Health & Retirement Services of Illinois

Newsletter March 2014

OUR NEWS LETTER HRSI

Audit: Changes to healthcare law could hurt IRS customer service

By Bernie Becker February 03, 2014, 04:27 pm

Changes to the tax provisions in President Obama's healthcare law could hurt the IRS's ability to tell taxpayers what's required of them, a new Treasury audit says.

Treasury's inspector general for tax administration said that the IRS – which is scheduled to become the public face for healthcare customer service in 2015 – has sufficient programs in place to inform taxpayers about ObamaCare's tax requirements.

But alterations to the Affordable Care Act – like the administration's decision last July to delay the so-called employer mandate for a year – could put a crimp in those customer service efforts, the inspector general said.

"Changes in ACA implementation will create challenges," Russell George, the tax administration inspector general, said in a statement. "Depending on the nature of any changes made to ACA tax provisions, the IRS's strategy and plans to provide customer service, outreach, education, and employee training could be affected."

"Changes to the provisions could also affect the IRS's plans to update its tax forms, instructions, and publications," George added.

The audit comes as the IRS is trying to cope with a reduced budget, something the agency's new commissioner, John Koskinen, has warned could hurt its customer service efforts. The IRS is scheduled to receive roughly $11.3 billion in fiscal 2014, well under both what the Obama administration requested and what the agency received in 2010 – the year the healthcare measure was signed into law.

In Our Newsletter

Koskinen has said that he believes his agency's implementation of ObamaCare is on track, but the Treasury inspector general warned that the IRS could have to cut back in other areas if it faces further budget cuts. In all, the IRS expects to get contacted more than 11 million times this year with Affordable Care Act questions.

Still, the inspector general also said that the IRS currently had solid strategies for educating taxpayers, updating tax forms and training employees on how to deal with ACA questions.

The healthcare law forces most people to obtain a minimum level of insurance coverage starting this year, or face a fine imposed by the IRS. The law also offers tax credits that help offset the cost for many consumers to buy health insurance.

Taxpayers will have to start reporting the amount of tax credits they receive and other ObamaCare-related information on their returns starting in 2015. The Health and Human Services Department will be the public face of the law until that year, with the IRS generally referring consumers to healthcare.gov and other HHS resources.

Congressional Republicans have pushed to delay other parts of the healthcare law – like the individual mandate – in the wake of the employer mandate delay.

In Southwest Georgia, The Affordable Care Act Is Having Trouble Living Up To Its Name

By JORDAN RAU KHN Staff Writer **FEB 03, 2014**

This KHN story was produced in collaboration with The Washington Post

ALBANY, Ga. — If Lee Mullins lived in Pittsburgh, he could buy mid-level health coverage for his family for $940 a month. If he lived in Beverly Hills, he would pay $1,405.

But Mullins, who builds custom swimming pools, lives in Southwest Georgia. Here, a similar health plan for his family of four costs $2,654 a month.

This largely agrarian pocket of Georgia, where peanuts and pecans are major crops and hunters bag alligators up to 10 feet long, is nearly the most expensive place in the nation to buy health insurance through the new online marketplaces created by the federal health law. The only place with higher premiums are the Colorado mountain resort areas around Aspen and Vail, a high-cost-of-living area unlike Georgia.

"We're not real happy with the way things are going in our neck of the woods," said David Hardin, Mullins' insurance broker.

All the dynamics that drive up health costs have coalesced here in Southwest Georgia, pushing up premiums. Expensive chronic conditions such as obesity and cancer are common among the quarter million people in this region. One hospital system dominates the area, leaving little competition. Only one insurer is offering policies in the online marketplace, and many physicians are not participating, limiting consumer choice.

Until these elements are brought under control, it will be challenging for the Affordable Care Act to fully live up to its name, not just here but in other parts of the country where premiums are high. In addition to this part of Georgia and the Colorado mountains, the most expensive of places include rural Nevada, parts of Wisconsin, most of Wyoming, southeastern Mississippi, southwestern Connecticut and Alaska.

Randy Gray (Photo by Jordan Rau/KHN)

In these places, government subsidies are shielding people with low and moderate incomes from the full cost of the premiums. Randy Gray, a flower shop owner in Albany, is paying just $32 a month, with taxpayers picking up the remaining $805. "That's just too good," he said.

But for those earning too much to qualify for federal financial help, the premiums can be overwhelming. A 60-year-old making $47,000 in Albany would have to pay a quarter of her income for the least expensive mid-level "silver" policy, the level most consumers are buying.

