Health & Retirement Services of Illinois
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OUR NEWS LETTER

What does "full retirement age" mean in regards to Social Security?

By Investopedia

In the United States, the term "full retirement age" generally refers to the age you must reach to be eligible to receive full benefits from Social Security. Depending on when you were born, this age can vary. The Social Security Administration has been slowly increasing this age as life expectancies lengthen. Early retirees receive a reduced benefit. There are several factors that determine how much you receive.

For individuals born prior to 1938, full retirement age is 65, while those born between 1938 and 1960 are on a graduated scale up to age 67. It is possible that the Social Security Administration might continue to raise the full retirement age as a means to cope with its solvency issues.

Once you reach full retirement age, if you are eligible, you receive benefits based on your average annual earnings during the 35 years when you made the most money. You must also have at least 40 credits. You can obtain four credits per year, meaning you must work at least a total of 10 years to become eligible for any benefits.

If you have not worked enough to qualify for benefits and you are married, you are likely to be eligible to receive a spousal benefit based on your working spouse's benefit. Your benefit in this case is to be at least equal to half of your spouse's benefit. If your own benefit amount is greater than half your spouse's, you and your spouse can collect on both of your benefits. Full retirement age must also be attained in order to receive 100% of your spouse's benefit if your spouse dies. Otherwise, your survivor benefits are reduced until you reach that age.

In Our Newsletter

Drug-spending spike puts more strain on government and you

Dan Mangan | @_DanMangan Tuesday, 8 Mar 2016 | ETCNBC.com

You might need to take a pill after reading about how much prescription drugs are costing us.

Spending on prescription medications "rose by a remarkable 12.6 percent in 2014" after years of modest growth, federal officials revealed Tuesday.

Growth in drug spending is believed to have "remained elevated in 2015," and even after slowing somewhat is expected to continue at a heated pace in the near future, officials said.

The projections indicated that prescription drug spending will eat up an increasing share of overall government and personal health budgets in coming years.

In 2015, the United States spent an estimated $457 billion on all prescription drugs, which is 16.7 percent of all personal health-care services — up 1.4 percentage points since 2013, according to an issue brief released by the office of the assistant secretary for planning and evaluation of the U.S. Health and Human Services Department.

The estimate includes spending both on retail prescription drugs and on medication directly administered by health providers.

The office also said that spending on prescriptions is projected to rise an average of 7.3 percent annually from 2013 through 2018.

That compares to an estimated rate of inflation for all health-care spending of an average of 5.2 percent annually during the same time period.

Most of the increases in drug spending since 2010 appear to be due to rising prices of medications, and shifts in the composition of drugs being prescribed toward higher-priced products, the office said. But another significant factor was an increase in the rate of prescriptions per person in the U.S.

Spending on specialty drugs "generally appears to be rising more rapidly than expenditures on other drugs," according to the issue brief.

The office also noted that the dramatic increase in drug spending came after years of relatively slow grow, particularly from 2008 through 2012, when drug spending inflation averaged just around 2 percent annually.

Officials did not estimate what the final drug spending inflation rate will turn out to be for 2015, but suggested it was in the ballpark of the rate seen in 2014.

And while "analysts do not expect the rates of increase seen in 2014 and 2015 to continue," they are projecting higher rates of drug spending inflation than was seen from 2008 through 2013.

By 2018, spending on all prescriptions drugs is projected to be $535 billion annually, or 16.8 percent of total personal health-care spending.

"The rising cost of prescription medicines is putting pressure on public and family budgets in the United States," the office said in its issue brief.

The office noted that a recent poll by the Kaiser Family Foundation "found that the affordability of prescription drugs tops the public's list of priorities for the president and Congress."

The issue brief pointed out that in some cases, the use of particular drugs might lead to reduced spending in other health sectors, such as in hospitals, because of "fewer acute health events occurring as a result of medication use."

But "evidence suggest that a rise in prescription drug therapy tends to raise" overall health expenditures "rather than lower them," the brief said.

Another issue brief released by the same office Tuesday said that Medicare's Part B program, which among other things covers infusible and injectable drug and biologic treatment by doctors, gives physicians "weak incentives" to consider lower-cost drug therapies to effectively treat a patient.

The brief said the federal Medicare program "has not implemented various value based practices typically used by commercial insurers" and the sponsors of Medicare's Part D prescription benefit program for self-administered drugs.

"There is growing concern that several features of the current Part B program do not create appropriate incentive for either providers, suppliers or patients to make high value choices among treatment options," according to the brief.

At the same time that brief was released, the federal Centers for Medicare and Medicaid Services announced that it is proposing to test new models "to improve how Medicare Part B pays for prescription drugs," suggesting those models might help lower drug spending in the program over time.

