Health & Retirement Services Of Illinois

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OUR NEWS LETTER

Delay In Obamacare Law Provision Raises Doubts At Critical Stage Of Rollout

Obama's administration decided Tuesday to postpone for a year the requirement for employers with at least 50 workers to offer health coverage.

By Jay Hancock and Julie Appleby July 03, 2013

Obamacare pamphlet at a Tea Party rally in Littleton

JESSICA RINALDI / REUTERS

The Obama administration's decision Tuesday to delay a major component of the Affordable Care Act — the requirement for employers with at least 50 workers to offer health coverage — postpones another feature of the law and hands ammunition to critics who contend it is unworkable.

But it could have a relatively small effect on the number of Americans who gain medical insurance next year. The law's other two major provisions, expanding Medicaid and requiring individuals to obtain coverage or pay a penalty, were projected to add far more people to the ranks of the insured than the employer mandate, according to the nonpartisan Congressional Budget Office. Those measures are still in effect, although many states have opted not to expand Medicaid next year.

Still, Tuesday's announcement could mean a drop in revenue for the Treasury. The CBO estimated about $10 billion in employer penalties would be collected in 2015, some of that presumably from employers who chose not to offer coverage in 2014.

The CBO also estimated that the health law would have little or no effect on job-based coverage the first year.

In Our Newsletter

“The large majority of employers already offer health coverage to their workers,” said Larry Levitt, a senior vice president at the Kaiser Family Foundation. “No one thought that the employer requirement was going to meaningfully change that.” (Kaiser Health News is an editorially independent program of the foundation.)

But other analysts said the delay could cause more workers to lose their health care coverage.

“The policy implications are fairly straightforward. Essentially for calendar 2014 the act of dropping coverage and dumping employees into the exchanges is on sale,” said Douglas Holtz-Eakin, former director of the Congressional Budget Office and now president of the American Action Forum. “Drop and dump, but no penalty.”

Workers hoping the law would compel their employer to start offering a medical policy next year may still be eligible to buy subsidized coverage directly from insurers through online marketplaces. Those exchanges will still be open for enrollment Oct. 1, the administration said.

For larger employers, the delay provides more time to work through complicated regulations issued by the Internal Revenue Service and the Department of Health and Human Services.

“The IRS has been good about putting out information, but it’s an enormous task to get it up and running, even with guidance,” said J.D. Piro, who heads the health law group at benefits consultant Aon Hewitt. The announcement, he said, “gives employers a lot more time to ask these questions and get their systems in place.

Of particular concern were rules determining which companies and workers are subject to the employer mandate. The definitions of what constitutes a 50-employee firm and who qualifies as a full-time staffer who is owed coverage were subject to considerable debate and analysis.

“I’m amazed at how the employers I’ve talked to have been struggling with how to react to the employer requirement,” Levitt said. “Even very large companies might have different definitions for part-time workers than what’s in the law.”

Some employers have reportedly been downsizing, increasing hires of temporary workers and cutting hours in an effort to avoid coverage requirements. Others have shifted to self-insured status — in which the company pays the medical bills directly — to avoid benefit requirements and taxes applying to insurance plans.

The announcement does not affect the ACA’s essential health benefits required to be offered by small employers. Companies with fewer than 50 workers aren’t obliged to offer coverage under the ACA. But if they do, and they aren’t among a minority of older, “grandfathered” plans, then they must offer minimum benefits with new price regulations that could drive up premiums.

“A lot of these small employers are thinking of dropping coverage because it is being priced much higher,” said Robert Laszewski, an industry consultant and former insurance executive. “Which begs the question: Why are large employers getting a pass for a year (from the coverage requirement) and small employers are not?”

Analysts said there also may be problems determining eligibility for insurance subsidies in the form of tax credits.

“If employers have no obligation to report coverage, how will the exchanges or the IRS verify claims that coverage is unaffordable or inadequate?” said Timothy Jost, a law professor at Washington and Lee School of Law. “Could this potentially mean that many more individuals will become eligible for premium tax credits, either because their employers drop or do not expand coverage, or fail to respond to requests to verify coverage?”

This is not the first setback for the health act as signed by President Barack Obama in 2010. Last year the Supreme Court allowed states to opt out of the requirement to expand Medicaid. So far, 23 states and the District of Columbia have elected to expand Medicaid, substantially reducing the number of people expected to gain coverage next year.

The administration also delayed a provision that would allow employees of small businesses to select from two or more health plans through an online marketplace. The administration says the small business exchanges, which offer tax credits to qualifying companies, are still on schedule, although without the shopping feature.

In Addition To Premium Credits, Health Law Offers Some Consumers Help Paying Deductibles And Co-Pays

By Michelle Andrews | Kaiser Health News,

When people talk about health insurance affordability, they typically focus on premiums, the sticker price for a policy. For the plans being sold through the online health insurance marketplaces next year, much of the discussion has been on tax credits that can reduce the monthly premium for people with incomes up to 400 percent of the federal poverty level ($94,200 for a family of four in 2013).

But the Affordable Care Act also established another type of financial assistance for people who buy plans on the marketplaces, also known as exchanges. Cost-sharing subsidies can substantially reduce the deductibles, copayments, coinsurance and total out-of-pocket spending limits for people with incomes up to 250 percent of the federal poverty level ($58,875 for a family of four in 2013). Those reductions could be an important consideration for lower-income consumers when choosing their coverage.

“Particularly for people who have to utilize a high amount of services, the reduction in total out-of-pocket costs” can be important, says Dana Dzwonkowski, an expert on ACA implementation at the American Cancer Society’s Cancer Action Network.

Cost-sharing reductions will be applied automatically for consumers who qualify based on their income, but only if they buy a silver-level plan, considered the benchmark under the law.

Silver plans are one of the four categories that will be sold on the exchanges, each named for a precious metal. Premiums for the plans will vary, and each will offer a different level of cost sharing for the consumer through deductibles and copayments, among other things. A silver plan will generally pay 70 percent of covered medical expenses, leaving the consumer responsible for 30 percent.

