Health & Retirement Services Of Illinois

February 2012 Newsletter

OUR NEWS LETTER

HRSI

Eyelid inflammation becoming more common

Blepharitis can result in red eyelids, discharge

Dr. Laura K. Green (Amy Davis, Baltimore Sun / September 14, 2011)

By **Meredith Cohn**, The Baltimore Sun

November 16, 2011

Blepharitis, usually identified by a sufferer's red, irritated eyelids, is becoming more common. And while doctors aren't sure why, it can be controlled with vigilance, according to Dr. Laura K. Green, residency program director of cornea, cataract and refractive surgery at the Krieger **Eye** Institute at Sinai Hospital of Baltimore. She said there are some simple things sufferers can do at home, such as keeping the eyelids clean, that can help ease the irritation.

What is blepharitis and what causes it?

Blepharitis is an inflammatory condition of the eyelids. The symptoms of blepharitis vary but usually include red eyelids; discharge, especially in the morning; an irritated feeling in the eyes, like something is in the eyes; and blurred or fluctuating vision. There are different types of blepharitis, however most cases result from clogging of oil glands in the eyelid, which results in red, inflamed and irritated eyelids. The surface of the eye may be prone to dryness because it is not receiving enough of the moisturizing oily secretions. Blepharitis can also be associated with other **skin conditions** like **psoriasis** or **rosacea**. Because your eyelids always are in contact with your eyes, this redness and **inflammation** can spread to the surface of the eye. In severe cases, a corneal ulcer (inflammation in the cornea seen as a white spot on the cornea) may occur.

In Our Newsletter

How do you know if you have this and not another malady?

Only an eye doctor can tell by doing a thorough examination whether you have blepharitis versus a bacterial or **viral infection** or another cause of a red, irritated eye. However, if you experience dry, irritated red eyes, especially with redness of the edge of the eyelid, then you probably have blepharitis.

When do you need to see a doctor?

If you have pain and redness in your eye, especially if accompanied by a decrease in vision, you should see your eye doctor.

Is it common, and is it curable?

Blepharitis is unfortunately very common. There are many theories as to why this is, but at this point, we do not know why it occurs or why it is becoming more common. Many patients report that taking omega-3 fatty acids, such as **fish oil** or **flaxseed oil**, can help to decrease their symptoms. Blepharitis is not curable; however, the good news is that it can be managed, and people should not have to suffer, because working together with your eye doctor, you can get it under control. Even if your blepharitis is under great control, it can recur years later, and some patients require daily eyedrops or oral antibiotics in order to keep it under control.

Are there special cleaners or ointments that work best?

For mild cases of blepharitis, the most effective thing is what we call lid hygiene — simply keeping the eyelids clean. A typical regimen for this would include using either baby shampoo or a commercially available eyelid cleanser (which are available in the eye care section of any pharmacy) to clean along the edge of the eyelid, with your eyes closed. You want to focus on cleaning right along the eyelashes. Then you should thoroughly wash the cleanser away with warm water, and leave the warm compress on your eyes for a few minutes. Warm compresses help to open up the clogged oil glands. Keeping your eyelids clean is an important part of any blepharitis treatment regimen.

Can you continue to wear contact lenses and makeup?

When your eyes are acutely inflamed with redness and discharge, it is best to discontinue contacts and eye makeup until the blepharitis is controlled. Patients who are managing their blepharitis and have it under control can wear contacts and eye makeup, but they should continue with an eyelid hygiene regimen.

RMD PRECAUTIONS & OPTIONS

Meeting your obligations & finding some opportunities.

Presented by Neal Halaway, Family Wealth Manager

After you turn 70½, the IRS requires you to withdraw some of the money in your retirement savings accounts each year. These withdrawals are officially called Required Minimum Distributions (RMDs).[1]

While you never have to make withdrawals from a Roth IRA, you must take annual RMDs from traditional, SEP and SIMPLE IRAs, pension and profit-sharing plans and 401(k), 403(b) and 457 retirement plans annually past a certain age. If you don't, severe financial penalties await.[1]

If you are still working as an employee at age 70½, you don't have to take RMDs from a profit-sharing plan, a pension plan, or a 401(k), 403(b) or 457 plan. Your initial RMDs from these accounts will only be required after you retire. However, you must take RMDs from these types of accounts if you own 5% or more of a business sponsoring such a retirement plan.[2]

You must take RMDs from IRAs after you turn 70½ regardless of whether you are still working or not.[2]

The annual deadline is December 31, right? Yes, with one notable exception. The IRS gives you 15 months instead of 12 to take your first RMD. Your first one must be taken in the calendar year after you turn 70½. So if you turned 70½ in 2011, you can take your initial RMD any time before April 1, 2012. However, if you put off your first RMD until next year you will still need to take your second RMD by December 31, 2012.[1]

Calculating RMDs can be complicated. You probably have more than one retirement savings account. You may have several. So this gets rather intricate.

- *Multiple IRAs.* Should you have more than one traditional, SEP or SIMPLE IRA, the annual RMDs for these accounts must be calculated separately. However … the IRS gives you some leeway about how to withdraw the money. You can withdraw 100% of your total yearly RMD amounts from just one IRA, or you can withdraw equal or unequal portions from each of the IRAs you own.
- *401(k)s and other qualified retirement plans.* A separate RMD must be calculated for each qualified retirement plan to which you have contributed. These RMD amounts must be paid out separately from the RMD(s) for your IRA(s).
- *Inherited IRAs.* The same applies – a separate RMD must be calculated for each inherited IRA you have, and these RMD amounts must be paid out separately from RMD(s) for your other IRA(s).[1]

This is why you should talk to your financial or tax advisor about your RMDs. It is really important to have your advisor review all of your retirement accounts to make sure you fulfill your RMD obligation. If you skip an RMD or withdraw less than what you should have, the IRS will find out and hit you with a stiff penalty – you will have to pay 50% of the amount not withdrawn.[2]

Are RMDs taxable? Yes, the withdrawn amounts are characterized as taxable income under the Internal Revenue Code. Should you be wondering, RMD amounts can't be rolled over into other tax-deferred accounts and excess RMD amounts can't be forwarded to apply toward next year's RMDs. [2]

What if you don't need the money? If you are wealthy, you may come to see RMDs as an annual financial nuisance - but the withdrawal amounts may be redirected toward opportunities. While putting the money into a savings account or a CD is the usual route, there are other options with potentially better yields or objectives. That RMD amount could be used to…

- Start a grandchild's education fund.
- Fund a long term care insurance policy.
- Leverage your estate using life insurance.
- Diversify your portfolio through investment into stock market alternatives.

There are all kinds of things you could do with the money. The withdrawn funds could be linked to a new purpose.

So to recap, be vigilant and timely when it comes to calculating and making your RMD. If you have questions or would like assistance please contact us and let's have a conversation about the destiny of that money.

Neal Halaway may be reached at (800) 739-4700x. 14 or at wealthstrategies@healthcareil.com

Citations.

1 - www.hartfordinvestor.com/servlet/Satellite?c=Page&cid=1284290138050&pagename=Investor%2FPage%2FCommon [9/23/11]

6 Ways to Retire Without a Mortgage

Kiplinger By *Michael DeSenne* | *Kiplinger*

Admit it: Whether you're 35 or 65, the prospect of retiring without a mortgage is an attractive one. No more monthly checks to your lender means extra money to spend on having fun once you exit the workforce. After years of punctual principal-and-interest payments, it's the least you deserve, right?

There are several smart ways to retire without a mortgage. We've come up with six that fit a variety of retirement scenarios. Some approaches benefit from an early start -- so if you are able, try to plan ahead. Other mortgage-free-retirement options can be put into effect even if you're close to collecting Social Security.