Even some people who qualify for federal assistance, such as Stacie Brown, owner of a pottery shop, are balking. The cheapest "bronze" plan for Brown, her husband and son would cost the family $300 a month but not begin paying medical bills until they exceeded the $6,300 individual deductible. The cheapest silver plan would cost $508 a month but not start paying until a $3,000 individual deductible was met. Her son's pediatrician was not in any of the networks and that was the one medical service she felt sure her family would use.

Brown ultimately bought a $256-a-month Assurant Health plan for her son, sold outside the marketplace, which covers his pediatrician and unlimited office visits. She and her husband have decided to forgo coverage for themselves, even though they may face a tax penalty of $700.

"I can't afford the affordable health care," she said. "I don't know anyone in this area who can afford it, and I do pretty well in life."

Others, such as Mullins, last year renewed their expiring plans for one final year. At $2,150 a month, Mullins' old plan is no bargain. "We've never had cheap rates down here," said Hardin, his broker. "A lot of people just choose to go without coverage. They just present themselves to the emergency room."

An Unhealthy Population

With prices double those in Atlanta, health insurance is pretty much the only thing that is abnormally expensive in Southwest Georgia. The average household income in the Albany metro area is $46,000, and half of the houses sell for less than $105,000. A dozen oysters at one of the fancier restaurants costs $9.

But all the ingredients for heavy health care needs—both medical and socioeconomic—are common in the 12 counties of Southwest Georgia, which are being treated as a distinct region in the insurance market. One in four children live in poverty and one out of every three people here are obese. Babies are more likely than those in most parts of the country to have low birth weights, according to data compiled by the University of Wisconsin Population Health Institute.

"If you look at the Georgia health indices for cancer, obesity, diabetes or pre-metabolic diseases, asthma, stroke, or heart disease, there are many counties that are worse than some Third World countries," said David Hefner, CEO of Georgia Regents Medical Center.

The lowest premiums in the country are around Minneapolis, known for its healthy population. Yet other parts of the country face the same kinds of health challenges as southern Georgia and have significantly lower insurance premiums. In a cluster of five South Carolina counties that the University of Wisconsin data show have demographics similar to Southwest Georgia, the lowest price silver plan is 39 percent less expensive.

Many insurance brokers and residents place the blame for high premiums on the expanding Phoebe Putney Health System, the nonprofit that runs six hospitals in Southwest Georgia. The Federal Trade Commission and Georgia's attorney general unsuccessfully tried to reverse Phoebe's 2012 acquisition of Palmyra Park Hospital in Albany because it made the system so dominant that they said Phoebe could essentially dictate prices. In a settlement, Phoebe was allowed to hold on to Palmyra, giving it 86 percent of the regional health care market.

Phoebe's dominance has also grown as it has purchased more physician practices. "Doctors you thought would never work for Phoebe are now Phoebe employees," said Sue Luckie, an insurance agent in nearby Leesburg.

Mullins, the swimming pool contractor, is not surprised. "Some of the surgeons I have built pools for have moved from Jacksonville," across the state border in Florida, he said. "I have said, 'What would you possess you to move here, this isn't a resort area?' They said, 'We get paid twice as much as in Jacksonville.' "

Fair Health, a New York group that assesses customary charges around the country, examined five common outpatient procedures and exams in Albany, Georgia—the largest city in the nation's second most expensive marketplace. For

Kaiser Health News, Fair Health compared the Albany physician charges to the South Carolina counties that had similar health demographics. All were about the same except for chemotherapy, where Albany doctors charged around $500 for the first hour and South Carolina doctors charged between $200 and $300 less. Real price information about Phoebe Putney Health Systems, the dominant hospital group, are not available.

'They Deliver The Care'

It's challenging to assess hospitals' prices here because, like most places, contracts between insurers and hospitals are kept private. Morgan Kendrick, president of Blue Cross and Blue Shield of Georgia, the only insurer in the marketplace, said Phoebe is "slightly more expensive" than hospitals in other markets, but the insurer has no other options.

Joel Wernick (Photo by Todd Stone)

"There are not many choices from the provider perspective," Kendrick said. "They deliver the care in that area, period, stop."

Joel Wernick, president and CEO of the hospital system, said complaints of high prices are unsubstantiated. "We've not really raised prices or altered our prices in some time," he said in an interview.

But insurance brokers and health policy experts said that Phoebe's rates for private insurers are higher than they would otherwise be to make up for the money the system loses when it cares for the large uninsured population. Aside from MillerCoors and Procter & Gamble, there are not a lot of large employers that hospitals and doctors usually rely on for rich payments. "At the end of the day, if you're an institution this size and you've got a small commercial population, you've got to get that money from somewhere," said John Crew, a Savannah consultant to hospitals and physicians.