The proposed payment models would affect Medicare payments for many specialty drugs, said Dr. Patrick Conway, acting principal deputy administrator and chief medical officer of CMS.

During a briefing with reporters, Conway said the initial proposed changes to payment models were designed to be "budget neutral."

But in the future they might "lead to savings" by incentivizing doctors to use "higher-value drugs that provide better outcomes to patients," he said.

How You Could Get Hit With a Surprise Medical Bill

One in three American adults has faced them

Almost exactly a year ago, John Elfrank-Dana, a 58-year-old father of three, slipped on the steps of a New York subway, slammed his skull on the metal and concrete, and was launched into what can only be understood as the seventh circle of modern medical billing hell.

As a public school teacher in New York City, Elfrank-Dana gets his medical insurance through the district's Emblem plan. He pays a small premium each month and, like the rest of us, thought that meant he was covered in the event of an emergency. He would pay his deductible—and the insurance would pick the rest, right?

But that, Elfrank-Dana quickly discovered, is not how it actually works.

Five weeks after sustaining that head injury, Elfrank-Dana started feeling dizzy, checked into the nearest emergency room in Bergen County, New Jersey, and was rushed in for a craniotomy, a surgical procedure that removes part of the skull. After that, the hospital visits started piling up. He was treated for a fistula, then another surgery to drain the blood from his head again, then a series of appointments to address a brain infection related to the original craniotomy. It just never ended.

At one point in that nightmare, the medical bills started rolling in. A few thousand here. Ten thousand there. Twenty-two thousand more. By end of the year, Elfrank-Dana was staring down roughly $106,000 in medical bills. And none of it was covered by his insurance.

"My insurance had made payments to the hospital and anesthesiologist but it was a fraction of what they were asking," Elfrank-Dana told TIME recently. "So they started going after me for the balance."

While Elfrank-Dana didn't know it at the time, he had become the latest victim of what is known, aptly, as "surprise medical bills." They arise when what an insurer pays a provider doesn't match up with what a doctor, physicians' group or out-of-network hospital actually charges. It happens all the time.

According to a 2015 survey by *Consumer Reports*, surprise medical bills are extremely common. An estimated 1 in 3 American adults with private health insurance fell victim to a surprise medical bill in the past two years.

This week's TIME magazine has a feature, "The Hidden Cost of Surprise Medical Bills," describing the problem, its causes, and solutions, an includes more stories from people like Elfrank-Dana. Here's the Cliff's Notes version.

Surprise medical bills happen most often when a hospital contracts with medical providers—including doctors, surgeons, anesthesiologists, lab technicians—that do not accept the same insurance plans that the hospital does. That means that patients, like Elfrank-Dana, can walk into an in-network hospital, see an in-network doctor, and suddenly find himself on the hook for thousands of dollars anyway, just because he inadvertently received care from a provider, such as a lab technician or physician, who was out-of-network.

Surprise medical bill are especially common in emergency rooms and surgical theaters. Often, a patient will go in for a procedure with an in-network surgeon at in-network hospital, but then wake up from anesthesia to discover that, at some point, an out-of-network physician had popped into the room to provide a consultation or help with the surgery. And when that happens? Boom: the patient receives an out-of-network bill.

The whole problem of "surprise medical bills" arises from the convoluted way that medical billing works in this country. As it is, an insurance company, like Emblem or Blue Cross Blue Shield, negotiates a set of repayment rates with hospitals and medical providers, which they then list as "in network." If a hospital or physicians group refuses to accept the insurance company's repayment rates—often because they're too low—then those providers are listed as "out-of-network."

But here's where it gets complicated. Often times, an insurance company will successfully negotiate with a *hospital*, but the hospital will then turn around and sign a sole contract with a group of, say, anesthesiologists or surgeons, who do not accept that same type of insurance.

That puts the patient in the awkward middle. A patient's insurance covers all in-network costs after the patient reaches his deductible, but meanwhile, the patient himself is receiving bills from any and every out-of-network provider that contributed to his care. In many cases, insurance plans pay just a small percentage of such out-of-network bills, or nothing at all.

Obamacare was supposed to fix these sorts of problems, and the 2010 law does go part of the way there. But it leaves open two big loopholes.

The first has to do with emergency medical care. Under Obamacare, Americans don't have to worry about whether the nearest hospital is in-network or out-of-network. During medical emergencies, insurance companies are required to bill patients as if the hospital where they end up is in-network, even if it's not. That means that if a patient usually pays a 20% co-pay for care at an in-network facility and 80% for care at an out-of-network facility, the insurers must abide by the 20% in-network co-pay.