Some retirees don't mind a mortgage, be it for the tax write-off or to prevent too much money being tied up in home equity. But if your goal is the peace of mind that comes with paying off your loan before you reach retirement, check out these six ways to retire without a mortgage.

Make Extra Mortgage Payments

Over time, a few bucks here and there tacked on to your mortgage payment can translate into thousands of dollars saved on interest and years shaved off the repayment period. The trick is to find small ways to cut corners on other household expenses so that you can apply those modest savings toward your mortgage. Simply swapping out traditional incandescent light bulbs for CFLs, for example, can save you $50 a year in energy costs. A programmable thermostat can save you up to $180 annually.

A little extra goes a long way. A $200,000 mortgage at 6% over 30 years works out to a monthly payment of about $1,200 (excluding taxes and insurance). You'll pay just over $231,000 in interest alone. But put an extra $100 a month toward the same mortgage and you'll save nearly $50,000 in interest and retire the loan five and a half years early.

Refinance Your Mortgage

A surefire way to trim the bill for your home loan is to refinance your mortgage to a lower rate for an equal or greater period of time. You'll enjoy reduced payments and less strain on your bank account. Not a bad idea if money is tight. What you won't enjoy is a mortgage-free retirement.

To pay off your mortgage early via refinancing, you'll need to switch to a shorter-term loan. In 2011, a popular refi option for homeowners who weren't underwater was going from a 30-year mortgage to a 15-year loan. Let's say you have 25 years left on a 30-year mortgage at 6% and still owe $175,000. You'd pay about $163,000 in interest over the remaining quarter century. For just $167 more per month, plus one-time closing costs, you could refinance to a 15-year mortgage at 4% and save $105,000 in interest. And, of course, you'd be mortgage-free a decade earlier.

Downsize Your Home

Think about it: At a time when you're supposed to be enjoying the simple life, do you really need a formal living room, separate dining room and two spare bedrooms that you never set foot in? If your answer is no, think about downsizing your home.

The beauty of downsizing to a smaller home in the same area is that you don't need to say goodbye to your friends, family and community. Of course, beauty can also be found in the fact that you might be able to pay cash for your new abode. That means no mortgage.

And don't limit your notion of downsizing. Just because you spent the past 30 years in a traditional ranch doesn't mean you need to purchase another ranch with less square footage. Check out conventional alternatives (condos, townhouses) as well as unconventional options (houseboats, RVs and even tiny homes).

Relocate to a Cheaper City

Can't find the right place at the right price to retire in your hometown? Move somewhere cheaper. Sure, there will be sacrifices, but what you'll give up in familiarity you'll make up for financially. The best places to retire combine ample activities with affordable real estate. And moving to an affordable locale will boost the odds that you won't have to take out a new mortgage.

Home prices aren't the only factor. Consider property taxes and homeowners insurance premiums as well. Both affect the overall affordability of a home. In New Jersey, for example, property taxes and insurance premiums combined average $7,270. You'd pay just $1,444 in, say, Kentucky, one of the ten most tax-friendly states for retirees. Some state and local governments reduce or even waive property taxes for residents 65 and older.

Feeling adventurous? You might be able to pay even less for a home and enjoy lower living expenses if you retire overseas. Look into bargain-priced and retiree-welcoming countries such as Belize, Mexico, Panama and Vietnam.

Get a Roommate

Don't discount the financial advantages of taking on a roommate. By letting out a spare bedroom and applying the rent you collect to your mortgage, you can knock years off the time it'll take to repay the loan. An extra $250 a month toward a $150,000, 30-year mortgage at 6% will erase the debt more than 13 years early. An extra $100 a month retires the mortgage seven years early.

The benefits to your bottom line extend beyond the mortgage. Rental income can help defray the cost of utilities -- gas, electricity, phone, cable, Internet -- and maintenance. Annual upkeep on a typical three-bedroom, two-bath detached home runs $7,910, on average, according to Homewyse.com, a homeownership Web site. As a bonus, a roommate can help with chores, providing a welcome respite for any homeowner weary of doing dishes and dusting bookshelves alone.

Rent Instead of Owning

A guaranteed way to retire without a mortgage is to sell your current home, pay off the loan in full, pocket the profits, and use the proceeds to rent a place to live instead. Although it might seem as if you'd just be writing a check to a landlord instead of a lender, the differences between renting and owning are considerable.

Among the advantages of renting in retirement: no lawn to mow; no leaky roof to replace; no property taxes to pay; no assets tied up in illiquid real estate; and no residential albatross around your neck preventing you from moving around as you wish. You can even save on little things, such as insurance. The average annual premium for renters insurance is $176, compared with $791 for homeowners insurance. As for losing the ability to deduct the interest you pay on your mortgage -- a popular argument in favor of homeownership -- keep in mind that the amount of interest due declines over time, so later in the life of a mortgage there is less and less interest to write off.

The single biggest risk of renting in retirement instead of owning is that you might run out of money to pay the

rent. If you own a home, by contrast, you could probably resort to a reverse mortgage when savings dry up. This is a legitimate concern, and one that you should address with your financial adviser. A well-structured portfolio can provide a reliable income stream deep into retirement. A part-time job can also stretch your nest egg.

Bad Couponing: 9 Tips to Avoid It

Karla Bowsher
Tuesday, January 10, 2012

If you photocopy a coupon or snatch one from a recycling bin, you're risking arrest. If you cut off a coupon expiration date or take more than your fair share, you risk being a jerk.

Four supermarket cashiers were recently brought up on criminal charges — for theft via coupon.

They used the cash register "coupon override function" to help customers steal nearly $70,000 worth of groceries from the Humble, Texas, Kroger where they worked, according to the Houston Chronicle.

Most coupon fraud doesn't come in the form of a four-person scheme that lasts three months, as this one did. But illegal couponing happens more often than you might think.

Some say it even happens on national television. In May 2011, during the first season of TLC's Extreme Couponing, the Coupon Information Corporation accused the hit show of depicting couponing practices that "may raise civil and/or criminal issues."

When the second season of Extreme Couponing got underway, the CIC, which is a 16-year-old national nonprofit, released its Considerate Couponing guidelines.

I think that some of their tips are simple common courtesy, but other tips will help you avoid criminal charges of your own. So I plucked their most relevant tips, added some, and broke them all down based on what's actually illegal, potentially illegal, and against the rules...

Illegal Activity

Making your own coupons. This may sound silly, but counterfeiting coupons is a crime just as counterfeiting money is. Last year, 22-year-old college student Lucas Townsend Henderson surrendered to the FBI, which brought him up on charges related to his creating and disseminating fake coupons online. The FBI estimates that stores lost hundreds of thousands of dollars as a result of Henderson's fake coupons, and he could face up to 30 years in federal prison. If you think you spot a fake, check the CIC's list of counterfeit coupons.

Photocopying coupons. This is also a type of counterfeiting. The use of fake coupons is tantamount to stealing because sto

res will not be reimbursed for the value of fake coupons and therefore will lose revenue they were counting on.

Using a coupon to buy a product it wasn't intended for. This is a type of coupon fraud and, according to the CIC, "almost always" a violation of federal, state, or local law. So if the fine print says your toothpaste coupon can't be used to purchase the travel-size tube, don't try to use it to buy that size and hope the cashier won't notice.

Stealing newspapers: You may have seen couponers do this on Extreme Couponing, but taking something that isn't yours is theft.

Bottom line: Think of coupons as dollar bills. If you wouldn't fake, photocopy, or steal a banknote, don't do it with coupons either.