Almost 11 percent of Phoebe's bills were not collected because the services were provided to patients who either couldn't or did not pay, according to the hospital's most recent audit. Erik Johnson, an expert on hospital finances at Avalere, a consulting firm in Washington, said the amount of uncompensated care is "very high."

"I would expect to see that in a public hospital," he said.

Expensive Therapies

Yet Phoebe has aggressively added expensive new treatment machines, such as the da Vinci Robotics Surgical System and TomoTherapy, which claims to deliver radiation with more precision. Phoebe told bond investors that its cancer center is "one of the busiest centers in the Southeast." Wernick said Phoebe's growth has enabled it "to achieve a very important community strategy to allow people to stay at home for certain services."

Dr. Joe Stubbs, who works at one of the independent physician practices in town, said Phoebe has not shown concern about the cost to patients. "They've forgotten that their mission as a nonprofit hospital is to provide the best quality at the lowest cost," he said.

Stubbs said that Phoebe has been too ambitious in offering services "that probably would be better off done in Atlanta," three hours north. "Bypass surgery, chemo, they could go to Atlanta," he said. "They want to have those things here because they could demand higher prices and get higher profit margins."

In recent months, Phoebe has taken some steps to reduce its costs. Last year it cut 160 jobs and hired consultants affiliated with the Geisinger Health System, which runs a central Pennsylvania hospital group known for efficiency, to help identify ways to save money.

"We may have to start lopping off services that are not economically rewarding," said Dr. Doug Patten, Phoebe's chief medical officer. "We probably have been overly permissive in the past in saying, 'Yes, we will take care of you.'

Obamacare 2.0: More regulation

By JASON MILLMAN | 1/31/14 6:10 AM EST

Part of a POLITICO Pro Special Report series on the Obama administration's executive action and regulatory agenda.

The president's health care law may finally be up and running, but the regulatory lift to get the Affordable Care Act working at full capacity is far from over.

Four years after the law's passage, some major provisions still await regulatory action or have been delayed because of the Obama administration's struggles to get core elements in place in time for the start of enrollment last October. Large businesses haven't seen final rules for the employer mandate, and insurers are waiting for more details on the benefits they'll have to offer in the future.

More than a dozen rules, ranging from technical to significant, are slated to come out this year or later. That count, detailed in a Congressional Research Service report this month, doesn't include several dozen proposed and final rules that were expected during a 12-month period dating back to last July. Pending changes like new nondiscrimination standards for health plans will broadly affect the health care industry. Others, such as new calorie-count requirements on menus and vending machines, will be felt in the business community.

Federal agencies' work since Obamacare became law totals tens of thousands of pages of specifics drafted on insurance market reforms and tax provisions. The fact that the work is still unfinished isn't surprising given the huge regulatory undertaking that the law triggered.

Facing tight deadlines, a bitterly divided Congress and negative public opinion, officials prioritized which ACA pieces to put in place before coverage expansion took effect Jan. 1. During the past several months, the administration showed that it wouldn't hesitate to act on its own to diminish political headaches stemming from Obamacare implementation failures.

Some of the most important actions ahead may be impossible to predict until after the initial open-enrollment period ends March 31. At that point, the administration will start to see how the health care law is playing out and decide how to best smooth out the rougher edges, said George Washington University professor Sara Rosenbaum. These include issues related to getting people connected to the right coverage and the right source of subsidy as well as minimizing the effects of "churn" among people bouncing between Medicaid and exchange health plan eligibility.

"There are so many downstream questions," said Rosenbaum, who supports the health law. "Like with any program, in implementation you need a second generation of policy, and the problem with the rocky rollout is

we're very delayed in focusing on the second-generation questions, which are inevitable in any major health reform effort."

The administration, though, is still addressing first-generation problems.

Following weeks of harsh criticism over policy cancellations, the White House announced in November that canceled individual health plans could be extended for at least another year, and the White House has left the door open to extending the policies beyond that. That delay came months after the administration unilaterally postponed the law's key employer mandate.

Final rules for that mandate, now scheduled to take effect in 2015, are being hammered out. Businesses with at least 50 employees will face fines if they don't offer health coverage meeting minimum standards to full-time workers and if employees then get subsidies on health insurance exchanges.

The administration is also now weighing whether and how to exempt some groups from an Obamacare fee — known as the "belly button tax" — that is intended to support a $20 billion reinsurance program. The program is meant to provide financial protection to insurers if too many sick patients sign up for coverage right away.

The proposed carve-out is getting new pushback from some sectors. Industry experts say it likely favors unions, while the unions say the proposal is vague and as written won't benefit them much.