The insurer will typically cover 60 percent of expenses in a bronze plan, 80 percent in a gold plan and 90 percent in a platinum plan. All exchange plans will offer a similar package of comprehensive services that cover 10 so-called essential health benefits and cover certain types of preventive care at 100 percent.

The federal cost-sharing subsidies essentially increase the insurance company's share of covered benefits, resulting in reduced out-of-pocket spending for lower-income consumers. A family of four whose income is between 100 and 150 percent of the federal poverty level ($23,550 to $35,325) will be responsible for paying 6 percent of covered expenses out-of-pocket compared with the 30 percent that a family not getting subsidized coverage would owe in a silver plan. A family with an income between 150 and 200 percent of the poverty level ($35,325 to $47,100) will be responsible for 13 percent of expenses, and one with an income between 200 and 250 percent of the poverty level will be responsible for 27 percent ($47,100 to $58,875).

In addition, people who earn 250 percent of the federal poverty level or less will also have their maximum out-of-pocket spending capped at lower levels than will be the case for others who buy plans on the exchange. In 2014, the out-of-pocket limits for most plans will be $6,350 for an individual and $12,700 for a family. But people who qualify for cost-sharing subsidies will see their maximum out-of-pocket spending capped at $2,250 or $4,500 for single or family coverage, respectively, if their incomes are less than 200 percent of the poverty level, and $5,200 or $10,400 if their incomes are between 200 and 250 percent of poverty.

Insurers have some flexibility in how they structure their plans to meet cost-sharing reductions. But in states that will require plans to standardize deductibles, copayments and coinsurance amounts, it's possible to see how out-of-pocket costs may vary.

In California, for example, a standard silver plan will have a $2,000 deductible, a $6,400 maximum out-of-pocket limit and a $45 copayment for a primary care office visit. Someone whose income is between 150 and 200 of the poverty level, on the other hand, will have a silver plan with a $500 deductible, a $2,250 maximum out-of-pocket limit and $15 copays for primary care doctor visits.

Healthy people might be inclined to go with an exchange bronze plan or the catastrophic plan (a high-deductible plan available only to people under age 30 that will have lower premiums than a silver plan), figuring they won't need the cost-sharing assistance.

"It's an individual calculation," says Jennifer Tolbert, director of state health reform at the Kaiser Family Foundation. (KHN is an editorially independent program of the foundation.)

However, she says, services that aren't preventive in nature may be subject to a much higher deductible than in a silver plan--$5,000 in the case of the California bronze plan--and could result in significant cost sharing.

"And remember, those people are going to be getting pretty significant premium tax credits for the silver plan, which will bring the cost of premiums down quite a bit," she says.

Consumers should keep in mind, though, the cost-sharing subsidies apply to in-network expenses only. That may become an issue in some plans with limited provider networks.

"In the exchanges, a lot of insurers are going to narrower networks as a way to keep costs down," says Christine Monahan, a senior health policy analyst at Georgetown University's Center on Health Insurance Reforms. "If you go out of network, you could be subject to higher cost sharing and balance billing."

Hospitals' grab for docs might be an expensive habit

Jul 9, 2013

In Cincinnati, the major health systems have hired hundreds of physicians in the last few years, making independent family practitioners or internists hard to find.

James Ritchie Staff Reporter- *Cincinnati Business Courier*

So much for economies of scale. Rather than saving money, hospital purchases of physician practices might be driving up health care costs, a survey has found.

About 32 percent of respondents to an American College of Physician Executives poll said costs increased after a hospital or health system bought a doctors' group, according to a press release. Only 5 percent said costs went down, while 16 percent said costs stayed the same. The remainder were unsure or said the question didn't apply to their organization.

Hospital employment for doctors is becoming the standard, especially in primary care, as Obamacare takes effect. In Cincinnati, the major health systems have hired hundreds of physicians in the last few years, making independent family practitioners or internists hard to find.

Hospital leaders say they can more effectively comply with quality-of-care standards and manage the health of populations when they control the MD practices. But the physician networks also ensure a stream of inpatient referrals and give the systems leverage in negotiating insurance reimbursement rates.

"The increasing trend to physician employment and related efforts towards successful physician integration are issues that affect many physicians at ACPE," said Dr. Peter Angood, CEO of the organization. "Understanding the long-term consequences of these trends is important not only to physician leaders but also to the future of health care as a whole."

But some respondents said told ACPE that while costs may increase, integration can bring other benefits.

"Our costs and charges are indeed higher with physician employment than without," said Dr. David McDermott, director of emergency services at Mayo Regional Hospital in Dover-Foxcroft, Maine. "However, in rural Maine,

if there was not hospital employment of physicians, the physicians would not be here. Costs have risen but we now have access."

And some said the math could change as Medicare and private insurers introduce new reimbursement models meant to reward quality of care instead of quantity of services offered.

The poll drew 459 responses from ACPE's 11,000 members.

Walgreen Joins Blue Cross to Promote Health Exchanges

By Alex Wayne - Jul 10, 2013

Walgreen Co. (WAG), the biggest U.S. drugstore chain, agreed to join with the largest federation of health insurers to promote the Affordable Care Act, lending a hand as the Obama administration strains to win over the public.

The Blue Cross Blue Shield Association, comprising 38 state and local health plans including 14 owned by WellPoint Inc. (WLP), said today it will set up an educational website with Walgreen and distribute information in the retailer's 8,000 stores. The campaign is aimed at encouraging people without insurance to use the government exchanges to shop for subsidized health plans.