Risky Businesss

Buying coupons. While buying coupons isn't illegal, you could be buying illegal coupons. Even if they're legit, the CIC points out that the coupon manufacturer could sue you or the seller for violating the "nontransferability" clause printed on all U.S. coupons.

Dumpster and recycling-bin diving: I got a laugh out of this: "The CIC, for reasons of safety, strongly recommends that no one enter into dumpsters." I think it's safe to say that people willing to brave a giant trash receptacle probably aren't concerned with safety. At the same time, the CIC correctly points out that diving into a dumpster on private land can get you arrested for trespassing, and that removing recyclables can get you arrested for theft. The same goes for removing recyclables from curbside recycling bins, also known as "scavenging."

Bottom line: Sure, these actions aren't always illegal in all areas, and you probably wouldn't get caught anyway. But that doesn't mean they're worth the risk.

Cheating the System

Removing expiration dates. The CIC calls cutting the expiration date off expired coupons "dishonest." It's also disrespectful: The store may not get reimbursed when they send your expiration-less coupons to the manufacturer.

Making multiple transactions: On Extreme Couponing, it's common practice to break up a grocery haul in order to bypass the store's or cash register's coupon limit. But just because a store allows it when national TV cameras are rolling doesn't mean it falls within their coupon policy.

Taking multiple coupons. You know those stick-on coupons you can pull off a product before you buy to use when you buy it? You're not supposed to steal them off every product on the shelves. The same goes for those of

you who hit the back button to force a limited Coupon.com coupon to print twice. When you take more than your fair share of a limited coupon, you're denying the next shopper their fair share.

Bottom line: Breaking rules isn't like breaking laws. It's more like cheating on a test — arguably unethical and best avoided whenever possible.

For Illegal Immigrant, Line Is Drawn at Transplant

Ruth Fremson/The New York Times

An illegal immigrant from Mexico, called Angel, undergoing a dialysis treatment. The government pays for a lifetime of dialysis, but not a transplant.

By NINA BERNSTEIN

Published: December 20, 2011

Without treatment to replace his failing kidneys, doctors knew, the man in Bellevue hospital would die. He was a waiter in his early 30s, a husband and father of two, so well liked at the Manhattan restaurant where he had worked for a decade that everyone from the customers to the dishwasher was donating money to help his family.

Enlarge This Image

Ruth Fremson/The New York Times

Angel, with his niece, is hoping for a kidney transplant to avoid a lifetime of dialysis.

He was also an illegal immigrant. So when his younger brother volunteered to donate a kidney to restore him to normal life, they encountered a health care paradox: the government would pay for a lifetime of dialysis, costing $75,000 a year, but not for the $100,000 transplant that would make it unnecessary.

For nearly two years, the brothers and their supporters have been hunting for a way to make the transplant happen. Their journey has taken them through a maze of conflicting laws, private insurance conundrums and ethical quandaries, back to the national impasse between health care and immigration policies.

The waiter's boss sought private insurance, she and the brothers said, speaking on the condition that their names be withheld for fear of provoking immigration authorities. The Catch-22: for the first year, the waiter, called Angel, would get no coverage for his "pre-existing condition," nor would he receive the dialysis that keeps him alive and able to work four days a week.

Doctors sought a transplant center that would take him. Hospitals in the city receive millions of taxpayer dollars to help offset care for illegal immigrants and other uninsured patients. But at one hospital, administrators apparently overruled surgeons willing to waive their fees. At another, Angel was told to come back when he had legal status or $200,000.

A last resort is a return to Mexico, where the operation costs about $40,000. But to pay off the necessary loans, Angel and his brother, a deli worker, would have to sneak back in through the desert. If they failed, they would be cut off from their children in Brooklyn, who are United States citizens.

"As a physician, it puts you in a real ethical dilemma," said Dr. Eric Manheimer, Bellevue's medical director, noting that a transplant would sharply reduce Angel's risk of death from complications. "The ultimate irony is it's cheaper to put in a transplant than to dialyze someone for the rest of their life."

Bellevue performs no transplants but, as a trauma center, often supplies organs harvested, with family consent, from illegal immigrants fatally injured at work.

"Here's the paradox: he could donate, but he can't receive," Dr. Manheimer said, calling the imbalance troubling. Organ registries do not record illegal status, but a study estimated that over a 20-year period noncitizens donated 2.5 percent of organs and received fewer than 1 percent.

To those focusing on immigration enforcement, however, the inequity runs the other way. "They should not get any benefit from breaking the law, especially something as expensive as organ transplants or dialysis," said Representative Dana T. Rohrabacher, Republican of California, who contends that care for illegal immigrants is bankrupting American health care and has sought to require that emergency rooms report stabilized patients for deportation unless they prove citizenship or legal residence.

"If they're dead, I don't have an objection to their organs being used," Mr. Rohrabacher added. "If they're alive, they shouldn't be here no matter what."

To Ruth Faden, the director of the Johns Hopkins Berman Institute of Bioethics, the brothers' case, like the transplant statistics, illustrates how quickly firm principles on both sides unravel in practice.

"We tie ourselves up in knots," she said, "because we've accepted as a country and in international human rights law that if someone shows up in extremis in your emergency room, the nurses and doctors and technicians are morally obligated, and legally obligated, to provide that life-saving care."

How to begin refusing care, she added, becomes a dilemma for "real people in real time."

The sudden onset of the waiter's illness in January 2010 left no time to spare. At Bellevue, he underwent surgery to implant a temporary venous catheter in his neck, to cleanse his blood of lethal toxins. The cause of his renal disease is most likely genetic: when he was 8 — about the age of his own sons now — his father died of kidney failure.

Through quirks of legislative history, nearly everyone with end-stage renal disease in the United States, regardless of income, is covered under federal Medicare for dialysis and transplantation, except illegal

immigrants. But regardless of a patient's immigration status, hospitals can be reimbursed for emergency care by Medicaid, the federal and state insurance program for the needy.

Unlike most states, New York, California and North Carolina define outpatient dialysis as an emergency measure. Studies show such regular dialysis is cheaper, with fewer life-threatening complications, than waiting until toxin levels require hospital treatment.

"What do I have to do to become normal?" Angel remembers asking. The medical answer was clear: a transplant, and anti-rejection drugs costing about $10,000 a year. But news that his brother and sister were compatible donors came with a blunt warning, the waiter recalled: "As long as you don't have your papers, you won't get a transplant."

Like many Mexican New Yorkers, Angel has relatives who migrated years ago without visas and are now citizens. An uncle still works for the restaurateur who helped him legalize. But immigration rules have changed, eliminating such paths.

"My boss, she tried to help me," said the waiter, who supported his mother and half-siblings from the age of 16, and worked his way up from busboy, paying taxes, mastering English and learning enough French to counsel diners on the wine list. "We find no way."

His boss kept hunting. "He deserves every break he can get," she said.

They consulted lawyers at LegalHealth, which counsels low-income patients. Randye Retkin, the director, said the waiter was one of a dozen patients in need of transplants who were referred to the nonprofit program by hospitals last year because of immigration barriers.

For many there is no remedy, Ms. Retkin said. She cited a Mexican mother of two who died without the small-bowel transplant she needed, just as lawyers won a yearlong legal battle for Medicaid to pay for it.

The waiter turned to the Mexican consulate, which appealed to Dr. Manheimer. The doctor said he persuaded surgeons at NYU Langone Medical Center to waive their $20,000 fees, but administrators would not absorb the rest. The hospital declined to comment.

Two other doctors, Hector J. Castro, a critical care specialist, and Kann H. Patel, a hematologist, sent Angel to Mount Sinai Medical Center. But there a financial transplant counselor told him he would have to pay double the typical cost in advance, to cover any complications.

