Health & Retirement Services of Illinois
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OUR NEWS LETTER

Administration tightens ObamaCare sign-up rules

By Peter Sullivan - 05/06/16 05:11 PM EDT

The Obama administration on Friday announced changes to ObamaCare sign-up rules that are intended to cut down on people gaming the system and address a complaint from insurance companies that they say is causing them to lose money.

The Centers for Medicare and Medicaid Services (CMS) announced that it is tightening the rules for enrolling in one of ObamaCare's extra sign-up periods.

The extra periods allow people to sign up for insurance outside of the regular enrollment period if they move. The change announced Friday requires that people have coverage at some point in the preceding 60 days, which is intended to prevent people from moving for the sole purpose of becoming eligible to sign up for health insurance.

Insurers have complained that current rules are too lax, allowing people to game the system and only sign up for insurance when they need care, driving up costs for insurers and contributing to losses on the ObamaCare marketplaces.

"CMS is committed to help strengthen the Health Insurance Marketplace," spokesman Aaron Albright said in announcing the changes.

The agency on Friday also clarified the six valid reasons for using an extra sign-up period. Further, in February, the administration announced that it would start requiring enrollees to submit documentation to prove that they qualify for enrolling in an extra period.

Some insurers still say that the rules have not been tightened enough.

Secondly, the administration on Friday **also announced** steps aimed at allowing ObamaCare's nonprofit health insurers, known as co-ops, to attract outside investors more easily.

Republicans have seized on the closure of 12 of the 23 co-ops due to financial problems, and the administration has been looking for ways to help improve the finances of the ones that remain.

In Our Newsletter

Insurers signal Obamacare rate hikes, but feds say don't believe it

BY DANIEL CHANG

With health insurance companies warning that losses from their Affordable Care Act plans are unsustainable, and large carriers leaving the so-called Obamacare exchanges in many states, industry analysts are expecting that monthly premiums will rise significantly in 2017.

Not so fast, says the Obama administration.

Pushing back on recent reports predicting big rate increases next year, the Department of Health and Human Services fired off a statement on Friday reminding Florida consumers they've seen this movie before.

When state officials predicted an average 9.5 percent increase in monthly rates for all individual plans in 2016, the actual amount paid by Floridians receiving government aid to pay their premiums was much lower, according to HHS.

INITIAL HEALTH INSURANCE RATE FILINGS FOR 2017 ARE DUE TO FLORIDA'S OFFICE OF INSURANCE REGULATION ON MAY 11. THE INITIAL FILINGS CONTAIN PROPOSED PREMIUMS BUT DO NOT ACCOUNT FOR THE EFFECT OF RATE REVIEW, CONSUMER SHOPPING BEHAVIOR, OR TAX CREDITS RECEIVED BY QUALIFYING INDIVIDUALS.

That's because government subsidies reduced the cost of coverage for about 91 percent of the estimated 1.7 million Floridians who selected an ACA plan for 2016. The average monthly subsidy for Floridians who received the financial aid, according to an April 12 study published by HHS, was about $302.

Consumers also saved money by shopping around for lower-priced plans, and relied on state officials to regulate premiums. Comparing the average monthly premium among Floridians who received subsidies, HHS reported that those consumers paid about $82✔ in 2015 and about $84✔ in 2016, an increase of 2 percent.

With the May 11 deadline approaching for insurance companies to file initial rate proposals for plans to be sold in Florida in 2017, HHS officials said Obamacare consumers are likely to see initial rates higher than what consumers will actually pay once the federal and state regulatory processes are completed by fall.

"Consumers' actual health insurance premiums depend on whether they shop around for the best deal and the availability of tax credits that lower premium costs, both of which changed the picture dramatically in 2016," said Richard Frank, HHS assistant secretary for planning and evaluation.

For consumers who buy their own health insurance but do not receive government subsidies to help pay their premiums, however, the rate hikes will be more painful, said Steven Ullmann, a health policy expert with the University of Miami School of Business.

Ullmann said that's partly because many of the individuals who buy Obamacare plans were unable to find or afford coverage prior to the ACA. People who are generally sicker tend to buy better health insurance policies.