That's a huge step in the right direction, but it still leaves patients wide open to surprise bills. After all, there's nothing stopping any out-of-network medical provider at that hospital, including emergency room doctors, from sending patients a separate bill later, charging them for whatever their insurance company didn't cover. That's what happened to Elfrank-Dana.

The second issue has to do with the total amount that patients can be charged out-of-pocket. Under Obamacare, insurers are required to cap out-of-pocket payments at $6,850 (and $13,700 for families). Again, that's progress. But those caps only include in-network care. If a patient like Elfrank-Dana reaches the $6,850 cap, but then receives $80,000 in surprise, out-of-network bills, after leaving the hospital, then, well, he's out of luck.

The big question on most people's mind is who's to blame. And the answer is a political hot potato: if you pass a law that prohibits saddling patients with "surprise bills," then someone else is going to be on the hook. And that someone else will be one of the three most powerful players in the American medical industry: insurance companies, hospitals and the physicians lobby. None of them want to be left holding the bag.

Jay Kaplan, the president of the American College of Emergency Physicians, says his heart goes out to patients, who he and his association work with on a person-to-person basis. "We want patients out of the middle as much as everybody does," he told TIME recently. He puts the onus on insurers to offer higher reimbursement rates, in order to include more providers in-network. "Insurance companies use their own black box database to determine how much they're going to repay physicians," he says, and often times, those reimbursement rates are just not enough for doctors to accept them.

Tom Nickels, an executive vice president of the American Hospital Association, agrees: it should be the insurance companies that pay more, expand their networks, and eliminate the problem.

Insurance companies, meanwhile, say that's not realistic. Insurers already offer medical providers reimbursement rates that are as high as possible, while keeping costs for consumers—you, me, our employers—are low as possible, said Clare Krusing, who represents America's Health Insurance Plans. If insurers began paying doctors and hospitals as much as they asked for, insurance premiums would spike.

"Providers that choose not to participate in a network plan have a variety of reasons, the main one being that they want to charge higher rates for their services," Krusing told TIME. "When you have a pricing structure like that that, patients are being asked to write a blank check."

According to the 2015 Medscape survey, the average compensation for $284,000 for specialists and $195,000 for primacy care doctors. Average salaries have increased modestly but consistently since the passage of Obamacare in 2010. Emergency room physicians made a mean salary of$306,000 in 2015, up from $270,000 in 2013.

A year after his accident, Elfrank-Dana says his billing saga continues. His insurance company and the surgeon at the New Jersey hospital eventually reached a settlement totaling about $56,000, but he's still on the hook for roughly $50,000 more for both the hospital bill and the anesthesiologist. He recently got help from a consumer rights advocate and a billing secretary at a New York-based hospital, both of whom are "coaching him," he says, on how to fight the charges. Despite two brain surgeries, Elfrank-Dana said that by last September, he started firing off one letter a day.

"It's so hard figuring out who's the bad guy," he added. "I know some people who take out a second mortgage to pay for these kinds of bills. For me, if I paid these bills, it would deplete my college savings for my kids. And I was saving for half of state school tuition for three kids. That's the opportunity cost here. It makes me all the more indignant."

5 Websites Every Retiree Needs to Visit

Most of the retirement planning information you need is now online.

By Emily Brandon March 11, 2016

Internet-savvy baby boomers have an advantage when it comes to preparing for retirement. Much of the retirement planning information you need is now available online. You can even sign up for Social Security and Medicare from your home computer, at a time that's convenient for you. There are also several useful websites that can help you make important decisions about the timing and selection of your benefits. You will be able to get the services you need more easily if you familiarize yourself with these websites.

1. Create a My Social Security account. *www.ssa.gov/myaccount*. There's no need to wait for a paper Social Security statement in the mail. You can view your Social Security statement online at any time. This important document includes your earnings history, taxes paid and a personalized estimate of your future Social Security benefit if you sign up at various ages. You can also find out how much you will be eligible for if you become disabled and what your family members might receive if you pass away. The Social Security Administration recommends signing in at least once per year to check the accuracy of your statement.

2. Apply for Social Security benefits. *www.ssa.gov/retire/apply.html*. There are no lines or wait times when you sign up for Social Security benefits online. You can start and stop your application at your leisure and submit your claim for payments without leaving your house. You need to be at least 61 years and 9 months old to apply for retirement benefits online, and can elect to begin your payments up to four months in the future.

3. Apply for Medicare. *www.ssa.gov/medicare/apply.html*. This website allows you to sign up for Medicare online, while continuing to delay claiming Social Security until later. Applying for benefits from home saves a trip to the Social Security office and makes it easy to gather the paperwork and fill out the application at your convenience. Eligibility to sign up for Medicare online begins at 64 years and 9 months. This tool is aimed at people who want to begin Medicare coverage while continuing to delay claiming Social Security in order to get higher Social Security payments later on in retirement.