"I'd really like to see the transparency for what will be the impact of the change," said Gretchen Young, who leads health policy for the ERISA Industry Committee representing large employers.

The Supreme Court may also force the administration to rewrite regulations if there's an adverse ruling on its contraceptive mandate. In the next few months, the court will consider whether for-profit, secular businesses can claim a religious exemption from the requirement that their health plans cover contraception. An array of religious-affiliated organizations are mounting similar challenges, contending that a regulatory exemption created by the administration falls short.

Meanwhile, two key agencies continue to revisit regulatory issues.

The FDA is still wrestling with long-delayed rules on the ACA's menu labeling provisions, which add calorie count requirements for most restaurant chains, vending machines and grocery stores. Food retailers and pizza chains were particularly angered by the requirements initially proposed.

HHS will soon reconsider rules on essential benefits, which dictate what health plans in the small group and individual markets must cover. The rules originally gave states and insurers more leeway to design benefit packages in 2014 and 2015, but consumer advocates pushed for a more prescriptive approach.

As issues around the health care law continue to emerge, the still-divisive politics of Obamacare make it unlikely that lawmakers will be able to agree on even minor fixes, said Sam Batkins, director of regulatory policy at the conservative American Action Forum. Because of that, the administration is likely to keep relying on the rulemaking process for fixes.

"You don't have to worry about Congress blocking anything through the regulatory process," Batkins said. "There may be legal challenges, but they've pretty much survived all the major legal challenges so far."

Obamacare Insurers May Be Forced to Add Medical Providers

By Alex Wayne Feb 4, 2014 3:32 PM CT

Insurers participating in Obamacare may have to expand their plans to include more federally funded health clinics, safety-net hospitals and other medical providers used by low-income people, under a U.S. proposal.

Health plans offered through government-run insurance exchanges may be required to cover 30 percent of “essential community providers” in their areas in 2015, an increase from 20 percent this year, according to a **letter** to insurers issued today from the Health and Human Services Department. Insurers’ provider networks will also be reviewed to ensure they provide “reasonable access” to health care.

As millions of Americans join health plans created through the 2010 Patient Protection and Affordable Care Act, consumers and regulators are paying greater attention to the breadth of available coverage. Insurers say smaller networks of hospitals and doctors help contain costs and improve care. Providers serving low-income people have complained that exchange plans won’t allow them to join the networks, said Sara Rosenbaum, a professor of health policy at George Washington University.

“Everybody is obviously very concerned that what’s going to happen is their patients will be swept away -- they will not be identified as preferred providers in networks,” Rosenbaum said in a phone interview. “Clearly something has set off alarm bells.”

About 3 million people signed up as of Jan. 24 for private health insurance plans offered by the new marketplaces, HHS has said. WellPoint Inc., the second-biggest U.S. insurer, said it had added 500,000 members through the exchanges set up by the law known as Obamacare.

Limiting Providers

More than two-thirds of health plans on exchanges have assembled provider networks considered “narrow” or “ultra-narrow,” in which as many as 70 percent of hospitals and other local health providers aren’t included, according to a December **study** by the consulting firm McKinsey & Co.

Narrow networks enable insurers to negotiate lower prices with hospitals and doctors, which can be passed on to consumers in the form of lower monthly premiums. The **insurance industry** argues the practice also enables them to more closely manage the care of patients, benefiting their health.

Exchange plans with broad networks of hospitals carry premiums 26 percent higher, on average, than similar plans from the same carriers with narrow networks, according to the McKinsey study.

Pushing Changes

“It is important to ensure patients can continue to benefit from the high-value provider networks health plans have established, which are helping to improve quality and mitigate cost increases for consumers as the new health care reforms are taking effect,” **Robert Zirkelbach**, a spokesman for America’s Health Insurance Plans, the industry’s Washington-based lobbying group, said in an e-mail.

Federally funded health clinics, public hospitals and other providers that serve low-income people have been lobbying the government for two years to require insurers to more broadly cover their services, Dan Hawkins, vice president for federal, state and public affairs at the **National Association for Community Health Centers**, said in a phone interview.

“HHS has done a miserable job of establishing a decent network adequacy standard to ensure that insurers are not red-lining low-income communities and communities of color and other vulnerable populations,” he said. “For them to say we’re going to change our rules from 20 percent to 30 percent, that’s whistling past the graveyard. That’s nowhere near adequate.”

Aaron Albright, a spokesman for the Centers for Medicare and Medicaid Services, which oversees the exchanges, said he couldn’t comment on a draft proposal.

