Health & Retirement Services of Illinois
Newsletter March 2016

OUR NEWS LETTER

Buying Supplemental Insurance Can Be Hard For Younger Medicare Beneficiaries

By **Susan Jaffe** February 3, 2016

Danny Thompson's kidneys have failed and he needs a transplant but in some ways, he's lucky: Both of his sons want to give him one of theirs, and his Medicare coverage will take care of most of his expenses.

Yet the 53-year-old Californian is facing another daunting obstacle: He doesn't have the money for his share of the medical bills and follow-up drugs, and he can't buy supplemental insurance to help cover his costs.

"It's frustrating to be in the shape I'm in," said Thompson, who depends on dialysis instead of his kidneys to cleanse his blood. "My plan is to get a transplant so I can go back to work."

Almost one in four Medicare beneficiaries has such a policy, known as Medigap, which is sold by private insurance companies. It can help pay for costs Medicare doesn't cover, including the 20 percent coinsurance required for medical expenses, including certain drugs, plus deductibles and co-payments. Those expenses have no out-of-pocket limit for beneficiaries.

Federal law requires companies to sell Medigap plans to any Medicare beneficiary aged 65 or older within six months of signing up for Part B, which covers doctor visits and other outpatient services. If they sign up during this guaranteed open enrollment, they cannot be charged higher premiums due to their medical conditions.

But Congress left it to states to determine whether Medigap plans are sold to the more than 9 million people younger than 65 years old who qualify for Medicare because of a disability.

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In 20 states and the District of Columbia, home to more than 2 million disabled Medicare beneficiaries, insurers are not required to sell Medigap policies to customers under 65. In other states, insurers cannot reject applicants if they enroll when they first join Medicare. Companies in some states, including Virginia, can still charge higher premiums to younger beneficiaries or those with kidney disease, often making policies unaffordable.

In California, Massachusetts and Vermont. insurers are required to sell Medigap policies to anyone with Medicare, *except* to people like Thompson who are under 65 and have end stage renal disease.

“If it was the reverse — if you were discriminating against somebody because they were 65 or older as opposed to younger — people would be outraged,” said Bonnie Burns, policy specialist for the consumer group California Health Advocates and a member of the National Association of Insurance Commissioners’ Medigap committee.

The federal health law provides no relief for these younger Medicare beneficiaries. One of its most popular provisions prohibits discrimination by insurance companies in the non-Medicare market based on pre-existing conditions or age, but the law is silent on Medigap.

Thompson, who lives in Menlo Park, near San Francisco, said 12 Medigap insurers have turned him down. Buying a health plan through Covered California, the state’s health insurance exchange, is not an option since he has primary insurance through Medicare. “That is for people who don’t have insurance, and I have insurance,” he said. “But it is as if I don’t.”

The transplant costs are substantial, and Thompson said he does not have the resources to cover his share. Kidney transplant patients can expect the preparation, surgery, tests and treatment for the first year to run more than $262,000, according to the American Kidney Fund. The immunosuppressant drugs, which patients will need for the rest of lives to ensure their body does not reject the new kidney, cost another $2,000 to $4,000 a month.

No Hospital Mandate

Hospitals and doctors are not required to provide care for Medicare patients unless it’s a medical emergency, a Medicare official said.

Joe Baker, president of the Medicare Rights Center, said that they can turn away Medicare patients for any number of reasons, including inability to pay their share of the bills or because providers are not taking new patients.

“Medicare beneficiaries under 65 with end stage renal disease get an organ transplant if they agree to pay their share of the costs Medicare doesn’t cover,” said Lisa Kim, a spokeswoman for Stanford Hospital, where Thompson has sought treatment.

To help Thompson find financial assistance, a Stanford social worker referred him to Christina Dimas-Kahn, who heads the San Mateo County office of the California Department of Aging's Health Insurance Counseling and Advocacy Program (HICAP). She said he is one of several clients with end stage renal disease that HICAP counselors have tried to help in the past few years, "But people with the disease don't have whole lot of options if they are under 65," she said.

Thompson recently learned that he could qualify for Medi-Cal, California's Medicaid program for low-income people, which Dimas-Kahn said would cover his transplant expenses. But Thompson said that coverage would kick in only after he paid a $2,500 deductible every month, which he cannot afford.

If Thompson divorced his wife of 30 years, her income wouldn't be counted along with his Social Security disability benefits and it's possible he wouldn't have to pay the deductible. That's not a good alternative, he said. "We made vows — rich or poor, in sickness or in health — you stay married."

'Crazy Patchwork' Of Regulations

Another solution could be moving to another state, such as Delaware. That's where Heather Block, a politically savvy project manager for federal and international organizations, took on her state legislature after she was diagnosed with advanced breast cancer.