4. Medicare plan finder. *www.medicare.gov/find-a-plan*. This website provides extensive information about the costs and coverage of every Medicare Part D plan that is available in your area. Medicare Part D plans are allowed to change their premiums, covered medications and the cost-sharing requirements for each drug every year. Retirees with Medicare Part D plans should use the Medicare Plan Finder annually to make sure that the medications they need will continue to be covered at the best possible price. You can switch Medicare Part D plans once per year during the annual enrollment period from October 15 to December 7.

5. Health care exchanges. *www.healthcare.gov*. If you want to retire before you are eligible for Medicare, you should take a look at the health insurance offered through your state's health insurance exchange. Each state offers

a variety of coverage options and subsidies to help pay for them if you qualify. These plans are not allowed to reject you or charge you more because of any pre-existing medical conditions.

3 Times It Doesn't Matter If You Use a Chip Card

credit.com

By Constance Brinkley-Badgett March 14, 2016

EMV chip cards made their debut in the U.S. last fall, and some retailers are still struggling to get the technology implemented in their stores.

The switch from magnetic-stripe cards has meant not just new cards, but new payment processes, as well, which some folks have found frustrating. While the transition hasn't been easy for some businesses and consumers, it means greater protection against fraud for a wide range of transactions.

Unlike the old magnetic-stripe cards, EMV chip cards create a unique transaction code that cannot be used again. For example, if a hacker stole the chip information from one specific transaction, it wouldn't be usable again.

"Issuers do not want their cards to be used at point of sale with a magnetic stripe anymore, as the stripe is highly susceptible to compromise, where chip-based transactions are not," Seth Ruden, a senior fraud consultant with Florida-based ACI Worldwide, said in an email.

While EMV technology doesn't prevent data breaches from occurring, it can make it much harder for criminals, except in circumstances where the chip's encryption capabilities aren't used. Here are three scenarios where using a chip card won't make your transaction any safer.

1. Online & Over the Phone

Buying some new shoes online? Ordering flowers over the phone from the local florist for your aunt's birthday? These "card-not-present transactions" mean your debit or credit card details, most often including not just your name and card number, but also the three-digit CVV code, must be shared in full. The EMV chip card's encryption is completely bypassed in these cases, and a chip card is no more or less safe than a non-chip card.

2. At Retailers Still Using Swipe Machines

While businesses that accept credit and debit cards could face increased liability for fraudulent transactions conducted with stolen cards or data if they don't have EMV readers in place, there's no law mandating that they actually have them. So, if you're purchasing something at a store that still requires you to swipe your card, any additional protections offered by the chip aren't doing you or the merchant (or the card issuer) any good.

"Anything that is magnetic stripe based is holding back the security efforts, and exposing the bank, merchant and the cardholder to prolonged risk-exposure during this transition period," Ruden said in an email.

3. When Your Card Is Carbon Copied (Old-School Style)

Remember the old manual credit card imprinters? The merchant lays your card in the little slot, places the carbon copy receipt on top then pushes the imprinter handle over it, making that satisfying "ka-chunk" sound?

Or how about when the delivery guy runs that same carbon copy receipt over your card and runs his pen across it?

If you're getting a delivery, or if you're at a merchant who is experiencing a power loss or other digital failure, your chip card isn't going to make a bit of difference in protecting the transaction from possible fraud. There are now pieces of paper with your card details on it that can be lost or stolen.

One of the best things you can do to protect yourself from stolen credit card information is to regularly check your account statements for signs of fraud. You can also spot possible fraud through sudden, unexpected changes in your credit score. You can keep track of that by getting your free credit report summary, which is updated every month on Credit.com and includes two of your credit scores. As soon as you identity something suspicious, act quickly to minimize the damage.

Can You Really Make A Huge Salary Without A Job?

By Alexandra Blackshaw | Smarter Web Life March 2016

How Would You Like To Quit Your Job and Make Money Without One?

Surely many of you have taken notice of all the media coverage surrounding the new buzz sweeping the US. If you haven't, this may be the best thing you read all year. Basically ordinary people of all ages are reporting to be making money from home using a simple formula from a free blog.

Because you don't need any previous experience, people all across the globe are now trying it for themselves to see if they can join the trend of earning money online. In many cases, they're even quitting their jobs too!

So how has all of this come about? The simple answer is, more and more people like the freedom of working from home and choosing flexible hours to earn more money than a regular job. Thanks to a new automated piece of technology called SiteBlog anybody can start making money fairly quickly with no skills required. It's so easy, everyone from school children to grandparents are now starting to use the system and having some fantastic success.

