Health & Retirement Services Of Illinois

March 2011 Newsletter

OUR NEWS LETTER HRSI

Seniors use computer program to try to stay sharp

BrainFitness has games, puzzles, tests designed for different ability levels.

By Karen Schwartz, Special to the Tribune February 2, 2011

Lee Meyer, 74, a resident at the Beacon Hill retirement community in Lombard, uses a Dakim BrainFitness program to sharpen his memory skills. (Chuck Berman, Chicago Tribune / December 19, 2010)

By Karen Schwartz, Special to the Tribune February 2, 2011

Imagine being able to improve your brain health and fight memory loss and dementia by playing a series of games on a computer.

Fifty seniors, ages 65 to 95, who live independently at the Beacon Hill retirement community in Lombard are doing just that. They've been trying out the Dakim BrainFitness software system first introduced to the Beacon Hill community a little more than a year ago.

Nearly 100 residents came to hear a company representative talk about the software program before it was installed, said Lea Anne Randell, the community's director of leisure services. "We have 50 registered users and people on a waiting list," she said.

Some of the residents who use the program have no problem with their memories, while others have early onset Alzheimer's disease, Randell said.

Resident Lee Meyer said he and his wife, Doby, started using the software as a way to prevent future problems with memory loss and dementia.

"It's fun being on the computer, and I like the challenge of seeing how high I can score," said Meyer, 74, a retired accountant who uses the computer after he goes to his morning fitness class. "And it's generally thought that people who do puzzlelike activities, it helps exercise their brain."

Meyer uses the computer four or five times a week and does number games that include ratios and percentages, as well as math problems. He also participates in word, puzzle and story games.

"I've played for 211 days, and my scores have been pretty consistent," he said. "My average has been 92.8 percent in all the games I've played."

The company said the program features colorful graphics, large type and music

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on a touch screen instead of the typical mouse and keyboard. Each 20-minute session consists of activities ranging from interactive puzzles and narrated literary passages with follow-up questions, to name-that-tune challenges and word association games.

Each resident's sessions are based upon their specific cognitive abilities, and they're given scores for each activity they complete. BrainFitness exercises measure short- and long-term memory, critical thinking, visuospatial orientation, computation and language, and get more challenging each session.

"We try to encourage people to use the system a minimum of 12 times a month," said Randell. "And if we see that somebody hasn't used it, we'll call the person and encourage them to go."

Residents use the software on two computers that are located in two separate buildings at Beacon Hill. There is no charge to use the computers, and except for a few hours in the middle of the night when new software is uploaded, the computers are available 24 hours a day, seven days a week.

Meyer said he has a good time using the system.

"I just want to do everything I can to retain my mental faculties," he said. "And the games are enjoyable."

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What's the difference between antacids?

If you've got an upset stomach or heartburn, you may feel like reaching for the first thing you can grab in your medicine cabinet. But not all over-the-counter acid reducers are the same. Here's what you need to know.

By Danielle Braff Special to Tribune Newspapers February 2, 2011

TUMS

What is it? Calcium carbonate, which acts as a buffer for acid.

Best for: Mild heartburn and on-demand use, but it may be cumbersome for chronic daily use because it only lasts about two to three hours.

Side effects: Rare: constipation, stomach pain, dry mouth, increased urination, metallic taste and kidney stones.

How to take: Can be taken when symptoms occur, on a regular basis with meals as a calcium supplement, or after meals to prevent heartburn. Should be taken with a large glass of water.

Warnings: Some mild drug interactions may reduce effectiveness of other medications. Anyone with kidney problems should check with their doctor before taking Tums.

Pediatric issues: Available in chewable form for children.

ROLAIDS

What is it? Calcium carbonate mixed with magnesium hydroxide, which means two buffers for acid.

Best for: Mild heartburn and on-demand use, but it may be cumbersome for chronic daily use because of the amount you have to take to keep up relief.

Side effects: Same as Tums, plus possible constipation. However, the magnesium could lead to diarrhea for some people.

How to take: Same as Tums.

Warnings: Some mild drug interactions may reduce effectiveness of other medications; magnesium products may be dangerous in patients with kidney disease; if you've had heartburn for more than three months, or if it's accompanied by sweating or dizziness, see your doctor.

Pediatric issues: Not recommended for children younger than 2.

ZANTAC

What is it? Histamine 2 receptor antagonist, which blocks acid secretion.

Best for: Mild-moderate gastroesophageal as an on-demand medicine or for chronic therapy. The onset of the action is 60 minutes, and it peaks at two hours. It will last for 12 hours.

Side effects: Headaches, nausea, vomiting, diarrhea, constipation, drowsiness, mild interaction with alcohol.

How to take: Can be taken before meals to prevent symptoms or on an empty stomach. Best effects are at night.

Warnings: Some mild drug interactions may reduce effectiveness of other medications. Rare: You may also experience bruising and bleeding from low platelets.

Pediatric issues: Used frequently in children younger than 1.

PEPCID

What is it? Histamine 2 receptor antagonist, which blocks acid secretion.

Best for: Mild-moderate gastroesophageal as an on-demand medicine or for chronic therapy. The onset of the action is 60 minutes, and it peaks at two hours. It will last for 12 hours.

Side effects: Diarrhea, dizziness, headache, constipation.

How to take: Can be taken before meals to prevent symptoms or on an empty stomach. Best effects are at night.

Warnings: Some mild drug interactions may reduce effectiveness of other medications. Rare: You may also experience bruising and bleeding from low platelets.

Pediatric issues: Used frequently in children younger than 1.

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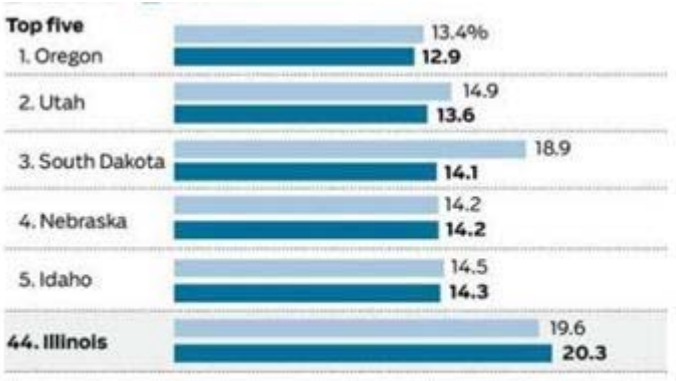
Insurer, hospital association roll out plan to cut readmissions.

Blue Cross and Blue Shield of Illinois seeks to lower costs, improve care

By Bruce Japsen, Tribune reporter February 2, 2011



Source: The Commonwealth Fund/Tribune

Reducing costly readmissions to hospitals is the goal of an initiative being rolled out this year by Illinois' largest health insurer and the state's hospital lobby.

Blue Cross and Blue Shield of Illinois and the Illinois Hospital Association said Tuesday that by 2014 they hope to cut readmissions by 33 percent. In 2009, there were more than 50,000 readmissions to the approximately 200 hospitals in the state.

Readmissions are a costly part of the nation's burgeoning tab for medical care and were often cited by President Barack Obama as he campaigned for the health overhaul that ultimately passed Congress and that he signed into law last year.

The private sector, too, rails against hospital readmissions when it's forced to pick up the tab for poorly done surgery or for a patient who gets an infection after being discharged. Just one additional day in the hospital because of a readmission can cost tens of thousands of dollars.

"With this project, we hope to achieve higher-quality care at a lower cost," said Dr. Scott Sarran, vice president and chief medical officer at Illinois Blue Cross. "We believe investing resources to improve transitions of care will have major payoffs in costs and quality."

