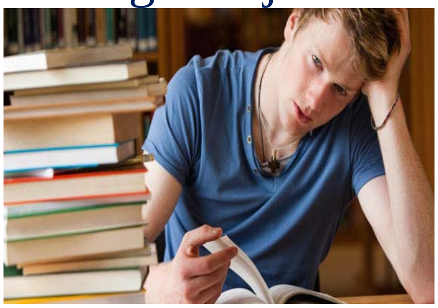
Health & Retirement Services Of Illinois

February 2013 Newsletter

OUR NEWS LETTER HRSI

College Majors That Are Most Demanding



Ever wonder which majors require the most study time? A new survey sheds some insight...

By Terence Loose

Are you ready to take on school but not sure you're ready to take on the hours of coursework and studying?

Good news. A new study by the National Survey of Student Engagement (NSSE) could help you decide which major might be the best fit for your lifestyle. The study surveyed 416,000 full-time, first-year students and seniors attending 673 colleges and universities during 2011.

Although the study included factors like the number of hours spent commuting to class or caring for dependents, let's focus on the areas associated with study time and working:

- **Average Weekly Hours of Study/Class Prep Time:** This is the time students spent studying out of class each week.
- **Number of Hours Faculty Expects You to Study:** This is the amount of time faculty members told researchers that students needed to study to be fully prepared.
- **Percentage of Seniors That Spent 20+ Hours Preparing for Class:** Again, in this study, "preparing" equals studying.
- **Number of Hours Working for Pay:** The number of hours that students spent working at a paid job outside of school.

It's important to note that not all majors are included in the study. "Some, such as architecture and nursing, for example, were not included," says Alexander C. McCormick, NSSE director and associate professor of education at Indiana University.

But McCormick is confident in the study's findings and hopes it helps students and faculty alike better understand what is, and should be, expected of them.

In Our Newsletter

It's also important to note that the number of hours that students reported for relaxing or socializing was virtually the same for each major: 10 to 11 hours per week. Seems like whether you're a science whiz or studying big biz, you'll still find some time to minor in fun.

Check out some key findings from the NSSE study. Consider it time well spent in the "Preparing for Class" category.

*#1 Most Demanding Area of Study - **Engineering***

Do you love to take things apart to see how they work? An engineering degree might be for you. Just make sure you're ready to hit the books, since engineering students reported studying more than any other major, according to the NSSE study.

Depending on the specific area of study, engineering majors might study everything from the link between architecture and construction, the scientific and mathematical basis of computer software, or the design of spacecraft and missiles, according to the College Board, an organization that administers academic aptitude tests like the SAT.

Typical Engineering Majors:* Aerospace Engineering, Architectural Engineering, Biomedical Engineering

AVG WEEKLY STUDY HOURS	EXPECTED STUDY HOURS	PERCENT WITH OVER 20+ STUDY HOURS	NUMBER OF HOURS WORKING FOR PAY
19 hours	**20 hours**	**42 percent**	**9 hours**

#2 Most Demanding Area of Study - Physical Sciences

Physical sciences students reported spending about 18 hours studying and preparing for class per week - this was second only to engineering students for the most study/prep time.

If you're curious about how the universe works or how chemicals affect our environment, this might be your area to study. Physical sciences students usually study brainy subjects like chemistry, geology, and physics. They also tend to spend time learning a lot about mathematics and the scientific method, says the College Board.

Typical Physical Sciences Majors:* Physics, Chemistry, Geology

AVG WEEKLY STUDY HOURS	EXPECTED STUDY HOURS	PERCENT WITH OVER 20+ STUDY HOURS	NUMBER OF HOURS WORKING FOR PAY
18 hours	**18 hours**	**36 percent**	**11 hours**

#3 Most Demanding Area of Study - Biological Sciences

Perhaps you're more interested in living organisms, such as bacteria, animals, and us. Well, get ready to work. Biological sciences students came in at a close third for study time. But they didn't party with the extra hour or two: they reportedly socialized an hour less per week than both physical sciences and engineering students.

When they do hit the books, biological sciences students generally study living organisms as well as the systems and processes that permit life, says the College Board. Typical courses could include biochemistry, genetics, marine biology, and zoology.

Typical Biological Sciences Majors:* Marine Biology, Molecular Biology, Cellular Biology

AVG WEEKLY STUDY HOURS	EXPECTED STUDY HOURS	PERCENT WITH OVER 20+ STUDY HOURS	NUMBER OF HOURS WORKING FOR PAY
17 hours	**19 hours**	**34 percent**	**11 hours**

#4 Most Demanding Area of Study - Arts & Humanities

Crave a little more creativity in your major? Then you'll likely want to check out the halls of the arts and humanities departments. And while you might not burn as much midnight oil to prepare for classes as those in engineering or physical sciences, you'll still study more than the average student.

But it's *what* you'll study that is very different. Arts and humanities students usually learn everything from philosophy to languages to literature, according to the College Board. And courses could include more artful fare, such as music and drama.

Typical Arts & Humanities Majors:* Theater, Philosophy, The Classics

AVG WEEKLY EXPECTED PERCENT WITH OVER NUMBER OF HOURS

STUDY HOURS	STUDY HOURS	20+ STUDY HOURS	WORKING FOR PAY
17 hours	**18 hours**	**31 percent**	**12 hours**

#5 Most Demanding Area of Study - Education

Don't be fooled by the fact that students in education reported an average of "only" 15 hours of study/prep time per week. Education students reported 13 hours of work for pay per week, and the most weekly hours caring for dependents: seven. That's a 45-hour week, before attending a minute of class.

Education students generally learn how to manage a classroom, how to design lesson plans, and how to effectively teach students, says the College Board. Education classes generally include topics such as educational psychology, teaching methods, and instructional technology.

Typical Education Majors:* Education, Middle School Teaching, Special Education

AVG WEEKLY STUDY HOURS	EXPECTED STUDY HOURS	PERCENT WITH OVER 20+ STUDY HOURS	NUMBER OF HOURS WORKING FOR PAY
15 hours	**15 hours**	**26 percent**	**13 hours**

*#6 Most Demanding Area of Study - **Social Sciences***

Tied with business as the area with the least amount of study/prep time reported, social sciences can still be a fascinating field if you are interested in learning more about psychology or sociology.