1.7MNumber of Floridians who signed up for an Affordable Care Act plan for 2016

Indeed, insurance companies are finding that many Obamacare consumers tend to be sicker because they were previously uninsured and likely deferred care. Ullmann said insurers also have suffered because young and healthy people are still not signing up for Obamacare plans.

"If that group had been enrolling at a higher rate, then it would have distributed risk more and it would have brought down the rates for everybody," he said. "That's still an issue."

Another issue impacting insurer losses: Many may have priced their plans low in 2014 and 2015 to capture a greater market share.

When insurers did not receive government payments promised to them in 2010 under the so-called Risk Corridor program, which was designed to protect insurance companies against the risk of covering patients who were too sick during the first three years of the ACA exchange, the losses became unsustainable.

Ullmann emphasized, however, that the gains in coverage achieved under the ACA should ultimately benefit all Americans. A May 2015 RAND study indicated 16.9 million people, net, were newly insured under the ACA.

"It does ultimately bring down the cost of healthcare for society," he said. "The reason being that people who now do have health insurance and therefore do have access to preventive care and to a primary care provider ... will not be utilizing the emergency room. And the emergency room is the highest cost and, if you will, lowest quality type of care because it's not consistent."

Raising Medicare's Eligibility Age Could Trigger Gov't Savings, But Tally Higher Total Health Spending

By **Michelle Andrews** May 6, 2016

Healthcare spending for some services dropped by nearly a third when people turned 65 and switched from private insurance to Medicare, according to a recent study. The decline was driven by lower prices paid by the Medicare program to doctors and other providers rather than a drop-off in the volume of services seniors receive.

The study offers a preview of the potential impact of raising the Medicare eligibility age to 67 from the current 65, said Jacob Wallace, a doctoral candidate in health policy at Harvard University who coauthored the study, which was published in the May issue of Health Affairs.

"What this study shows, pretty clearly, is that while the government may save money by increasing Medicare eligibility to 67, overall national health care spending will go up," Wallace said.

Using the claims data of 200,870 retired people who transitioned to traditional Medicare from private insurance at age 65, researchers tracked healthcare spending on a per member, per quarter basis for two types of services, outpatient imaging and procedures. The study looked at claims paid for people between the ages of 62 and 68.

When people turned 65 and enrolled in Medicare, the amount that insurers and beneficiaries spent on those services dropped 32.4 percent on average, or $38.56.

The spending decline wasn't tied to a reduction in beneficiaries' use of health care services, the study found. Rather, once seniors enrolled in Medicare, doctors continued to see these patients, but at reduced rates.

"It crystallized for me that Medicare, due to its large market share, is able to extract larger discounts from providers than other payers," Wallace said. "Medicare is able to pay physicians 30 percent less than other payers, without leading to a reduction in access."

The impact on individual patients is less clear, since the change in their spending upon enrolling in Medicare would depend on the generosity of the private coverage they had before. But since Medicare generally pays less for services than private insurance, it's fair to say that seniors might expect to pay less as well for services when they're responsible for paying a percentage of the cost in the form of coinsurance, Wallace said.

As for raising the Medicare eligibility age to 67, the study's findings are consistent with a 2011 analysis by the Kaiser Family Foundation, the study said. (KHN is an editorially independent program of the foundation.) That study estimated that raising the Medicare eligibility age would have saved the federal government $5.7 billion in 2014 but would also have increased the out-of-pocket costs of 65- and 66-year-olds by $3.7 billion and employer retiree health care costs by $4.5 billion.

"These findings, like ours, may seem counterintuitive but show the importance of looking at the total picture when trying to understand the effects of a seemingly straightforward proposal," said Tricia Neuman, director of the program on Medicare Policy at the Kaiser Family Foundation who coauthored the analysis.

The Social Security horror stories just keep piling up

Philip Moeller, co-author of “Get What's Yours: The Revised Secrets to Maxing Out Your Social Security”

Three big Social Security myths dispelled; Sharon Epperson breaks down a few common myths about social security and explains how you can make the most of every check.

Among all of Social Security's arcane rules, secrets, and claiming surprises, the greatest personal revelation to me has been that the agency often gives out confusing, inconsistent, and even flat-out wrong information. Color me naïve, but when I began research for our book, I assumed the Social Security Administration (SSA) was the place to go for accurate information.