There is no guarantee that all Illinois hospitals will participate in the program, but Illinois Blue Cross is kicking in $1 million a year to help facilities pay for educational programs for their doctors and other health care workers.

Incentives built into the health law will push hospitals to improve quality by reducing readmissions. For example, hospitals that fall in the bottom quarter for certain heart- and pneumonia-related readmissions of patients insured by Medicare will have reimbursements reduced.

In addition, market forces are pressuring health insurers and hospitals to lower costs and improve quality.

Insurance companies like Illinois Blue Cross and UnitedHealth Group already are warning hospitals that health facilities that don't abide by certain quality measurements could be left out of health plan networks.

Depending on the sign-up rate of hospitals, Illinois Blue Cross executives say $150 million could be saved in the first year by lowering the state readmission rate to the national average.

A study by the Commonwealth Fund indicates the readmission rate for hospitals in Illinois is 20 percent for patients insured by Medicare, the health insurance program for people age 65 and older. A 33 percent reduction in readmissions of such patients would reduce that to 13 percent in Illinois.

Hospital administrators say Illinois Blue Cross' efforts will help health professionals provide more consistent patient care. In addition to providing financial support, hospitals say, the insurer has access to data on thousands of physicians in Illinois and knows through claims data how doctors perform. It can use that data to improve outcomes and reduce patient admissions by sharing best practices.

Among the key initiatives the insurer and hospitals say could be used to reduce readmissions: redesign hospital discharge processes, develop and improve palliative care programs, and work to reduce infections.

Illinois Blue Cross "is providing additional support for us to be able to identify best practices that are scalable for many of the independent physicians that are out there," said David Crane, president of Adventist Midwest Health, which operates hospitals in the Chicago suburbs of Bolingbrook, Glendale Heights, Hinsdale and La Grange. "We are providing our physicians with data about their own experiences and allowing them to compare themselves to the best evidence-based data."

The trend toward quality improvement, measurements and standards has been in the works for several years, but implementation of the new health law is adding to the urgency, health care executives say.

This year, Blue Cross said it hoped to recruit 85 percent of the state's hospitals into the program, develop an improvement plan and "take action based upon the plan."

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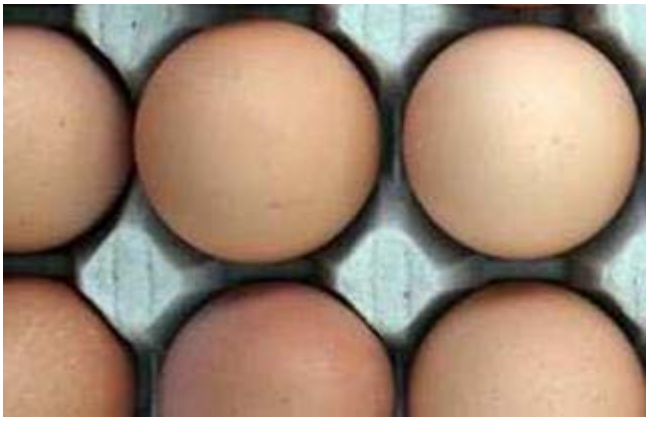
Eggs tested by USDA have lower cholesterol and more vitamin D than previously thought.



The USDA says eggs have less cholesterol and more vitamin D than previously thought. (Chris Ratcliffe / Bloomberg)

By Mary Forgione, Tribune Health February 8, 2011

Eggs are getting a bit of a reprieve on the cholesterol front. A U.S. Department of Agriculture report released Tuesday says eggs are lower in cholesterol and higher in vitamin D than previously thought.

The federal agency released these findings (helpfully publicized by the egg industry) after testing a random sample of eggs across the country in 2002 and examining their nutrient value. It found the average large egg contained 185 milligrams of cholesterol (14% less than prior measures) and 41 IU of vitamin D (64% more).

Why the shift? The decrease in cholesterol might reflect an improvement in hens' diet, the agency says in a statement. Here's the full USDA statement.

And the American Heart Assn. offers this primer on cholesterol. Note that dietary cholesterol is but one factor in blood cholesterol levels -- and that those levels are more complex than you might think (think "fats"). The AHA says: "Saturated fatty acids are the main culprit in raising blood cholesterol, which increases your risk of heart disease. Trans fats also raise blood cholesterol. But dietary cholesterol also plays a part. The average American man consumes about 337 milligrams of cholesterol a day; the average woman, 217 milligrams."

You can expect to see the revised nutrition information on egg cartons soon. But one thing hasn't changed: Eggs are still about 70 calories each

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Health Care Law!

58% Favor Repeal of Health Care Law; Most Still Expect Costs To Rise and Quality To Suffer.

Monday, February 07, 2011

The majority of voters still support repeal of the new national health care law and remain convinced that it will drive up the cost and hurt the quality of health care in the country.

A new Rasmussen Reports national telephone survey finds that 58% of Likely U.S. Voters at least somewhat favor repeal of the health care law, with 44% who Strongly Favor it. Thirty-seven percent (37%) are opposed to repeal, including 26% who Strongly Oppose. (To see survey question wording, click here.)

These numbers mark little change from a week ago and are consistent with findings since March of last year when Democrats passed the law. Support for repeal has ranged from 50% to 63% in weekly tracking since then. The new Republican-controlled House recently voted to repeal the law, but the Senate with its Democratic majority is not expected to follow suit.

Similarly unchanged is the belief by 56% of voters that the cost of health care will go up under the new law, a view shared by 53% to 61% since last March. Twenty percent (20%) disagree and expect costs to go down. Nineteen percent (19%) say they will stay about the same.

Only 21% say the quality of health care will get better under the new law. Fifty-two percent (52%) say quality will get worse, while 22% predict that it will stay the same. Since last March, the number who think the new law will worsen health care quality has ranged from 48% to 55%.

(Want a free daily e-mail update? If it's in the news, it's in our polls). Rasmussen Reports updates are also available on Twitter or Facebook.

The survey of 1,000 Likely Voters was conducted on February 4-5, 2011 by Rasmussen Reports. The margin of sampling error is +/- 3 percentage points with a 95% level of confidence. Field work for all Rasmussen Reports surveys is conducted by Pulse Opinion Research, LLC. See methodology.

Thirty-six percent (36%) of voters believe the health care plan will be good for the country. As they have nearly every week since last March, most voters – 53% now – say the plan will be bad for America. Just three percent (3%) say it will have no impact.

Fifty-eight percent (58%) think the plan will increase the federal budget deficit. Eighteen percent (18%) say it will reduce the deficit, and 13% say it will have no impact. This, too, is in line with findings for months. Earlier polling showed that voters discount CBO projections of deficit reduction because they overwhelmingly believe the new law will cost more than projected.

Most Democrats continue to support the health care law, and the majority of Republicans and voters not affiliated with either of the two parties remain opposed. But while GOP voters and unaffiliateds feel strongly that the law will increase costs and the deficit and hurt the quality of care, Democrats have noticeably mixed feelings on these three questions.

The Political Class is even more supportive of the new law than Democrats are. Seventy-four percent (74%) of Mainstream voters support repeal, but 83% of the Political Class are opposed to it.

Most Political Class voters also believe the health care law will lower costs and improve quality. The majority of those in the Mainstream disagree on both counts. The Political Class is more ambivalent about the law's impact on the deficit, while 73% of Mainstream voters think it will increase the deficit.

Although the Congressional Budget Office claims repealing the health care law will increase the federal budget deficit, a plurality of voters disagrees with that assessment. At the same time, most voters feel free market competition will do more to cut health care costs than government regulation.

More than half the states are challenging the constitutionality of the new federal health care law in court, many focusing on the requirement that every American must have health insurance. More voters than ever oppose that requirement and think states should have the right to opt out of some or all of the health care law.