"Personally, I'm troubled by it," said Dr. Sander Florman, who directs the Recanati/Miller Transplantation Institute at Mount Sinai. "We're looking at human beings."

But Dr. Florman confirmed that the waiter's experience reflected policies at the hospital. "Our general approach is we're not the immigration police," he said. "On the other hand, there has to be a mechanism to pay for it."

Mount Sinai officials say they provided $67.3 million in uncompensated care last year, and received $25 million from the state to offset such costs. "Mount Sinai struggles each day to balance its limited resources with its strong commitment to provide compassionate medical care," it said in a statement, noting that kidney transplantation, unlike dialysis, is not an emergency procedure under Medicaid.

For nearly everyone else, however, there is a Medicare option. Scholars trace the unusual program, now costing $40 billion a year, to a 1962 Life magazine article titled "They Decide Who Lives, Who Dies," about laymen at a

Seattle hospital who judged which patients would get scarce treatment on the first "artificial kidney machine." The outcry that followed is often credited for the birth of bioethics and for the 1972 law guaranteeing coverage.

That law did not mention citizenship, said Dr. Scott Sanoff, who teaches medicine at the University of Virginia, but later restrictions, and murky state-by-state variations in Medicaid, left decisions on illegal immigrants' access to care to each medical center, often without any payment mechanism. The life-and-death nature of the decisions has been obscured, he added: In the case of Angel, "his life expectancy could be more than doubled with the transplant compared to dialysis."

The waiter now shuttles between a basement dialysis center, the restaurant and his family's cramped but well-kept walk-up. There, as their children clustered nearby, his brother, 26, said they would not give up.

"He's more than my brother, he's like my father," he said. "If I can give him life, I have to."

The future of Medicare up for debate

December 21, 2011

Used to be, it was politically dangerous to try to tinker with Medicare. Former Arizona Governor Bruce Babbitt lost the support of key Democrats in his bid for the 1988 presidential nomination when he talked about means-testing Medicare and other entitlements. And the 1988 Medicare Catastrophic Coverage Act, which would have significantly expanded coverage, was repealed soon after passage. The reason: Terrified lawmakers capitulated to furious higher-income seniors who were to be charged higher premiums than other beneficiaries.

Lawmakers and politicians don't seem quite as scared these days. Sure, seniors may still be shouting "Don't Touch My Medicare!" at town hall meetings. But as the federal budget deficit widens, the White House and congressional lawmakers in both parties are becoming bolder in calling for cutbacks in the popular health care program for the elderly. Some recommendations for Medicare cuts that would have been considered heresy a few years ago are now moving to the center of public debate.

Many of these proposals would shift more of the cost burden from the federal government on to beneficiaries. Workers who are approaching retirement -- and many current retirees -- should plan to sock away more money for future health care costs.

The impetus for this shift: Growing Medicare costs, which will explode as baby boomers become eligible for the program (the first of the boomers enrolled this year). According to the 2011 Medicare trustees report, the hospital trust fund, which is financed by payroll taxes, will be exhausted by 2024, five years earlier than projected the year before. Meanwhile, the costs of Part B, which pays for outpatient services, and Part D, the prescription-drug program -- both financed by beneficiary premiums and the federal government -- are consuming an ever-increasing share of the economy, according to the trustees.

Dallas Salisbury, president of the nonpartisan Employee Benefit Research Institute, says that "the federal government is proving to be the last to get in line" behind both the private sector and the states in reining in health care spending. Companies and many state governments, he says, have been cutting benefits and forcing beneficiaries to pay more.

Salisbury compares the political environment now to 1983, when Congress ended up following many recommendations of a bipartisan national commission on Social Security. "Everyone became adults suddenly. They said, 'Nobody wants to do this, but we don't have that option, so let's march down that aisle together,'" Salisbury recalls.

Signs of growing bipartisanship on Medicare are recommendations by two deficit-cutting commissions in the past year. A year ago, a distinguished panel of budget experts -- led by Alice Rivlin, budget chief in the Clinton White House, and former Republican Senator Pete Domenici -- proposed significant cuts for Medicare. Soon after, a congressional commission, headed up by Clinton White House Chief of Staff Erskine Bowles and former Republican Senator Alan Simpson, issued its own recommendations for benefit cuts and premium hikes. The four testified Nov. 1 before the congressional "super committee."

Here are some Medicare ideas gaining traction among policymakers:

1. Limiting Medigap coverage. The Simpson-Bowles commission would prohibit Medigap plans, which help cover out-of-pocket costs not covered by basic Medicare, from covering the first $500 of an enrollee's cost-sharing liabilities and limit coverage to 50 percent of the next $5,000 in Medicare cost-sharing. Supporters note that Medigap plans lead to excessive use of health care. President Obama has proposed a surcharge on Medigap plans bought by new beneficiaries.

2. Higher Part B and Part D premiums. Currently, Medicare Part B premiums cover 25 percent of total outpatient costs, with the federal government picking up the rest. The Rivlin-Domenici plan would gradually raise the beneficiaries' share to 35 percent of costs.

About 5 percent of higher-income beneficiaries already pay higher premiums for Part B and for Part D. Obama has proposed extending the freeze on indexing income thresholds for inflation until 25 percent of beneficiaries pay the higher premiums.

3. Charging for home health care. Currently, beneficiaries pay nothing for Medicare home health care. Obama would impose a $100 co-payment for each episode, which is defined as five or more home health care visits not preceded by a stay in a hospital or a skilled nursing home.

4. Raising the Medicare eligibility age from 65 to 67. Legislation by Independent Senator Joe Lieberman of Connecticut and Republican Senator Tom Coburn of Oklahoma would raise the age gradually, by two months every year beginning with people born in 1949. Some experts believe that this will become more feasible when insurance exchanges under health care reform go into effect, because people in their 60s with preexisting conditions should have an easier time finding affordable insurance before Medicare kicks in.

5. Providing vouchers. The Rivlin-Domenici plan would, in effect, provide vouchers, or "premium support," which beneficiaries could use to enroll either in traditional fee-for-service Medicare or in a competing private insurance plan. The fixed premium-support payment would grow at a certain rate each year. If costs of traditional Medicare grow faster, beneficiaries who want to stay in the fee-for-service program would have to pay more.

Whether lawmakers will approve any of these specific proposals is far from clear. One thing is certain, though: Future beneficiaries will pay more out-of-pocket for their health care. As it stands now, a couple both age 65 living to average life expectancy could need as much as $295,000 to cover premiums for health insurance coverage and out-of-pocket expenses during retirement, according to Salisbury's group. A couple who lives to age 95 could need as much as $550,000. And these numbers do not include long-term-care costs.

The take-home message: You will need to set aside a lot of money to pay for your health care costs during retirement.

Group recommends coordinating care for dual-eligibles, leaving more up to states

January 12, 2012

In order to promote coordination between Medicare and Medicaid services and to save money, the federal government and states should create an integrated care model for dual-eligible beneficiaries, a new report recommends.

The 9 million people who qualify for both Medicare and Medicaid accounted for around $230 billion in federal and state spending in 2006, according to the report from the Association for Community Affiliated Plans (ACAP). A majority of these people are eligible for long-term care services.

By creating a new state plan option called the Very Integrated Program or VIP, a permanent integrated, capitated care model could be used by states as their Medicaid state plan.

The VIP is not unlike the Program of All-Inclusive Care for the Elderly or PACE, but the latter has had limited implementation, with only 23,000 dual eligibles enrolled. In order to have enough beneficiaries, the state plan option would have passive enrollment, meaning beneficiaries would have to opt out rather than opt in.