"I considered myself lucky when I became eligible for Medicare but that 20 percent co-pay with no out-of-pocket maximum is exorbitant for anyone let alone someone with a serious illness," she said.

Block could get Medicare before turning 65 because she qualified for disability benefits, but she couldn't get Medigap coverage**.** Two years ago, she spearheaded a successful campaign to change state law, forcing insurers to sell Medigap policies to anyone when they first enroll in Medicare regardless of age, without basing rates on their health conditions.

"It is insane that we have to go through this crazy patchwork of state regulations," said Block, whose monthly charges for cancer drugs alone range as high as $9,800. Without Medigap, medical bills would eventually deplete her savings.

Prospects for a nationwide solution are dim because expanding Medigap coverage could lead to these beneficiaries with disabilities receiving more care and raising costs for the Medicare program. Congress is looking for strategies to curb Medicare spending, not increase it, Burns said.

The health insurance industry's trade association opposes expanding Medigap to include all Medicare beneficiaries younger than 65 with end stage renal kidney disease. Since treatment for those patients can be so

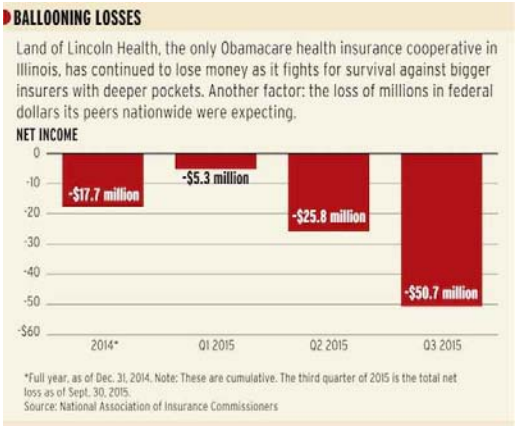
expensive, adding them could increase Medigap premiums for everyone, said Cindy Goff, a vice president at America's Health Insurance Plans. She pointed to Medicare statistics that show when the program covers patients over 65 with end-stage renal disease, their care averages nearly nine times more than other Medicare beneficiaries.

Older adults are "super price-sensitive" and raising premiums "would basically price them out of being able to get the Medigap protection they want," said Goff.

"The insurance company knows that these patients coming through the door are going to use services," said LaVarne Burton, president of the American Kidney Fund. "In most instances, if they don't get treatment, they will die."

Will losses sink Illinois' Obamacare co-op?

By Kristen Schorsch, Crain's Chicago Business | February 1, 2016



With a $50 million net loss heading into last fall's enrollment period for Obamacare, it wouldn't be surprising if Illinois' Land of Lincoln Health experienced the same fate as peers that have folded across the country in the past year.

The Chicago-based health insurance co-op is one of 23 spawned by the Affordable Care Act to create competition on the health insurance exchanges and force down prices. But just three years in, 12 of the 23 have closed, says Sabrina Corlette, senior research fellow at the Center on Health Insurance Reforms at Georgetown University, beset by sick and expensive enrollees, legacy insurers with deeper pockets and federal funding that has disappeared.

Iowa Insurance Commissioner Nick Gerhart oversaw the 2015 closure of CoOportunity, the co-op serving Iowa and Nebraska and one of the largest in the nation with more than 100,000 enrollees.

“They had explosive growth,” Gerhart says of the reasons behind the co-op's demise. “They had extraordinary claims that came in right out of the gate. It was . . . the perfect storm.”

If Land of Lincoln were to shutter, the Illinois Department of Insurance would either take over or monitor the company as it pays down claims. Enrollees would be offered a special enrollment period to find new health plans, and the larger insurers on the exchange, Blue Cross & Blue Shield of Illinois, UnitedHealthcare, Aetna and Humana, likely would scoop up most of their business.

Formed as an alternative to big insurers and their pricey health plans, Land of Lincoln launched during the online marketplace's 2013 debut. It had a lackluster performance that first year with around 3,600 enrollees. The co-op made a comeback in Year Two, with about 35,000 enrolling after the exchange created plans centered on Chicago-area health systems, including Advocate Health Care and Presence Health, two of the biggest in the state.

Enrollment has boomed in its third year so far to nearly 70,000 members. But so did operating losses. The co-op ended 2014 with a nearly $18 million net loss. As of Sept. 30, just nine months into 2015, that loss nearly tripled to $50.7 million on $109.8 million in revenue, according to the co-op's most recent financial statement. Land of Lincoln announced in October that it was capping enrollment in a bid to cut costs.

Then recently, the co-op said it would drop University of Chicago Medicine from its network on March 1. The Hyde Park-based system is an academic medical center that treats the sickest patients, such as those who need expensive transplants or to manage costly chronic conditions.