A federal judge in Florida has ruled that the entire health care law is unconstitutional, and many expect the fate of the current law to be decided in the U.S. Supreme Court. Scott Rasmussen explains in a recent analysis how a negative Supreme Court ruling on President Obama's number one legislative achievement may actually benefit him in the 2012 election.

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Preparing for Long-Term Care: Any Good Options?

By Janet Morrissey Tuesday, Feb. 08, 2011

A huge wave of baby boomers may need long-term care in their golden years — and yet fewer than half have taken steps to prepare for it. That's the sobering conclusion of a recently released industry study that shows two-thirds of Americans believe it's important to plan for long-term care, but only 44% have taken steps to protect themselves — and most of those steps only involve boosting their savings accounts. But while it's clear that not enough people are thinking about preparing for their long-term-care needs, it's not at all clear what, if

any, the best solutions are.

"People recognize that long-term care is a need, but they attribute that need to somebody else," says Mike Hamilton, an assistant vice president at Lincoln Financial Group, which conducted the survey and sells hybrid policies that combine life insurance and long-term care benefits in a single policy.

Even if they aren't among the many Americans in denial or who believe their children will look after them, many people underestimate the need and cost of long-term care, and many wrongly believe that savings and government programs, such as Medicare and Medicaid, will easily cover the tab if needed.(See the five ways to get the most out of health care reform.)

"They're in for an enormous rude awakening," says Jesse Slome, executive director of the American Association for Long-Term Care Insurance.

Most Americans, after all, don't have nearly enough in general savings. The average cost of a nursing home ranges from $85,000 to $120,000 a year, while hiring an aide to spend six hours a day on average in the home starts around $40,000 a year, says Steve Schoonveld, a member of the American Academy of Actuaries. Medicare, meanwhile, only covers up to 100 days of long-term care and often involves co-payments. Medicaid will cover long-term nursing-home care but only after the person has drained his or her savings account.

Long-term-care insurance is an option but one that's fraught with risks and regrets for those who don't do their homework, don't check the fine print or don't choose a reputable company. There have been horror stories of people paying premiums on long-term-care insurance policies for years, only to find the benefits won't cover their needs 20 or 30 years down the road when health care and long-term-care costs are significantly higher. (Inside the war on health care reform.)

"A policy benefit worth $50 or $100 in coverage a day today — even if they have inflation protection — may not come near meeting their needs by the time they need coverage," says Judy Feder, a senior fellow at the Center for American Progress and a professor of public policy at Georgetown.

In other cases, some insurers have been slapping hefty increases on premiums, making them no longer affordable for people who had been paying premiums on their policies for years. For example, a number of firms, like John Hancock, a unit of Manulife Financial, recently announced plans to raise rates on existing policies as much as 40% after underestimating both health care costs and the number of people who would hang onto their policies through retirement. "We've found that more people used their policies than had been anticipated and the increase is needed to meet the needs of our policyholders in the long term," says Marianne Harrison, president of long-term-care insurance at John Hancock. "The question is, How much confidence do you have in what you're buying that the rates won't go way up or the company won't sell its book of business?" says Jim Firman, CEO of the National Council on Aging. New York Life and Northwestern Mutual are among the companies that have not raised rates, at least not yet, he says.

And while some raised rates, others, such as Allianz SE, Minnesota Life Insurance Co. and MetLife, have either suspended or scrapped sales of future long-term-care policies altogether. The huge premium increases left many cash-strapped policyholders scrambling for ways to make the payments or risk losing the policies they had already spent years paying into.

"You need an insurance company that's really stable, solvent, has a smart reserves policy and is being careful about its hedging," says Jacob Hacker, a political-science professor at Yale University and author of The Divided Welfare State: The Battle over Public and Private Social Benefits in the United States and Health at Risk: America's Ailing Health System — and How to Heal It.

Consumers also need to pay attention to the fine print when signing up, says Jennifer Jaff, executive director of Advocacy for Patients with Chronic Illness, which handles many of the appeals that policyholders file against insurers who deny claims. There are myriad options available — ranging from daily benefit limits to length of coverage — that must be carefully screened and selected before signing on to prevent unexpected surprises down the road. (Read "Wellness: Does Your Doc Know What to Look For?")

Jaff says some people wrongly believe their policy will kick in whenever they feel ready to move to an assisted-living facility or nursing home, and then find their request is denied. Most policies require the person either have significant cognitive problems, like Alzheimer's, or be unable to do at least two everyday-living activities, such as bathing, dressing, using the toilet, eating or getting in and out of bed. "If someone just has problems remembering to take their medication, that's not covered," Jaff says.

The federal government has recognized these issues and jumped into the fray to offer a potential solution by passing the late Senator Ted Kennedy's Community Living Assistance Services and Support Act, often dubbed the CLASS Act, as part of the health care reform legislation, which takes effect this year. The act will create the first publicly funded long-term-care insurance program.

The CLASS Act will be a voluntary program that will allow people to pay low monthly premiums, likely between $100 and $200 a month, to qualify for cash benefits of at least $50 a day to be spent on long-term-care services. The Secretary of Health and Human Services has until October 2012 to finalize terms and details of the plan, after which Americans can sign up for the program.

Georgetown's Feder calls the government program a "good first step," as people's premium rates will be locked in and they cannot be turned down for health reasons. However, the program is voluntary, and both Feder and Yale's Hacker say its success will depend on widespread participation in order to provide good benefits at low premium rates. Although employers that sign up for the plan will offer an automatic payroll deduction, employees are free to opt out of it. "There are uncertainties" since it's voluntary, says Feder, who speculates people may still need private insurance as a supplement to meet all of their long-term-care needs. (Comment on this story.)

Most observers agree it's better to look at the options sooner rather than later. A long-term-care policy can cost twice as much or not be available at all for health reasons when purchased in your late 60s rather than your 40s or 50s, says Martin Corry, director of health policy at Buchanan Ingersoll & Rooney, who recommends people start looking in their 40s. So far, few have heeded that advice. Only 10% of the population between the ages of 45 and 62 have purchased long-term-care insurance policies, says Steve Nussbaum, president of Nussbaum Long-Term Care Planning & Insurance. "Clearly, there's still a critical mass of people who haven't dealt with this issue," he says.

Many are reluctant to buy it because they worry about spending money on a policy they'll never use, which Slome insists makes little sense. "Tell me any kind of insurance that you own that you hope to get your money back," he says. It all comes down to protecting assets, he says. "Very simply: Are you willing to invest 1% of your overall savings and investments each year to protect the other 99%?" he asks. "If you have half a million in investments, are you willing to invest $5,000 to protect the other $495,000?"

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6 health-related books worth a read.

By Kristen Gerencher, MarketWatch February 9, 2011

Health care is a deeply personal matter. Several books published in the last year or so stand out for their enlightening, entertaining and often personal stories on the health and science front.

This is hardly an exhaustive list of all the worthy titles. But in case you missed them, here are six health books you might consider cracking open for yourself or giving to a loved one.

"**The Immortal Life of Henrietta Lacks" by Rebecca Skloot**
(Crown; 369 pages; $26 hardcover)

There's something for nearly every kind of reader in this story that began when a poor black woman sought treatment for cervical cancer in 1951 and a doctor in Baltimore took a tissue sample without her consent. The practice wasn't uncommon at the time, but Lacks' sturdy "HeLa" cells proved to be most

uncommon.

After she died, scientists were able to use her cell line to develop a raft of new therapies including the polio vaccine, and the profitable business of human biological materials was born. Despite her enormous contribution to medical science, Lacks' descendants were unable to afford health insurance, and they suffered two decades before learning the truth. Skloot's patience in winning the family's trust pays off and she lets Lacks' daughter Deborah emerge as a poignant protagonist, weaving a moving family portrait into a cautionary tale about health care injustice.