Under the plan, states could provide long-term care services in a managed care environment or with a limited pool of providers, say report authors Jane Hyatt Thorpe, J.D. and Katherine Jett Hayes, J.D. of George Washington University.

"States are uniquely experienced in the provision of long-term care services and supports, as well as behavioral health benefits and services, which often are more robust under Medicaid than Medicare," the report says. It notes that a dual-eligible in a home-based setting with managed care may require fewer hospitalizations and admittance to a long-term care facility, thus "resulting in savings to the Medicaid programs and the health plans administering the combined benefit."

Insurers Offer Gym Memberships With Medicare Programs

By Sarah Frier - *Jan 12, 2012 12:53 PM CT*

UnitedHealth Group Inc. and Humana Inc. are among insurers offering fitness memberships with their Medicare programs as a way to draw healthier and less costly patients, said a report in the New England Journal of Medicine. Photographer: Alessandro Rizzi

The offer of a fitness club membership is helping insurers including UnitedHealth Group Inc. (UNH) and Humana Inc. (HUM) draw healthier and less costly patients to their Medicare programs, said researchers reporting in the New England Journal of Medicine.

The study found 35.3 percent of new enrollees in a fitness membership benefit plan reported “excellent” or “very good” health, compared with 29.1 percent in the group without the benefit. The number of plans offering the memberships rose to 58 in 2008 from 4 in 2002, the researchers said.

The five largest insurers are looking to expand their roles in offering government-subsidized health plans as the number of Americans covered by them grows under the 2010 U.S. health law. In doing so, the companies may try to “cherry pick” members who are more likely to be healthy using the fitness memberships, said Amal Trivedi, an assistant professor of community health at Brown University in Providence, Rhode Island, and the author of the report released yesterday.

“In general, the government’s goal is to have plans compete on their value to Medicare beneficiaries, and not on their ability to cherry pick the healthiest patients,” Trivedi said in a telephone interview. “They have still found a way to do that in a market that’s very regulated.”

Researchers compared about 5,000 people using 11 Medicare Advantage plans offering fitness-club memberships with those who didn’t receive the benefit. The research by Trivedi and Alicia Cooper was based on patient self-reporting, and the groups weren’t randomly assigned to plans.

Advantage Plans

Medicare Advantage is a U.S.-supported program in which managed-care health plans are sold by commercial insurers. The plans cover and help coordinate medical services, physician fees and hospitalizations and offer benefits not offered by traditional Medicare plans. The U.S. prescription drug program for the elderly is regulated so companies can’t deny coverage for high-risk members.

Cigna Corp. (CI) has a Medicare Advantage HMO plan in Arizona that offers a program that reimburses $200 for fitness classes, said Leigh Woodward, a spokeswoman for the Philadelphia-based company, in an e-mailed response to questions.

“The Golden Vitality program isn’t part of a strategy to get a healthier risk pool, but part of our overall health and wellness strategy, which aligns with Cigna’s mission to help the people we serve improve their health, well-being and sense of security,” she said.

‘Popular’ Program

Humana's program "is very popular with our members," said Jim Turner, a spokesman for the Louisville, Kentucky-based insurer, in an e-mail. "The main reason is to help our members stay physically active and live healthier lives."

Advantage programs are required to offer benefits that aren't part of the traditional Medicare plans, said Tyler Mason, a UnitedHealth spokesman. "We work hard to combine a benefit package that offers value to our members. This includes gym memberships when possible," he said in an e-mail.

Cynthia Michener, an Aetna Inc. (AET) spokeswoman, said in an e- mail that the company provides health incentives in programs besides Medicare and government programs, and is not reacting to regulation. Jill Becher of WellPoint Inc. (WLP) didn't return a request for comment.

The government has added standard benefits packages, risk- adjusted payment and guaranteed coverage to balance the industry, said Trivedi, whose study was sponsored by the National Institute on Aging.

The commercial business accounts for less than half of the combined revenue for insurers for the first time in at least two decades, according to a Bloomberg Government report. Quarterly revenue from Medicare, the U.S. program for the elderly and disabled, increased by one third, to $16.4 billion, from the third quarter of 2008 to the same period in 2011 for the four largest insurers that reported figures.

Advantage plans may produce a $10 billion increase in revenue by 2015 as more baby boomers retire, industry analysts have said.

Seniors must get creative to afford prescription costs

Rx for program cuts (photos.com)

For 70-year-old south suburbanite K. Brown, cutbacks in the Illinois Cares Rx program, which helps pay pharmaceutical costs for those in need, have been devastating. Brown fell $50 a month over the earning threshold required to retain the benefits, and her out-of-pocket costs for prescription drugs soared.

Under Illinois Cares Rx, Brown had been paying about $1,700 per year for prescription medications. Without the program benefits, she will pay almost $3,900.

"It's terrible," she says. "I just have to cut back on everything. I can't put anything in the cleaners. When I go shopping, I have to make do with $50 or $60 worth of groceries, and that has to last the month. It's no fun. It's hard . . . I called AARP, and they said if you're one dollar over, you're ineligible."

Program changes

The Illinois Cares Rx program was created in 2006 to supplement the federal Medicare Part D implementation. It was designed to wrap around Medicare Part D and fill in gaps in coverage, helping make prescription drugs affordable for low-income older adult and disabled populations, says Januari Smith, Springfield-based spokeswoman for the Illinois Department of Healthcare and Family Services, and the Illinois Department of Human Services.

For the last several years, approximately 220,000 Illinoisans participated in the Illinois Cares Rx program, and about 178,000 continue to be served, says Maribeth Stein, outreach specialist with Oak Park-based AgeOptions, suburban Cook County Area Agency on Aging.

But following changes to income eligibility standards that went into effect Sept. 1, 2011 and were necessitated by the state's budget crisis, approximately 40,000 of those formerly served, Brown among them, are no longer eligible.

Under the new income thresholds, individuals cannot make more than $21,780 a year, down from $27,610, Smith says. A family of three's income cannot exceed $37,060 annually, down from $45,657. Co-payments for generic drugs surged to $5 from $2.50, and brand name drugs cost $15, up from $6.30.

Stein reports her agency is delighted that about 178,000 people in the state continue to benefit, because there

had been talk that given Illinois's precarious fiscal condition, the program would be eliminated altogether. But the fact remains those no longer eligible now must find a way to fund monthly premiums for their Part D plans, may have to suffer through the deductible phase, and also have higher co-pays than when Illinois Cares Rx was subsidizing their co-pays.

"This isn't a huge problem for those on a couple of generic medications," Stein says.

"But it can be catastrophic for those who are on brand name prescription medications, or many different medications."

Some of the clients with whom AgeOptions works must take 10 to 12 prescription medications, and could be out several hundred dollars a month and thousands of dollars per year. A number of them are financially dependent on Social Security alone, and their medication costs are now 30 to 40 percent of their monthly incomes. "It's a really tragic situation," Stein says.

Getting creative

Benefits counselors who work with the public have had to get very creative in their strategies to help those formerly covered by Illinois Cares Rx find alternative methods of payment for their medications, Stein says. "There are programs sponsored by the individual drug companies that can help those who've left the Illinois Cares Rx program find assistance paying for medications," she adds. "Not all medications have an assistance program, but those that do have their own rules and criteria. And many of them have the caveat that if you're on Medicare Part D, you don't qualify for their assistance programs."

Some Illinoisans who no longer benefit from Illinois Cares Rx are working with their physicians to determine whether the doctors can provide free samples of some medications. There are also patient assistance programs offered by various disease foundations, such as the American Diabetes Association, the American Cancer Society, the National Organization for Rare Disorders, the Chronic Disease Fund, and the HealthWell Foundation, Stein reports.