Land of Lincoln President and interim CEO Jason Montrie declined an interview request. In a statement, co-op spokesman Dennis O'Sullivan says Land of Lincoln's “continued growth is a testament to the desire for a new health insurance alternative in the market. Land of Lincoln Health remains committed and focused on providing our members with access to high-quality, affordable care for years to come.”

The Department of Insurance has at least two pathways should Land of Lincoln get into deeper financial trouble. If the co-op decides to stop selling policies altogether, it could pay outstanding claims under the department's supervision. The process could take more than a year, says Alissandra Calderon, a department spokeswoman.

More aggressively, the department could petition the courts to become Land of Lincoln's receiver. In that case, the Illinois Life and Health Insurance Guaranty Association, a nonprofit that assesses fees to member insurance companies, would pay the co-op's outstanding claims to patients and their doctors if Land of Lincoln ran out of money.

Similar funds covered more than $100 million in claims when CoOportunity closed.

Anne Melissa Dowling, director of the Department of Insurance, says her staff is in daily contact with Land of Lincoln. She has asked it to set up a concierge line for people affected by U of C Medicine leaving the insurer's network.

Carriers on the exchange this year formed smaller, more narrow network plans. Such plans are cheaper for consumers because they don't include many expensive specialty hospitals. The trade-off is that those enrollees have a smaller pool of doctors they can see at discounted rates.

Enrollees flocked to Land of Lincoln partly because Blue Cross & Blue Shield of Illinois, the dominant insurer in the state, dropped its popular broad plan on the exchange this year.

“To the defense of the companies, they were responding in many cases to what consumers were asking for in narrow networks,” Dowling says. “But I think the consequences of them were probably unanticipated.”

Co-op closures around the country have been rough. Colorado HealthOP fought its state-ordered closing in 2015, vowing that it would have been profitable in 2016. When New York regulators shut down Health Republic last year, the largest co-op by enrollment with more than 200,000 members, it told enrollees to find a new health plan or the state would assign them to one.

The federal Centers for Medicare and Medicaid Services, which oversees the exchanges, eventually will want its money back. The federal agency doled out more than $2 billion in loans to launch the co-ops, including about $160 million to Land of Lincoln.

CMS likely will have to get in line.

Costs to treat common ailments a prescription for pain

Laura Ungar, USAToday *February 1, 2016*

A month's worth of Glumetza diabetes pills cost Marge Meffert $746 last April. Then the price began skyrocketing — to $6,714.

It wasn't an isolated surge. The price of Lantus insulin rose 34% in a year. A widely used antibiotic called doxycycline jumped from $20 to $1,849 in six months. And a heart-rhythm drug called Isuprel costs six times what it used to: $1,300 a vial.

While the cost of cancer and HIV medicines tend to grab headlines, vaulting drug prices increasingly include medicines for more common conditions afflicting millions.

The issue has raised the ire of Congress, which is tackling prescription drugs in a hearing Feb. 4 before the House Committee on Oversight and Government Reform. And it's forcing hard choices among patients, who face high insurance deductibles and co-pays that leave them shouldering a larger share of health care costs.

"Usually what ends up happening is people end up not taking their medicine. And you're talking about basic medicines … It's a vicious cycle," says Praveen Arla, a family practice physician in Bullitt County, Ky. He says he's not surprised companies are raising prices. "if the government and the market allows you to do it, you will," he says.

Drug company officials defend their actions, saying, among other things, they must make enough money for research and development.Holly Campbell, a spokeswoman for the trade group PhRMA, says companies reinvest an average of 20% of revenues into the creation of new treatments. But Arla and other critics say companies are hiding behind the innovation argument and are angling for bigger profits.

"Look at the stocks," Arla says. "The stocks are doing great."

According to an analysis for USA TODAY by S&P Capital IQ, total returns in the S&P Composite 1500 Pharmaceutical Industry Index, a subset of the S&P Composite 1500 Index, rose 6.2% in 2015; and the S&P SmallCap 600 Pharmaceuticals Industry Index rose 29.4% in the same period. Among drug companies globally, profits through the third quarter of last year were up 26% compared with the year before.

Darlene Twymon of Rochester Hills, Mich., had to stop taking a rheumatoid arthritis drug that was working well because she had to pay $2,000 a year toward the $42,000-a-year medicine. "I couldn't afford it anymore," she says.

Meffert, of Louisville,is able to keep taking her diabetes medicine only because Medicare covers the vast majority of the cost. "They want to raise Medicare," she says, "and I can understand why."

Why so high?

The latest drug trend report from pharmacy benefits manager Express Scripts contains ample evidence of the cost crisis. It says prices for brand-name medicines more than doubled in five years, and overall drug spending went up 13% in 2014 after years of declines. Drugs for diabetes, which afflicts 22 million Americans, topped the list for spending increases among medications to treat common conditions at 18%, says Express Scripts Chief Medical Officer Steve Miller.