"The Healing of America" by T. R. Reid
(Penguin Press; 288 pages; $16 paperback)

A journalist goes on a self-described "medical pilgrimage" from India to Germany to compare wealthy countries' health systems through the prism of his aching shoulder. Reid is a particularly engaged patient as he collects medical advice from doctors and other culturally-specific health care practitioners aiming to help him past the pain of an old injury. But he's just as interested in getting answers as to why the industrialized world's health systems evolved as they did and why the U.S. outspends them all while leaving 50 million people uninsured and failing to get better health results for its money.

With humor, Reid reminds readers that no health system is perfect. But he trains his eye on Switzerland and Taiwan as examples of similar free-market democracies that found the political will to cover nearly everyone.

"**The Emperor of All Maladies" by Siddhartha Mukherjee**
(Scribner; 572 pages; $30 hardcover)

For all the talk and news about cancer, it seems to exist in a world that has moved past basic questions about its scientific and social history. Not so on Mukherjee's watch. In a comprehensive biography of cancer, he introduces a cast of characters, including Sidney Farber and others with familiar names that grace cancer wards, and describes their early trials and errors that led to advances in cancer treatment. But a victory lap is out of the question. The author wants to know how scientists' shifting understanding and treatment of this disease can be used to predict its future, and his descriptions of patients' cases unfold with humane elegance. He uses the tale of the ancient Persian queen Atossa, who asked a slave to cut off her cancer-ridden breast, to orient readers on a treatment time line that extends to the present.

"The Checklist Manifesto" by Atul Gawande
(Metropolitan Books; 209 pages; $24.50 hardcover)

Even the most highly skilled and trained among us is prone to forgetting crucial steps or neglecting to ask critical questions when the pressure is on. So says Gawande, a New Yorker writer and surgeon at Boston's Brigham and Women's Hospital, who takes readers on a tour of how different professions and skilled trades manage the growing complexity of their tasks. By studying the ways of people such as successful skyscraper-builders, chefs in top-notch restaurants and institutional investors, he draws parallels to how U.S. health care teams can improve their performance and reduce deadly medical errors with the use of checklists. With wit and gravitas, Gawande lends new urgency to an old idea.

"Designated Fat Girl" by Jennifer Joyner
(skirt!; 264 pages; $16.95 paperback)

At her heaviest, Jennifer Joyner weighed 336 pounds. She suffered from uncontrolled diabetes, high blood pressure and had given birth three weeks early to a 12-pound baby. By this point in her life — at age 34 — she understood her relationship with food was destructive. To curb her obsessive eating, she underwent gastric bypass surgery. The procedure left her feverish, nauseous and in excruciating pain from an abscess that complicated her recovery. "By having the gastric bypass I took away my physical ability to abuse food," she said about her life. "That doesn't mean that I stopped my desire to self-sabotage. I'm still struggling with it. But at least now I know what's going on there, and I can keep my

eye on it."

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Some Seniors Are In For Sticker Shock On Drug Premiums!

By Mary Agnes Carey KHN Staff Writer Feb 11, 2011

What's the Medicare Doughnut Hole? See FAQ: The Shrinking Medicare Doughnut Hole

The Obama administration often touts the health-law provision that over the next decade will close the unpopular "doughnut hole" -- a gap in Medicare prescription drug coverage.

But officials rarely cite another provision, one that might cause sticker shock among some seniors. Starting this year, more affluent beneficiaries will have to pay higher premiums for their drug benefits.

Since 2007, Medicare beneficiaries with incomes of $85,000 ($170,000 for couples) have had to pay more on a sliding scale than the standard premium for Medicare Part B, which covers physician and outpatient services. The health law extended this "income relating" to Medicare Part D, which covers prescription drugs. The change took effect in January.

In addition, the law froze the income thresholds that determine which seniors pay the additional costs. That means those thresholds won't be adjusted for inflation through 2019, and more and more seniors will fall into this group.

In 2011, the standard Medicare Part B monthly premium is $115.40; higher income beneficiaries will pay between $161.50 and $369.10. Part D premiums vary widely depending on the specific plan, but the national average is $32.34; higher income seniors will pay between $44 and $101, according to the Kaiser Family Foundation.

Some seniors' advocates fear that requiring wealthier seniors to pay higher Medicare premiums will encourage those beneficiaries to leave the program and get private insurance. And, since seniors with higher incomes tend to be healthier, their departure could drive up costs for the sicker seniors left behind.

"Where is that line where it becomes too much and then you have a two-tiered system?" said Nora Super, director of government relations for health at the seniors' group AARP.

Others say it makes perfect sense to require seniors with higher incomes to pay more for Medicare. "Given where we are fiscally in this country, I really don't have a big problem with making that argument that we ought to be asking seniors in that income category to pay a larger share of the value of the benefit they are receiving," said James Capretta, a fellow at the Ethics and Public Policy Center, a

conservative think tank. Capretta also said he doubted that seniors could get a better deal from a private insurer than from Medicare.

The federal health program for the elderly and disabled currently covers about 47 million enrollees, and the number is expected to rise to 60 million by 2019.

According to the Centers for Medicare and Medicaid Services, this year 1.7 million seniors will pay the higher premium for Medicare Part B coverage and 822,000 will pay it for Part D coverage.

The percentage of seniors paying the higher premium for Part B has remained at about 5 percent of beneficiaries since 2007. Now, with inflation adjusting gone, about 5.7 million seniors will be paying the higher Part B premiums by 2019; that's about 10 percent of the total. Nearly 3.4 million beneficiaries will be paying more for their Part D coverage, according to CMS.

The Kaiser Family Foundation, in a separate analysis, estimated that those figures could be substantially higher. Kaiser projected that by 2019, 7.8 million beneficiaries will be paying the higher Part B premiums and of that group, 4.2 million also would pay the higher Part D premiums. Kaiser also estimated the combined premium costs in 2011 would range from $206 to $471 per month. By 2019, that price tag would be $299 to $683 per month, depending on beneficiaries' income. (KHN is an editorially independent program of the foundation.)

By 2019, nearly one-fifth of Part B beneficiaries who enroll in the program for the first time will pay income-related premiums for their physician and outpatient coverage, according to the Foundation.

AARP lobbied against increasing premiums for higher-income seniors, but the pleas "sort of fell on deaf ears," Super says, in part because Democrats need money to finance the health law. The Medicare income-relating provisions will raise about $36 billion through 2019, according to the Congressional Budget Office. AARP continues to oppose the provision and hopes to have it taken out of the law.

Meanwhile, AARP and other seniors groups are concerned that charging wealthier seniors more could encourage insurers to create policies that would be more attractive than Medicare.

"If you're paying $400 a month you might be able to find insurance in the private market that would be less than that," said Maria Freese, government relations and policy director for the National Committee to Preserve Social Security and Medicare. "If you're healthier we need to keep you in the system in order to keep costs low for everybody else."

Capretta said the odds are "very low" that wealthier seniors would leave Medicare in droves or that insurers would build new products to cover them. "You take an awful big risk by opting out of Medicare, which is guaranteed issue, community-rated insurance. I don't think a lot of people would do that."

Jonathan Blum, deputy CMS administrator and director of the agency's Center for Medicare, said he's not aware of any seniors who have left the program because they had to pay more for their Part B coverage, and he added that CMS is "confident that higher-income beneficiaries will stay in the Part D program based upon the history and the fact that the Part D benefit is more generous."

He also said that while higher-income seniors would be required to pay more for their drug coverage, the benefit is more generous this year, pointing to the 50 percent discount for brand-name prescription drugs once seniors hit the "doughnut hole."