Thousands Of People Making Money With New Craze!

So we know that making a blog is now easy, but how do you actually make money from it?

There are many ways you can profit from owning a blog. We all know about the semi-famous millionaire bloggers but these guys are a rare breed. You have to set your goals more realistically, so we recommend aiming to earn around $3000 – $6000 /month. This is not one of those scams which claim you will earn money on autopilot, this is nothing like that.

This is a legitimate, proven way to setup a blog live on the internet, which you can earn an income from advertising on the blog. In order to earn any money from a blog, you must be prepared to post at least one 400 word blog per week.

We suggest you aim to earn $3000 – $6000 /month…

Companies like Google & Amazon allow you to add their advertising to your blog with just a few clicks thanks to the easy to use drag and drop system SiteBlog utilizes.

SiteBlog is not something which you turn on, go to bed and have made millions overnight. Anything which claims to be able to do this is a scam and does not exist. SiteBlog is a real system and you must write blog posts

weekly in order to earn a steady additional income. You will probably NOT make money in your first 2 weeks at least. It's expected to take you at least 5 blog posts and a month to get your blog established on the internet.

There is some bad news though. Due to the extremely high demand the special promotion is only available until **March 17, 2016**, so we urge you to act fast to avoid disappointment.

5 things NOT to buy at Lowe's and Home Depot

By Catey Hill March 15, 2016

Shoppers assume that large home improvement stores like Lowe's (LOW) and Home Depot (HD) have the best prices — and they're often right — but not always.

"In general, the big stores that specialize in home improvement are great resources to save a lot of money on big-ticket items for the home, especially major appliances, lawn and garden equipment and home repair/remodeling products," says Brent Shelton, a spokesperson for FatWallet.com. Plus, he adds, the salespeople have specialty knowledge, there is a large selection of home improvement items, and these stores' seasonal prices on many items are often nearly unbeatable, even when comparing them to low-cost, big-box stores like Walmart (WMT) and Target (TGT) and online sites like Amazon (AMZN) .

Furthermore, savvy shoppers can get even deeper savings with a little legwork. Both Home Depot and Lowe's have sections of their sites where they list products offering rebates — some saving you hundreds of dollars — and discounts. Plus, carrying a store card (if you're careful and pay your bill in full and on-time) can yield savings. Lowe's, for example, has a card offering shoppers 5% off purchases and both stores have cards with 0% financing options, which, can be especially helpful for big-ticket items you need a few months to pay off, assuming you pay the card before that period is up.

And if you're willing to do research on competitor's prices and deal with customer service at the store, both Lowe's and Home Depot offer a price match guarantee that's among the most competitive in the retail industry. Both say they will beat a local competitor's prices by 10% if you bring in the local competitor's current ad, though there is a long list of exclusions to this policy. At Home Depot, for example, it will not beat an online price from a competitor by 10% and the store notes that this offer excludes special orders, bid pricing, volume discounts, open-box merchandise, labor and installation, sales tax, rebate and free offers and more. (Home Depot and Lowe's have not responded to our request for comment.)

But don't just assume big home improvement stores are your best bet. For one, your local hardware store will sometimes price match if you ask them to, and they may carry a discount line of goods that competes with those at a large home improvement store, says Shelton. Plus, the service at your local store may feel more personal.

And, the asking prices at home-improvement stores aren't always great deals. Here are five things that experts say you may be better off buying elsewhere:

Cleaning supplies

While it's tempting to impulse-purchase cleaning supplies while you're picking up new paint and some nails at a home improvement store, experts say you should proceed with caution. You could pay 5% to 10% more for brand-name cleaning products at a home improvement store versus a store like Target or Walmart. Plus, she adds, the big-box stores often have even cheaper generic alternatives.

MarketWatch's search of online prices for some cleaning items on Monday showed this trend to be true in some cases. A gallon of Simple Green All-Purpose Cleaner cost nearly $10 on both Lowe's and Home Depot's sites, while it was less than $8.50 on Walmart.com; a three-pack, 105-count of Clorox wipes cost nearly $7 at Lowe's ,

and wasn't available at Home Depot, while it was on special at Target for less than $5 (and regularly priced at less than $6.

Home decor

"While home decor is certainly related to home improvement, consumers should shop elsewhere for deals on wall art and other decorative items," says Kendal Perez here, a savings expert with CouponSherpa.com, who recommends purchasing these products at shops like TJMaxx (TJX), Ross (ROST) and HomeGoods. Among the examples Perez found: A roughly 18x18 framed piece of art titled the "Puffball Floral A" was priced at roughly $31 at Home Depot, compared to Kmart's (SHLD) price of $22.49 for the same piece. Adds Shelton: "Rugs, furniture, picture frames, wall art, etc. are limited and often cheap in quality but not cheap in price unless on clearance at home improvement stores, and tend to be basic, and limited for style selection, as well."