Spending was driven almost exclusively by price hikes, not increased use. Use of diabetes drug Lantus, for example, rose 0.5% while the price rose 34%, Overall, use of diabetes drugs rose less than 2%, while prices rose 16%. Use of drugs for mental and neurological disorders dropped 0.5% as prices rose nearly 10%.

Drug companies and industry experts offer several explanations for the price hikes.

Take the case of Glumetza. Officials for Canada-based drug maker Valeant say they expect a generic competitor to enter the market as soon as next month, and point out that it's common to raise prices in the period before that happens. They also cite their more than 200 active research and development programs and six new drug applications approved by the federal government in the last three years. Valeant has been the subject of Congressional scrutiny over pricing practices, such as raising the prices of newly-acquired drugs.

Laurie Little, Valeant's senior vice president of investor relations, says the company tries to shield consumers from rising prices: "We offer significant patient assistance programs to help ensure out-of-pocket costs don't prevent patients from receiving the medicines they need, and the introduction of a generic competitor to Glumetza will lead to a dramatic reduction in the overall cost to the market."

Experts agree competition from generics, especially when a patent is about to expire, drives up prices for all sorts of medicines — as do research and development costs. According to the Tufts Center for the Study of Drug Development, it takes an average of $2.6 billion and 15 years to develop and win approval for a new drug. Drug makers also may raise prices when they buy drugs from other companies, as happened when Valeant bought Isuprel from Marathon Pharmaceuticals. Another cost driver is "shadow pricing," when companies mirror competitors' price increases.

The changing makeup of the pharmaceutical industry also makes a difference. In the past, says Express Scripts' Miller, the landscape was dominated by huge companies selling hundreds of medicines that could afford to have winners and losers. Today's market includes a growing number of small companies dependent on just a few products.

But industry observers say market forces don't tell the whole story, and contend that sometimes price hikes are simply a way to boost the bottom line.

"There are certainly cases within the industry where they see an opportunity to raise prices and they're doing that," adds Gary Claxton, vice president of the Kaiser Family Foundation. As for patients, "if they need the particular drug, there's not a hell of a lot that they can do in the short-term."

Patient pain continues

Recent surveys by the wellness company HealthMine found that a third of consumers with diabetes or pre-diabetes, and a third of people living with heart disease risk, struggle to afford drug treatments. A Kaiser Health tracking poll last summer suggests patients blame drug makers, finding that 72% of Americans consider drug costs unreasonable and 74% feel drug companies put profits before people.

Despite public sentiment, experts expect the trend to continue — with Express Scripts projecting that spending for diabetes drugs, for example, will rise more than 18% both this year and next.

Insurers and pharmacy benefit managers are taking steps they hope will reduce costs.

One strategy is to exclude expensive medications from drug formularies to shift people toward cheaper drugs, says Nadina Rosier, North America health and group benefits practice leader of pharmacy at the professional services firm Willis-Towers Watson. Patient assistance programs sponsored by drug companies also provide some financial help.

"The ultimate answer, quite frankly, is there needs to be some attention to these drugs," says Jim O'Donnell, regional pharmacy director for KentuckyOne Health. "Even some generics that have been around for years have gone from $40 to $1,700 a vial. That's like going into Starbucks and paying $90 for a cup of coffee."

For now, however, experts expect drug prices to continue pushing up the nation’s health care costs, which already make up nearly 18% of U.S. economic activity — and keep needed medicines out of reach for many.

Speeding up your home Wi-Fi might be as easy as changing one setting

BGR

Chris Smith BGR News February 08, 2016

You've tried everything when it comes to fixing your home Wi-Fi, but it's still broken and the first thing you should do is check our tips, tricks and hacks to see if any of them help. There's another issue we haven't covered in the past that could be causing issues with your home network though, and it has something to do with the Wi-Fi bands that you're using. Now, Apple and Cisco have just acknowledged the issue and provided some details that might help.

The two companies released a document a few days ago that primarily targets enterprises, detailing best practices for Wi-Fi networks. The paper says that "both Cisco and Apple's joint recommendation [is that] the use of the 2.4GHz band is not considered suitable for use for any business and/or mission-critical enterprise applications."

However, if you live in a crowded area, the same problem might affect your home Wi-Fi setup.

In other words, your slow Wi-Fi network might be fixed by using a simple trick the two companies have suggested. "Cisco and Apple strongly [recommend] a 5GHz-only (802.11a/n/ac) wireless network for Apple devices."

While the document targets businesses and specifically mentions Apple gear, this is a good tip for all home wireless networks, and any other kind of hardware that supports both bands.

Meanwhile, we'll remind you that Apple and Cisco announced a major partnership not so long ago, and this document is likely a result of that. The question is, how long are we going to have to wait until Apple and Cisco kill the 2.4GHz Wi-Fi band completely?