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FAQ: The Shrinking Medicare Doughnut Hole.

By Marilyn Werber Serafini KHN Staff Writer Feb 11, 2011

See related story: Some Seniors Are In For Sticker Shock On Drug Premiums upbove

The widely unpopular "doughnut hole" -- the coverage gap in the Medicare drug benefit -- is headed for oblivion, under the new health law. Beginning this year, seniors who hit the doughnut hole will get substantial discounts on both brand-name and generic drugs. Those discounts will increase over time, effectively closing the gap by 2020. The change is "quite significant," says John Rother, AARP's executive vice president for policy and strategy. In the past, when people had to pay full price for the drugs in the coverage gap, they sometimes stopped filling prescriptions, he says.

Q: How does Medicare drug coverage, and the doughnut hole, work this year?

Drug plans vary, but here's generally how it works: After paying a deductible of $310, beneficiaries with Medicare drug coverage are responsible for 25 percent of the cost of their prescription drugs; the drug plans pick up the other 75 percent, explains the National Council on Aging. Once the seniors run up an additional $2,530 in costs – of which $632.50 is paid by the senior and $1,897.50 is picked up by the drug plan – the beneficiaries enter the doughnut hole.

At that point, beneficiaries are fully responsible for their drug bills. To soften the blow, under the law, seniors this year will get a 50 percent discount on brand-name drugs and a 7 percent discount on generic drugs until they have spent an additional $3,607.50. At that point, seniors escape the doughnut hole and the drug plan covers about 95 percent of the cost of prescriptions for the rest of the year.

Q: How much will seniors save this year?

The discounts can save seniors as much as $1,800 a year, according to the NCOA. AARP's Rother estimates that typical seniors who hit the doughnut hole will save about $700.

Q: Who saves?

About 4 million Medicare beneficiaries will fall into the doughnut hole this year, and thus could benefit by the law's provision, NCOA says. Low-income people who receive federal help with Medicare, such as those who also qualify for Medicaid (the state-federal program for the poor and disabled) won't get the discount.

Q: Won't drug makers raise prices to make up their losses?

That could very well happen, says the Congressional Budget Office. Medicare drug plans negotiate prices with pharmaceutical manufacturers and pharmacies, and this year's discounts will come off of those agreed-to prices. Drug makers could partially offset that lost income by raising the prices they charge the drug plans, CBO Director Douglas Elmendorf told Rep. Paul Ryan, R-Wis., in a letter last fall. Higher prices would affect all beneficiaries, not just those who hit the doughnut hole. Elmendorf also said the plans might increase the prices they charge to pharmacies or reduce rebates paid to insurers.

Q: What happens after 2011?

Under the law, the doughnut hole will disappear by 2020. Starting that year, beneficiaries will be responsible for 25 percent of the cost of their drugs – no matter the size of their bill.

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www.healthcareil.com

Natural remedies for the 15 most common aches, pains, and health complaints.

by Yahoo!Green, on Mon Feb 7, 2011 2:05pm PSTBy Sarah Irani, EcoSalon

(Photo: Flickr / tillwe)

Is the economy beating you up? It's time to get creative. Next time you have an ache or pain, forget about a costly trip to the drugstore and test-drive some of your grandmother's remedies instead. It'll save money and be gentler on your body and the environment. Recessionistas (and gents), welcome to the DIY medicine cabinet.

1. Stop Bleeding

You'd think it would burn, but a sprinkle of cayenne pepper on a cut will quickly stop the bleeding and actually relieve the pain.

2. Toothache

There's nothing so bad as the shooting pain of a toothache. You don't want to ignore a tooth problem, because an infection that close to your brain can be extremely dangerous if it spreads. But in order to reduce swelling and pain while you wait for a dentist appointment, try putting a few drops of clove oil on your tooth and gums, and bite down on a smashed piece of garlic (which has excellent antibacterial properties). This has always worked for me.

3. Rashes and Allergies

Prescription and OTC antihistamines can cause some serious side effects. Before you head for the strong stuff, try green tea, which contains compounds with antihistamine properties. You'll need to drink 2-3 cups a day to get the full effect.

4. Athlete's Foot

It's a foot fungus, and it stinks. Air those piggies, then soak them in salty water, wash them with garlic juice, or soak them with diluted white or apple cider vinegar. All of these things will help kill the fungus.

But you have to be persistent, consistent, and diligent: No matter what treatment you use, do it a few times a day and stick with it until at least a week after you think the symptoms are gone! Fungus excels at hiding out and coming back when you least expect it.

5. Acne and Sensitive Skin

First, you really have to look at your lifestyle, because imbalances in your health can show up in your skin. But in the meantime, wash your face with oatmeal. It's a gentle exfoliant and draws out oil and impurities.

6. Ear Infections

Ear infections can become quite serious and cause permanent damage, so please see a doctor if your ear ache has become severe.

But if you feel like your infection is mild and at the beginning stages, put a few drops of garlic oil or white vinegar into your ear canal and lay down on the opposite side to let those drops do their work. Garlic and vinegar create an environment that won't support the bacteria causing the infection. Repeat a few times a day until the symptoms

disappear. (If your symptoms last longer than a few days, you should definitely see a doctor!)

7. Sore Muscles and Bruises

After a hard afternoon of rowing with a friend, I resigned myself to a few days of burning muscles and soreness. But my friend saved the day with a tube of arnica cream. He rubbed it on my shoulders and voila, instant relief and absolutely no aches the next day. The humble arnica flower makes an incredible cream that no medicine cabinet should be without. Use it immediately to speed up the healing of bruises, sprains, sore muscles, and other general aches.

8. Flatulence

Some foods, like beans and raw veggies, are more likely to cause gas, but if you find flatulence to be too common of an occurrence, try taking a digestive enzyme with your meals. You can find these at any health food store.

In the meantime, make use of digestive spices such as ginger, anise, peppermint, coriander, and dill. You can make tea with these ingredients or incorporate them into your food.

9. Dandruff

Have you looked at the ingredients in dandruff shampoo? It seems like they contain almost everything in the Toxic Ingredients You Must Avoid list. Better to try something natural first before resorting to chemicals. Many people swear by rubbing aloe vera gel onto the scalp (leave it on for 20 minutes than rinse it out). This will certainly help with dry, itchy scalp.

Another remedy is a rinse with apple cider vinegar. Try these remedies a few times before deciding if they work for you. Even dandruff shampoo requires regular use to see results, so give the natural stuff a chance!

10. Headache and Migraine

Try rubbing peppermint or lavender oil on your temples and the base of your neck; sniffing these oils may also help.

Rub a fresh cut lemon or lime on your forehead. Feverfew is a good herbal remedy for headaches.

Have a little caffeine by way of green tea, and don't forget to use an ice pack for 20 minutes to dull the throbbing.

11. Indigestion and Heartburn

It almost goes without saying – but consider why you're getting heartburn in the first place. Did you overeat? Too much grease or spicy food? Eating late at night? Scout out the cause and try to stop this before it happens. Then, put down the antacids.

The belching, bloat, and heartburn caused by indigestion come about because you don't have enough stomach acid to do the job right. A spoonful or two of apple cider vinegar will help break down the excess food that is causing you trouble and bring your stomach back to balance.

12. Constipation

First, drink more water and eat more fruit and salads. You're backed up for a reason and taking lots of laxatives is not the answer. Meanwhile, drinking a few teaspoons of olive oil mixed with a bit of orange or (diluted) lemon juice can help things get moving.

Another surefire remedy is 1/4 teaspoon of epsom salts drunk in 1/2 a glass of water. Sometimes calorie restriction or avoidance of healthy fats (such as the good fats found in fish, nuts, and avocados) can worsen constipation.