If you are intrigued as to how the human mind works, or why societies function, or how to lower crime rates, this could be the major for you. You generally study those subjects as well as other interesting questions about the human condition, according to the College Board.

Typical Social Sciences Majors:* Psychology, Sociology, Criminology

AVG WEEKLY STUDY HOURS	EXPECTED STUDY HOURS	PERCENT WITH OVER 20+ STUDY HOURS	NUMBER OF HOURS WORKING FOR PAY
14 hours	**18 hours**	**23 percent**	**13 hours**

*#7 Most Demanding Area of Study - **Business***

Though business majors were found to study the least when compared to the other surveyed degrees, that doesn't mean they didn't keep themselves busy. These students logged the most hours when combining the two areas of caring for dependents and working for pay - six and 16, respectively.

Business students usually study the process of buying, producing, and selling goods and services. They also could learn more about the areas of accounting, marketing, and management, says the College Board. So, perhaps they just learn to manage their time better.

Typical Business Majors:* Business, Finance, Management

AVG WEEKLY STUDY HOURS	EXPECTED STUDY HOURS	PERCENT WITH OVER 20+ STUDY HOURS	NUMBER OF HOURS WORKING FOR PAY
14 hours	**15 hours**	**19 percent**	**16 hours**

**All major information taken from CollegeBoard.com, a century-old nonprofit organization serving 3,800 colleges and university.*

Five proven ways to cut mortgage costs

If you want to reduce your mortgage bills, then consider these surefire tips to help you cut your mortgage costs.

HOMES *By Sarah Tann | Yahoo! Homes – Mon, Nov 26, 2012 2:56 PM EST*

Photo: Thinkstock

Let's not sugarcoat it: High mortgage costs can be a real pain in the butt.

In fact, some 84 percent of homeowners say mortgage costs are a big concern for them and that "high interest rates, high payments, and taxes and escrow are the top three most frustrating issues regarding consumers' current mortgages," according to a September 2012 mortgage study conducted by Carlisle & Gallagher Consulting Group, a management and technology consulting firm.

The good news: There are ways to alleviate some of this financial stress.

Keep reading for some proven tips on how to cut your mortgage costs.

Tip #1 - Refinance Your Mortgage

What makes refinancing your mortgage a buck-saving option?

For starters, refinancing, which is the process of paying off your existing mortgage with a new one, could help you lower your monthly payments *if* you qualify for a lower interest rate.

Perhaps that's why Joffrey Long, president of Southwestern Mortgage in Granada Hills, California, says that refinancing is a viable option to help lower mortgage expenses.

"Any consumer, at any time, who has a mortgage and is paying interest should be aware of the opportunity to refinance," says Long, who is also the education chair for the California Mortgage Association.

And the opportunity to refinance could result in huge savings.

Where's the Proof? Consider this example from "A Consumer's Guide to Mortgage Refinancings" published by the Federal Reserve Board, which oversees national monetary policy and banks. It compares monthly payments on a 30-year fixed-rate loan of $200,000 at 5.5 percent and 6 percent:

Monthly payment @ 6 percent	$1,199
Monthly payment @ 5.5 percent	$1,136
The difference each month is	$63

Over 10 years, you will have saved	$7,560

That's a considerable amount of savings for just a .5 percent interest rate drop, isn't it? Now just imagine how big your savings would be if you could lower your interest rate by 1 or 2 percent.

However, it's good to keep in mind that refinancing is not for everyone, says Long, and that costs and long-term property plans are things to consider before taking this big step.

Tip #2 - Shop Around for a Super-Low Interest Rate

Whether you're perusing for your first home loan or thinking about refinancing your existing mortgage, shopping around is a key cost-cutter when it comes to your mortgage payments.

According to Long, shopping around is one of the most important ways for homeowners to cut mortgage costs, but unfortunately, some people overlook it because they're too comfortable with their current bank.

"There's a comfort level that people have with big banks," Long says, "and it makes sense because they've been with the bank for many years. But, it's a good idea to check with independent mortgage bankers and lenders to make sure that the rates you're receiving are indeed competitive."

Where's the Proof? "Shopping, comparing, and negotiating may save you thousands of dollars," says the Federal Reserve Board. Just think about it: If you don't compare rates from multiple lenders and banks, how will you truly know if the rates you're receiving are indeed the lowest?

Tip #3 - Take a Second Glance at Your Home Value

When the value of your property goes down, it's not the best news in the world. One upside, however, is that you may not have to pay as much in property taxes, and that could be *great* news.

And because property values fluctuate up and down depending on the real estate market, it's always a good idea to reassess your home's worth to make sure you're not paying more than you need to in property taxes.

In fact, "After several years without a reassessment, some properties will be over-assessed and some will be under-assessed," notes the New York State Department of Taxation and Finance's website. "This is because some properties will have increased in value, while others may have decreased or stayed the same. Without a reassessment, all of the properties will continue to pay the same amount of taxes."

That's why Long says reassessing your home is important. "If your home is assessed at more than it's worth, a reassessment could help reduce property taxes," he says.

Where's the Proof? Just consider this example from the New York State Department of Taxation and Finance:

	Property A	**Property B**
Market value 20 years ago	100,000	100,000
Taxes 20 years ago	$2,000	$2,000
Market value today	300,000	150,000

Taxes today, after a reassessment	$2,667	$1,333

So what's the big takeaway here? If you don't reassess your home value, you could be paying *much* more in mortgage costs than you have to.

Tip #4 - Give Your Credit Score a Healthy Boost

Oh, credit scores...they can make life amazing - or incredibly miserable. And when it comes to cutting your mortgage costs, a good credit score could be the difference between beautifully low or unpleasantly high payments.

Why? Because according to a consumer credit guide published by Federal Reserve Board, your credit score is used by lenders to evaluate how you handle your financial responsibilities. So, if you've been rather reckless with your finances, you'll likely have a lower credit score which is often reflected in a higher interest rate. Likewise, the higher your credit score, the lower your rate will be.

And this is precisely why raising your credit score is always a good idea.