Are Fish Oil Pills Good for You? Here's What to Know About the Possible Benefits

By Philip Lewis February 2016

Fish oil pills have become a popular supplement for many across the nation. Americans spend nearly $1.2 billion annually for fish oil pills and related supplements, according to the *Washington Post*. Fish oil pills and supplements contain omega-3 fatty acids, a group of polyunsaturated fatty acids that can be found in certain types of fish and shellfish.

"I believe that fish oil is helpful. It promotes a stronger immune system, better cardiovascular health, less inflammation, healthier joints, improved vision, a more robust metabolism and healthy weight management," Dr. Frank Lipman, founder of the Eleven Eleven Wellness Center in New York City told *Yahoo News*. "Fish oil has also been shown to improve skin, hair, and nails, as well as cognitive functions like your thinking power, attention, mood and memory."

But a huge inconsistency in whether or not fish oil pills are actually effective remains. The majority of research regarding fish oil pills has provided very little evidence that the supplements are effective at all.

.The National Center for Complementary and Integrative Health lists the health benefits of fish pill dietary supplements as "unclear." Even though no research has been fully backed yet, supporters of fish oil pills claim that the supplement can help improve the health of the heart and is important for brain development.

Professor of Medicine at Harvard Medical School JoAnn E. Manson told the *Washington Post* that although omega-3s could potentially protect against heart disease, the evidence that the fish oil pills helps in any tangible way is sorely lacking. "It's amazing how popular the fish oil supplements have become without conclusive evidence of their efficacy," Manson told the *Post*.

Research shows that omega-3 fatty acids can decrease triglyceride levels which reduce your risk for heart disease, decrease risk of abnormal heartbeats, and can lower blood pressure some. However, the jury is still out on whether or not the pills are doing anything at all. Some studies have shown that levels of omega-3 fatty acids actually found in fish oils is significantly lower than what's stated on the label.

The American Heart Association recommends eating fatty fish, like salmon, trout or tuna, at least twice a week.

The 6 most important ages on the road to retirement

Matthew Frankel, The Motley Fool February 12, 2016

Retirement age is different for different people

Retirement planning is a lifelong process -- that is, there aren't any ages that *don't* matter to your retirement. However, there are some milestones in your life that are more significant than others. Here's a quick guide to the six most important ages you'll reach on the road to your retirement, and what you need to know about each one.

Age 55: If you have a retirement plan through a current or former employer, such as a 401(k), this could be an important age for you. After you turn 55, you are allowed to withdraw retirement savings penalty-free as long as you have separated from service with the employer. This could be useful if you plan to retire early, but be aware that this doesn't apply to IRAs.

This is also the age when you're considered a "senior citizen" by many businesses, so take advantage of the discounts.

Age 59-1/2: This is the normal age at which you can withdraw money from your retirement accounts, including IRAs, without paying a penalty to the IRS. You can do so even if you're still working, although I recommend leaving retirement savings alone for as long as possible.

Age 62: At age 62, you are eligible to collect Social Security benefits if you choose to do so. Just be aware that filing for Social Security early reduces your monthly benefit amount *for life*. If you file for Social Security as early as possible, your standard retirement benefit will be reduced by 30%. On the other hand, if you choose to wait beyond your normal retirement age, your benefit can increase.

Here's how claiming early or late can affect your Social Security benefit, and what this could mean to a hypothetical $1,500 monthly benefit.

If you file for Social Security at age 62, your benefit will be 75% of your full retirement benefit, and a $1,500 benefit would end up being $1,125. Similarly, here are the percentages and benefits at other ages:

Age 63 ... 80% ... $1,200

Age 64 ... 86.7% ... $1,300

Age 65 ... 93.3% ... $1,400

Age 66 ... 100% ... $1,500

Age 67 ... 108% ... $1,620

Age 68 ... 116% ... $1,740

Age 69 ... 124% ... $1,860

Age 70 ... 132% ... $1,980

Note: This assumes a full retirement age of 66 (See the age section below).

Age 65: This is the age of eligibility for Medicare, and it's also considered to be "full retirement age" by many private and public-sector employers. However, keep in mind that this is *not* full retirement age for Social Security purposes.

It's important to note that even if you don't intend to file for Social Security benefits at age 65, you still need to apply for Medicare, which you can do at www.ssa.gov *three months* before you turn 65. This is important to do, simply because for every 12-month period you are eligible for Medicare Part B (medical insurance) and don't sign up, your monthly premium will increase by 10% unless you qualify for a Special Enrollment Period based on your or your spouse's health coverage at work.

