (Photo by Jason Merritt/Getty Images for UCLA)

Expensive new blockbuster drugs, such as a $1,000-a-pill hepatitis C treatment called Sovaldi, highlight the need to do something soon, the California Democrat said, backing recommendations made in a report released Wednesday by two advocacy groups, the Medicare Rights Center and Social Security Works.

"We could save money, lower the deficit and not ask seniors to pay more," said Waxman, a long-standing drug industry critic who is retiring at the end of this session. "The only opposition is from drug companies because they will make a little less money if they have someone negotiating prices with them."

He spoke just hours before the maker of Sovaldi — Gilead Sciences — reported record sales of $5.7 billion in the first six months of the year.

The drug industry has long opposed price controls, or allowing the government to negotiate for Medicare drug prices.

Imposing price controls on Medicare could hurt seniors by altering "the competitive nature of the program" and "could increase beneficiary premiums, cause job loss, and reduce incentives for innovation," said Robert Zirkelbach, a senior vice president at the Pharmaceutical Research and Manufacturers of America.

The advocacy groups suggested four ways Medicare could save on drug costs, including the passage of legislation introduced last year by Waxman and Sen. Jay Rockefeller, D-W.V., to require drugmakers to offer discounts similar to those they make in the Medicaid program, for people who are enrolled in that program as well as in Medicare, often referred to as "dual eligibles."

Such rebates would save an estimated $141 billion over 10 years, the groups said.

The other recommendations include:

– Allow Medicare to create its own "public" drug insurance plan that could directly negotiate drug prices, as Veterans Affairs does now. Under current law, private insurers that offer Medicare drug insurance to enrollees negotiate with drugmakers, but the main Medicare program is prohibited from doing so.
– Get bigger discounts from manufacturers to eliminate the Medicare Part D "doughnut hole" – the period in which enrollees pay the full cost of their drugs – in 2016, rather than in 2020.

– Reduce the reimbursements to doctors, hospitals and others who administer some Medicare drugs from 6 percent over the sales price to 3 percent.

None of the ideas are new and all will be controversial. Doctors and oncology centers, for example, oppose cutting reimbursements, saying the additional funds help them pay for office overhead, staff and patient services. Private insurers oppose drug plans run by the government. And drugmakers fight price setting or additional controls.

Still, the price of Sovaldi — and other blockbuster drugs in the pipeline – "should be a wake-up call for legislators who have not been focused on this issue," said Joe Baker, president of the Medicare Rights Center. "This is an expensive drug – and an effective one, but it is price-prohibitive."

The drug went on the market late last year, touted as an improvement over older drug regimens. But, with an estimated 3 million Americans infected with the virus, the per-treatment cost of at least $84,000 is a big worry for insurers, including government programs.

Gilead has defended the price, saying the drug cures many people, thus reducing future medical costs.

Despite the backlash over Sovaldi's price, Waxman says Congress is unlikely to take any action this session to grant Medicare power to negotiate or demand rebates.

"Republicans, but even a lot of Democrats, are looking to the drug companies for campaign support," he said.