Another option is the website www.rxassist.org, a current and comprehensive directory of patient assistance programs, which helps folks in need locate manufacturer-sponsored assistance programs, she adds.

AgeOptions may be a resource for some older adults in suburban Cook County.

"Because the topic of economic security among older adults is at the forefront of consciousness among anyone in aging services, at AgeOptions, we have a program called the Economic Security Initiative, or ESI," Stein says.

The program covers the issue of economic security holistically, focusing on issues of affordable housing, money management, access to benefits, employment, health, transportation, legal services and more. Services are offered over the phone by trained counselors who work with those 55-plus at incomes 250 percent or lower of the federal poverty levels. "People who have lost eligibility might get help from ESI in this area and others," Stein says.

As for Brown, she has advice for individuals still in the workforce but nearing retirement age. "Save, save, save," she says.

Problems finding new Medicare primary care doctors small but growing

MedPAC's chair calls the trend "worrisome" and says it's another argument for repealing the SGR formula, which is keeping some physicians from accepting new patients.

By Charles Fiegl, amednews staff. *Posted Jan. 9, 2012.*

Washington -- A federal survey of Medicare beneficiaries shows that slightly more patients are having difficulty finding new primary care physicians to care for them.

Searching for a new family physician or internist who is accepting Medicare patients was more difficult than scheduling an appointment with a new specialist, according to an annual survey on physician access conducted by the Medicare Payment Advisory Commission. The 2011 survey found that 3.6% of Medicare patients reported having no problem finding a new primary care physician, while 2% had what they considered small or big problems finding one. All other patients surveyed were not looking for a new physician last year.

In previous years, surveys showed patients having relatively fewer problems scheduling appointments with new primary care physicians, said Cristina Boccuti, a MedPAC principal policy analyst, during a Dec. 15 commission meeting. Non-Medicare patients also reported more trouble last year.

"In general, for both Medicare and the privately insured groups, access to primary care physicians is trending down, which has been concerning the commission for a number of years," Boccuti said.

MedPAC Chair Glenn Hackbarth called the trend "worrisome" and said the new data reinforced the need to eliminate the sustainable growth rate formula that helps determine Medicare pay rates. The SGR was scheduled to reduce Medicare payments by 27.4% on Jan. 1, but Congress in December 2011 delayed the cut by two months, establishing a new deadline of March 1. The uncertainty caused by the SGR has dissuaded some physicians from accepting new Medicare patients or has prompted them to limit new appointment slots.

A third of Medicare patients looking for a new primary care doctor had trouble finding one in 2011.

Federal lawmakers have continued to defer on a decision to eliminate the SGR by enacting temporary patches for the last decade, Hackbarth said. As a result, the cost of a repeal that would simply maintain current Medicare rates over 10 years has grown to $289.7 billion, according to the Congressional Budget Office. Repealing the formula and providing annual payment updates pegged to the increased costs over time of providing care would cost $352.7 billion, the CBO said.

The fiscal and political climate in Washington is not conducive to writing off these costs, Hackbarth said. The committee also has had concerns that any savings found in Medicare would continue to be used for purposes other than payment reform. For instance, the 2010 health system reform law was financed in part by more than $400 billion in Medicare cuts.

"So our fear as we discuss the SGR over the course of this calendar year is that we were getting closer and closer to the point where continuing the SGR could become a destabilizing force in the Medicare program, and hence the urgency of moving ahead with repeal," he said.

Commissioners discussed renewing their October 2011 recommendations to Congress for repealing the SGR. One recommendation suggests that Congress replace the SGR formula with a 10-year pay freeze for primary care, while reducing payments for other services by 5.9% for three years and then holding rates steady for years four through 10.

The American Medical Association has opposed that recommendation because it says the drastic cuts and freezes to physician pay would not preserve patients' access to care. Many physicians already are facing pay cuts related to Medicare requirements on electronic prescribing, electronic medical records and quality reporting. Reducing base pay or freezing rates would leave doctors unable to care for Medicare beneficiaries and unable to transition to new payment models that better coordinate patient care, the AMA has said.

ADDITIONAL INFORMATION:

Some hard times finding a new physician

The Medicare Payment Advisory Commission's 2011 physician access survey compared beneficiaries and privately insured individuals 50 to 64 years old. The survey found that most patients can find a new doctor when they need one, but slightly more people reported difficulties accessing a new source of care than in 2010. The 2011 survey found that:

- 6% of Medicare patients looked for a new primary care doctor.
- 3.6% had no problem finding a new primary care physician, while 0.7% had a small problem and 1.3% had a big problem.
- 14% sought care from a new specialist.
- 12.1% had no problem finding a new specialist, while 1.1% had a small problem and 1% had a big problem.

Source: "Assessing payment adequacy: fee-schedule and ambulatory surgical center services," MedPAC, Dec. 15, 2011 (www.medpac.gov/transcripts/phys asc public dec2011.pdf)

First Person: Strategies of a Dollar Store Shopper

YAHOO! CONTRIBUTOR NETWORK

By *Sophie Walton* | *Yahoo! Contributor Network* – 18 hours ago

Thu, Jan 19, 2012, 10:15AM EST - US Markets close in 5 hrs and 45 mins

For a long time, dollar stores marketed themselves to lower-income families as a way to save money. However, in recent years dollar stores have become a popular place for consumers of all income brackets. With the recession, dollar stores experienced an increase in volume as people tried to find bargains and ways to save money on everyday purchases. I am no exception, but I knew the value of dollar stores long before the recession.

When my husband and I were first married and barely able to pay rent, I began shopping at the dollar store. When things got better, I continued to shop at the dollar store because it allowed us to save money. When the recession took its toll on our income, the dollar store continued to save us money each month.

Now that dollar stores have gone through some significant changes (they carry name brand products, frozen foods, perishable foods, higher dollar merchandise, etc.), I have had to learn a few new tricks about shopping at the dollar store.

Always check expiration dates - This has always been true. The stores get merchandise that is nearing the end of its "use by date" and pass along the savings to you. However, sometimes you may find items that have passed their use-by date, so check carefully before placing items in your buggy.

Know competitor's prices - I have found items in the dollar store that cost more than the same item at the grocery store. Therefore, I keep a list of the average price of items I buy on a regular basis to make sure I am getting a bargain at the dollar store. I also check the current ads to make sure those items are not on sale that week at my grocery store.

Be cautious of generic cleaners - Unfortunately, over the years I have not had as much luck with generic cleaning products at the dollar store. I have to use twice the amount I would if using a name-brand product, which negates the savings. Now that most dollar stores are carrying name brands, I can save money on my cleaning supplies and still purchase name brands that I know and trust.

Use coupons - Do not forget that dollar stores honor manufacturer's coupons just as other retailers do. Combining your coupons with low prices at the dollar store on necessary household items such as paper towels, toilet paper, shampoo, etc. nets a big savings over other stores.

Look for health and beauty products - Dollar stores are updating their inventory with popular health and beauty aids at lower prices than drugstores. Use manufacturer's coupons for great savings but make sure to check the use-by date before you buy.

Do not forget about the other items in the store - Dollar stores are now carrying better clothing and household items than before, so check the prices before purchasing items at a larger retailer. You can often save money on socks, underwear and kid's clothing. Pet supplies, kitchen items and garden tools are also great buys at the dollar store.

My friend complained that she hated shopping at the dollar store because it was not "pretty." I fail to see how that could matter if you were saving money but I guess the owners of dollar stores were listening to people like

her. Most dollar stores are now well-lit, with wider, better organized isles. The facelift has attracted more consumers who are looking for better bargains and like the convenience offered by dollars stores.