Age 66 (or 67): Depending on the year you were born, your full retirement age for Social Security is between age 66 and 67. If you have a full retirement age other than 66, your benefit will still be decreased or increased for applying early or late at the same annual percentages in the chart above. That is, your benefit will decrease by 6.7% for each year you apply early, up to three years, and by 5% for each year beyond that. And, your benefit will increase by 8% for each year you delay collecting benefits beyond your full retirement age.

For example, if your full retirement age below is 66 years, 8 months, and you choose to wait until 67 years, 8 months, your benefit will increase by 8%.

If you were born in 1943-1954, your full (normal) retirement age is 66. Here are the retirement ages for other birth years:

1955 ... 66

1956 ... 66 years, 2 months

1957 ... 66 years, 6 months

1958 ... 66 years, 8 months

1959 ... 66 years, 10 months

1960 or later ... 67 years

Age 70: This age is significant for a couple of reasons. First, age 70 is the last age you can wait to file for Social Security benefits. Well, you can actually wait as long as you want, but there are no additional benefits to be had for waiting longer.

Second, at age 70-1/2, you'll need to start taking distributions from your retirement accounts if you haven't already done so. Based on the IRS's life expectancy tables, you can calculate the amount you'll need to take out at age 70-1/2 and every year beyond that age. This rule, known as required minimum distributions (RMDs) doesn't apply to Roth IRAs or other Roth accounts.

Finally, it's important to note that not all of these ages are significant for everybody. For example, when you reach age 59-1/2, you have the option of withdrawing money penalty-free from your retirement accounts, but that doesn't mean you should. These ages are important for you to know, but it's equally important to tailor your own retirement plan to fit your life and goals.

SPONSOR CONTENT: The $15,978 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. In fact, one Market Watch reporter argues that if more Americans knew about this, the government would have to shell out an extra $10 billion annually. For example: one easy, 17-minute trick could pay you as much as $15,978 more... each year! Once you learn how to take advantage of all these loopholes, we think you could retire confidently with the peace of mind we're all after.

HACKING OF HEALTH CARE RECORDS SKYROCKETS

For John Kuhn, a simple X-ray after a snowboarding accident turned into an accounting nightmare when the hospital billed him $20,000 for a surgery he never had.

"So I had to go down in front of the billing department no less and pull up my shirt and show them that I did not have any major scarring on my stomach at all," Kuhn said.

Check Your Health Records: 1 in 3 Americans' Info Compromised in 2015 2:18

It turns out the hospital's hard drive had been stolen along with Kuhn's medical records.

He's not alone, experts say health care-record hacking is skyrocketing — up 11,000 percent last year alone.

Roughly one out of every three Americans had their health care records compromised and most are completely unaware. Such hacks give criminals a wealth of personal information that, unlike a credit card number, can last forever.

Kuhn's records were among the 100 million health care records stolen last year.

Many of those records show up for sale on the "dark web" where hackers openly advertise themselves and what they've stolen.

One site offers fresh healthcare profiles stolen last year in California boasting "you can use those profiles for normal fraud stuff or to get a brand new healthcare plan for yourself."

FROM MAY 27: How to Protect Your Medical Records From Hackers 2:25

Etai Maor showed NBC News the type of computer station where such transactions are made.

"This is where information from big data breaches ends up as a commodity and is sold," he said.

Stolen credit cards go for $1-$3 each. Social Security numbers are $15. But complete health care records are a gold mine, going for $60 each.

That's because criminals can use such records to order prescriptions, pay for treatments and surgery and even file false tax returns.

"You basically own a person. You have all the information. You can create a new account, you can fake his whole identity," Maor said.

And, unlike credit cards that can be quickly canceled, health care information lives forever.

To avoid getting hacked, security professionals advise the following:

- Following good password practices

- Avoid using the same email account for banking and shopping.
- Use pin codes on your IRS returns.
- Avoid giving out your social security number, even the last four digits, to hospitals and doctors' offices.

"You really need to push back on those situations and say 'Look, can I give you a PIN or some piece of information that I can change on a regular basis?'" Caleb Barlow, vice president of strategy at IBM Security.

In the meantime, Kuhn said he's grateful that demonstrating he never had surgery helped get his hospital charges dismissed.

And he has a bit of advice for others who might find themselves in a similar situation.

"If your name is ever involved in a security breach of you've been notified by an organization of a security breach, you should definitely take advantage of the free credit monitoring that comes after that," Kuhn said. "Also it's critically important before you go to the healthcare institution, that you understand their security policies, that you understand what they are doing with your information, how did they protect your information at that point."

Costs, changes led Obamacare enrollment to fall short of earlier estimates

Jayne O'Donnell, USA TODAY *February 16, 2016*

Corrections and clarifications: *An earlier version of this story misstated the number of insurers on the federal exchange for Alaska.*

The number of people who signed up for health insurance for 2016 on the state and federal exchanges was up to 40% lower than earlier government and private estimates, which some say is evidence that the plans are too expensive and that people would rather pay a penalty than buy them.