Small appliances

While there are sales at home-improvement stores that can give you great deals on small appliances, you may be better off getting the item at a warehouse club like Costco(COST) or Sam's, says Coupons.com savings expert, Jeanette Pavini, who also writes for MarketWatch. "Around the holidays, warehouse clubs typically stock more small appliances and prices are extremely competitive," she says. (Though, buyers beware: Warehouse clubs don't always have the best selection at any given time on these items). You may also often find good deals at big-box stores and online, Shelton says.

A couple of examples: On Monday, at Costco online, the Danby 0.7 cubic-foot stainless steel microwave was priced at $49.99, while it was $60.77 on Home Depot's site; at Lowe's the Kitchenaid 9-cup food processor in contour silver costs $179.99 but on Amazon it is only $143.68 (interestingly, the fire engine red version of this product is the same price on both sites).

Grilling accessories

Often, "grill accessories are better priced at TJMaxx and HomeGoods compared to Home Depot and Lowe's, and Amazon also beats their prices in some cases," says Perez. For example, a Chef Buddy 20-Piece Stainless Steel Grill Tool Set with Case was priced at $35.22 from Home Depot on Monday, compared to $24.95 from Amazon; a Blackstone 6-Piece Grilling Tool Set was priced at $29.99 from Lowe's, compared to $29.46 from Amazon.

Batteries

Home improvement stores often make it simple to grab a box or two of batteries, but beware: You may be able to find better deals elsewhere, experts say. In fact, "the best place to buy batteries is at a warehouse store like Costco," says Woroch. "Otherwise, Walmart is your next best option if you're in a pinch."

Marketwatch found evidence to support that: While Costco was selling a 40-battery, 2-pack of AA Duracells for $14.99 (less than 38 cents per battery), Home Depot's battery offerings for Duracell AA were limited to a 10-pack selling at $7.98 (nearly 80 cents per battery) and Lowe's was selling a 24-pack for $12.47 (nearly 52 cents per battery).

Three Changes Consumers Can Expect In Next Year's Obamacare Coverage

By **Julie Appleby** March 15, 2016

Health insurance isn't simple. Neither are government regulations. Put the two together and things can get confusing fast.

So it's not surprising that federal regulators took a stab at making things a bit more straightforward for consumers in new rules unveiled in late February and published Tuesday in the Federal Register. Because those rules are part of a 530-page, dizzying array of changes set for next year and beyond, here are three specific changes finalized by the Department of Health and Human Services that affect consumers who buy their own health insurance in one of the 38 states using the online federal insurance exchange.

1) Consumers could have access to more information about the size of the insurers' network of doctors and hospitals.

Most consumers care about two things: the cost of the plan and whether their doctor or hospital is in the plan's network. The new rules would require insurers to give consumers 30-days' notice when a provider is being removed from the network. They must also continue to provide coverage for that provider for up to 90 days for patients in active treatment, such as those getting chemotherapy or for women in the later stages of pregnancy — unless the provider is being dropped for cause. Consumers will also see another change: The relative breadth of each plan's network will be noted with three size designations, which are roughly equal to basic, standard and broad.

2) Consumers could be given slightly more warning about "surprise" medical bills from out-of-network providers.

One of the most common complaints from consumers — even before the federal health law passed — concerns bills they get from out-of-network providers. Such bills can hit consumers even when they go to facilities that are in an insurer's network because not all of the doctors and other medical staff in those facilities are part of the network. The new rules make a small change, requiring that amounts paid by consumers for ancillary care — such as anesthesiology or radiology — count toward their annual out-of-pocket maximum. That's important because once a patient hits that out-of-pocket maximum, the insurer is responsible for all in-network medical costs for the rest of the year. But the new rule only applies in cases where the insurer hasn't warned patients — generally at least 48 hours before the hospitalization or procedure — that they might receive care and bills from such out-of-network providers. Consumer advocates say insurers will simply issue form letters to as many

patients as they can to avoid the rule, while insurers complain the rule doesn't get at the heart of the matter: the high charges they say are set by out-of-network providers.

3) Consumers' out-of-pocket costs could be more standardized.

This provision could be the rule's most substantive change. Regulators are requesting that next year insurers voluntarily offer plans with a standard set of coverage costs — from deductibles to copayments for drugs or doctor visits.