‘Strengthen’ Networks

“But, in general, CMS is working to strengthen the network adequacy requirements that took effect for this year for the first time under the Affordable Care Act,” Albright said in an e-mail. “These are important provisions and include requirements that insurers have adequate provider networks for consumers, including access to essential community providers that serve low-income, medically underserved individuals.”

Albright’s agency said in the letter that if it determines a health plan’s provider network is inadequate it may exclude it from the exchanges. The agency said it would particularly focus on insurers’ coverage of hospitals, mental health clinics, cancer centers and primary care physicians.

Ideally, the government would require insurers to contract with every essential provider in their service areas, Hawkins said. In addition to community health centers and public safety-net hospitals, essential providers include AIDS clinics, family planning clinics, children’s hospitals and other facilities qualifying for a federal program that provides deep discounts on drug prices, Rosenbaum said.

Don't Be Fooled by Latest Medicare Scare Campaign From an Insurance Front Group

Wendell Potter Become a fan
Author, consultant; columnist at Center for Public Integrity and healthinsurance.org Posted: 01/27/2014

If you go to 601 Pennsylvania Avenue, N.W., Suite 500, in Washington, D.C. in search of what you've been told is the address of a grass roots organization concerned about "cuts" to Medicare, you will likely be surprised what you find there.

You will indeed find an organization that is lobbying hard to keep federal dollars flowing, but it is anything but grass roots.

Ads supposedly sponsored by the Coalition for Medicare Choices started appearing last week on buses and subway trains and on Washington TV stations warning that seniors will face higher costs, fewer benefits and a loss of provider choice if Congress and the Obama administration don't take action to keep planned rate cuts from going into effect.

The ads are part of what POLITICO described as "the new seven-figure campaign ... that is the group's biggest mobilization to date for Medicare Advantage," the alternative to traditional Medicare that is operated by private insurance companies.

The real sponsor of the ads is the real tenant of 601 Pennsylvania Avenue., N.W., Suite 500: America's Health Insurance Plans, which is one of the best-funded and influential lobbying and PR outfits in the nation's capital.

As I noted last week, several insurance companies make a boatload of money by participating in the Medicare Advantage program. The Government Accountability Office noted in a recent report that the federal government spent about $135 billion on the Medicare Advantage program in 2012 alone. And much of that was in the form of overpayments that the government has been sending to private insurers for years.

Brian Biles, professor of health policy at George Washington University, explained in testimony before the Senate Committee on Aging last Wednesday that Medicare has paid private plans more than the costs of traditional Medicare since 1997 when Congress authorized extra payments to entice private plans to operate in rural areas. Six years later, those extra payments were extended to just about all private Medicare plans.

Biles testified that those extra payments to Medicare Advantage plans nationwide averaged 13 percent -- or $1,100 per enrollee -- in 2009. The Congressional Budget Office projected that year that the excess payments would total more than $150 billion over ten years.

As lawmakers were debating health care reform in 2009, they inserted a provision in what became the Affordable Care Act to get rid of those overpayments. Alarmed, AHIP has been hard at work ever since trying to figure out how to keep the Centers for Medicare and Medicaid Services (CMS) from carrying out that provision of the law.

And for good reason. Insurers like UnitedHealth and Humana with a substantial number of Medicare Advantage enrollees are able to convert those excess payments into hefty profits. Financial analysts at Goldman Sachs

estimated a few years ago that 66 percent of the net income at Humana, where I used to work, came from its Medicare Advantage business.

Not all of that money goes to profits, however. Some of it is used to add benefits like dental and vision and gym memberships, which many seniors enrolled in the plans do indeed value. But another big chunk of the extra payments goes to advertising and sales activities -- and to AHIP to finance the group's lobbying and PR campaigns.

The Coalition for Medicare Choices current campaign is heavy on intimidation, all of it directed toward members of Congress. Under the headline, "Seniors are Watching," is this warning:

"In 2010, Seniors saw Washington cut Medicare Advantage funding by $200 billion, causing rate cuts that already hurts them. Now more rate cuts are looming. Rate cuts that would mean higher costs, lost benefits and lost provider choices for seniors. As next year's Medicare Advantage rates are being set, seniors are watching more closely than ever. They don't want to see any more rate cuts. More than 1.5 million seniors are ready to defend the Medicare Advantage coverage they like and want to keep. They know from experience that seeing is believing."

That reference to "coverage they like and want to keep" is, of course, a not-so-subtle reference to President Obama's ill-advised assurance that "if you like your health care plan, you can keep it."

And there was this thinly veiled threat in the POLITICO story from "an insurance industry source familiar with the campaign:"

"If CMS doesn't keep Medicare Advantage payment rates flat next year, it is going to create a huge political problem for members of Congress this fall when they have to face millions of angry seniors who just found out they are losing benefits and choices they were promised they could keep."