July 5 (Bloomberg) -- Douglas Holtz-Eakin, president of the American Action Forum and a former Congressional Budget Office director under President George W. Bush, talks about the delay in enforcing the employer mandate of President Barack Obama's health-care law. He speaks with Tom Keene, Adam Johnson and Scarlet Fu on Bloomberg Television's "Surveillance." (Source: Bloomberg)

July 3 (Bloomberg) -- Peter Orszag, vice chairman of investment banking at Citigroup Inc. and former director of the Office of Management and Budget, talks about the Obama administration's delay of the so-called employer mandate in its signature health-care law and its potential impact on the U.S. economy. Orszag speaks with Scarlet Fu and Erik Schatzker on Bloomberg Television's "Market Makers." (Peter Orszag is a Bloomberg View columnist. The opinions expressed are his own. Source: Bloomberg)

The announcement may provide a lift two weeks after theNational Football League threw water on the idea of becoming a partner with the Obama administration, which has struggled to sell the law's benefits amid roadblocks by Republican opponents. The Walgreen-Blue Cross effort would be the largest by private industry to promote the 2010 health-care law.

"There's a lot of confusion, a lot of questions, and it'll take a tremendous collaborative effort to make sure people have the information they need to make informed choices," Brad Fluegel, chief strategy officer for Deerfield, Illinois-based Walgreen, said in a statement.

While the core parts of the law take effect next year, about 4 in 10 people polled by the nonprofit Kaiser Family Foundation in April said they weren't even sure it was still on the books.

The companies didn't disclose financial terms of the partnership.

Health Destination

Chicago-based Blue Cross includes plans that cover about 100 million people in the U.S. Walgreen stores see about 120 million customers a year, Fluegel said today in a phone interview. About 16 percent of Americans were uninsured in 2011, according to Kaiser, and Fluegel said Walgreen believes its customers "are fairly representative of America."

"We are a health destination for a lot of those customers," he said. "We wanted be able to keep them informed, educate them on the changes and what their options are. It's a question people are going to be asking our store personnel, pharmacists, other professionals."

The promotional materials Walgreen distributes won't recommend any specific insurance plan and customers won't be able to enroll in stores, Fluegel said.

Shares Rise

Walgreen gained 3 percent to $47.85 at the close in New York. The company's shares have increased 29 percent this year. WellPoint rose less than 1 percent to $84.75 and has advanced 39 percent this year.

Blue Cross and Blue Shield plans participating in the effort include some that haven't committed to sell policies in their states' exchanges in 2014, said Maureen Sullivan, senior vice president of strategic services at the association.

"They're looking to participate in the future," she said in a phone interview. "Even if they're not playing the first year, they want people to know this is what's happening. It's a commitment to the local community."

The Obama administration has been criticized by opponents and supporters for not doing enough to promote the law. The online exchanges are supposed to be ready Oct. 1 for people to start signing up for insurance that would start Jan. 1.

Hotline Opened

U.S. officials opened a hotline for questions about the law last month and activated a website that outlines its provisions. The administration also has hired the advertising and public relations firm Weber Shandwick to design publicity campaigns for the law, which will begin closer to October, Health and Human Services Secretary Kathleen Sebelius has said.

The government has announced programs totaling about $212 million to promote the law, including grants to federally funded health clinics to hire people who will help patients sign up for insurance. Sebelius' department said today that 1,159 clinics will be awarded grants of at least $59,000, and may enroll as many as 3.7 million people into the health law's insurance expansions.

“We have a robust plan to get the job done,” Sebelius told reporters in a conference call today.

The administration has complained that efforts to do more have been stymied by congressional Republicans, none of whom voted for the health law. Republicans have refused to approve more funding for implementation and they opened an investigation into Sebelius’s urging of corporate support for a nonprofit, Enroll America, that has been handling some promotion.

NFL Talks

Sebelius stumbled again last month when she told reporters she had discussed a partnership with the NFL to promote the law. Senate Republican Leader Mitch McConnell of Kentucky wrote to the NFL on June 28 demanding to know more about the talks. A league spokesman, Greg Aiello, then denied there had been any“substantive” discussions and said there were no plans to help promote the law.

The exchanges will sell insurance online and over the phone from companies such as Indianapolis-based WellPoint. People who lack coverage through their jobs will be eligible for tax credits to help pay monthly premiums if they make less than four times the poverty level -- about $94,000 for a family of four.

The plans begin Jan. 1, when the law requires most Americans to carry insurance. About 7 million people are expected to enroll in exchange plans next year, rising to 25 million by 2018, according to the Congressional Budget Office.

The law also encourages states to expand their Medicaid programs for the poor to cover people earning close to poverty-level wages. About 24 states have refused so far, Sebelius said on June 24.

EATING FRUITS AND VEGETABLES TIED TO LONGER LIFE

A woman looks at fruits and vegetables at a market stall in Madrid (Juan Medina Reuters, REUTERS / July 11, 2013)

Valerie DeBenedetteReuters, *July 11, 2013*

NEW YORK (Reuters Health) - Eating fewer than five servings of fruit and vegetables each day is linked with a higher chance of dying early, according to a large study from Sweden.

People who said they never ate fruit and vegetables died an average of three years sooner than those who ate plenty of apples, carrots and tomatoes, researchers found.

Many public health organizations worldwide recommend eating five servings of fruit and vegetables a day, but previous studies have been inconclusive on whether meeting that guideline helps improve health and by how much, researchers said.

The new study, published in the American Journal of Clinical Nutrition, shows the five-a-day recommendations are optimal, said AlicjaWolk, who worked on the research at the Karolinska Institute in Stockholm.

Her team did not find any improvement in survival for people who ate more than five servings of fruit and vegetables each day, compared to those who just met the guideline.

The results are based on data collected from more than 71,000 Swedes, aged 45 to 83, who were followed for 13 years.

Participants were surveyed about their diets in 1997 and 1998 and reported how often they ate fruit - including oranges, apples, bananas and berries - and vegetables, such as carrots, beets, lettuce, cabbage, tomatoes and pea soup.

Nearly 11,500 of those enrolled had died by December 2010.

Wolk's team found that people who had reported eating no fruit or vegetables at the start of the study were 53 percent more likely to die during the follow-up period than those who got their five daily servings.