In 2010, the non-partisan Rand Corporationestimated 27 million people would have exchange policies this year and the Congressional Budget Office at that time was estimating 21 million for 2016. CBO even said last June that 20 million people would have plans purchased on the exchanges this year. Just 12.7 million signed up for plans, however, by the end of open enrollment Jan. 31 and about 1 million people are expected to drop their plans — or be dropped when they don't pay their premiums.

"That's not the only mistake CBO made but it was a really big one," says Brian Blase, a former aide to the Senate Republican Policy Committee, who is now a senior research fellow at the free-market Mercatus Center, which is funded in part by Charles and David Koch, two industrialists who have long opposed the Affordable Care Act.

Late last month, CBO revised its estimate down to an average of 13 million people a month enrolled on the exchanges this year.

Health and Human Services Secretary Sylvia Burwell last week called the recent enrollment numbers "a success" and it is on track to beat her lowered projection that 10 million people will have paid-for plans at the end of 2016.

The law has led to a drop in the uninsured rate to about 12%, which is down more than 5% since the requirement that people have health insurance took effect in early 2014, according to Gallup. Along with the nearly 13 million who bought plans on the government exchanges, it's also unclear how many millions of people are buying individual policies through insurance brokers and companies. But concerns remain and the mix of people buying plans on the exchanges.

Both supporters and critics of the law agree that the exchanges need a better balance of low and higher-income people buying insurance as insurers set their rates based on who they expect will purchase plans. If there are more unhealthy people, rates go up and lower income people tend to have more health problems. But higher-income people tend to already be insured too.

The two sides also agree the plans have proven too expensive for many people who make more than 400% of the federal poverty limit ($97,000 for a family of four), making them ineligible subsidies and tax credits to help pay for their insurance. The Centers for Medicare and Medicaid Services reported last month that just 3% of those buying plans on the federal and state exchanges earned more than this amount. The Urban Institute, a research nonprofit that does work for state and federal government as well as foundations, estimated last year that 25% of exchange customers would earn more than 400% of the poverty limit.

Reasons why supporters say enrollment is lower than the original projections include:

• The process hasn't completely recovered from the disastrous rollout of the federalHealthcare.gov website in the fall of 2013, says Matthew Buettgens, a senior research associate with the Urban Institute.

• CBO expected a lot more employers to drop their plans and send workers to the exchanges for their coverage, notes Katherine Hempstead, director of the insurance coverage team at the Robert Wood Johnson Foundation. That hasn't happened, however.

• CBO also thought more people who didn't get subsidies would still buy on the exchanges, but several million are believed to buy direct from insurers or brokers. While that affects the overall enrollment numbers for the exchanges, Hempstead says, it also means these people are still getting better plans with ACA's protections, including a prohibition against discriminating with preexisting conditions.

Critics say signups were slower than expected because having insurance may not be as important to people as the administration thought it would be, given other financial needs. And it's often cheaper to pay the penalty and pay cash for health care, insurance brokers say. That's unless people are eligible for subsidized coverage.

Young, healthy people in particular don't feel like they should have to pay for benefits the plans have to cover, such as mental health and maternity care, says Sam Gibbs, executive director of AgileHealthInsurance.com, a private insurance exchange. Nearly half of the firm's clients are in this bracket and purchased insurance plans that don't meet the ACA but will protect them in the event of a serious injury or illness. They will pay the tax penalty and still save money, Gibbs say.

Donald Kirkendall, an insurance broker in Orlando, Fla., was paying $247 a month for a Cigna plan two years ago, but after that premium increased too much, he switched to an Aetna plan that got canceled because it didn't comply with the ACA. The Humana plan he switched to just increased to $697 a month.

"Who can afford that?" he asks. "And I do this for a living."

One of the two insurers in Alaska was told late last month that it couldn't sell or renew plans any more in the state due to its precarious financial situation, but Moda Health got a reprieve last week and can now sell through 2016. Insurance broker Trish Mack, who is based in Anchorage, says she has had at least a dozen clients who weren't eligible for subsidies come in to enroll in insurance but decide to pay the penalty instead of for insurance.

CMS has already made some changes to address insurers concerns, most notably by reducing the number of special enrollment periods when people can sign up for plans. Insurers have complained they wound up with too many sick people because the administration allowed too many people to sign up during the year — and some waited until they were sick and dropped coverage later.

Christopher Condeluci, who helped draft the law as a Senate Finance Committee Republican aide and supports aspects of it, says it's a problem that "three years into the law's implementation, the market is not stabilized." Condeluci, an attorney who is now a principal in CC Law & Policy, says insurers need more flexibility to offer plans that are affordable and cover only what people really need.