The Real Best Places to Retire in 2012

By *Tom Sightings* | *U.S.News & World Report LP* – 20 hours ago

A blizzard of articles give advice about the best places to retire. They generally recommend fleeing the North and heading for the Sunbelt, to places in the Carolinas, Florida, or Arizona. Occasionally they offer a surprise retirement spot in Iowa or Indiana. Sometimes they even tout retirement locales outside the United States.

These articles rely on statistics such as the cost of living or winter temperatures. But they miss the most important thing--the human element. Here are the real best places to retire:

Stay home. As we get older, moving, making new friends, and acclimatizing ourselves to new surroundings gets more difficult. Don't underestimate the value of your current community. Think long and hard before you cut those connections to go off to get a sunburn.

Your hometown likely offers more senior citizen benefits than you think including tax breaks, low-cost transportation, and subsidized meals. We have friends in the outer suburbs of New York who always thought they would retire somewhere warmer. But they finally realized how important their church community was to them and decided to stay put. Now they visit the senior center for a free meal every Thursday night. They walk at the mall two or three mornings a week and stay for coffee with new acquaintances. And they are still active in their church, among the friends they've known for decades.

Move near your children. My brother-in-law spent most of his career working around Pittsburgh, Pa. After he retired, he and his wife gathered together all the brochures and ultimately decided to move to Massachusetts. Their daughter lives outside of Boston and their son is in Rhode Island. They moved from a four-bedroom suburban home to a two-bedroom bungalow in their daughter's town. Their yard is smaller, just right for Grandpa to keep an eye on the grandkids while he relaxes on the patio. They've met new friends through their daughter, and they love their new life, in an area often billed as cold and expensive.

Follow your friends. One fellow I know retired to Maryland. Why? His long-time golfing partner retired there a few years earlier. He moved to the same town, joined the same golf club, and soon they were prowling the links together, just like old times. A year later, another friend joined them, who had a relative living nearby, and they all now play golf twice a week.

Their wives, who had known each other casually, are now close friends. They started a bridge club, brought in some other women, and from there developed meaningful connections to the community. These couples now feel as though, as one of the women put it, "We've lived here all our lives."

Move back home. One friend of mine grew up in El Paso, Texas. She went to college in California, then got married and moved to Washington, D.C. Some 25 years later, her husband died and she felt lost in the big city. She moved back west, to nearby New Mexico, where she started a small business which included some clients in Washington. Now she lives in her beloved mountains and travels to Washington occasionally to see clients.

Another woman grew up outside New York. She got married and moved to Oregon and spent most of her 20s and 30s around Portland. Eventually she got divorced and moved first to California, then Arizona, with a year-long stint in Alaska. But when she retired, she felt the pull of Portland, where she still had friends. To her, that was home. And that's where she moved.

No matter where you end up in retirement, remember that relationships are more important than the weather. The warmest climate can be found amidst the safety and security of family and friends.

Column: Why doctors might be turning on 'ObamaCare'

By Marc Siegel

Updated 1d 22h ago

The final verdict may not be in yet, but some of the early returns on "ObamaCare" are not good. Indeed, many doctors are becoming wary of the law at a time when only one in three Americans support it.

- 

  File photo by Gerald Herbert, AP

  In the Rose Garden: President Obama greets doctors after speaking about health care reform in 2009.

USATODAY OPINION

In addition to its own editorials, USA TODAY publishes a variety of opinions from outside writers. On political and policy matters, we publish opinions from across the political spectrum.

Roughly half of our columns come from our Board of Contributors, a group whose interests range from education to religion to sports to the economy. Their charge is to chronicle American culture by telling the stories, large and small, that collectively make us what we are.

We also publish weekly columns by Al Neuharth, USA TODAY's founder, and DeWayne Wickham, who writes primarily on matters of race but on other subjects as well. That leaves plenty of room for other views from across the nation by well-known and lesser-known names alike.

In late December, a survey of 501 physicians was released by the Deloitte Center for Health Solutions research group, whose parent company serves clients in the health care industry. Nearly half (48%) expected health reform to hurt their incomes this year, while 73% said it would not reduce costs.

Though this isn't a scientific survey, and other such surveys have and will show physicians' support for the Affordable Care Act, the early glimpse of the law's potential impact will likely lead to economic pain for doctors and a diminished system for their patients. Indeed, the Deloitte survey found that 69% of the physicians are "pessimistic about the future of medicine" because of the law.

I'm not here to judge doctors who back ObamaCare. But as a practicing physician, I simply need to look at the economics of medicine, apply my own experience and see the law as it unfolds to know that physicians across this country should be demanding if not a new system, at least a better one.

The early days

In June 2009, when President Obama attended a "white coat" ceremony at the American Medical Association headquarters in Chicago, and this organization of physicians (roughly 17% are members) went on to deliver its endorsement of the president's legislation, physicians had a nagging question: Did we agree with the AMA's position, or was the organization taking us for a ride? The answer is becoming clearer as the law is being implemented.

An online survey in September by the Jackson & Coker physician recruitment firm — based on 1,611 doctors who chose to respond — reflected that the majority of doctors don't believe that the AMA represents their views. The primary reason: the AMA's support of the legislation. Just 13% of those surveyed backed the Affordable Care Act.

Doctors traditionally have been unhappy with insurance mandates because third-party payers, whether public or private, represent a seemingly unnecessary interface between us and our patients. Many doctors today prefer to accept cash, even at a great discount, rather than having to deal with the burden imposed by insurers.

Yet the glaring inadequacy of the health care reform law is that putting the bureaucratic burdens on steroids does little to change the trajectory of health care spending. The law also floods the system with patients while tightening the financial screws on those in the health care industry.

We're two years into this experiment, and the realities of the law — more regulations, more patients with low-paying insurance, higher costs but lower payments to doctors — are sinking in.

When surveyed by Deloitte, 83% of doctors said one likely change to the medical system as a result of the law would be increased wait times — an inevitable outcome of insuring millions more patients without a matching increase in the number of doctors. Not too surprising. Most doctors surveyed also noted that the changes will "pose considerable implementation challenges." I suspect it would be hard to find someone in the health care industry — or any employer, for that matter — who would disagree with that expectation.

And it doesn't get better

It's one thing to mandate insurance for all, but quite another to do so without incentivizing physicians or those considering the profession. In fact, the law does the opposite: For many doctors, there becomes a financial *disincentive* to practice medicine.

The Association of American Medical Colleges estimates that the USA will be 160,000 physicians short by 2025 (when all patients would be insured under ObamaCare), and this is without even considering those doctors who will limit their practice to insured patients because of decreasing reimbursements or who retire early when faced with increasing costs with little return.

Doctors are catching on fast to the essential deficiencies of ObamaCare, but so are America's patients. The concern of doctors is reflected among the American people: Support for the law has sunk to 29% in the latest Associated Press poll.

Think of ObamaCare as a heavy horse-drawn cart loaded with all of America's patients and best technologies. As the cart gets heavier and heavier, does it make sense that we don't add more horses but instead feed the ones we have less and less while expecting them to pull the additional weight?

I think more and more doctors are going to pull up lame if the law's many shortfalls aren't addressed — and stat.

Marc Siegel, a physician, is an associate professor of medicine and medical director of Doctor Radio *at NYU Langone Medical Center. He is the author of* The Inner Pulse *and a member of USA TODAY's Board of Contributors.*

BCBSIL Named Best in Customer Satisfaction in 2012 Insure.com Survey January 25, 2012

Blue Cross and Blue Shield of Illinois (BCBSIL) is ranked the best in a 2012 customer satisfaction survey among large health insurers in the U.S., according to a leading consumer insurance information website, Insure.com.