"Whether you buy or refinance, raising credit does help decrease mortgage rates," says Long.

Where's the Proof? You don't have to look much further than this chart, which shows what kind of interest rates you could get - based on your credit score. The data is pulled by myFICO, a division of the Fair Isaac Corporation, with interest rates as of November 13, 2012.

FICO Score	**APR**
760-850	2.926 percent
700-759	3.148 percent
680-699	3.325 percent
660-679	3.539 percent
640-659	3.969 percent
620-639	4.515 percent

As you can see, a good credit score can definitely work in your favor. However, Long warns that boosting your score is a long term proposition, so it may take awhile before you can reap the benefits of an improved score. "It's not just going to go up overnight, so by the time you've raised your credit score, the low rate you want may no longer exist."

Long recommends checking with your lender to find out what kind of score is necessary to qualify for the loans and rates you want - then figure out if the effort will be worth it.

Tip #5 - Make Extra Mortgage Payments

You're probably thinking this is a crazy and contradictory suggestion, but trust us - it's not.

No, this tip is geared towards people who may have a little extra money to spend and are looking to invest it wisely. In this case, by paying off their mortgage quickly.

In fact, doing so will reduce future interest costs and save you money, notes a 2011 consumer mortgage report by the Federal Deposit Insurance Corporation (FDIC), an agency designed to promote public confidence in banks.

"By adding a little more money to your monthly payment or sending all or part of your payment in sooner than you're scheduled to, you can repay your loan faster and cut your total interest costs by thousands of dollars over the life of the loan," said FDIC's associate director, Luke Brown, in the 2011 consumer report.

Where's the Proof? Let's say you had a $200,000, 30-year fixed-rate mortgage at 6 percent, with a monthly payment of $1,199. If you made just one extra payment a year (13 instead of 12), you could save $47,000 in interest and cut five years from your loan term, says Zillow in its report "7 easy ways to trim your mortgage costs."

Of course, before deciding to embark on this route, you should first determine if you have the funds necessary - and then some, says Long. He recommends having at least six months worth of household income saved up for emergencies *before* making any extra payments.

Health care law may mean less hiring in 2013

Paul Davidson, USA TODAY8:12p.m. EST December 30, 2012

President Obama leaves Air Force One upon arrival Nov. 30 at Andrews Air Force Base. He signed the Affordable Care Act on March 23, 2010.(Photo: Jose Luis Magana, AP)

Story Highlights

- Some businesses plan to trim employee hours
- Others may add more part-time workers
- Retail and hospitality industries affected

Many businesses plan to bring on more part-time workers next year, trim the hours of full-time employees or curtail hiring because of the new health care law, human resource firms say.

Their actions could further dampen job growth, which already is threatened by possible federal budget cutbacks resulting from the tax increases and spending cuts known as the fiscal cliff.

"It will have a negative impact on job creation" in 2013, says Mark Zandi, chief economist of Moody's Analytics.

Under the Affordable Care Act, businesses that employ at least 50 full-time workers — or the equivalent, including part-time workers — must offer health insurance to staffers who work at least 30 hours a week. Employers that don't provide coverage must pay a $2,000-per-worker penalty, excluding the first 30 employees.

The so-called employer mandate to offer health coverage doesn't take effect until Jan. 1, 2014. But to determine whether employees work enough hours on average to receive benefits, employers must track their schedules for three to 12 months prior to 2014 — meaning many are restructuring payrolls now or will do so early next year.

About a quarter of businesses surveyed by consulting firm Mercer don't offer health coverage to employees who work at least 30 hours a week. Half of them plan to make changes so fewer employees work that many hours.

The health care law will particularly affect companies with 40 to 45 workers that plan to expand and hire. Many are holding off so they don't cross the 50-employee threshold, says Christine Ippolito, principal at Compass Workforce Solutions, a human resource consulting firm in Melville, N.Y.

Ernie Canadeo, president of EGC Group, a Melville-based advertising and marketing agency with 45 employees, planned to add 10 next year but now says he may add fewer so he's not subject to the mandate. Still, he says, he'll eventually have to hire more workers to grow. "If business demands that I hire, then I have to hire," he says.

Others already over the 50-employee threshold plan to add more part-time workers or cut the hours of full-timers, says Rob Wilson, head of Employco, a human resource outsourcing firm. Many, he says, will hire more temporary workers, whom they won't have to cover.

Nearly half of retailers, restaurants and hotels will be affected by the law, according to Mercer. They employ large numbers of part-time and seasonal employees, including many who work about 30 hours a week.

Since such low-wage workers are widely available, it often hasn't been cost-effective or necessary for employers to offer them coverage. Providing them benefits could be costly because employees must pay no more than 9.5% of their wages in insurance premiums, forcing employers to contribute significantly more than they do for higher-wage workers.

"I think you may see employees with fewer hours as a consequence," says Neil Trautwein, vice president of the National Retail Federation.

Thirty-one percent of franchisees surveyed recently by the International Franchise Association said they plan to pare staff to get under the 50-employee threshold.

Affordable Care Act could help bridge gaps

Though the Affordable Care Act won't fix every problem in the system, it will expand health care coverage to 30 million previously uninsured Americans.

New health exchanges will be required to cover mental-health care and substance-abuse treatment, says Rachel Garfield, senior researcher at the Kaiser Family Foundation.

The new law will cover more people in other ways, Garfield says.

•Young people will be more likely to have coverage, because the law allows them to stay on their parents' plans until age 26.

•More people will be eligible for Medicaid, such as low-income adults without children, or will be able to buy coverage through new health exchanges.

•Plans won't be able to discriminate against patients who have an existing mental-health condition.

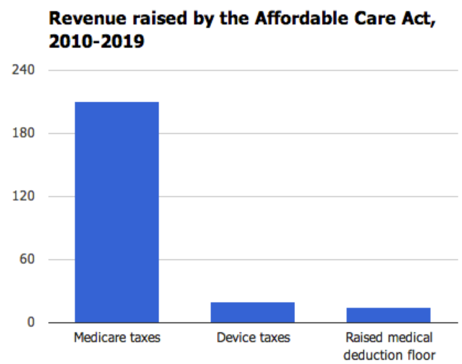
•The law also eliminates the lifetime cap on benefits, so families won't exhaust their coverage.