Possible changes by a Democratic administration or on Capitol Hill "might be too little too late, " Condeluci adds, and he doubts congressional Democrats would want to take a chance opening the law up for debate again. Republicans, he says, would just as soon repeal it and replace it with something that gave insurers more flexibility to offer lower-priced plans with fewer benefits.

But Buettgens says that with 12.7 million signups, which reduced the uninsured rate to below what it was before the ACA, "it's difficult to call that a failure." Besides, he notes, insurers are just beginning to understand this new market and "have very little actual claims experience."

"Various projections were higher than that, but there's been steady growth," he says. "It's much too early to be making definitive statements about the future of the marketplace."

CBO was also wrong on another key projection: It said the health law would cost $142 billion over 10 years, but it revised those estimates down by 11% last year.

Delay Of New Health Law Forms May Confuse Some Taxpayers

By **Michelle Andrews** February 16, 2016

As the 2015 tax filing season gets underway, tax preparers said a delay in new health law tax forms is causing confusion for some consumers, while others want details about exemptions from increasingly stiff penalties for not having insurance.

Under the law, most people must have health insurance or pay a fine. In 2015, the penalty was $325 per adult and $162.50 per child up to $975, or 2 percent of household income, whichever is greater. This is the first year that employers, insurers and government programs such as Medicare and Medicaid are required to send consumers tax forms that report whether they offered or provided health insurance that was considered affordable and adequate under the law. The forms, 1095-B or 1095-C, are designed to help consumers in filling out their taxes but don't need to be filed with their tax returns. The issuers also send copies to the Internal Revenue Service.

Some consumers, however, may not receive the forms until shortly before the April 15 tax filing deadline because the IRS has pushed back the due date from Jan. 31 to March 31 for employers and others that provide insurance.

What's a consumer to do? File anyway, even without the form, the IRS says. If people make a mistake on their return because they didn't have the 1095-B or 1095-C forms and relied on information from their employer or other coverage providers instead, they won't have to amend their return, the IRS said.

For the 85 percent of people who had coverage all year, the delay is a non-issue, said Tara Straw, a senior policy analyst at the Center on Budget and Policy Priorities who manages one of the IRS' Volunteer Income Tax Assistance program offices that provides free tax help for lower income people. These people can just check the box on their return that reports that they had full-year coverage. If their 1095-B or 1095-C reports that they did not have coverage all year, they can simply ask their employer or insurer to correct their records and what they sent to the government.

"But there will be a small number of people who enrolled in marketplace coverage that now show overlapping coverage, and we're quite worried about those people," Straw said.

Consumers whose income fluctuated near the cutoff for Medicaid coverage, for example, could potentially be on the hook for repaying advance premium tax credits they received for marketplace coverage when they were actually enrolled in Medicaid. Problems could arise if the new forms are inaccurate or tax preparers aren't familiar with the rules in such situations.

"We've heard about some problems" in this area, Straw said.

In these types of situations, consumers may need to contact the marketplace and whoever provided their other coverage to correct the forms.

"People will need to be proactive in this," Straw said. "Be your own advocate and make sure the forms are accurate before you just repay."

People who have marketplace coverage receive 1095-A forms that report when they had coverage and the amount of advance premium tax credits received. The 1095-A forms were not delayed and went out on schedule in January.

In addition to questions about the 1095 forms, consumers are asking tax preparers at H&R Block about qualifying for exemptions from the penalty for not having insurance, said Lindsey Buchholz, a tax attorney at H&R Block's Tax Institute.

Among the most asked about of the roughly two dozen exemptions is the one that allows people to avoid a penalty because the lowest priced coverage available to them either from their employer or on the marketplace would have cost more than 8.05 percent of their income, the threshold at which it's considered unaffordable, Buchholz said.

"Most of the time they don't qualify for the exemption because they would have qualified for premium tax credits, and the assistance makes it affordable," she said.

People can also apply for exemptions because of hardship, including eviction or foreclosure, bankruptcy, the death of a family member and medical debt, among others.

"We're seeing more interest in hardship exemptions this year," probably because the penalties for not having insurance are increasing, Buchholz said.

One common exemption that many people overlook relates to the federal tax filing threshold. If consumers' household income is below the level that requires them to file an income tax return, they're exempt from the penalty for not having health insurance. In 2015, the threshold for a single person was $10,300 and for a married couple filing jointly it was $20,600.

Last filing season, more than 300,000 people overpaid the penalty for not having insurance, according to the IRS' Taxpayer Advocate Service.

The IRS eventually notified people of the overpayments, said Straw.

"The IRS sent letters, but they didn't send checks," she said. Although amending a tax return isn't hard, some taxpayers would likely seek out professional help. "For some people the cost of correcting it will be greater than the size of the check."