I know better now, and so should you. I am not saying the SSA can't be trusted. But I am very much saying that you need to know enough about the rules to look out for yourself and to question what you're told. If you disagree with the way your claim is processed or other information you get from the agency, you absolutely should stick to your guns and stand up for yourself.

Since the first edition of "Get What's Yours" was published in early 2015, I and co-authors, economist Larry Kotlikoff and PBS economics correspondent Paul Solman, have been inundated with questions, problems, and flat-out horror stories from not only the public but also financial professionals and even more than a few brave souls who work for Social Security.

Here are several major areas where bright yellow caution signs have been erected in dealing with Social Security.

Meeting with representatives

The agency invites people to make in-person appointments but this word doesn't always make it out to the actual field offices where such meetings are supposed to take place.

People tell us some offices refuse to even schedule meetings, while the waiting list at others can be several weeks long. If you run into this issue, visit the "Get What's Yours" website and tell us about it. We will hound the SSA on your behalf.

Filling out online claims applications

Social Security has been pushing people to do as much business with the agency online as possible. Staffing and office-hour cutbacks in recent years have made online transactions its most cost-effective way to meet growing public demand for service.

Trying to find helpful tools to navigate these online forms, however, is another matter. I have tried without success to get the agency to sit down with me and explain how its various online applications work.

Social Security changes: Why Congress is messing with your benefits

One issue is that the information you enter on one screen may dynamically shape the contents of the next screen you see. This diversity of claiming options and response choices can be confusing and insufficient to reflect the needs of many people. If you must file online, and this often is the only feasible option, make sure you make print-outs of the process so that you later can document what you've done if problems arise.

The new rules

We have just come out with a new edition of our book, necessitated by the sudden enactment of new Social Security rules last fall. Much has been written and said about these rules. However, it's a safe bet there will be continued confusion about them. Briefly, anyone turning 66 before April 29 had the right to file-and-suspend by that date. If you are one of these fortunate people, you will continue to enjoy some claiming rights that are no longer available.

Also, if you were at least 62 as of last January 2, you are grandfathered under the new rules and will retain the ability to file a restricted application for just your spousal benefit, while deferring your own retirement benefit and letting it grow for up to four years. If either of these situations applies to you, make sure you know your claiming rights. And don't let Social Security deny you those rights.

Suspending benefits

Once you've reached what is called full retirement age, you have the right to suspend your benefits and enjoy delayed retirement credits that will increase your benefit at the rate of 8 percent a year. The new rules do not take away this right, although we've heard tales from people who tell us about SSA representatives who think they do.

What is changed, and it's a very big change, is that anyone who suspends any type of benefit is no longer able to receive another Social Security benefit. Nor is anyone else able to claim a benefit based on the record of someone whose own benefit has been suspended.

Health costs can devour Social Security income

The list goes on, but by now I hope you've seen the wisdom of learning about your Social Security claiming options before you file a claim for benefits. Please remember that your decisions likely will have an impact on you, and possibly other family members, for the rest of your life and perhaps theirs as well.

Study confirms medical costs rising for post-ObamaCare patients – along with premiums

By Doug McKelway Published April 18, 2016

For Americans wondering why their health care premiums and deductibles are rising so dramatically, a new study by the Blue Cross Blue Shield Association provides some answers.

The study, released on March 30, found that people who enrolled in BCBS after the Affordable Care Act became law had higher rates of disease than those who'd been enrolled before ObamaCare took effect, suggesting insurers indeed are taking on higher-risk and higher-cost patients. Their costs are rising, along with premiums in general.

The study claims to represent "a comprehensive, in-depth study of actual medical claims among those enrolled." Blue Cross Blue Shield represents more patients in the health insurance exchanges than any other insurer.
The study found:

- New enrollees in individual health plans in 2014 and 2015 had higher rates of hypertension, diabetes, depression, coronary artery disease, HIV and Hepatitis C than those enrolled before ObamaCare.
- New enrollees received significantly more medical care, on average, than those with individual or employer-based plans.
- New enrollees had more inpatient admissions, outpatient visits, prescriptions filled and emergency room visits.
- Medical costs for new members were, on average, 19 percent higher than for employer-based members in 2014, and 22 percent higher last year. Average monthly medical spending for those newly enrolled members also rose at a higher rate in that period.