And though it's counterintuitive, some people relieve their constipation by actually cutting back on grain consumption! True, grains contain fiber, but some people don't digest grains very well. Other causes of constipation include stress, depression, inactivity, and nutritional deficiencies. If your constipation is chronic, it may be a sign of a more serious problem, so please seek medical advice and adjust your lifestyle.

13. Sore Throat

Sore, scratchy throats are usually a sign of a cold or flu coming on, so you don't want to ignore this symptom, but you can relieve the pain by gargling with warm salt water a few times a day and then drinking a soothing honey-lemon tea.

14. Burns

So you bumped up against the stove again? Ouch. Rinse first with cold water, but then immediately apply aloe vera gel to the burn.

For those of us who don't have aloe in the house, slice a potato and rub its cool, soothing juices all over the burn.

And honey, with its antibacterial properties, is also good topical ointment. If you can catch the burn immediately, mustard is also reportedly a great salve.

15. Nausea

The classic cure for nausea or carsickness is ginger tea or candied ginger. You can chew on the stuff raw, if you like, but it's so spicy and strong it might just make you feel worse.

Sniffing real peppermint or lavender oil can also help.

Give some of these remedies a try – and share your own tried-and-true treatments, too.

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www.healthcareil.com

Americans on budgets push up price of 'cheap' beef.

By Reuters Posted February 2011

Beef cuts on display at a supermarket in New York in January. (Emanual Dunand/AFP/Getty Images)

With more Americans tightening their belts, demand for cheaper cuts of U.S. beef has actually pushed the price of select-grade beef higher than the generally more expensive choice cuts.

For the first time in nearly two years, select-grade beef prices are above those for better-quality choice grade, according to U.S. government data.

The data showed that demand for select has grown while supplies have declined.

Select beef on Monday averaged $168.22 per cwt — 55 cents more than the choice beef priced at $167.67.

The inversion of the so-called choice-select spread was the third widest since the U.S. Agriculture Department began tracking the data in 2001 and only the tenth time the spread has inverted.

"When the choice-select spread approaches zero, or occasionally gets inverted, it's generally an indication of weak demand — consumers not willing to pay more for the good stuff," said Ron Plain, agriculture economist at the University of Missouri.

Live cattle futures are trading near the record high set last month at the Chicago Mercantile Exchange, and the high beef prices have capped demand for all cuts.

Consumers are also grappling with record-high food prices and turning to normally economical choices, including select beef cuts such as the chuck or round commonly ground into hamburgers.

Select beef is leaner but less flavorful than choice, which has more marbling and fat. Choice cuts such as the sirloin and tenderloin are more often found in restaurants.

“It’s very unusual to have this inverted, and it’s self-correcting,” said Jim Robb, agriculture economist at the Livestock Marketing Information Center.

“People in the marketplace, especially the end users on the hotel and restaurant side, even the grocery store side, say, ‘If there is no premium for choice over select, send me your choice product,’” Robb said.

Due to efficiencies in cattle breeding, feeding and other factors, more of the meat is also graded at a higher level. On average, 65.11 percent of beef is rated choice and 26.5 percent is rated select while only 3.71 is rated top-of-the-line prime, USDA said on Monday.

“We are producing, proportionally, more choice beef than select beef,” Robb said. “The bottom line for consumers is that we’ll see a little bit more choice product showing up at the grocery stores.”

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Experts seek to change confusing medication labels.

Michelle Andrews Kaiser Health News February 15, 2011.

"Take two tablets by mouth twice daily." This printed instruction, common on prescription pill bottles, might seem straightforward. Yet in a study, nearly half of patients misunderstood what it or other common label instructions meant.

Now the non-profit organization that sets quality and safety standards for drugs approved by the Food and Drug Administration is aiming to simplify, clarify and standardize the labels that are affixed to those drugs.

The U.S. Pharmacopeia proposal, developed in conjunction with a group of independent experts, was released early this year for public comment. If adopted by state pharmacy boards nationwide, its developers hope it will help remove one of the many barriers that discourage people from taking their prescription drugs.

Medication compliance, or "adherence," as it's called, is a big problem. Despite the fact that 87 percent of people in a recent survey said they thought prescription medicines were important to their health, only about half of those surveyed take their drugs as directed. People skip doses, take the wrong number of pills, and take pills at the wrong time of day, among many other problems. Poor adherence results in up to $290 billion in medical expenses each year, according to NEHI, a health research organization.

In general, people are more compliant with drugs for acute conditions such as a bladder infection than for chronic problems like diabetes. But both are problematic, and the reasons people offer for not taking their drugs are as varied as the drugs they're not taking. In that patient survey, 59 percent said they stopped taking their medication because they were feeling better and didn't think it was necessary to continue, while 25 percent said they stopped because they weren't feeling any better. Thirty-seven percent were worried about side effects, while 24 percent said their drugs were too expensive.

With such varied reasons for noncompliance, experts agree that solutions must be varied, too. "There is no silver bullet," says Bob Nease, chief scientist at Express Scripts, a large pharmacy benefit manager for employers and insurers.

Simple forgetfulness may be the culprit in many cases of nonadherence, especially when a drug doesn't actually make people feel any different. Drugs to treat high cholesterol or high blood pressure fall into this category. Many researchers and others involved in medication adherence issues are excited about the potential of technology to both educate patients and provide a "tickler" system to remind them to take their drugs.

Researchers at the Center for Connected Health in Boston, for example, found that sending daily text messages to patients with a type of eczema increased drug adherence, as did wireless pill bottle "GlowCaps" that light up and beep when high blood pressure patients miss a dose.

The center, a division of Partners HealthCare, works to identify ways that technology can help change patient behavior and improve health outcomes. With medication adherence, "What we've found is that the power of simple reminders is enormous," says the center's director, Dr. Joseph Kvedar.

Even the unlikeliest people need an assist now and then. Kvedar uses a GlowCap to remind him to take his cholesterol lowering drug every night.

At 9 p.m., the pill cap lights up to remind him it's time to take his pill. If he's not near his pill bottle, a small plug-in unit in his kitchen that looks like a nightlight glows at the same time to remind him. When he takes his dose, the cap relays the information wirelessly to the company network. But if he still hasn't taken his pill after an hour has passed, the cap emits a ring tone. If he fails again to take a dose after another hour, the system calls him on his cell phone to remind him.

Kvedar says he would have expected his adherence would be 100 percent, but "I've discovered with the GlowCap that I would have forgotten some nights."

There are many lower tech ways to improve adherence, say experts. Communication is key. If doctors and pharmacists make a point of explaining possible side effects and the importance of completing a course of treatment, for example, a patient may be less likely to discontinue taking a drug if he experiences a side effect.

As for costs, reducing or eliminating copayments for drugs increases patients' adherence, says Dr. Niteesh Choudhry, an assistant professor of medicine at Harvard Medical School who has conducted research on the subject. Increasingly, companies are picking up the tab for medications to treat their employees' chronic conditions, with the expectation that doing so means they'll save money down the road through lower medical costs.

While no single strategy or technology will get everyone to take their medicine as directed, experts agree that clear instructions on the pill bottle are a basic requirement if that's to happen. Many of the USP recommendations seem commonsensical: place patient information and instructions at the top of the label in bigger type than the doctor or pharmacy name or information on refills and expiration; use everyday words like high blood pressure instead of hypertension; keep auxiliary information, such as warnings, simple and straightforward.

And to avoid confusion over things such as dosages and when to take the medication, the recommendations say, keep those instructions separate and simple, using numbers instead of words when appropriate. With those guidelines in mind, perhaps fewer people would be confused by the instruction that started this column. The new and improved pill bottle would read, "Take 2 tablets by mouth in the morning and 2 tablets by mouth in the evening."