Translation: AHIP will be behind those huge political problems during the re-election campaigns this fall.

IRS undecided on health insurance coverage lawsuits

Obamacare enforcement not clear

By Tom Howell Jr. The Washington Times Thursday, February 6, 2014

The IRS is still trying to decide whether it will end up suing anyone who refuses to obtain health insurance or pay the tax penalty required under Obamacare's "individual mandate," and how much they would have to owe before the tax agency begins to care.

With the mandate deadline less than two months away, it's the latest uncertainty as the administration tries to figure out how far it should go in enforcing the most controversial parts of the Affordable Care Act.

"I don't know if a decision has been made about that," IRS Commissioner John Koskinen told Congress on Wednesday, vowing to try to get an answer for Rep. Sam Johnson, a Texas Republican who was prodding him on the issue.

Starting this year, the Affordable Care Act penalizes Americans who can afford health insurance but choose not to obtain it. Known as the individual mandate, it sparked a wave of conservative protests before the Supreme Court upheld it in 2012 as a legitimate use of Congress' power to tax.

But it is not clear how far the IRS plans to go in enforcing the mandate during next year's tax season, when filers must begin to report whether they held health insurance in the prior year.

For one thing, the law prohibits the agency from filing liens on the delinquent person, which limits its options.

"I have no idea under what circumstances the IRS would bring lawsuits," said Timothy Jost, a health policy expert at Washington and Lee University School of Law. "Basically, they're going to try to grab people's refunds."

An IRS spokesman declined to comment on the issue Thursday, beyond what Mr. Koskinen said to Congress on Wednesday.

Mr. Johnson said in written statement Thursday that "not only has Obamacare canceled health plans and increased premiums for millions of Americans, but now it can take people to court for not having health insurance. That's wrong, this is America."

The individual mandate was included in the law to make sure enough young, healthy people purchased insurance on Obamacare's new health exchanges and kept premiums in check when people with pre-existing medical conditions, who no longer can be denied coverage, enrolled.

Several exemptions from the mandate were built into the health care law, covering everyone from illegal immigrants and prisoners to those who have religious conscience objections, such as the Amish; and health care sharing ministries members, who take care of each other's health care costs through direct payments.

People also are exempt if they do not earn enough to file tax returns, or if the cost of the lowest-price plan available to them costs more than 8 percent of their household income.

For non-exempt filers, the penalty for lacking health coverage starts at $95 for low-income taxpayers in 2014, rising to $659 in 2016. Higher-income taxpayers who reject coverage will pay more — 1 percent of their income in 2014, rising to 2.5 percent in 2016.

An IRS spokesman said that the Form 1040 for tax year 2014, which will be drafted and finalized this fall, will include instructions on how to calculate any applicable payment under the mandate.

Brendan Buck, a spokesman for House Speaker John A. Boehner, Ohio Republican, predicted the administration will decide to strictly enforce the law in order to try to keep Obamacare on track.

Prison life has never been so good! Uncle Sam now pays for TV, drugs

IG report finds lack of oversight for payments

By Phillip Swarts The Washington Times Monday, February 10, 2014

Food stamps. Free meals. Cable TV. Unemployment and disability benefits. And now prescription drugs.

It's a good time to be in prison, where inmates are mistakenly receiving tens of millions of dollars in benefits at taxpayer expense.

The latest folly comes compliments of Medicare, which gave such poor oversight to its prescription coverage that it allowed $11.7 million in drug benefits to go to inmates from 2006 to 2010, according a report released Monday by the Health and Human Services inspector general.

"Individuals who are incarcerated in correctional facilities … are generally not eligible for federal health care benefits," the agency's internal watchdog said in a report that blamed officials at the Centers for Medicare and Medicaid Services for poor management.

Investigators found that medical companies that gave drugs to inmates were improperly allowed to claim Medicare reimbursements because CMS lacked the safeguards necessary to screen out prisoners, and did not supply the medical companies the information needed to check for themselves.

The revelation was made a year after the same inspector general found that Medicare inappropriately paid $33.6 million to health care providers to cover costs associated with medical treatment for inmates.

CMS officials acknowledged the problem but said their accounting is so disorganized that they don't even have a way to recoup the drug benefits they have misspent.

An audit last fall by the inspector general of the Social Security Administration found more problems with prisoners receiving taxpayer dollars. In a sampling of 100 Social Security disability recipients, one out of four had been receiving the benefit — wrongfully — while incarcerated.