Participants who ate at least one serving of fruit daily lived 19 months longer than those who never ate fruit, on average. And those who ate at least three servings of vegetables per day lived 32 months longer than people who reported not eating vegetables.

Fruits and vegetables contain different types of vitamins, and fruit is generally higher in calories, Wolk noted.

Most diet discussions consider them as a combined group, she told Reuters Health. "But when I speak to lay people I actually say, â€˜Eat vegetables more than fruit, but eat both.'"

Women in the study tended to eat more fruit and vegetables than men.

People who said they ate fewer fruits and vegetables were more likely to smoke and tended to be less educated and eat more red meat, high-fat dairy products, sweets and snacks. On the other hand, those who ate a lot of fruit and vegetables tended to take in more calories per day overall than those who did not, Wolk noted.

The study cannot prove that eating fruits and vegetables lengthened lifespans, and there could have been other differences between those who ate produce and those who didn't.

But when the researchers accounted for gender, smoking, exercise, alcohol consumption and body weight, the overall results did not change.

Few very large studies have looked at the effect of eating fruit and vegetables on a person's chance of dying early, according to the study authors.

Those that have showed contradictory results, said Kelly L. Pritchett, a registered dietician from Central Washington University in Ellensburg and a spokesperson for the Academy of Nutrition and Dietetics. Larger studies have suggested there is no clear benefit, but "smaller studies found a stronger decrease in mortality risk," she said.

This study "falls right in line with the recommendations," Pritchett, who wasn't involved in the new research, told Reuters Health.

Still, one weakness of the study, the Karolinska researchers noted, is that diet information was reported by the participants - rather than measured independently - and people may not always report what they eat accurately.

HSAs continue to see growth among patient population

■The accounts paired with high-deductible health plans have increased steadily in the past five years, as employers have tried to control health care costs.

By Sue TerMaatamednews staff— Posted July 15, 2013

About 15.5 million people were covered by health savings accounts/high-deductible health plans as of January — an increase of about 2 million from 2012, according to a June report by America's Health Insurance Plans. Such plans have been on the rise the past five years.

About 11.4 million people were enrolled in 2011, compared with 10 million in 2010, 8 million in 2009 and 6.1 million in 2008, the report said. AHIP has been tracking such plans since they were authorized by the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

The plans are designed to give patients incentives to manage their health care costs by using savings accounts coupled with high-deductible plans. Deductibles in such plans are at least $1,200 for a single person and $2,400 for families.

Under the plans, employers regularly add money to employee health savings accounts. Employees can use this money for medical expenses when they haven't reached their deductible amount. Money unused in a year is rolled over to the next year.

"These plans are giving consumers more control over their health care dollars," said Clare Krusing, an AHIP spokeswoman.

HSA/HDHP plans have not been as popular with some physicians, said Cyril Chang, professor of economics and director of the Methodist Le Bonheur Center for Healthcare Economics at the University of Memphis in Tennessee. That's because patients may not want to pay out of pocket for health care or dip into their health savings accounts set up by employers for what might be medical false alarms, Chang said.

Although the plans are designed to make patients think twice about health care costs, not going to the doctor can come back to hurt patients if they don't seek care when they really need it, he said.

"Since you're paying for a bigger share [of health care costs], you're price conscious," Chang said. "This could be a good thing, but is the employee really qualified to decide? They can be penny-wise and pound-foolish. The question is: Are they making the right choice?"

Premiums on the rise

Chang said employers are turning to HSA/HDHP plans because insurance premiums are rising, and they want to control expenditures and ensure their costs are more predictable from year to year.

Premiums for a family of four increased an average of 4% in 2012 for those with employer-sponsored coverage. The single coverage rate went up 3%, according to a 2012 survey by the Kaiser Family Foundation and the Health Research & Educational Trust.

That report also noted that while worker earnings grew 47% from 1999 to 2012, premiums jumped 172%. The employee contribution to premiums grew 180%.

In 2012, the premium contribution for a family of four working at a company of three to 199 staffers was $5,134, up from $1,831 in 1999. Workers at companies with 200 or more employees paid $3,926, compared with $1,398 in 1999.

Blue Cross study: 1 doctor overseeing care better for health, cuts costs

By Robin Erb July 8, 2013

Free Press Medical Writer

A single doctor overseeing your care not only improves your health, it shrinks the cost of maintaining it, according to a new study based on the actual cases by Blue Cross Blue Shield of Michigan doctors.

The study found adult patients who belong to a Patient Centered Medical Home (PCMH) saved an average of $26.37 a month per person, or an estimated $155 million collectively over the first three years, according to the study published this month in the journal, Health Services Research.

The results are especially relevant as the most sweeping provisions of the Affordable Care Act of 2010 take effect in the coming months.

Many of the predicted savings of the health care reform law are based on better coordination of care, which theoretically keeps chronic conditions from getting worse. That, in turn, can reduce costly hospitalizations.

“It made sense, but there weren’t solid numbers behind it,” said Dr. Michael Fetters, one of the study authors, a family medicine doctor, and a professor at the University of Michigan.

In a medical home model, a primary care provider coordinates care and tracks a patient’s progress — working with other health care providers, reviewing test results provided elsewhere, and following up with patients to make sure they’re following a care plan.

It’s a more proactive model of health care, said David Share, a BCBSM senior vice president.

“That’s not standard practice (in some offices) where it’s more on the patient to stumble in the door and raise his or her hand and say ‘I have a need,’ ” he said.

Researchers looked at 2,432 practices throughout 82 of Michigan’s 83 counties.

They measured the degree to which the practices had embraced the patient-centered model. Did patients have 24-hour access to clinic staff? Did the primary care physician track all patient test results?

They then examined costs for patients over time — comparing practice costs in 2008 against those patient costs in 2009 and 2010 as doctors’ offices embraced more PCMH policies.