"The findings underscore the need for all of us in the health care system, and newly insured consumers, to work together to make sure that people get the right health care service in the right care setting and at the right time," said Alissa Fox, senior vice president for BCBSA, in a press release.

A report from Freedom Partners earlier this year showed premiums on the individual market are rising by double digits in most states.

A recent Daily Caller examination of annual reports from insurers also found storm clouds on the horizon of the exchanges. It found that eight of the 11 remaining exchanges may fail this year, despite assurances from the Obama administration.

"What we would like to see in general is increased competition, that's exactly what we got," White House Press Secretary Josh Earnest said on April 11. "We also were looking to save money. Over the next ten years we will find ... tens of billions of dollars in deficit reduction as a result of the Affordable Care Act."

Earnest's observation stands in stark contrast to that of Thomas Miller, a resident fellow at the American Enterprise Institute who specializes in the Affordable Care Act. He told Fox News that the exchanges, "were artificial, a hopeful creation propped up by political forces in Congress which wanted to try to use public money to experiment with a different type of health insurance coverage. It never made a whole lot of sense from the start."

The Affordable Care Act has resulted in historic increases in coverage for workers who've not had health care coverage before, according to a report Monday in The New York Times, which used census samples provided by the University of Minnesota Population Center. But it's a success that comes with huge costs, in the form of higher insurance premiums and deductibles for many Americans.

There may be political costs, too, in this election year, with illegal immigration a hotly contested issue. The Times study found, "Hispanics, a coveted group of voters this election year, accounted for nearly a third of the increase in adults with insurance." It added that health coverage for low-skilled workers “saw sharp increases,” and many who benefited were not citizens.

Insurers warn losses from ObamaCare are unsustainable

By Peter Sullivan - 04/15/16

Health insurance companies are amplifying their warnings about the financial sustainability of the ObamaCare marketplaces as they seek approval for premium increases next year.

Insurers say they are losing money on their ObamaCare plans at a rapid rate, and some have begun to talk about dropping out of the marketplaces altogether.

“Something has to give,” said Larry Levitt, an expert on the health law at the Kaiser Family Foundation. “Either insurers will drop out or insurers will raise premiums.”

While analysts expect the market to stabilize once premiums rise and more young, healthy people sign up, some observers have not ruled out the possibility of a collapse of the market, known in insurance parlance as a “death spiral.”

In the short term, there is a growing likelihood that insurers will push for substantial premium increases, creating a political problem for Democrats in an election year.

Insurers have been pounding the drum about problems with ObamaCare pricing.

The Blue Cross Blue Shield Association released a widely publicized report last month that said new enrollees under ObamaCare had 22 percent higher medical costs than people who received coverage from employers.

And a **report from** McKinsey & Company found that in the individual market, which includes the ObamaCare marketplaces, insurers lost money in 41 states in 2014, and were only profitable in 9 states.

“We continue to have serious concerns about the sustainability of the public exchanges,” Mark Bertolini, the CEO of Aetna, **said** in February.

The Aetna CEO noted concerns about the “risk pool,” which refers to the balance of healthy and sick enrollees in a plan. The makeup of the ObamaCare risk pools has been sicker and costlier than insurers hoped.

The clearest remedy for the losses is for insurers to raise premiums, perhaps by large amounts — something Republicans have long warned would happen under the healthcare law, known as the Affordable Care Act (ACA).

“The industry is clearly setting the stage for bigger premium increases in 2017,” said Levitt of the Kaiser Family Foundation.

Insurers will begin filing their proposed premium increases for 2017 soon. State regulators will review those proposals and then can either accept or reject them.

Michael Taggart, a consultant with S&P Dow Jones Indices, pointed to data from his firm showing per capita costs for insurers are spiking in the ObamaCare marketplaces.

“We made a significant change in the rules with the ACA, and we're still working through the process to see how that market stabilizes,” Taggart said at a panel on Wednesday. “Is [a death spiral] a possibility? Sure it's a possibility. I wouldn't attempt to put a probability on it, because I think there are a lot of things going on.”

One factor helping to prevent a death spiral is ObamaCare's tax credits, which cushion the impact of premium increases on consumers.

“What we're likely to see is more of a market correction than any kind of death spiral,” Levitt said. “There are enough people enrolled at this point that the market is sustainable. The premiums were just too low.”

