Health & Retirement Services of Illinois

Newsletter February 2019

OUR NEWS LETTER

In Our Newsletter

A HEALTHY START TO THE NEW YEAR

NONFATAL INJURY AND ILLNESS CASES ON THE DECLINE

PRICE LISTS THE FIRST STEP TOWARD HEALTH CARE REFORM

HEALTH COSTS TOP CONCERN FOR AMERICANS PLANNING RETIREMENT: POLL

TAKE ACTION TO PREVENT VISION LOSS

MEDICARE`S NEW MOBILE APP

Happy New Year from Medicare!

Get a healthy start to the year by seeing your doctor for your Medicare yearly wellness visit. It's covered if you've had Medicare Part B for longer than 12 months.

Use this visit to develop or update your personalized prevention plan to help you stay healthy all year long. This wellness visit is covered once every 12 months. Yearly "Wellness" visits

If you've had Medicare Part B (Medical Insurance) for longer than 12 months, you can get a yearly "Wellness" visit once every 12 months to develop or update a personalized prevention plan.

Your costs in Original Medicare

You pay nothing for this visit if your doctor or other qualified health care provider accepts Assignment.

The Part B deductible doesn't apply.

However, you may have to pay coinsurance, and the Part B deductible may apply if:

- Your doctor or other health care provider performs additional tests or services during the same visit.
- These additional tests or services aren't covered under the preventive benefits.

What it is

This plan is designed to help prevent disease and disability based on your current health and risk factors. Your provider will ask you to fill out a questionnaire, called a "Health Risk Assessment," as part of this visit. Answering these questions can help you and your provider develop a personalized prevention plan to help you stay healthy and get the most out of your visit. It can also include:

- A review of your medical and family history.
- Developing or updating a list of current providers and prescriptions.
- Height, weight, blood pressure, and other routine measurements.
- Detection of any cognitive impairment.
- Personalized health advice.
- A list of risk factors and treatment options for you.

- A screening schedule (like a checklist) for appropriate preventive services. Get details about coverage for screenings, shots, and other preventive services.
- Advance care planning

Nonfatal injury and illness cases on the decline

by Bethan Moorcraft 02 Jan 2019

The latest Bureau of Labor Statistics (BLS) 'Employer-Reported Workplace Injuries and Illnesses' report states there were approximately 2.8 million nonfatal workplace injuries and illnesses reported by private industry employers in 2017. That's nearly 45,800 fewer nonfatal injury and illness cases than the prior year.

Of the cases reported, nearly one-third resulted in days away from work. The private industry incidence rate for days away from work was 89.4 cases per 10,000 full-time equivalent workers, and the median days away from work in 2017 was eight, unchanged from 2016.

A return-to-work program allows workers who are unable to perform their usual job duties because of a nonfatal injury or illness to return to work in a limited or temporary light-duty capacity. Being proactive and supportive about getting employees back into work is a win-win for everybody involved – the employer, employee and the workers' compensation insurer.

The employer retains their employee and reduces the costs of a replacement; the employee is being cared for and supported through an injury and is able to get back to normality as quickly as possible; and the insurance company also wins because it doesn't have to pay out such a lengthy and costly claim.

"An efficient return-to-work program should explain to employees the availability of modified duties and the benefits of returning to work quickly, such as restoring their income and maintainngi their skills," said David Macy, vice president of claims at EMPLOYERS Insurance, a small business workers' compensation insurance specialist.

He added: "The policy needs to include language about the need for a return-to-work doctor's note that details any physical limitations or restrictions the employee may have. It's also important to keep in mind that the nature of the work is meant to be temporary, so these jobs should have a time limit."

Among the 19 private industry sectors analyzed by the BLS, only manufacturing, finance and insurance experienced statistically significant changes in their overall rates of nonfatal injuries and illnesses in 2017. They each saw declines of 0.1 cases per 100 full-time equivalent workers compared to 2016.

In manufacturing, the leading type of injury in 2017 was sprains, strains and tears, at 34,110, unchanged from 2016. The average number of days away from work for manufacturing employees who suffered from sprains, strains, and tears was 10, one day fewer than in 2016.

Such improvements suggest employers are starting to understand the benefits of workplace safety, robust return to work programs, and treating employees like valuable assets.