The differences weren’t as drastic for pediatric patients, in part, because children don’t suffer from as many chronic conditions, Share said.

5 Undeniable Reasons Your Prescription Drug Costs Are So Ridiculously High

By Keith Speights | June 28, 2013 |

Americans spend a little less than $1,000 annually per person on average for prescription drugs. That's the average, which means that many spend a lot more. Why are prescription costs so ridiculously high? You might not like the answers, but here they are.

1. You're paying for other drugs that you don't use.
When you put your money down at the pharmacy for Lyrica, the nerve and muscle pain drug from **Pfizer** (NYSE: PFE) , you're really paying for your Lyrica prescription plus a whole host of other drugs. How's that possible? The answer lies in the realities of the drug development process.

Dr. Josh Bloom with the American Council on Science and Health estimates that it takes a drugmaker an average of 14 years to bring a drug to market -- at a total cost of around $1.3 billion. However, only one out of every 50 drugs that start down the development path actually make it to market. And, of those that do, typically only two out of 10 will make a profit.

Pfizer spent around $890 million on cholesterol drug torcetrapib, only to cancel the drug's development program in 2006 after serious safety concerns. The big pharmaceutical company wrote off $2.8 billion on inhalable insulin Exubera after consumers simply didn't like it.

How did Pfizer make up for those and other losses? Like all the other drugmakers, it added to the cost of the drugs that did succeed -- so Lyrica and others cost more than they would have otherwise.

2. You're paying for the world.
The weight of the world might not be on your shoulders, but the weight of subsidizing the world's drugs is. Prescription drug costs are higher in the U.S. than in any other country. Per-capita pharmaceutical spending in Canada, the second-highest nation, is a whopping 33% lower than in the U.S.

Two words explain why: price controls. Most other countries establish fixed price limits that they will pay for prescription drugs. What this means, though, is that pharmaceutical companies raise their prices for prescription drugs sold in the U.S. to make up for charging lower prices throughout the rest of the world.

You might think the simple solution is to implement price controls in the U.S., too. Such a move probably would lower prices for the drugs currently available.

The problem, though, is that it would provide financial disincentives for pharmaceutical companies to develop as many new drugs as they do now. If that happened, it could end up actually increasing overall health care costs, since taking prescription drugs is frequently much less expensive than other medical treatments.

3. You're paying for others to find out about the drug you use.
Marketing is king in the world of pharmaceuticals. And it demands a king's ransom. Unfortunately, you ultimately pay that ransom every time you buy a prescription drug.

Pfizer's advertising budget last year totaled more than $622 million. Over half of that budget was spent promoting three drugs -- Celebrex, Viagra, and Lyrica.**Eli Lilly** (NYSE: LLY) wasn't far behind with an ad budget topping $433 million. Nearly 94% of that amount was spent on only two drugs, in this case Cymbalta and Cialis.

Nielsen's tracking found that the top 10 pharmaceutical companies spent $2.7 billion last year on direct-to-consumer advertising. However, that figure doesn't include online advertising or physician promotions, so the actual marketing budgets for the big pharma companies is even larger. Research firm Cegedim estimates that total pharmaceutical industry spending on promoting drugs was around $28 billion in 2010.

You're also likely picking up part of the tab for the companies mistakes in how they promote their products. For example, **Abbott Labs** (NYSE: ABT) settled federal and state lawsuits accusing the company of inappropriate promotion practices for epilepsy drug Depakote for a cool $1.6 billion last year.

At the time of the settlement, the Justice Department said that the case demonstrated that "those who put profits ahead of patients will pay a hefty price." A hefty price was surely paid, but Abbott's profits for 2012 were more than 26% higher than either of the previous two years.

4. You're paying Uncle Sam.
Don't forget your good friends at the IRS. The passage of the Affordable Care Act brought new fees for large drugmakers totaling $80 billion. That amount is spread over multiple years, though. "Only" $2.8 billion was paid by pharmaceutical companies last year.

Technically, the big pharma companies pay these fees, which basically are excise taxes. However, those companies can't pay the IRS unless it first gets the money from its customers. Ultimately, you're paying Uncle Sam.

5. You're paying for profits.
Regardless of what product you purchase, you're paying for the maker of those products to make money. It's no different with prescription drugs. The concern is over whether prices paid by consumers contribute to excessive profits.

Most pharmaceutical companies generate nice profits. Despite Lilly's woes from losing patent protection for some of its big drugs, the company still had a profit margin of over 20%. Even though Abbott paid a steep fine last year for a legal settlement, its profit margin was 13% -- better than a lot of companies.

Pfizer ranks first among all Dow index stocks in terms of profit margin, with a margin of nearly 27%. The other two pharmaceutical companies in the Dow have profit margins higher than the average Dow company. However, of the top 10 Dow stocks ranked by profit margin, four are technology firms. Pharmaceutical companies generate high profit margins, but they're not always the highest among all industries.

A little good news
You're paying ridiculously high prices for prescriptions, but there is a little bit of good news. In 2012, Americans

actually spent less on prescription drugs than the prior year for the first time on record. It was only 1% less -- but that's still better than spending more.

I figure this improvement amounts to maybe having an extra $10 in the wallet for the average American. You might want to hold on to that money. You'll probably need it soon enough.

Wondering if you'll spend more of your extra money because of Obamacare? Don't worry -- you're not alone. To help prepare investors for the massive changes coming to the American health care system, The Motley Fool created a special free report that makes this complex topic easily understandable. Download "Everything You Need to Know AboutObamacare" and discover how the law may impact your taxes, health insurance, and investments. Click here for your free copy today.

Link: http://www.fool.com/fool/free-report/18/sa-everythingobamacare-display315585.aspx?aid=5479&source=isaeditxt0900026

Medicare, Social Security Are Bargains for Beneficiaries

By PHILIP MOELLER July 16, 2013

In the current debates over cuts to federal spending, organizations that advocate for seniors overwhelmingly argue against cuts to Medicare or Social Security. Public opinion polls also find big majorities against cuts. Perhaps the most-used defense of the programs is that they provide benefits people have paid for through payroll taxes and Medicare insurance premiums. "You paid for it – you earned it," is a common rallying cry.