"There's no effective way to stop these improper payments, because no one really has any incentive," said Michael Cannon, a health policy analyst at the Cato Institute, a libertarian think tank. "It's all someone else's money, so nobody cares to prevent fraud as much as they should. This is maybe the main reason why government is less efficient than markets."

Getting an exact amount of how much is being wasted annually from Medicare payment mistakes is difficult, but some estimates place the number as high as $50 billion.

Erroneous benefits to prisoners also have been flowing through states. Investigations at the state level found $1 million in food stamps given to inmates in Louisiana. Fiscal watchdog Citizens Against Government Waste reported that prisons in Illinois spent $2.3 million on cable TV bills. A House of Representatives hearing in September found that prisoners received $23 million in unemployment benefits in New Jersey, $2 million in Illinois and $600,000 in Wisconsin.

“It is an injustice that the tax dollars of law-abiding citizens are paying for these benefit checks for people who have broken the law and simply should not qualify for these benefits,” Rep. David G. Reichert, a Washington Republican who chairs the Ways and Means Human Resources subcommittee, said during the hearing.

Benefits behind bars

Medicare Part D pays for prescription drugs, but convicted felons are supposed to lose their benefits when they go to prison — along with many of their other rights and privileges. Instead, the Justice Department’s Bureau of Prisons takes charge of many health concerns for inmates.

Officials at CMS agreed there was a problem and said they would work to fix it.

“The lack of a more robust set of CMS internal processes regarding access to services under the Medicare Part D program has been a concern to CMS,” a response from the agency said. “CMS is taking steps to address this issue and ensure that this requirement is executed in accordance with the information we receive from the correctional facilities and the Social Security Administration.”

However, Medicare officials challenged the inspector general’s recommendation that they try to recoup the taxpayers’ money.

“There is no effective way of fully recovering these payments without first implementing the appropriate policies and procedures,” the agency said.

Investigators said CMS never checked the claims to see whether they were coming from inmates and didn’t give health care providers enough information.

“CMS did not provide sufficient and timely information to sponsors that would have allowed them to readily and accurately verify a beneficiary’s incarceration status and dates of incarceration,” the inspector general said.

The Medicare agency did not give health care providers any information on names or contact information for correctional facilities, which services would most likely be used by inmates, and the fact that some beneficiaries were incarcerated.

Without this data, the inspector general said, health care companies relied on public websites to try to determine whether their patients were in prison, an often hit-or-miss plan.

Wasteful payments in Medicare and Medicaid have long been targets of lawmakers trying to reduce spending and fiscal abuse in the government.

“We have a solemn responsibility to ensure that these programs have the resources they need to provide quality care and services, and part of that effort means cracking down on vulnerabilities in these programs that put taxpayer dollars at risk for waste, fraud and abuse,” said Senate Homeland Security and Governmental Affairs Committee Chairman Thomas R. Carper, Delaware Democrat.

Mr. Carper and a bipartisan group of lawmakers introduced a bill last year to increase penalties for Medicare and Medicaid fraud and bolster oversight at CMS to prevent erroneous payments.

“Americans who rely on Medicare and Medicaid expect Congress to work together to reduce waste and fraud,” said Sen. Tom Coburn of Oklahoma, the committee’s ranking Republican. “Improper payments divert scarce resources away from those most in need.”

HEALTH CARE

Fox News Poll: Voters regret ObamaCare

By Dana Blanton Published February 13, 2014 FoxNews.com

Oct.2, 2013: A man looks over the Affordable Care Act (commonly known as Obamacare) signup page on the HealthCare.gov website in New York in this photo illustration.Reuters

Over half of American voters regret that the Affordable Care Act passed, and nearly two-thirds say it never would have -- if we knew then what we know now.

In addition, more than half think the health care law will ultimately be bad for the country, and that it's more about the government controlling our lives than getting Americans health care.

These are just some of the findings from a Fox News poll released Thursday.

Click here for the poll results.

Fifty-five percent of voters wish the health care law had never passed. That includes majorities of young people under age 30 (55 percent) and those with annual household incomes under $50,000 (52 percent), as well as more than a quarter of Democrats (28 percent).

Some 37 percent are glad the law passed.

The poll also finds that by a 51-42 percent margin, people think in the long run the law will be bad for the country.

Democrats are alone in thinking the health care law will be a good thing in the end: 70 percent feel that way, which is twice the number of independents who say the same (35 percent) and more than five times the number of Republicans (13 percent).

Overall, 64 percent of voters don't think the law would have passed if we knew back in 2009 what we know today. Majorities of Republicans (74 percent), independents (68 percent) and even Democrats (54 percent) say it wouldn't have passed.