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Imaging tests are often done for the doctor -- not the patient.

By Shari Roan, Los Angeles Times February 15, 2011

A significant number of imaging tests are done for "defensive" purposes, a study found.

(Spencer Weiner / Los Angeles Times)

Imaging tests such as MRIs and X-rays frequently are performed so that doctors can protect themselves from lawsuits, according to a new study.

A review of 2,068 orthopedic patients throughout Pennsylvania showed that almost 35% of the imaging

costs were ordered for "defensive" purposes, researchers from Children's Hospital of Philadelphia reported Tuesday at the annual meeting of the American Academy of Orthopaedic Surgeons in San Diego.

Medical malpractice lawsuits often hinge on charges that the doctor should have ordered more tests, said the lead author of the study, Dr. John Flynn, associate chief of orthopedic surgery at Children's. "Such a claim may be the driving force of so much of the defensive test ordering," he said in a news release.

The study involved 72 doctors who voluntarily participated. Overall, 19% of the tests were ordered for defensive purposes. But often they were expensive tests, such as MRIs. Even doctors who had been in practice for a long time were likely to order tests for defensive purposes, Flynn said.

Defensive medicine is not unique to orthopedics. A 2005 study of 824 doctors in the Journal of the American Medical Assn., found that almost 93% said they practiced defensive medicine. It's time for the nation to quantify how much of annual healthcare expenses are "wasted" on defensive medicine, Flynn said.

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Data shows healthcare costs increased by 6.1% last year.

Thursday, February 17, 2011

Healthcare costs rose 4X faster than other prices in 2010
US healthcare costs rose 6.1% during 2010, almost four times the 1.6% consumer inflation rate, according to Standard & Poor's Healthcare Economic Composite Index.

That's bad, but not as bad as in 2009, when healthcare prices rose 8.2%, while consumer prices fell slightly according to the US Department of Labor.

In 2010, commercially-insured healthcare costs rose 7.8%, while Medicare costs rose just 3.3% due to US Government cost controls, according to S&P.

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Complete blood counts: A look under the hood!

By Rajiv Pruthi, The Mayo Clinic February 16, 2011

Q: At my annual physical, my doctor recommended I have a complete blood count. What is it, and why is it necessary? I'm healthy, and as far as I know, I'm not at high-risk for any medical problems.

A: A complete blood count is a blood test that can be used to evaluate your overall health. The test measures a variety of components and features of your blood.

What it measures

A complete blood count examines several parts of your blood, including hemoglobin, white blood cells and platelets.

Hemoglobin is often thought of as a transport vehicle. As a protein within your red blood cells, hemoglobin carries the oxygen that you inhale into your lungs to the rest of the tissues in your body. It also takes carbon dioxide from those tissues and brings it back to your lungs, so you can get rid of it when you exhale.

White blood cells are part of your immune system. There are several types of white blood cells, but they're all important for the body's defense against infections. For example, one type of white cell called a neutrophil fights off bacterial infections. So if you have a bacterial ear infection or pneumonia, those white cells actually eat the bacteria. Once they ingest the bacteria, they release enzymes that kill it.

Platelets work as a type of scanning system. They examine the inner surfaces of blood vessels looking for holes. If the platelets find a hole, they seal it. So their job is to prevent or stop bleeding.

Interpreting results

A complete blood count shows the amount of each of these substances in your blood. If the results of a complete blood count reveal levels of blood components that fall outside normal ranges, there could be a problem that needs further evaluation. But the ranges aren't the same for everyone. Your gender, ethnic group and age have an impact on what's considered normal. Talk to your doctor about levels for each measurement that are appropriate for you. If you have abnormal levels, additional testing to find more information is almost always needed.

A complete blood count can point to a possible problem, but it generally cannot be used to specifically diagnose a disorder. For example, an elevated white blood count may signal an infection. Low hemoglobin levels signal anemia. A decrease in your platelet count might be a sign of an autoimmune disorder. But there are many other possible causes for blood count numbers to be high or low, ranging from relatively benign disorders such as vitamin or iron deficiencies to potentially more serious blood diseases.

Additional follow-up tests can identify more clearly what the underlying cause might be.

The complete blood count is an important step in assessing your health. Many diseases and conditions can affect your blood. But these disorders may show only minimal symptoms or, in some cases, no symptoms at all. The first sign of an abnormality may appear on the complete blood count. For that reason, it's important that everyone have this test once a year. Your blood can reveal vital clues about what's going on throughout your body.

How often should I have one?

Having a complete blood count each year as part of an annual physical is a good idea, even for healthy people. The test is an excellent way to screen for blood abnormalities that could signal an underlying disorder, such as anemia or infection, which may not show any other signs or symptoms.

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Employers weigh next step in health care.

By Guy Boulton of the Journal Sentinel Feb. 19, 2011

Rick Wood Mike Sobolik (left) talks with Daniel Cahalane, president of American Roller & Plasma Coatings. Like many executives of U.S. companies, Cahalane is mulling what steps to take in health coverage since federal health care reform was enacted.

Reform could lead to some companies dumping coverage.

Bill Goetz (left) and Wayne Kern, employees at American Roller & Plasma Coatings, apply a layer of rubber to a roller being refurbished at the Union Grove plant.

When he first got into the myriad details of federal health care reform, what struck Daniel Cahalane, the president of American Roller & Plasma Coatings LLC, was that the penalty for not offering health benefits to employees was a fraction of their actual cost.

Cahalane wondered if the company's largest competitors would drop their health benefits, forcing American Roller to do the same to remain competitive.

For now, the Union Grove company has no intention of doing that.

American Roller, which makes coatings and rollers used in printing, packaging and plastic, offers health benefits to its 250 employees for a reason: to attract and retain people.

"To not have benefits is a huge leap," said Cahalane, 42, an engineering graduate of Marquette University.

A common contention among opponents of federal health care reform is that employers will stop providing health benefits after 2014, opting instead to pay a penalty.

The penalty is $2,000 for each full-time employee if no coverage is offered or $3,000 for each employee who receives the federally subsidized coverage. It applies only to employers with more than 50 workers.

That's clearly a lot less costly than spending $10,000 or more a year on family coverage, excluding the

worker's share of the premium. And Cahalane isn't the only person to do the math.

Dave Osterndorf, chief health actuary for Towers Watson, a benefits consulting firm, regularly has clients ask him why they don't just pay the penalty.

"There's the immediate answer that the reason you are not going to drop coverage is the reason you have coverage today: It's an attractive piece of compensation," Osterndorf said.

Nothing requires employers to provide health benefits now - there's not even a penalty. Companies provide benefits to compete for the workers they need to make money.

"That hasn't changed," said Scott Weltz, an actuary with Milliman, an actuarial and consulting firm.

Tax advantage

What will change under the law is individuals would be able to buy health insurance through online marketplaces, or exchanges, and health insurers would be required to cover people with pre-existing health problems after 2014.

That could make buying their own insurance an affordable option for employees.

The contention is that employers would increase wages to offset the cost. Even with the penalty, some employers would come out ahead. So, too, would some workers. And employers would be free of the headache of providing health benefits.

"We didn't go into this to be benefit specialists," said Tim Nerenz, executive vice president of the Oldenburg Group, a manufacturer of heavy equipment and architectural lighting.

He said the ideal would be to let everyone buy their own health insurance - and many health economists agree with him. For now, the Oldenburg Group is keeping its options open.

"The default setting is to drop coverage," Nerenz said.

But that would mean forgoing one of the key advantages of getting health benefits through an employer: The benefits are tax free.

An employee's share of the premium in most companies also is paid for with pretax dollars.