In reality, however, that statement is far from accurate. Consumer payments that flow to Social Security and Medicare fall well short of paying for the programs' benefits, and the gap is getting wider each year.

Eugene Steuerle, a fellow at the Urban Institute in Washington, publishes widely cited research that Social Security and, particularly, Medicare, are bargains for beneficiaries. The Urban Institute, a public policy research nonprofit, updates the numbers annually.

Social Security comes much closer to paying for itself, but lower-income workers and couples with only one working spouse come out way ahead in terms of benefits they receive versus the taxes they (and their employers) pay to support the program. High-income earners often pay more in taxes than they receive in benefits over their expected lifetimes.

Medicare pays far more in benefits than it receives in tax payments, even for many affluent beneficiaries. Last year, the government spent $574 billion on Medicare. Nearly $267 billion was spent on Medicare's hospital insurance program (Part A of Medicare). This is the part that has its own dedicated trust fund, which paid all of these expenses but is slowly depleting its reserves.

The other $307 billion was spent on doctor and other covered outpatient services (Part B) and prescription drugs (Part D). While these programs do collect insurance premiums, their revenues cover only 30 percent of their expenses. The other 70 percent – roughly $215 billion – comes straight from general federal revenues.

Totaling up lifetime benefits makes it dramatically clear how big the programs are, even for middle-income families. Receiving $25,000 a year in Social Security and Medicare benefits amounts to half a million dollars for an individual older than 20 years and $1 million for a couple each receiving that much.

Every year, Social Security calculates average wages for typical workers. The calculations assume that for every year of their working lives, people have received either that year's average wage, a low wage (45 percent of average), a high wage (160 percent of average) or the maximum wage subject to Social Security taxes ($110,100 in 2012 when the calculations were done and $113,700 in 2013).

Here are six scenarios from the Urban Institute for people who turned 65 in 2010 and chose to begin both Social Security and Medicare benefits. All the figures are expressed in 2012 dollars. This means, among other things, that although benefits will be paid in the future and payroll taxes have already been paid, the comparison

between lifetime benefits and taxes is still an apples-to-apples measurement and is not skewed by the effects of inflation.

1. Single man earning $44,600 a year (the projected average wage level in 2012): He would come out $96,000 ahead over his lifetime, receiving $457,000 in Social Security and Medicare benefits and paying out $361,000 in taxes for the two programs. On Social Security alone, he would "lose" $23,000, receiving $277,000 in benefits but paying $300,000 in Social Security taxes. For Medicare, he would enjoy a net gain of $119,000, receiving $180,000 in lifetime benefits and paying only $61,000 in Medicare taxes.

2. Single woman earning $44,600 a year: She would come out $148,000 ahead over her lifetime, receiving $509,000 in Social Security and Medicare benefits and paying out $361,000 in taxes for the two programs. On Social Security alone, she would gain $2,000, receiving $302,000 in benefits and paying $300,000 in Social Security taxes. For Medicare, she would enjoy a net gain of $146,000, receiving $207,000 in lifetime benefits and paying only $60,100 in Medicare taxes.

3. One-earner couple earning $44,600 a year: They would come out a whopping $493,000 ahead over their lifetimes, receiving $854,000 in Social Security and Medicare benefits and paying out $361,000 in taxes for the two programs. On Social Security alone, they would enjoy a $167,000 surplus, receiving $467,000 in benefits while paying $300,000 in Social Security taxes. For Medicare, they would enjoy a net gain of $326,000, receiving $387,000 in lifetime benefits and paying only $61,000 in Medicare taxes.

4. Two-earner couple, with one spouse earning $44,600 a year and the second earning $20,000 (the projected low wage in 2012): They would come out $354,000 ahead over their lifetimes, receiving $877,000 in Social Security and Medicare benefits and paying out $523,000 in taxes for the two programs. On Social Security alone, they would enjoy a $55,000 surplus, receiving $490,000 in benefits while paying $435,000 in Social Security taxes. For Medicare, they would enjoy a net gain of $299,000, receiving $387,000 in lifetime benefits and paying only $99,000 in Medicare taxes.

5. Two-earner couple, with both spouses earning $44,600 a year: They would come out $244,000 ahead over their lifetimes, receiving $966,000 in Social Security and Medicare benefits and paying out $722,000 in taxes for the two programs. On Social Security alone, they would lose $21,000, receiving $579,000 in benefits but paying $600,000 in Social Security taxes. For Medicare, they would enjoy a net gain of $265,000, receiving $387,000 in lifetime benefits and paying only $122,000 in Medicare taxes.

6. Two-earner couple, with one spouse earning $71,400 a year (the projected high wage in 2012) and the second earning $44.600: They would come out $159,000 ahead over their lifetimes, receiving $1,080,000 in Social Security and Medicare benefits and paying out $921,000 in taxes for the two programs. On Social Security alone, they would lose $72,000, receiving $693,000 in benefits but paying $765,000 in Social Security taxes. For Medicare, they would enjoy a net gain of $231,000, receiving $387,000 in lifetime benefits and paying $156,000 in Medicare taxes.

Officials worry Medicare pushing seniors out of hospitals prematurely to cut cost

By Stacey Singer / *Cox Newspapers* Published: July 18. 2013

Outpatient vs. inpatient

For Medicare beneficiaries, it matters. Here's why:
• Inpatients have better coverage under Medicare Part A. There's a one-time deductible of $1,184 for up to 60 days' care.
• Outpatients' bills are covered under Medicare Part B. Patients must pay both their deductible and 20 percent of doctors' charges. They'll probably also have to cover the hospital's charges for medications.
Medicare only pays its nursing home benefit following a "qualifying hospital stay." That requires a three-day inpatient stay; any time spent in observation doesn't count toward the three days. Plus, the day of discharge doesn't count toward the three days.
Note: Rules may differ for beneficiaries with a Medicare Advantage plan.
Source: Centers for Medicare & Medicaid Services

WEST PALM BEACH, Fla. — At 7:30 in the morning, George Matsoukas' phone rang with urgent news about his 96-year-old mother, who had fallen and broken her pelvis two days earlier.