Three Obamacare tax changes start in 12 days

Posted by **Sarah Kliff** on December 19, 2012 at 1:31 pm

No matter how the "fiscal cliff" negotiations end, there's one thing that's for sure: Come 2013, the country will face new taxes.

That's due to the Affordable Care Act, which has three new tax provisions that take effect at the end of 2012. Taken together, they're expected to raise $245.4 billion in revenue by 2019 (the most recent budget window for which data is available) and help pay for the 33 million Americans expected to gain coverage under the health law. Here's how they break down, with numbers courtesy of the Joint Committee on Taxation.



Let's start with the biggest revenue generator: New Medicare taxes. Employers already take out 7.65 percent of workers' wages to support the elderly and disabled. Of that, 1.45 percent goes toward paying Medicare's hospital bills.

The Affordable Care Act increases the Medicare hospital tax by 0.9 percent, beginning in 2013, for anyone who earns more than $200,000 ($250,000 for joint filers). It also creates a new, 3.8 percent tax on investment income, setting income thresholds at the same $200,000 and $250,000 levels mentioned above.

It sounds like a decidedly dull and familiar provision: We already pay, after all, a hospital insurance tax. John McDonough, a former health policy adviser to the late-Sen. Ted Kennedy, argues that it's actually a really transformational way in how we pay for the Medicare program.

"It represents a major shift in federal tax policy–for the first time, unearned income will be subject to Medicare taxes, albeit less than for earned income," he writes in Inside National Health Reform. "For progressives, this is an enormous and positive breakthrough in tax policy."

He also notes that it has had an immediate impact on Medicare projections, too, as the new tax was a "significant factor" in the Medicare trustees conclusion that the Affordable Care Act extended the Medicare Hospital Insurance Trust Fund from 2017 to 2029.

The Medicare taxes may raise the most revenue, but it's the medical device tax that has garnered the most attention here in Washington. That provision levies a 2.3 percent tax on the sale price of a medical device, to be paid by the manufacturer.

What counts as a medical device? Think of the various gadgets in your doctors' office, everything from gloves to defibrillators to the pacemakers inserted into patients. Things that consumers tend to purchase — glasses, hearing aids and contact lenses — are not subject to the provision.

The medical device tax doesn't necessarily single out device makers: Drug manufacturers and health insurers will also face similar fees, all part of the plan to finance an insurance expansion meant to cover 33 million Americans. This provision in particular is expected to raise $20 billion over the next decade.

Still, the Medical Device Tax has come under siege on both sides of the aisle: Repeal legislation passed the House easily this past summer, with 37 Democrats joining Republicans in support. Seventeen Democratic senators recently fired off a letter to Health and Human Services asking for a one-year delay on the provision. Ten days out from implementation, however, the medical device tax doesn't seem to be heading anywhere.

Last but not least, we have the smallest revenue raiser, which changes who can deduct medical expenses in their tax filings. Up until now, anyone who spent more than 7.5 percent of their adjusted gross income on health care could claim that amount as a deduction; spend 7.4 percent, however, and you're out of luck.

That threshold will rise to 10 percent on Jan. 1. Some do get an exemption: Anyone who will turn 65 within the next four years can still use the 7.5 percent threshold through 2017.

State regulators address possible premium increases, abuse with PPACA

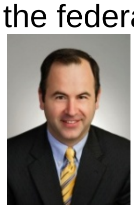
By **IFAwebnews Staff**

Filed in:Health Insurance News, **National**

See more:AHIP, CMS, HHS, Kevin McCarty, Michael Consedine, PPACA

State insurance regulators are pressing federal officials at the likely prospect that premiums will increase and healthier Americans will leave the marketplace as health care reform is implemented.
The National Association of Insurance Commissioners (**NAIC**) wrote in a letter that members are concerned high premiums will force young and healthy Americans out of the market in favor of penalties, leaving a larger and unhealthier population. Rates could skyrocket for that remaining population, observers have said.
The letter was sent to the Centers for Medicare and Medicaid Services in response to new rules that apply to the Patient Protection and Affordability Care Act (PPACA), which requires most Americans to obtain health insurance by Jan. 1, 2014, or pay penalties.
The rules were released by Health and Human Services, which has yet to release all rules related to PPACA.
"State insurance regulators remain concerned about the impact the market reforms will have on premiums," the letter stated.
The NAIC is seeking more time and the ability and authority to develop systems to respond to what it says will be "rate shock" for younger consumers.

Kevin McCarty
"States need as much flexibility as possible under the law to work with issuers to address this problem," the letter said. Among recommendations would be a transition period with reduced rates to reduce rate shock for younger consumers, making it less likely they will leave and "further destabilize the market."
The NAIC is headed by Florida Insurance Commissioner Kevin M. McCarty. Pennsylvania Insurance Commissioner Michael Consedine was recently elected secretary-treasurer of the group for 2013.
AHIP (America's Health Insurance Plans) sent a letter to HHS with similar concerns, saying that "costs will increase for everyone" if young people don't stay in the market. AHIP wrote that it is "crucial" that the federal government be flexible to "mitigate disruption for consumers."



Michael Consedine
While it may not be possible to eliminate cost increases, AHIP asserted, addressing the problem now may help initiate a "broader national conversation" as the law is implemented and costs rise.
Through the NAIC letter, state commissioners wrote that adverse selection is of "great concern" to them, but that a guaranteed issue, no pre-existing condition environment has the potential for abuse, as first noted by HHS. Their advice is to let states use state's tried-and-true tools, such as waiting periods and penalties for late enrollment.

“States need flexibility to develop a regulatory environment that will discourage adverse selection while preserving consumer protections, rather than having the federal government prescribe open enrollment as the tool that states must use,” the letter stated.

States are also “concerned” about the amount of data insurers are required to provide, and the subsequent associated cost. The states explained in the letter that they already work with insurers to ensure information collected from them is “necessary to enforce laws and regulations.”

The NAIC wants the federal government to work closely with state insurance regulators to ensure an “undue burden” is not place on health insurers, which would “result in unnecessary costs.”