As Cammie McAda, vocational rehab employer services leader in the professional services team at Guardian stated: "The industry is starting to recognize that people really count. At Guardian, we encourage people to be proactive about getting people back into work [after a nonfatal injury or illness]. At the end of the day, everybody benefits!"

Price Lists The First Step Toward Health Care Reform

Past and prospective hospital patients have an extra reason to celebrate now that the date has changed from Dec. 31 to Jan. 1.

A Centers for Medicare and Medicaid Services rule enacted in April requires every American hospital to publish its standard price list online in 2019. While that won't make scheduling a surgery as simple as ordering a pizza, it's an important first step in bringing price transparency to the notoriously opaque and byzantine health care bureaucracy.

The figures you'll see aren't likely to correlate with those on your hospital bill even if you're uninsured and paying out of pocket. That's because hospital price schedules, called chargemasters, generally contain the kind of inflated base costs that no one really pays. It's akin to the manufacturer's sticker price for a new car before rebates, discounts and dealer incentives are added.

"The list prices are so high that the vast majority of hospitals don't even try to collect list prices from uninsured patients," Benedic Ippolito of the American Enterprise Institute told the Journal-News of Middletown, Ohio.

Those prices sometimes rear their ugly heads, however, when an insured patient visits an out-of-network hospital or clinic. Those health care providers may charge you the difference between what your insurance company pays and its full list price, a practice known as balance billing.

Federal regulations already require hospitals to make prices available, the Associated Press notes, but the April rule ensures that the information will be placed online "in machine-readable format that can be easily processed by computers."

We wouldn't be surprised if that leads to a cottage industry of comparison websites that break down the data and allow patients to see how much a common procedure could cost from providers within a 50-, 100- or 300-mile radius of their home address. Without the prices that hospitals charge insurers, that information may have little real-world value. But it could still nudge health care closer to the world of free-market price competition.

Perhaps insurance companies can use the public data as leverage to reduce costs for their in-network patients. Lower costs, in theory, would then lead to lower premiums.

Patients could augment the charge master data dump by anonymously revealing what they and their insurers paid in the same way that websites like Glassdoor and PayScale aggregate average salary information to give job-seekers an estimate of the pay range for their position within a company, industry and region.

James C. Capretta, a scholar who holds the Milton Friedman Chair at the American Enterprise Institute, wrote in May that the insurer-as-broker system keeps health care costs artificially high.

“Price transparency does not exist today because medical care isn’t bought and sold in a typical market,” Capretta explains. “Because hospitals and physicians get so little of their revenue directly from consumers, they have no need to compete on price, and thus no need to make meaningful prices publicly available. Patients paid directly for only 11 percent of the services provided to them in 2016.”

Dale Folwell, North Carolina’s elected state treasurer, wants to enlist each government worker and retiree on the state health plan in the effort to push providers toward lower prices. In a symbolic but meaningful change, he redesigned enrollees’ insurance cards to bear the message: “Paid for by you and taxpayers like you.” In doing so, he deputized everyone on the state’s plan as a watchdog on the lookout for inflation, waste and fraud.

No one expects doctors and nurses to work for free or hospitals to compromise quality in a race to the bottom on price. But when true costs are clear as mud, it’s crystal clear that a whole lot of middlemen have found ways to wedge themselves between physician and patient and extract a tidy profit.

Health and Human Services Secretary Alex Azar cites price transparency and cost competition as key planks in his platform to make health care more affordable.

“America’s health care system has to change, and President Trump’s administration recognizes that,” Azar said in a prepared statement. “This payment proposal takes important steps toward a Medicare system that puts patients in charge of their care and allows them to receive the quality and price information needed to drive competition and increase value.”

Azar’s vowed to “disrupt our existing system” of health care, and every patient stuck with a barrage of bills for basic procedures knows it needs some serious disruption. We hope he is successful.

Online price lists won’t fix health care overnight, but as the calendars change to 2019, patients will have more information available at their fingertips than they did the year before. That merits a champagne toast.

Health Costs Top Concern For Americans Planning Retirement: Poll

Nearly two-thirds (65%) of Americans are confident they have saved enough -- or will save enough -- to retire comfortably, yet this confidence is tempered by worries over health care costs. In fact, the high cost of care is the top reason many aren't saving as much as they would like to now, and it tops the list of future worries.