Dr. Mandy Cohen, the chief operating officer of the Centers for Medicare and Medicaid Services (CMS), said in an interview that there is “absolutely not” a risk of a death spiral or collapse in the ObamaCare marketplaces.

While acknowledging that “companies are needing to adjust” to the new system, she pointed to the 12.7 million people who signed up this year, 5 million of whom were new customers, as a sign of success.

“What brings us the most confidence about the long term stability and health of the marketplace is its growth,” Cohen said.

Another risk, should regulators reject large premium increases, is that insurers could simply decide to cut their losses and drop off the exchanges altogether.

“Given that most carriers have experienced losses in the exchanges, often large losses, it only makes sense that most exchange insurers will request significant rate increases for 2017,” said Michael Adelberg, a former CMS official under President Obama and now a consultant at FaegreBD.

“Market exits are not out of the question if an insurer is looking at consecutive years of losses and regulators are unable to approve rates that get the insurer to break-even.”

The most prominent insurer eyeing the exits is UnitedHealth, which **made waves** in November by saying it was considering whether to leave ObamaCare in 2017 because of financial losses. The company last week announced that it is dropping its ObamaCare plans in Arkansas and Georgia, and more states could follow.

The Department of Health and Human Services argues that the attention on UnitedHealth is overblown, given that the insurer is actually a fairly small player in the marketplaces.

It’s more important to watch what happens with Blue Cross Blue Shield plans, which are the backbone of the ObamaCare marketplaces.

There have been some rumblings of discontent from Blue Cross plans. The plan in New Mexico already dropped off the marketplace there last year after it lost money and state regulators rejected a proposed 51.6 percent premium increase. Now, Blue Cross Blue Shield of North Carolina says that it might drop out of the marketplace because of its losses.

Blue Cross of North Carolina CEO Brad Wilson said in an interview that the company had lost $400 million due to its ObamaCare business.

“We're not alone, and I think that that also is evidence to suggest that there are systemic and fundamental challenges that we all need to have a civilized conversation about,” Wilson said.

He said a key factor in the decision on whether to stay in the market next year will be whether regulators approve whatever premium increase the company ends up proposing so as to try to make up for its losses.

Asked about the risk of a death spiral, Wilson said he is not worried about that happening “tomorrow,” but has concerns if the situation does not change over time.

“There’s not going to be something magical happen that will cause this to turn around,” Wilson said. He is pressing for changes like further tightening up extra sign up periods that insurers say people use to game the system and repealing the Health Insurance Tax, which could help lower premiums.

Cohen of the CMS said that her agency is in close touch with insurers and Blue Cross Blue Shield of North Carolina in particular. But she pushed back on talk of Blue Cross of North Carolina dropping out of the marketplace, stating flatly, “I have no concerns about them leaving the market.”

She referred to **problems** the company has had with its computer systems that have led to some people being enrolled in the wrong plan, along with other issues that have added to the company’s administrative costs.

"I know that they have struggled with some of their internal operations … but that is not related to anything to the health of the market itself or the risk pool," Cohen said.

Overall, while the system set up by ObamaCare itself might be resilient, premium increases are sure to fuel Republican arguments that the law simply isn't working.

"There's more political risk here than anything else," Levitt said.

This Is Why You Shouldn't Swipe Your Chip Credit Card

Consider yourself warned!

By Lauren Smith MAY 18, 2016

You probably have a wallet full of credit cards with chips at this point. Banks have been rolling them out like crazy and they're supposed to be safer — as long as you use them the right way, that is. That's why the fact that some retailers — including Bed Bath & Beyond, Staples, Chick-fil-A, and Panera Bread — don't have chip card readers up and running at all of their locations is a big concern.

You see, if you swipe a chip card instead of inserting it into slot, the merchant is responsible for covering any fraudulent charges — not the bank. And some retailers aren't in a financial position to cover major security breaches, like that corner store you picked up a gallon of milk from in a pinch. That means you get stuck covering the snafu, according to Adam Levin, founder of Identity Theft 911 and author of *Swiped.*

However, retailers claim the readers must be certified by credit card companies to make sure they work before using. Some have even been waiting up to six months to get certified, even though the new system was supposed to be fully implemented by October 2015. Either way, if you approach a check-out without a chip insert, just pay with cash instead. Or if you do swipe, make sure you monitor your account closely to watch for fraudulent charges.