The NAIC expressed a host of concerns and recommendations about PPACA’s implementation, including “large increases” in premiums for individuals as those in high-risk pools move the individual market, allowing states to align geographic and service areas to avoid carrier “cherry-picking of service areas,” taking the authority away from the federal government in determining minimum sizes of families and returning it to states, and giving the states more time to develop tools to address adverse selection.

Just Explain It: Why taxes for most are rising while others don't pay any federal income tax

By ZelkadisElvi | Just Explain It

The fiscal cliff has been averted, but at a cost. Most Americans will pay higher taxes this year.

According to the Tax Policy Center, 77% of American households will face higher federal taxes in 2013.

Here's how it breaks down. If you're an individual making over $400,000 a year, or a family pulling in more than $450,000 -- your taxes will increase by almost 5%.

Tax rates on capital gains and dividends for wealthier households will go from 15% to 20% under the agreement.

Every worker will see an increase in taxes. That's because Congress let the payroll tax cut expire on December 31st. So for every $100 you earn in 2013, up to $113,700, you'll take home $2 less than you did last year.

The debate over taxes was a major part of last year's presidential election. President Obama did what he said and raised taxes on the wealthy. The question of who should bear more of the tax burden was a hotly contested topic. *Is our tax system fair? And are the wealthy asked to do more while others contribute nothing?*

It has often been quoted that almost half of Americans don't pay federal income taxes. In fact, former Republican Presidential nominee Mit Romney created controversy last year when he described those that don't pay federal income taxes as "victims... who are dependent upon government."

The truth is most Americans pay taxes in some form or another, but not everyone pays the federal income tax. Bob Williams, a Senior Fellow at the Tax Policy Center, says "the income tax was set up in a way that allows people not to pay it by doing particular things." Williams authored a report that found 46% of Americans in 2011 (47% in 2010) didn't pay federal income tax because they took credits and deductions for things like, going to school, retirement savings plans, childcare and mortgages.

Here's a look at how a family might end up not paying any federal income taxes.

If a couple earning $51,000 with childcare expenses of three thousand dollars a year for their two kids under 13. At that income level, the family would have a basic tax liability of almost $2,600. But after standard deductions, credits for childcare, this family's net tax bill would be -$12. The family wouldn't have to pay federal income tax at all in 2012.

In certain cases wealthy Americans who earn over $1 million don't have to pay federal income taxes either. For example, if your business losses offset positive income or, if you're given credit for foreign taxes to avoid double taxation.

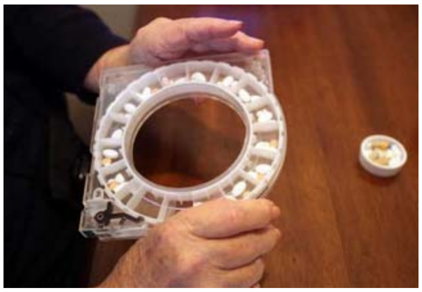
Billionaire investor Warren Buffett believes the rich don't pay enough in taxes. Buffett said his 2010 tax bill was $6.9 million. That was about 17.4% of his income. Even though that's a lot of money, he was taxed at a much lower rate than 20 other people in his office. An average of 36% of their income went to taxes.

If all of this seems complicated to you, you're not alone. Income taxes have been a point of contention in this country since Abe Lincoln and Congress introduced them 150 years ago. About the only thing Americans agree on is that the tax code has to be simplified.

Talking pill cases, tennis shoe tracking devices, video cameras help seniors stay in their homes

Gadgets now available to modest-income families

December 25, 2012 |



Purchase Image

A high-tech pill dispenser has a digital voice that tells Ed Rockett, 83, when it's time to take his medicine. / Regina H. Boone/Detroit Free Press

By Robin Erb

Detroit Free Press Medical Writer

Purchase ImageZOOM

Ed Rockett, 83, of Farmington Hills uses various devices to live independently, including a timed pill dispenser. He is part of a pilot program at his senior living facility to test the new pill dispenser and the video monitor that is trained on the area immediately around his dispenser. / Regina H. Boone/Detroit Free Press

From talking pill dispensers to tracking devices tucked inside tennis shoes to digital medical scanners that can transmit vital signs to the doctor, today's gadgets help seniors stay in their homes and can give relief to loved ones and caregivers.

"It gives them peace of mind," Ed Rockett, 83, said of his sons. The Farmington Hills resident, a retired educator, said he doesn't mind the pleasant digital voice from his pill dispenser that reminds him in the morning and evening that it's time for his meds.

Nor does it bother him that his son, a three-hour drive away, is sent a short video each time the senior Rockett walks into the path of a motion-sensor activated camera in his dining area where he takes his pills. Near Houghton Lake, an e-mail pings the smartphone of Rockett's son, also named Ed, to let him know a new video is available.

The younger Rockett said he glances at the video to make sure his father is moving around easily: "It's not so much about him taking his medicine. It's nice to see him and we joke. I can say 'Hey, you're wearing the same shirt as yesterday.' We have a good time with it."

The new gadgets -- once available only to hospitals and the wealthiest consumers -- are accessible now to more modest-income homes.

Wisconsin-based GrandCare Systems provides consoles and software, for example, in seniors' homes that can not only measure blood-sugar levels or pulse-oxygen but also provide video communication with loved ones and function almost as an entertainment center as well.

Marketing coordinator Ashley Taylor said the company provided one for a relative. At first, like many seniors, he was resistant, Taylor said. But he changed his mind, she said, "as soon as I loaded up the system with Betty Boop cartoons and Pink Floyd music."

For his part, the elder Rockett is part of a pilot program at his senior living facility to test the new pill dispenser and the video monitor that is trained on the area immediately around his dispenser. It's connected to a call center operated by Guardian Alarm. If Rockett misses a pill, the dispenser would alert Guardian, which in turn, would call Rockett's appointed loved ones.

"You never think it will happen to you, getting older," Rockett said, chuckling.

Many products can be found in self-help and medical goods shops, but they're also offered online. Some are sold directly by manufacturers; others have been collected in online stores such as the Alzheimer's Store at www.alzstore.com. It offers products ranging from clothing and accessories to telephones and medical equipment for those with memory loss.