It was their family physician, with what seemed to him a bizarre and unreasonable demand: Matsoukas needed to come immediately to remove his frail mother from JFK Medical Center in Atlantis, Fla. Matsoukas, a retired community college instructor who lives in West Palm Beach, was baffled.

His mother, Aspasia Matsoukas, couldn't stand, walk or use the bathroom on her own. She suffered from mild dementia and was in pain. Yet they would not admit her to the hospital, he was told. Further, they wouldn't transfer her to a skilled nursing facility, either. They said George Matsoukas, who is 70, had to deal with that himself.

"They wanted her out," he said.

Matsoukas soon learned that his family had fallen in to a Medicare cost-cutting Twilight Zone known as "observation status" — a world where a patient can be anywhere in a hospital, receiving treatment for days, yet never "admitted" according to their hospital bill.

The consequences of an "observation status" determination can be severe for consumers: Medicare, the nation's health insurance plan for people older than 65 and some others, won't pay a dime toward a stay in a skilled nursing home or rehabilitation hospital without a previous three-day, criteria-appropriate admission.

Plus, patients are on the hook for outpatient hospital co-payments and drug costs, bills that they wouldn't have gotten if they had been admitted. Worse, because there's no out-of-pocket cap on these observation hospital bills, some consumers have been hit with shockingly high charges that even Medigap supplemental insurance won't cover.

The American Hospital Association says it's not their fault. Hospitals are in an impossible situation, caught between understandably angry consumers and a new cadre of third-party Medicare billing auditors known as

RACs, or “recovery audit contractors," they argue. Since 2006, RAC auditors have been able to win “bounties" for catching coding errors and fraud. One of their most lucrative “errors" is to flag inappropriate admissions.

The consumer outcry is finally beginning to be heard. An advocacy group has filed a class action lawsuit accusing Medicare of denying seniors their right to hospital coverage; a bill with over 70 co-sponsors in Congress would force Medicare to change its policy; and the federal agency itself has proposed clarified rules, but in a way that many warn will hurt even more consumers.

Most hospitals in U.S. lack observation units

The day his mother was ordered out of the hospital, George Matsoukas was forced to quickly assemble $6,700 before she could be transferred.

“I called all over. Nobody would accept her without up-front payment," Matsoukas said. “Some of them wanted over $15,000."

That was June 3. His mother is still in the rehabilitation hospital today, reluctant to stand or step, although she’s undergoing regular physical therapy. When he visits, he hears the same story from many other patients and their families, people who landed in the same Medicare purgatory, observed, not admitted.

“I couldn’t comprehend how she wasn’t in the hospital when she was in the hospital," Matsoukas said.

Recent studies have shown a sharp uptick in the use of “observation" status instead of admissions. Brown University’s ZhanlianFeng and colleagues, writing in the policy journal Health Affairs last year, found a 34 percent jump in the use of observation status in just two years — from 2007 to 2009. By 2011, the number of observation hospital stays was over 1.6 million, according to federal data.

Scholars looking to control Medicare’s runaway spending actually suggest using observation more, but in properly designed observation units with specialized staff and clear protocols.

Only a third of U.S. hospitals have such low-cost observation units, according to a team led by Brigham Women’s Hospital Observation Unit Director Dr. Christopher Baugh, writing in Health Affairs last year. If every hospital had such a unit, Medicare could save more than $3 billion a year, his group wrote.

In an interview, Baugh explained patients would save, too, because calling something “observation" without a properly designed observation program simply results in cost shifting. Observation units have a long history of offering consumers more efficient and lower-cost services, but they are designed to be used only for certain conditions where clarity is needed — chest pain, fainting and asthma attacks, for example.

Broken pelvises, which Matsoukas’ mother suffered in a June 1 fall, aren’t among them.

“For a 96-year-old with a broken pelvis, I know what the medical need is now and I know what it’s going to be three days from now," Baugh said. “I think there are policy reforms that Medicare needs to make to account for these situations. They are a vulnerable population that is falling through the gaps."

The U.S. Department of Health and Human Services has proposed clarifying its rule to say all hospital stays of two nights or less are automatically presumed observation, a proposal that groups — including the Center for Medicare Advocacy — think may worsen the situation.

The Connecticut-based center has filed a class-action lawsuit on behalf of Medicare beneficiaries, Bagnall v. Sebelius, which recently received its first hearing.

Meanwhile, bipartisan bills have been filed in Congress. They would require Medicare to treat observation and inpatient stays equally when determining nursing home care coverage. The bill is supported by groups like AARP and the American College of Emergency Physicians. The emergency physicians note that Medicare's three-day requirement for coverage of skilled nursing care is itself obsolete, a 50-year-old relic of a time when hospital stays were much longer.

For inpatients who have had a three-day hospital stay, Medicare provides a benefit of 20 days of nursing home care, followed by another 80 days of partial coverage.

George Matsoukas, who got his mother into the Consulate Health Care rehabilitation home in West Palm Beach, said he has learned that a doctor's ruling can be appealed within the hospital, to its quality improvement organization — but it has to be done during the hospital stay.

He tried to take his complaint to Medicare, to no avail. He was told they wouldn't second-guess his mother's doctor. So he has filed a complaint with the state Board of Medicine against the doctors who made the call.

"My mom is the victim of a bureaucratic system that is broken," Matsoukas wrote in his complaint.

"How could a senior in her condition not be admitted to the hospital, and be sent on to the care she needed in dignity and in a positive way?"