3 Reasons It's Dumb to Take Social Security Benefits at 67

Is it smart to start receiving Social Security benefits at 67? Well, perhaps not. Here are three reasons why you might not want to.

Selena Maranjian May 20, 2016

One of the biggest decisions most of us make regarding Social Security is when we choose to begin receiving benefits. For many of us, 67 is the magic age at which the Social Security Administration considers us ready for normal, or full, retirement. Thus, it's the age that many people consider retiring at. Is it smart to start receiving Social Security benefits at 67? Well, perhaps not. Here are three reasons you might not want to.

The magic age of 67

Let's first set the scene. If you were born in 1960 or later, your "full" retirement age (as defined by the Social Security Administration) is 67. If you start collecting your Social Security benefits then, you'll receive the full amount you're entitled to. (The magic age is 65 for those born in 1937 or earlier, and somewhere in between 65 and 67 for those born between 1937 and 1960.)

You don't have to start at age 67, though. You can start collecting as early as age 62 and as late as age 70. You'll collect significantly smaller monthly checks if you start at age 62 and significantly larger ones by waiting to start at 70. More specifically, for every year beyond your full retirement age that you delay (up to age 70), your benefits will increase in value by about 8%. On the other hand, if you start collecting at age 62, you can expect your checks to be about 30% smaller.

Reason No. 1 Not to Take Social Security Benefits at 67: You're Financially Pinched

A good reason to not start collecting Social Security benefits at age 67 is if you could use the money earlier. Many people, for example, have not saved up as much for retirement as they would have liked to. According to the 2016 Retirement Confidence Survey of the Employee Benefit Research Institute, about 26% of respondents said they had less than $1,000 saved for retirement. Yikes!

Many people end up retiring early not by choice, too, because of a job loss, or perhaps a health setback takes them out of the workforce. If such a thing happens to you before you turn 67, you would do well to consider whether it makes sense to start collecting Social Security early.

It's also smart to start collecting early if you have reason to believe you won't have a long life. If many family members have died relatively young, it might be best to start collecting early, in order to enjoy the money you're entitled to.

Reason No. 2 Not to Take Social Security Benefits at 67: You Can Wait

On the other hand, it might be best for you to wait beyond age 67 to start collecting Social Security. That could be the case if you're still working at age 67 and plan to work a few more years. It could be the case if you've retired but have ample retirement income, too. If so, by waiting a few more years you can build up the size of your checks. If you delay from 67 to 70, you can make your checks fully 24% bigger. That's enough to turn a $2,000 monthly benefit ($24,000 per year) into a $2,480 one (nearly $30,000 annually).

Getting bigger checks can be particularly worthwhile if you stand a good chance of living a long time. In your later years your nest egg may have grown thin, but you'll still have Social Security income to count on.

Reason No. 3 Not to Take Social Security Benefits at 67: It's a Wash

Many people agonize over when to start collecting benefits, torn between wanting money as soon as possible and wanting big checks. Here's some possibly surprising news, though: According to the Social Security Administration, "If you live to the average life expectancy for someone your age, you will receive about the same amount in lifetime benefits no matter whether you choose to start receiving benefits at age 62, full retirement age, age 70 or any age in between."

That's right -- for those who live average lifespans, it's pretty much a wash. Given that, if you expect to live close to an average-length life, you might as well start the income stream early. Even if you end up living a long time, you won't lose as much as you think. After all, had you delayed starting to collect from age 67 to age 70, you'd have missed out on three years' worth of payments -- that's 36 not-insignificant checks.

Everyone's situation is different, so give this decision some careful thought. Delaying or starting early can make good sense for some -- but don't dismiss the idea of starting to collect on time, at age 67. It can make sense, too.

The $15,834 Social Security bonus most retirees completely overlook

If you're like most Americans, you're a few years (or more) behind on your retirement savings. But a handful of little-known "Social Security secrets" could help ensure a boost in your retirement income. For example: one easy trick could pay you as much as $15,834 more... each year! Once you learn how to maximize your Social Security benefits, we think you could retire confidently with the peace of mind we're all after.