Advocates say it's best to consult with health care providers for suggestions on what to use. Among the products:

• **Pill dispensers:** Some not only dispense an allotted number of pills at pre-set times, they allow caregivers to record messages and they also send out alerts through a resident's phone line if pills go untouched.

Southfield-based Guardian Alarm sells several types at www.guardianmedicalmonitoring.com.

Guardian's dispensers are electric, with a battery backup.

• **Emergency buttons:** Personal Emergency Response Systems, or PERS, are provided by many home security systems, allowing seniors to call for help if they've fallen or are suddenly disoriented. They can be worn as a pendant or wristband. Through Guardian, the average monthly monitoring fee is about $30; set-up or activation is usually less than $50.

Newer versions offered elsewhere also contain a sort of gyroscope that senses if the wearer falls.

Some emergency systems don't require a security system to be hooked up. Rather, a wireless signal prompts a phone to call programmed numbers such as 911 or a family member.

• **Stove-top sensors:** Special stoves come equipped with a Safe-T-element cooking system that automatically switches off the stove top if the temperature exceeds 700 degrees, said Kevin Callahan, CEO of Ontario-based Pioneering Technology, the manufacturer. Costs vary, depending on the stove.

At www.thiscaringhome.org, the burners cost $170, plus installation. For information, go to www.pioneeringtech.com.

Unattended stove tops and cooking fires caused an estimated 156,400 fires and 420 deaths in 2010, according to the National Fire Protection Association.

• **Tele-health sensors:** A number of devices can measure a person's vital signs -- weight, blood pressure, blood sugar, for example -- and send the readings to doctors or caregivers.

The devices are good especially for seniors who have difficulty finding transportation for frequent visits to the doctor. The devices provide doctors with better, more-complete health monitoring. Purchasing an entire system can cost more than $1,000 but offer not only easy-to-read, touch-screen consoles that track vital sign readings but also photos, files and messages from loved ones. Caregivers log on remotely with a password. Go to www.grandcare.com.

• **Phones:** New phones come equipped with large buttons and video screens that can make it easier for a person to keep in touch or call for emergency help. The VTechCareLine, for example, features buttons that can be fitted with loved ones' pictures and it comes with a pendant that can be used to send an alert should a person fall or face another emergency situation. Unlike safety pendants connected to an alarm system, there is no monthly fee. Go to www.vtechphones.com .

• **Movement trackers:** A number of trackers are on the market for those with memory problems, but Los Angeles-based GTX, has teamed up with New Jersey-based shoe manufacturer Aetrex Worldwide to provide shoes with GPS trackers inconspicuously stitched inside.

GPS trackers in cell phones, or placed in a car or purse may be left behind -- but even a fading memory that can no longer recall the names of loved ones holds fast to a lifetime of routine.

"They just have to remember to put on their shoes," said Patrick Bertagna, CEO of GTX. Go to www.navistargpsshoe.com.

• **Alarm systems:** For loved ones in danger of wandering off at night, door and window alarms that start at less than $50 can be installed on windows and doors, alerting others in the home. Similar alarms can be placed in beds or chairs or around toilets.

Go to www.alzstore.com or www.telehealthsensors.com.

• **Camera-monitoring:** The Virtually There Care Monitor, like others, allows loved ones to check in on seniors from miles away. Set up discreetly anywhere in the home, it can record videos at pre-set times or be programmed to allow live remote viewing through a password-protected website. Generally, the lens is trained on commonly-traveled areas of the home: hallways, living rooms or kitchens, for example, said Laura Seriguchi, director of business development for Guardian Medical Monitoring, which provides the monitoring.

"It's up (to) the consumer and family to determine which areas will be covered," she said.

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It's Legal For Some Insurers To Discriminate Based On Genes

byDAVID SCHULTZ
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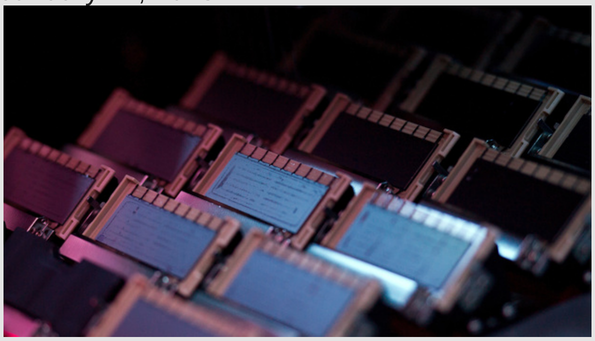

Enlarge imagei

Slides containing DNA sit in a bay waiting to be analyzed by a genome sequencing machine.

David Paul Morris/Bloomberg via Getty Images

Getting the results of a genetic test can be a bit like opening Pandora's box. You might learn something useful or interesting, or you might learn that you're likely to develop an incurable disease later on in life.

There's a federal law that's supposed to protect people from having their own genes used against them, the Genetic Information Nondiscrimination Act, or GINA. Under GINA, it's illegal for an employer to fire someone based on his genes, and it's illegal for health insurers to raise rates or to deny coverage because of someone's genetic code.

But the law has a loophole: It only applies to healthinsurance. It doesn't say anything about companies that sell life insurance, disability insurance or long-term-care insurance.

"GINA was a fabulous accomplishment," says Robert Green, a researcher in the genetics department at Harvard Medical School. "It was long in coming and much needed. But I think that it was not perfect."

Green oversaw a study that examined how people react after they learn they have ApoE4, a gene associated with Alzheimer's. He found that people who discover they have the gene are five timesmore likely than the average person to go out and buy long-term-care insurance.

"It would be a natural thing that people might consider if they find out that they are at an increased risk for Alzheimer's disease. This is a logical outcome to getting genetic-risk information," Green says.

But when people go make that "logical" decision, there's nothing stopping the insurance companies from demanding to see the results of their genetic test. In fact, a long-term-care company could legally requiresomeone to take a genetic test before selling him a policy.

Green says it's especially ironic that GINA does not apply to long-term-care insurance policies, since they cover the costs of nursing homes, assisted living facilities, home health aides and other things that people with Alzheimer's disease often need to use.