MARKETING 'OBAMACARE' SHAPING UP AS BIG CHALLENGE

BY CARLA K. JOHNSON Jul 24, 2:29 PM EDT AP MEDICAL WRITER

AP Photo

CHICAGO (AP) -- It will make you stronger. It will give you peace of mind and make you feel like a winner. Health insurance is what the whole country has been talking about, so don't be left out.

Sound like a sales pitch? Get ready for a lot more. As President Barack Obama's health care law moves from theory to reality in the coming months, its success may hinge on whether the best minds in advertising can reach one of the hardest-to-find parts of the population: people without health coverage.

The campaign won't come cheap: The total amount to be spent nationally on publicity, marketing and advertising will be at least $684 million, according to data compiled The Associated Press from federal and state sources.

About 16 percent of Americans are uninsured, but despite years of political debate and media attention, more than three-quarters of them still know little about the law known as "Obamacare," according to recent surveys.

"It's not sugar cereal, beer and detergent," said Brooke Foley, chief executive officer of the Chicago-based Jayne Agency, one of the advertising firms crafting messages to reach the uninsured.

The Obama administration and many states are launching campaigns this summer to get the word out before enrollment for new benefits begins in October.

The targets are mostly the working poor, young people who are disengaged, or those who gave up their insurance because of the cost. Three-quarters are white. Eighty-six percent have a high school education or less. Together they make up a blind spot in the nation's health care system.

"They've been shut out. It's too expensive and it's incredibly confusing," said David Smith of the advertising agency GMMB, pitching the health law's benefits in Washington and Vermont.

Their confusion might only have been magnified by the administration's surprise announcement recently postponing part of the system that affects businesses. But that change should not affect many individuals. A bigger complication is that in about half the states, Republican governors are declining to cooperate, which will limit the marketing.

The states that have been more receptive to the health care overhaul and are further ahead in their planning will receive proportionally more federal money for outreach, advertising and marketing than Republican-led states that have been hostile to the law.

AP research from all 50 states shows the amount of government spending will range from a low of 46 cents per capita in Wisconsin, which has ceded responsibility for its health insurance exchange to the

federal government, to $9.23 per capita in West Virginia, which opted for a state-federal partnership.

About $4.8 million in public money will be spent trying to sign up New Jersey's 1.3 million uninsured, for example, compared to the nearly $28 million spent reaching out to Washington state's much smaller 960,000.

Texas has the highest percentage of uninsured people in the nation, three times more than Illinois. But only a fourth as much public money will be spent on getting people enrolled in Texas.

Austin resident CarylMauk, 46, remains confused about the Affordable Care Act even though Texas' federally run exchange is just two months away from opening for enrollment.

She has not had insurance since she had to quit her nursing job in 2011 because of a heart condition. She's been struggling with chest pains, arthritis and fatigue but doesn't know what to make of the new program.

"Sometimes I just get overwhelmed," Mauk said. "I don't want to get bad news again, and that slows me down in making calls."

In the GOP states, community groups with federal grants will lead the effort. Private companies from Walgreens to Cosmopolitan magazine have launched their own educational campaigns.

Ads based on research about the uninsured will soon start popping up on radio, TV and social media. Grassroots organizers are recruiting their pastors, barbers and mothers and arming them with carefully worded messages. In some neighborhoods, volunteers will go door-to-door.

The pitch: If you don't make much money, the government can pick up some of the cost of your health insurance. If you can afford a policy, by law you have to get one. People will be directed to healthcare.gov, a government site, for more information.

The political stakes for the Obama administration in a big response are high. If only the sickest people sign up, the cost of their medical care could overburden insurance carriers and sink the new marketplaces. The new system depends on a balanced pool.

The ad campaign already underway in Colorado demonstrates the search for an effective message.

There, TV commercials show people being magically transformed into champions. One minute they're shopping for health insurance on a computer, the next they're winning at a horse race, in a casino or at the World Series with champagne corks flying. The slogan: "When health insurance companies compete, the only winner is you."

That's because market research shows Coloradans like competition, said Tom Leydon, CEO of Denver-based advertising and digital marketing agency Pilgrim.

The celebratory scenes "remind people of the good feeling they get when they win," he said.

Despite the focus on winning and champions, there may be little if any cooperation for the publicity blitz from the professional sports leagues, which would have the potential to reach tens of millions of people.

Two Republican Senate leaders warned the leagues about getting involved in "a highly polarized public debate."

In states where there will be no official cooperation, Enroll America, a coalition of health companies and advocates, has deployed volunteers to hand out brochures at a farmers market in Austin and hold house parties in Cincinnati, and plans a seven-figure ad buy across the nation.

"There has to be an echo chamber," said John Gilbert, national field director for the Enroll America media campaign. "If I'm uninsured and it's October, I won't be able to go anywhere without (hearing) the message of enrollment."

Chicago resident Martin Upshaw, whose fast food job doesn't provide health benefits, said the cost has kept him uninsured.

"The bottom line is the dollar sign," said Upshaw, 27, who survived a shooting three years ago. "I would love to be able to go in and see a doctor and make sure I'm OK."

In Chicago, the Jayne Agency's staff talked to more than 50 patients at an emergency room to hone the best message. The slogan they chose: "Don't Just Get By." The ad campaign features real people and their health stories.

On a recent Sunday in southwest Houston, volunteers recruited by Blue Cross Blue Shield set up information tables at a community center where three Methodist church services are held.

"I'm looking to get where I can go to the doctor and have a $25 to $30 co-pay," said churchgoer Yolanda Boykin, 60, whose current job through a temp agency does not provide health insurance.

Another part of the campaign nationwide, focused on young men, is refining messages for their mothers.

Market research has shown that young adults say it's often a parent, a girlfriend or a sibling who will push them to sign up for something like health insurance, said Julie Bataille, helping lead the outreach for the Obama administration, so the campaign will "make sure moms are aware."

To contact us: go to www.healthcareil.com or Call (800) 739-4700