Say your employer drops health benefits but increases your pay by $9,000 so you can buy coverage for your family. You already were paying $3,000 a year before taxes for your share of the premium. You now have an additional $12,000 in taxable income. In the 25% tax bracket, that works out to $3,000 in federal income taxes.

You also would pay more in payroll and state taxes. And your employer would pay a penalty.

Some lower-paid employees could come out ahead because they would be eligible for subsidies that limit the cost of health insurance to 9.5% of their income. But employers have to offer health benefits to all their employees. Carving out just their lowest paid workers isn't an option.

In addition, older workers - generally those who are the highest paid and who make the decisions - probably would end up paying more for health insurance.

The new regulations under the federal law place a cap on what health insurers can charge their oldest customers to three times what they charge their youngest. But when people get health benefits through an employer, their share of a premium is the same whether they are 64 or 24.

Few to drop benefits

Some employers, particularly those with low-wage workers, will want to look at the alternatives, said Weltz, of Milliman. But once they do, they often conclude that they want to continue offering benefits for now.

In a survey released in November, Mercer, a benefits consulting company, found that just 6% of employers with more than 500 workers said they were likely to drop health benefits after 2014.

Among employers with 10 to 499 workers, 20% said they were likely to stop offering benefits.

But if Massachusetts is a guide - it enacted health reform legislation in 2006 similar to the federal law - few of those employers will follow through, Mercer noted.

The number of employers who offer health benefits in Massachusetts has increased since the state enacted the law.

Massachusetts, one of the most affluent states, isn't typical.

"But is it so different in the behavior of its employers?" said Austin Frakt, a health economist at the VA Boston Healthcare System and a professor at Boston University School of Public Health.

Frakt expects the federal law to increase the number of people getting health insurance through an employer.

Studies by Rand Health, part of Rand Corp., a public policy research institute, and the Urban Institute, a policy research institute, came to the same conclusion.

The controversial requirement that everyone have health insurance could increase the number of people enrolled in employer health plans. It also could make health benefits more attractive to prospective employees.

The two studies, based on economic models, also predicted that more small employers would provide benefits, partly because plans sold through the exchanges would have lower administrative costs.

Those costs now average more than 30% of the premium for employers with fewer than 10 employees, according to one study.

Economic models are far from perfect, and some employers will stop offering benefits as costs continue to rise. But that's a long-standing trend. The percentage of population under 65 with coverage peaked in the mid-1970s.

The law also is almost certain to bring about unforeseen consequences.

Many of the rules and regulations have yet to be written. And until they are, employers can't gauge how the law will affect them, said Nerenz, of the Oldenburg Group.

"All employers are trying to figure out what it means," he said. "And now, with the constitutional questions, we are trying to figure out whether we need to figure it out."

For now, at least, employers still have an incentive to provide health benefits: the need to attract and retain workers.

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HealthGrades ranks top 50 hospitals for 2011.

By mmerrill Created 02/23/2011 Published on Healthcare IT News

DENVER – Use of computerized physician order entry (CPOE) systems is one key factor to providing superior clinical quality, CEOs at HealthGrades 50 Best Hospitals for 2011 reported.

According to HealthGrades, an online healthcare quality rating and services company, the hospitals on its list have demonstrated superior and sustained clinical quality over an 11-year time period, based on an analysis of more than 140 million Medicare patient records for 26 medical procedures and conditions.

To be recognized with this distinction, hospitals must have had risk-adjusted mortality and complication rates that were in the top 5 percent in the nation for the most consecutive years. On average, patients treated at America's 50 Best Hospitals had a nearly 30 percent lower risk of death and 3 percent lower rate of complications.

HealthGrades' study found that if all U.S. hospitals had performed at this level, more than a half million deaths of patients on Medicare could have been prevented between 1999 and 2009.

[See also: HealthGrades study: 'Unacceptably wide gap' between top peforming hospitals, others]
http://www.healthcareitnews.com/news/healthgrades-study-unacceptably-wide-gap-between-top-peforming-hospitals-others

"As our nation searches for a solution to providing Americans with access to high quality healthcare at an affordable price, these hospitals are setting the standard, demonstrating that consistent, sustainable clinical excellence is achievable," said Rick May, HealthGrades' vice president of clinical quality services and co-author of the study.

The hospitals on HealthGrades' list are in 28 cities in 19 states. The West Palm Beach, Fla. area leads the nation with six of these top-performing hospitals. Chicago and Cleveland come in next with four recognized hospitals each.

[See also: HealthGrades ranks top 50 cities for hospital care]
http://www.healthcareitnews.com/news/healthgrades-ranks-top-50-cities-hospital-care

For the first time, HealthGrades also conducted a survey of CEOs from America's 50 Best Hospitals to find out what made them stand apart. Besides CPOE other factors that CEOs named were:

- transparency of clinical quality outcomes,
- positive operating margins,
- above average tenure of executive team, and
- investment in physician feedback and leadership development.

America's 50 Best Hospitals 2011 by city/state:

Baltimore, MD

- Franklin Square Hospital Center
- Greater Baltimore Medical Center
- Good Samaritan Hospital
- Cedar Rapids, IA
- Saint Luke's Hospital Cedar

Chattanooga, TN

- Memorial Healthcare System

Chicago, IL

- Evanston Hospital including: Highland Park Hospital, Glenbrook Hospital
- Skokie Hospital
- Alexian Brothers Medical Center
- Community Hospital

Cincinnati, OH

- St. Elizabeth Edgewood
- Christ Hospital

Cleveland, OH

- Summa Akron City and St. Thomas Hospitals
- Akron General Medical Center
- Marymount Hospital
- Hillcrest Hospital

Colorado Springs, CO

- Centura Health - Penrose St. Francis Health Services

Dayton, OH

- Grandview Medical Center

Detroit, MI

- Saint Mary Mercy Hospital
- Beaumont Hospital - Royal Oak, MI
- Beaumont Hospital – Troy, MI

Erie, PA

- Hamot Medical Center
- Eugene, OR
- Mercy Medical Center
- Flint-Saginaw, MI
- Genesys Regional Medical Center

Harrisburg, PA

- Lancaster General Hospital

Houston, TX

- Memorial Hermann Healthcare System – Southwest including Memorial Hermann Northwest Hospital, Memorial Hermann Southeast Hospital and Memorial Hermann the Woodlands Hospital

Jacksonville, FL

- Flagler Hospital Saint Augustine

Los Angeles, CA

- Glendale Memorial Hospital and Health Center
- Saint John's Health Center

New York, NY

- Hackensack University Medical Center
- Community Medical Center

Orlando, FL

- Munroe Regional Medical Center
- Central Florida Regional Hospital
- Ocala Regional Medical Center/West Marion Hospital

Panama City, FL

- Bay Medical Center

Philadelphia, PA

- St. Luke's Hospital - Bethlehem Campus including St. Luke's Hospital - Allentown Campus
- Lehigh Valley Hospital Allentown PA

Phoenix, AZ

- Banner Del E. Webb Medical Center
- Mayo Clinic Hospital

Raleigh, NC

- Rex Hospital

Richmond-Petersburg, VA

- Henrico Doctors' Hospital including Parham Doctors' Hospital, Retreat Doctors' Hospital

St. Louis, MO

- St. Luke's Hospital

Tampa, FL

- Sarasota Memorial Hospital

Traverse City, MI

- Munson Medical Center

W. Palm Beach, FL

- Martin Memorial Medical Center
- Boca Raton Regional Hospital

- Palm Beach Gardens Medical Center
- Lawnwood Regional Medical Center and Heart Institute
- Jupiter Medical Center
- Delray Medical Center

Wilkes Barre, PA

- Mercy Hospital Scranton

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