The new rules aim to make comparison shopping easier. The change also gives a nod to a cost hurdle that may keep some consumers from enrolling: having to pay hundreds if not thousands of dollars in deductibles before some common services are covered. To entice those consumers, federal regulators created six standard plans that include specific flat-dollar copayments for urgent care visits, most prescription drugs, primary care, mental health and substance abuse treatment — without the consumer first having to spend money to meet an annual deductible. "Insurers will have to compete head-to-head providing the same benefit package, one that most consumers will find fairly attractive," said Tim Jost, a consumer representative to the National Association of Insurance Commissioners and former law professor who writes widely on the health law.

Still, the standard copayments in plans will likely seem high for some consumers. For example, the bronze plan standard design sets a $45 copayment for a primary care visit and $35 for a generic drug prescription. Copayments are smaller in the standardized silver plans, which set a $30 flat rate for a primary care visit, $65 for a specialist, $15 for generic drugs, $50 for brand name products and 40 percent of the total cost for the most expensive type of drugs, deemed "specialty drugs." Those amounts are slightly higher than the average costs in silver-level plans sold this year, according to an analysis by consulting firm Avalere.

Insurers opposed the idea of standardized plans, saying they could stifle innovation, lead to higher premiums and make it less likely they will be able to create plans that appeal to a broad variety of consumers. Still, a handful of states, including California, Connecticut, Massachusetts, New York, Oregon, Vermont and the District of Columbia, have designed standardized plans that all insurers in the state marketplace are required to sell. But, because this part of the regulation is voluntary — meaning the federal government is requesting rather than compelling insurers to make these changes — it is unclear how much impact it will have on consumers and the marketplace.

So, in the next open enrollment period, consumers could see such standardized plans available in addition to the varied policies currently sold, which can have widely different payment packages. For example, one plan may have a lower deductible but higher out-of-pocket costs for doctor visits, while another might exclude certain office visits from the annual deductible, while a different option does not. Such variations have provided choice for consumers but also made comparing and contrasting plans difficult.

Meanwhile, HHS also finalized its annual increase in the cap on how much consumers can be charged out of pocket annually for such things as deductibles and copayments. The rule applies to those who buy their own coverage and many employers plans. Next year the cap will be $7,150 for an individual or $14,300 for family coverage.

Obama proposal to revamp Medicare Part B faces more opposition

By ED SILVERMAN @Pharmalot MARCH 17, 2016

Just days after the Obama administration unveiled an experiment torevamp the Medicare Part B program, more than 300 hundred groups representing physicians, drug makers, and patients are urging the government to withdraw its proposal.

Although some details must still be worked out, the administration wants to encourage greater use of lower-cost, but equally effective treatments. The Part B program covers injectable and infused medications for the elderly. The government also maintains its plan will be budget-neutral, or will not cost additional money.

The move reflects growing concern over the rising cost of medications, a hot-button topic that is straining payer budgets and angering Americans. The administration hopes to lower its drug spending by reducing reimbursement fees for physicians.

But the groups, some of which tried to persuade the administration not to proceed with its plan and complained the process was not transparent, argued that patients will be harmed.

The initiative is “misguided and ill-considered” and will “adversely affect the care and treatment of Medicare patients with complex conditions,” such as cancer, macular degeneration, and rheumatoid arthritis, the groups wrote in a letter today to US Senate and House leaders.

“These vulnerable Medicare patients and the providers who care for them already face significant complexities in their care and treatment options, and they should not face mandatory participation in an initiative that may force them to switch from their most appropriate treatment,” they added.

Under the Part B program, doctors, and hospitals buy a medicine, and the government reimburses the average sales price plus 6 percent. But the experiment, which would run five years starting this fall, would pay physicians the average sales price, as well as another 2.5 percent and a flat fee of $16.80.

A lot of dollars are at stake. Not surprisingly, many physicians are upset and argue that the experiment will unfairly hurt their practices while doing nothing to lower drug costs. And drug makers oppose the effort over concerns that their revenue will take a hit.

Among the organizations that signed the letter are the National Cancer Care Alliance, the Prevent Cancer Foundation, and Rush to Live. Several drug industry trade groups and numerous medical societies also signed on. We should note that some patient groups listed receive industry funding.

But the proposal has won praise from consumer advocates that argue the current reimbursement system provides an incentive for doctors to prescribe more expensive treatments. The math differ depending upon drugs being compared, but physician behavior is expected to change.

“We don’t like to think reimbursement plays a role in prescribing decisions, but there’s research out there that says it does,” said Maura Calsyn, director of health policy at the Center for American Progress. “If you change those incentives, you might change the decisions.”

Not everyone is convinced, however, that the experiment will work. One reason is that the government plans to focus on certain zip codes, but large oncology practices that operate multiple locations may be able to shift some patient to other offices and escape the lower reimbursement rate.