Rep. Louise Slaughter, a Democrat from western New York, introduced GINA in the House back in 2007. She says she fought hard for the law because she didn't think it was fair that a few wayward strands of DNA could make you essentially uninsurable.

"There were countless people in this country who were not eligible for insurance at all,simply by the way they were born," Slaughter says.

But she knows the law still has gaps that need to be closed. "And we plan to do that," she says.

If that happens, the insurance industry will have a thing or two to say about it.

Insurance works best when lots of people purchase policies but only a few actually need to use them. Selling these kinds of policies suddenly becomes unsustainable if genetic testing becomes widespread, and most — or even all — of the people who buy long-term-care policies do so knowing they're probably going to develop Alzheimer's sometime down the road.

When Green talked about his study to a room full of insurance executives a few years ago, he found out just how frightened the industry is of this scenario.

"These very mild-mannered people in the audience got very, very heated," he says. "They were standing up and saying, 'This kind of situation is going to put us out of business.' "

A spokesman with the company Genworth, the largest seller of long-term-care policies in the U.S., said in an email to NPR that it doesn't want to lose its ability to "utilize all information." Genworth isn't restricted by the law now, and it doesn't want that to change.

Like bikinis, HMOs can be too skimpy

By Julie Appleby, Kaiser Health News,

Health plans resembling the HMOs of old may be poised to make a comeback in online insurance markets slated to open this fall under the health law.

Such plans, which sharply limit a consumer's choice of doctors or hospitals, fell into disfavor in the 1980s and 1990s because of their restrictions.

But the plans -- which have already reappeared among employers looking to slow rising premiums -- are expected to play a prominent role in the exchanges, where individuals and small businesses will shop for coverage starting Oct. 1.

Insurers, which are currently designing their plans, "will start with as tight a network control as they can," says Ana Gupte, a managed care analyst at Sanford Bernstein.

That trend worries consumer advocates, who fear skimpy networks could translate into inadequate care or big bills for those with complicated health problems.

Because such policies can offer lower premiums, insurers are betting they will appeal to some consumers, especially younger and healthier people who might see little need for more expensive policies.

Plans may also benefit from offering such policies because they are less attractive to those with medical problems, who can no longer be turned away beginning in January 2014.

"Plans will basically say they can minimize their risk by creating narrow networks," says John Weis, president of Quest Analytics, an Appleton, Wis., firm that analyzes networks for insurers.

State or federal regulators, who must review the policies, are unlikely to permit them to exclude an entire class of doctors, such as cancer or diabetes specialists. But there might be more subtle ways to discourage consumers with medical problems.

"They might have too few oncologists, or only general oncologists," for example, says Stephen Finan, policy director with the American Cancer Society Cancer Action Network.

Cost vs. choice

"Narrow networks may be more than adequate 90% of the time," Finan says, but are "not well-suited to deal with complicated medical conditions and chronic diseases."

That's because there may be few or no specialists available for complex conditions, so patients may have to seek care outside of the networks. If the policy doesn't cover non-network care, the patients may end up footing the bill themselves. Even if policies allow for outside-the-network coverage, patients can incur large co-pays or other costs. "Your (financial) exposure could be high," Finan says.

While the health law requires policies to include standard essential benefits, ranging from emergency room and hospital care to prescription drugs, it is less prescriptive about the size of the policies' networks of doctors and hospitals.

In March, the Obama administration issued rules stating that insurers must "maintain a network of a sufficient number and type of providers … to assure that all services will be available without unreasonable delay."

That fell short of the standards sought by consumer advocates but pleased other groups that say insurers should have broad discretion.

The administration noted that "nothing in the final rule limits an exchange's ability to establish more rigorous standards."

Shaving costs

Insurers contend that by limiting network size, they can offer plans with higher-quality or more-efficient doctors and hospitals, which might slow spending or improve care.

Driven by consumer and employer demand for lower-cost plans, insurers are already rolling out narrow network policies that have shaved premiums 10% or more. A recent survey by benefit firm Mercer found that 23% of large firms offered such plans in 2012, usually among a choice of plans, up from 14% in 2011.

In Massachusetts, insurer Harvard Pilgrim launched its Focus Network in April, touting 10% lower premiums. While it includes 50 hospitals and 16,000 physicians, it excludes some high-cost systems.

In California, Blue Shield has a number of SaveNet HMO plans with networks averaging a little more than half the size of its standard ones. Next year, for example, one serving Marin and Sonoma counties will offer a network of about 100 primary care doctors and 325 specialists.

Still, narrow network plans are a hard sell to employers, particularly the large ones, which don't want to hear gripes about limited choice simply to save 10% on premium costs.

But small businesses and individuals buying their own coverage in the online markets might regard that trade-off differently. "If my doctor is in the (narrow) network and cheaper, it might work," says Wall Street analyst Carl McDonald at Citi Research, a division of Citigroup Global Markets.

Competing on price

To stand out from competitors, some plans are likely to offer the lowest possible rates, and would "narrow their networks" to do so, says Chet Burrell, CEO of insurer CareFirst in Maryland. He acknowledged that narrow networks could be "a subtle but powerful way" to discourage less-than-healthy applicants. "The question will be, what degree of tolerance will a state have to permit narrow networks?"

State rules on what makes an adequate insurance network vary. Some states, including California, specify that specialists must be available within a certain driving time or distance. Others simply say insurers must have sufficient numbers of providers. Some states don't have any requirements.

"State rules are very, very loose," says Weis at Quest, who says states should consider adopting the rules that apply to Medicare Advantage, the private alternative to Medicare. In that program, the federal government requires networks to include primary care physicians and more than 25 types of specialists within a specified travel distance.

Even though state rules vary, regulators say plans that are too skimpy will be called out by regulators, consumers or both.

"If you have a crummy network, no one will buy the plan," says consultant Robert Laszewski, a former insurance executive.

"We will look very closely at how plans put their packages together," says Sandy Praeger, the elected insurance commissioner in Kansas.

Many current insurance policies allow members to go out of network. But members face significant co-payments, which often start at 30% of the bill and can go as high as 50%.