By a 16 percentage-point margin, people think the health care law is more about the government "controlling our lives" (56 percent) than about "helping individual Americans get the health care they want" (40 percent).

Most Republicans (80 percent) and independents (60 percent) think the health care law is about government controlling our lives. A third of Democrats agree (33 percent).

Meanwhile, only nine percent say their family is better off under the new law. Nearly three times as many say they are worse off (25 percent), while a 65-percent majority says the law hasn't made any difference to their family.

Before the law went into effect, 21 percent thought their family would be better off, 35 percent worse off and 39 percent thought it wouldn't make much difference (October 2013).

Fully 76 percent of voters overall and 61 percent of Democrats blame the Obama administration for mismanagement of the roll-out and implementation of the new health care system.

The fallout is less confidence in the government in general: more than four times as many voters say implementation of Obamacare has made them feel less confident (48 percent) in the federal government as say more confident (11 percent). Another 41 percent say it hasn't made a difference either way.

Of course high opinions of leaders in Washington are in short supply elsewhere too: Just 14 percent of voters approve of the job Congress is doing, while 81 percent disapprove.

The Fox News poll is based on landline and cell phone interviews with 1,006 randomly chosen registered voters nationwide and was conducted under the joint direction of Anderson Robbins Research (D) and Shaw & Company Research (R) from February 9-11, 2014. The full poll has a margin of sampling error of plus or minus three percentage points.

SCIENCE REFRESHES ITS VIEW OF AGING

By Joan Cary, Special to the Tribune *February 18, 2014*

How do we stay healthy and mobile into our senior years? How do we stave off dementia?

Exercise regularly. Stay mentally active. Nurture rich social connections. Find things you enjoy doing and people you enjoy doing them with, scientists said at the annual Association for the Advancement of Science meeting in Chicago.

"We don't know how to be old because old age is relatively young. It's something new to us," University of Illinois psychology professor Elizabeth Stine-Morrow told a crowd, many of them middle-aged scientists, at the Hyatt Regency for a program Sunday on "The Science of Resilient Aging."

"A century ago, the average life span was 45 or 50 ... and 4 to 5 percent of the population was over 65," she said. "By 2050, it's going to be over a fifth of the population."

Experts say that by 2050, for the first time in history, the proportion of adults over age 60 is expected to match the number of people younger than 15, each group representing 21 percent of the population.

It's called the Silver Tsunami. But, they emphasized, it's never too early or too late to work on aging well.

Kirk Erickson, associate professor of psychology at the University of Pittsburgh, studies the effects of exercise on aging. He offered promising news, especially for those who had visited the hotel's fitness center that morning or chosen a cold walk over a cab ride to the hotel.

Exercise is good for your brain.

"We see changes in brain regions that typically show decline and deterioration later in life. The brain shrinks, unfortunately, as we get older," Erickson said. "But research has proven that the brain remains highly modifiable into late adulthood. And exercise is one way to modify it."

Erickson pointed to studies of people ages 59 to 81 who were all free of dementia. Those who exercised more frequently, who did something as simple as taking a brisk walk three times a week, had a larger hippocampus, the part of the brain associated with memory and spatial navigation, he said.

After a year of this exercise, they showed an actual increase in the size of the hippocampus. Greater hippocampus volume correlates with improvement in memory.

Scientists also addressed the need to stay mentally active. Symptoms of cognitive decline appear later in people with more "cognitive reserve," said Yaakov Stern. A Columbia University professor of clinical

neuropsychology, Stern was Skyped in to talk at the conference after being stuck home in the East Coast snowstorm.

The cognitive reserve theory aims to explain why some people with Alzheimer's pathology maintain normal lives until they die, while others show the severe symptoms associated with the disease. Lifelong experiences, stimulating activities, education and midlife occupation, as well as leisure activities in later life, can help build this cognitive reserve to protect us, he said. And the earlier we start to build, the better. It is never too late to get going.

And when you start, it's good advice to find others who enjoy starting with you, experts say.

Being alone is one thing. Being lonely is something else, said John Cacioppo, a social neuroscientist at the University of Chicago who studies the biological effects of loneliness.

Studies have shown, he said, that socially isolated people have increased health risks and higher mortality.

Loneliness — perceived social isolation — doesn't just make you less happy, he said. It makes you depressed.

"It isn't just about being with others. The frequency of contact is unimportant," Cacioppo said. "It's what that person means to you that really matters."

On the topic of social media, Cacioppo asked whether it's a way to make friends or a substitute for connection.

"If you have no contact, then it's better than nothing," he said. "But it's not a substitute for face-to-face contact."