The government has not "accounted for behavioral and treatment changes that could occur," wrote Adam Fein of Pembroke Consulting, who tracks drug distribution, on his blog. "These marketplace realities will undermine the … ability to draw accurate conclusions" from the experiment.

Whether the opposition will derail or alter the effort remains to be seen. At the time the experiment was announced last week, a 60-day window opened for submitting comments. Already, though, some lawmakers are objecting.

In a brief statement last week, Kevin Brady (R-Texas), who chairs the House Ways and Means Committee; Fred Upton (R-Mich.), who heads the House Energy and Commerce Committee; and Orrin Hatch (R-Utah), the Senate Finance Committee chairman, expressed anger over the proposal.

"This decision was made with a complete lack of transparency and clear disregard for the people and stakeholders who will be impacted the most," they said. "The model could ultimately result in seniors receiving different standards of care based solely on where they live in the country."

7 tips for slashing your cable bill from guys who do it for a living

Money By Kerri Anne Renzulli March 2016

Stop paying more than you have to for cable.

Everyone hates dealing with their cable companies and arguing about the inevitable rate hike every year. Even though we know we're probably shelling out too much, the thought of waiting on hold for an hour, dealing with unhelpful customer service reps, and navigating the mind-boggling array of options, add-ons, and upgrades keeps us overpaying paying month after month (or looking to cut the cord all together).

We hate negotiating so much, in fact, that more than a few companies have sprung up offering to take on the odious task for us—for a fee, of course. One such company out of Nashville, BillFixers, works to pry cash out of the purses of big cable and cell phone providers like Comcast and Verizon and put it back in the hands of the consumer, provided they get to keep 50% of the savings you'll see in the first year.

After assisting 1,500 clients to reduce their costs, Bill fixer's founders, brothers Julian and Ben Kurland, have amassed a wealth of knowledge about the tricks companies use to keep your rates high and the easiest ways to haggle them down. Below are seven of their top deal-snagging tips.

1. Know the lowest going rate. Before calling, you need to know the cheapest price for your services or package. Without this little bit of homework, you won't be able to recognize whether you're getting the best deal possible. "This is the biggest tip we could give," Ben Kurland says. "Go online and search for what your rate would be if you were a new customer in your area. That's the gold standard." If you're already a subscriber, the company's website may only display existing customer rates. Get around this by searching through an incognito window on your browser.

If you have competing providers in your area, check their prices online and, if you still want to remain with your carrier, use the information as leverage to bring your current rate down.

2. Go straight to the cancellations department. "The best deals come from staff with the retention/cancellation department. Reps there have access to the best options," Julian Kurland says. Someone who works in the billing department may not be authorized to make the same offers. Opt for the "Cancel My Service" selection on your provider's call center directory and "start the negotiation high," Kurland advises. "Say you're going to leave." He notes that the cancellation department is the most likely hub to remain in house and not be outsourced to another country, which may give representatives additional leeway.

3. Be persistent. Julian Kurland says it typically takes Billfixers between one and three hours on the phone to get the best price. Why so long? "You can't just make one call. We make three to five calls, typically. It's such a gamble whether you get a helpful service representative or not." Adds his brother, "You have to find the right person—someone who wants to help and isn't going to give you the runaround."

4. Don't lose your cool. It's easy to let your frustration at being transferred five times or waiting an hour to speak with a human carry over into your conversation with the representative, but as that classic adage states, you'll catch more flies with honey than vinegar. Rein in your anger and try to be as friendly as possible. "Customer service reps get yelled at all day. It's a nice surprise for them to be treated nicely," Ben Kurland says. "They hold all the power, so being courteous only increases the likelihood they'll want to help you."

5. Skip the freebies. Cable companies try to appease cranky customers by offering HBO or other premium channels free for a period of time, typically six months. If you're not interested, ask instead for free service upgrades, like faster Internet speeds. Just be careful when accepting any deal. These promo offers are set up to expire, so you have to remember to call back and cancel when time is up, or you'll end up paying for that extra. "There are no free freebies when dealing with a cable company," Julian Kurland says.

6. Ask for an extra break. Depending on the company, customer service reps may be able to offer you a break in the form of a one-time credit. Don't be afraid to ask for one, even after you've already lowered your monthly price.

7. Don't take their word for it. Once you have a firm offer, write down your new prices and contract terms, Julian Kurland says. Then call back and verify that your account accurately reflects the price you were quoted earlier. "You want to make sure that the customer service rep entered the right notes into the system," he explains. "If they made a mistake, you won't know until the next billing cycle, and then you could be on the hook for that payment amount and have to negotiate terms all over again." the size of the check."