It is often hard for consumers to figure out how much they might be charged if they go out of network, says Lynn Quincy, senior policy analyst at Consumers Union. In addition to meeting separate annual deductibles for such care, patients can be "balance-billed" by doctors or hospitals for the difference between what the insurer pays and the total charges.

That will remain the case under the federal health law. "There's no escaping that we're going to see" insurance policies that include networks both wide and narrow, says Quincy. "That can be OK if there are much better tools to reveal to consumers how adequate those networks are and how much it might cost to go outside of them."

Kaiser Health News is an editorially independent program of the Henry J. Kaiser Family Foundation, a non-profit, nonpartisan health policy research and communication organization not affiliated with Kaiser Permanente.

Reports: Medicare paid $120M in illegal care

By KELLI KENNEDY

-Associated Press

Thursday, January 24, 2013

MIAMI (AP) - The taxpayer-funded Medicare program paid more than $120 million from 2009 to 2011 in violation of federal law for medical services for inmates and illegal immigrants, according to two reports issued Thursday by federal health officials.

Under federal law, Medicare generally does not pay for services for either group of patients. But the program was billed for more than $33 million in inmate care and more than $91 million for illegal immigrant care over that period, according to the reports from the Department of Health and Human Services inspector general.

In 2011, Medicare expenditures were $549 billion, making Thursday's figures a fraction of the program's annual budget. But the reports come as the Obama administration and Congress look for savings in a lean budget year. Putting a dent in Medicare fraud, estimated at $60 billion a year, has the potential for major savings.

The reports recommend that federal health officials establish a better system to automatically flag charges for inmates and illegal immigrants to stop illegal payments before they are made.

The Centers for Medicare and Medicaid Services already had a system in place to do so, but the reports found that the system didn't catch improper bills until they had already been paid. The reports also noted that the agency didn't instruct its contractors to try to recoup the lost funds.

The agency agreed in the report that the system needs to be improved, and in April, Medicare is launching a process to help detect and recoup lost money.

"For cases where Medicare is informed of patients' unlawful presence after claims have been paid, we are working to implement a process for quickly and completely recouping these improper payments," the agency said in a statement Thursday.

Sen. Tom Carper, D-Del., chairman of the Senate subcommittee on Federal Financial Management, said the improper payments must be recovered, and he commended the agency for its plan to take action.

"Paying more than $120 million in Medicare funds for health care services for people who are clearly not eligible for Medicare benefits is unacceptable," he said.

The Centers for Medicare and Medicaid Services has already been using a new, highly touted $77 million technology system since 2011 designed to stop fraudulent payments before they are paid.

But lawmakers have been skeptical about the effectiveness of the system, and federal health officials have said they are still working out kinks. Still, initial reports in December showed that the system has saved about $115 million and spurred more than 500 investigations, according to federal health officials.

Immigration reform could add millions of people under Obama health law

By Elise Viebeck - 01/26/13

Comprehensive immigration reform could make millions of people suddenly eligible for assistance under President Obama's healthcare law, assuming a final deal paves the way for undocumented immigrants to receive papers.

Illegal aliens are now prohibited from purchasing coverage through the Affordable Care Act's insurance exchanges, which will launch next year.

They are also ineligible for Medicaid under most circumstances, making the law's expansion of the program fruitless for people without documents.

Even young illegal immigrants with "deferred action" status, known as "DREAMers," cannot access the law's benefits.

But the picture could change completely if Hispanic lawmakers get their wish — an overhaul of U.S. immigration policy that includes a path to legalization.

"We have to figure out a way in which [undocumented immigrants] incorporate themselves into the larger workforce, and into our society in general, and not be a burden," said Rep. Luis Gutierrez (D-Ill.), a leader in the immigration debate.

"Do we want them to go to the exchanges? Absolutely we do — if and when they don't have healthcare through their employer," he said.

Immigration is expected to be a major issue for President Obama's second term, and advocates like Gutierrez are pushing hard to make reform a reality.

Recent polls show the public is increasingly on board. According to a CNN/ORC poll from Jan. 21, 53 percent want a path to legalization for illegal immigrants — a major shift from 2011, when most wanted Washington focused on deportations.

The consequences for Obama's signature healthcare law, as well as healthcare providers, could be huge.

Rep. Raul Grijalva (D-Ariz.), a member of the Congressional Hispanic Caucus, said the legalization of undocumented people would benefit hospitals now burdened by uncompensated care.

If nothing changes, undocumented immigrants will be a major share of the uninsured, second only to those who are eligible but do not apply for coverage under the healthcare law in 2014, according to the Urban Institute.

Federal reimbursement for uncompensated care was also slashed under the Affordable Care Act, raising the stakes for hospitals that serve low-income populations.

"I think hospitals and healthcare providers would see it as a huge plus," Grijalva said, referring to an immigration policy that legalizes undocumented people and makes them eligible for federal benefits.

"The bottom line is, these people would be contributing toward their own healthcare and not being dependent. They'd be paying taxes. I'd see that as a plus rather than a negative," he said.

The idea of providing "ObamaCare" benefits to immigrants has long inflamed partisan rancor.

Most famously, it prompted Rep. Joe Wilson (R-S.C.) to shout "You lie!" during Obama's 2009 healthcare address on the House floor, when the president pledged that healthcare reform would not cover undocumented aliens.

Looking ahead, it is possible that immigration changes could upend the law's cost picture, which is already of major concern to critics.

Sarah Hale, director of healthcare policy at the American Action Forum, cautioned that it is far too early to predict whether a new immigration policy would raise the health law's tab.

"There are three or four moving parts that could push the cost one way or the other, like state choices on the Medicaid expansion," she said.

"But if there are a huge swath of people who are newly eligible for an insurance subsidy or for Medicaid, then naturally that is going to impact the budget number."

Grijalva argued that the status quo is unsustainable, no matter what the immigration debate yields.

Most undocumented workers seek care in emergency rooms or storefront clinics, which may not accept credit or insurance, he said.

"All of that, as public health officials say, does not contribute to the overall quality of health in any community," Grijalva said. "And besides, most often, somebody else is paying for it."

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