"We're not a publicly traded company, in fact, we're member owned," said Karen Atwood, president of BCBSIL, "So, to be recognized for customer service and satisfaction by our members is indeed a high honor, one that we don't take lightly. We're continuously working to improve how we care for our members and the communities we serve."

Insure.com is not affiliated with any insurance company, nor is it a health insurance producer itself. According to the company's announcement, more than 4,500 insurance customers were surveyed between February and August 2011 for customer service ratings and reviews. Top companies were included by market share, but not all large companies are represented in the rankings due to lack of data. The top companies in each category earned Insure.com's *People's Choice Award*.

The survey broke out five measurements of customer satisfaction for large insurance companies:

- Customer service
- Claims experience
- Value for the price paid
- Percent who plan to renew their policies
- Percent who would recommend their insurers

Austin Waldron, BCBSIL's senior vice president of Customer Service, explained, "Our customer service philosophy is to 'take the member out of the middle.' This means we do the legwork, the translation of complicated terms, and reach out to hospitals and doctors, helping BCBSIL members navigate the sometimes confusing health care system. Our customer service teams consist of great people doing great things for our members, and we are proud to be recognized for our efforts."

Insure.com provides a comprehensive array of information on life, health, auto and home insurance. The site offers a vast library of originally authored insurance articles and decision-making tools that are not available from any other single source. Insure.com does not provide nor solicit insurance, and is not a licensed insurance producer. Insure.com is not advertising on behalf of any of the companies listed or mentioned on its site.

To see more about how insurance companies measured up, visit: Best Insurance Companies.

Chicago's largest health insurers

By Gabrielle Tompkins January 23, 2012

Crain's has just published its list of Chicago's largest health insurers, ranked by total enrolled members as of Dec. 31, 2011. This list was last published in 2009.

Topping the list this year is Blue Cross & Blue Shield of Illinois with more than 3 million enrolled members. It's followed by United Healthcare of Illinois and Humana Inc., in second and third place, respectively.

The list also highlights the types of plans offered, an enrollment breakdown, and affiliated physicians and hospitals.

Could You Be a 15-Percenter? Decoding Tax Rates

Could you be a 15-percenter? A look at factors that determines your tax rate

By *Candice Choi, AP Personal Finance Writer* | *Associated Press* – Wed, Jan 25, 2012 5:37 PM EST

NEW YORK (AP) -- Millionaires can be just like everyone else. At least when it comes to paying taxes.

Mitt Romney released records this week that show he pays a tax rate of about 15 percent of his income. The relatively low figure is raising eyebrows because it's on par with the rate paid by many middle-class households. That's despite the Republican presidential candidate's impressive income of $45 million over the past two years.

The disparity seems to fly in the face of the basic rule that tax rates move in tandem with wages; the more you earn, the more you pay. So Romney's disclosure may stir suspicions that the system is tilted toward the rich.

In his State of the Union speech Tuesday night, President Barack Obama focused on the issue by noting that a quarter of all millionaires pay lower tax rates than millions of middle-class households.

"We need to change our tax code so that people like me, and an awful lot of members of Congress, pay our fair share of taxes," Obama said in a speech that repeatedly touched on the gap between the rich and poor.

On average, the wealthy pay taxes at a much higher rate than the middle-class individuals. But the primary reason that many pay a lower tax rate is that more of their income comes from investments, which is generally taxed at a far lower rate than wages.

Even if investment income doesn't play a big role in your finances, understanding the basics of how tax rates work can help even the average wage earner save hundreds, if not thousands of dollars a year.

Here's an overview of what you need to know:

___

TAX RATE BASICS

Although it's common to grumble about taxes, taxpayers often don't know precisely what percentage of their income goes to the government. So an essential starting point is to look at how tax rates are applied.

Taxpayers can currently fall into one of six federal tax brackets depending on their taxable income. This amount includes items such as wages and distributions from retirement accounts. The tax rate for each bracket ranges from 10 percent to 35 percent. This is the most basic building block of tax planning because your taxable income can be reduced considerably by various credits, exemptions and deductions.

Here's the breakdown of how much single filers would pay in federal income taxes depending on their taxable income for 2011:

1. 10 percent - income up to $8,500

2. 15 percent - over $8,500 up to $34,500

3. 25 percent - over $34,500 up to $83,600

4. 28 percent - over $83,600 up to $174,000

5. 33 percent - over $174,400 up to $379,150

6. 35 percent - amount over $379,150

Keep in mind that these are marginal rates, meaning your income is taxed in tiers. The first $10,000 you earn, for example, is taxed at a lower rate than the next $10,000.

So let's say you earned $100,000, putting you in the 28 percent tax bracket. This doesn't mean you'd fork over $28,000 in federal income taxes. It means that the amount you earn above a certain threshold is taxed at 28 percent. Your federal income taxes would actually be closer to about 22 percent of your income.

The current federal rates are set to expire at the end of this year. If Congress doesn't act by then, the rates would revert to levels from before the Bush-era tax cuts, which ranged from 15 percent to 39.6 percent.

For now, federal income tax rates overall are near historic lows, says Joseph Rosenberg, a research associate at the Tax Policy Center in Washington, D.C. He also said that nearly half of Americans do not pay any federal income taxes as a result of various exemptions given to those with dependents and limited incomes.

Federal income taxes are only a piece of the larger tax picture, however. Payroll taxes, which go toward Social Security and Medicare, eat up another 5.65 percent of wages. That rate returns to 7.65 percent if the payroll tax cut pushed by Obama isn't extended past February.

State taxes are another factor and can vary widely, with rates ranging from as low as 3.4 percent in Indiana to 11 percent in Hawaii and Oregon, according to H&R Block's Tax Institute. A handful of states, including Alaska and Florida, do not have an income tax.

THE EXCEPTIONS

Not all income is taxed at the rates outlined above. A key exception is any money earned from long-term investments, such as stocks, mutual funds and real estate held for at least a year. This income is classified as capital gains and is taxed at a flat 15 percent. That's regardless of whether it's $100 or $1 million.

"This is why someone who's a millionaire might have an effective tax rate that's lower," said Gil Charney, a tax analyst with H&R Block's Tax Institute. "A higher percentage of their income is going to be from long-term investment income."

In Romney's case, a chunk of his income in 2010 and 2011 came from Bain Capital, the private equity firm he founded and managed between 1984 and 1999.

Bain still pays Romney "carried interest," which is a classification of pay for managers of hedge fund and private equity firms. Critics say this type of compensation and should be taxed as salary at ordinary rates. But as it stands, carried interest is considered capital gains because it's profit in excess of what investors paid into the fund, Charney said.

The tax rate for capital gains wasn't always 15 percent. The rate has moved up and down through the years. In the 1970s, for example, the figure was close to 40 percent. And if Congress doesn't act by the end of the year, the capital gains tax rate will revert back to 20 percent.

___

REDUCING TAXES

Tax rates are subject to political influences. But there are a few standby strategies taxpayers can use for reducing their tax bill.

A key tactic is to reduce taxable income; this is why financial planners are such advocates of maximizing contributions to 401(k) accounts. Workers can reduce their taxable income by as much as $17,000 a year. For traditional individual retirement accounts, the maximum contribution is $5,000 a year.

Most large employers also let workers set aside up to $5,000 of pre-tax wages in a health care flexible spending account. This money can be used for a variety of medical costs, including co-pays, prescription drugs and supplies such as cold packs.

There are also numerous tax breaks for donations and education and health care costs that you may incur anyway.

Not everyone will be able to get their tax rate down to 15 percent. Yet there are numerous steps you can take to minimize your tax bill.