	Under 50	Over 50
Expect to work full-time as long as possible	85%	67%
Contribute the maximum to a workplace plan	65%	47%
Have worked with a financial planner*	70%	58%
Have a health savings account	49%	31%
Would consider purchasing an immediate annuity	39%	20%
Would consider a reverse mortgage	31%	10%
Planning to relocate in retirement	43%	32%

Source: Kiplinger – Personal Capital Poll, November 2018. *Among those with a long-term financial plan.

These conclusions are among the major findings of a new nationwide poll released today by *Kiplinger's Personal Finance* and leading hybrid digital wealth management company Personal Capital.

"Health costs represent a growing concern among aging Americans—which is why it's crucial to begin saving for retirement well in advance," said Mark Solheim, editor of *Kiplinger's Personal Finance.* "Saving as much as possible today ensures a comfortable and secure retirement tomorrow. Our poll shows a promising trend: By and large, Americans are prioritizing retirement planning. Most are stashing a respectable chunk of their income in savings, and nearly three-fourths have a long-term financial plan."

Surprisingly, the poll also finds that younger Americans are more actively preparing for retirement than those over 50. For example, they are more likely to contribute the maximum to their workplace retirement plan and are more likely to have a health savings account. They are also more open to alternative ways to fund retirement, such as purchasing an annuity, applying for a reverse mortgage, or relocating in retirement.

"It's encouraging to see so many Americans prioritizing retirement savings and working with a professional to build long-term financial plans," said Jay Shah, CEO of Personal Capital. "Yet, fewer than 50 percent of those polled said they also had a withdrawal plan - a critical and often overlooked part of planning for retirement. We recently added a new tool to our digital

Retirement Planner that gives people more clarity around which accounts to withdraw from and when in order to confidently maximize retirement income."

The poll, conducted in November 2018, surveyed investors between the ages of 35 and 64, equally divided between men and women, who had made at least one investment transaction in the past year. Excerpts from the poll will appear in the February issue of *Kiplinger's Personal Finance* magazine, with more results at kiplinger.com/links/poll.

TAKE ACTION TO PREVENT VISION LOSS

Glaucoma is a group of diseases that can cause permanent vision loss and blindness. Some forms of glaucoma don't have any symptoms, so you may have glaucoma even if you don't have any trouble seeing or feel any pain.

If you find and get treatment for glaucoma early, you can protect your eyes from serious vision loss. **Medicare will cover a glaucoma test once every 12 months if you're at high risk.**

Glaucoma tests

Medicare Part B (Medical Insurance) covers glaucoma tests once every 12 months if you're at high risk for glaucoma. You're at high risk if one or more of these applies to you:

- You have diabetes.
- You have a family history of glaucoma.
- You're African American and age 50 or older.
- You're Hispanic and age 65 or older.

Your costs in Original Medicare

- You pay 20% of the Medicare-approved amount and the Part B Deductible applies.
- In a Hospital outpatient setting , you also pay a Copayment .

Note

To find out how much your test, item, or service will cost, talk to your doctor or health care provider. The specific amount you'll owe may depend on several things, like:

- Other insurance you may have
- How much your doctor charges
- Whether your doctor accepts assignment
- The type of facility
- Where you get your test, item, or service

Note

Your doctor or other health care provider may recommend you get services more often than Medicare covers. Or, they may recommend services that Medicare doesn't cover. If this happens, you may have to pay some or all of the costs. Ask questions so you understand why your doctor is recommending certain services and whether Medicare will pay for them.

Things to know

An eye doctor who's legally allowed to do this test in your state must do or supervise the screening.

MEDICARE'S NEW MOBILE APP

Is your medical item or service covered by Medicare Part A and/or Part B? Now there's a quick way to check!

Download Medicare's official "What's Covered" app — available for free on the App Store and Google Play.

Use the app at the doctor's office, in the hospital, or anywhere you use your smartphone or tablet. Once it's installed, you can use "What's Covered" even when you're offline.

Search or browse in the app to learn **what items and services are covered, how to get covered benefits, and basic cost information.** Learn more about our new app at **Medicare.gov**.

If you're reading this on your phone or tablet, get the app directly from the App Store or Google Play

Dental Coverage
for as
low as
$15
a month!

Click Here for more
Details
OR
Call 1-800-739-4700

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