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OUR NEWS LETTER

GOP lawmakers denounce fraud in ObamaCare

By Peter Sullivan - 09/12/16

Republican lawmakers are denouncing the Obama administration after a watchdog report found that the ObamaCare marketplaces remain "vulnerable to fraud."

The nonpartisan Government Accountability Office submitted applications from fictitious people for ObamaCare coverage. Those applicants in many cases were approved for coverage, with financial assistance, by the administration.

The **new GAO report** follows up on its previous investigations, which found similar results of fictitious applicants being approved for coverage.

“When a fire is raging, the first thing you do is grab a hose — but there is no urgency by the administration,” House Energy and Commerce Committee Chairman Fred Upton (R-Mich.) said in a statement. “It’s déjà vu all over again as it seems the situation only continues to get worse, and we all are paying the price.”

In four applications, the GAO reused fictitious identities from 2014. Even though none of them had filed tax returns for 2014, a prerequisite for getting financial subsidies under the health law, all four were approved, the GAO said.

In eight other cases, newly created fictitious identities were also able to obtain subsidized coverage.

The ObamaCare marketplace directed 11 of these 12 applicants to submit extra documentation to prove their eligibility. In some cases, the GAO tested applicants without proper proof of their immigration or citizenship status.

Five applicants submitted all documents and kept coverage. Three applicants submitted partial documentation and also were allowed to keep coverage. Three other applicants submitted no additional documentation at all. One applicant’s coverage was terminated but the other two kept it, the GAO said.

“As if Obamacare’s recent headlines were not damning enough, we find out today that the Obama Administration continues to fail the test when it comes to enrollment verification,” Senate Finance Committee Chairman **Orrin Hatch** (R-Utah) said in a statement. “Continuing to leave taxpayers vulnerable, years after the system was implemented, is a disgraceful way for the administration to leave our healthcare system.”

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In response, HHS said that it has already implemented 43 GAO recommendations in the past year and is working on more. It said that while it appreciates the organization's work, it is "disappointed" that GAO has not provided more details on how its investigation worked or specific recommendations for stopping the fraudulent applicants.

The department also noted that fraud is harder, and illegal, in the real world.

"Within HealthCare.gov we have multiple checks to verify that applicants provide correct eligibility information on their applications, and GAO deliberately circumvented those checks by giving false information, which is against the law for actual applicants," HHS spokesman Matt Inzeo said in a statement.

Congressional Democrats have **pushed back** on previous GAO reports on the subject, noting that there is no actual fraud documented in them, only cases where the GAO tests its own fictitious applicants. Sen. **Ron Wyden** (D-Ore.), for example, has said that it is much harder for someone to cheat the system in the real world when they actually have to show up at a doctors office and have their photo ID checked.

OBAMACARE TROUBLES TRIGGER A HMO COMEBACK

Bruce Japsen , Contributor

The once-hated health maintenance organization (HMO) is having a comeback under the Affordable Care Act as insurers look to control the medical expenses of Obamacare patients.

HMOs, with their restrictive features that generally limit the choices of doctors and hospitals to their provider networks, gave rise to the patients' rights movement of the 1990s. That anti-HMO movement led to laws that required plans cover longer hospital stays for baby deliveries and allow better access to specialists.

But with health plans dogged by sicker-than-expected patients, insurers are returning to HMOs in hopes of offering a more affordable product that keeps medical expenses in check. And some are ditching preferred provider organization (PPO) options because it's more difficult to control costs once patients go outside of networks.

"The reason that HMOs are so broadly used is because plans can limit the provider network in order to reduce premiums ," said Caroline Pearson, senior vice president of Avalere Health, which is tracking the rollout of the ACA. "Low-premium plans have drawn the highest enrollment on exchanges, so that is where insurers have focused their effort."

Just last week, Iowa's largest health insurance company, Wellmark Blue Cross and Blue Shield, announced a new HMO plan called Blue Simplicity that is "ACA-compliant" and available in Iowa off exchange as part of its offerings. "It's apparent that continuing to offer plans with broad networks, combined with the rich benefits of the ACA, is not consistent with managing continually rising costs," said Wellmark CEO John Forsyth. "While we could seek additional premium increases to mitigate rising costs, this is not sustainable for our members' pocketbook."

Recently Extended Home Refinance Plan Banks Don't Want You Knowing

Hundreds of thousands of homeowners still eligible

28 September, 2016

HARP Gives Homeowners One Last Chance for A Mortgage Bailout

A forgotten mortgage stimulus program that was passed by Obama to help the middle class has been extended until Sept. 30, 2017. The program is called HARP, which stands for the Home Affordable Refinance Program. The program itself is totally free, and gives homeowners a once in a lifetime mortgage bailout. Like most government benefits this program will expire, but there is still time left for more than thousands of qualified homeowners to take advantage. It's important that homeowners don't wait though as the program will expire next year.

Calculate your new house payment and see if you qualify from our lenders »

HARP eliminates mortgage payments, reduces what homeowners owe, lowers interest rates

HARP is a program with no downside. HARP doesn't add any cost to your refi because it's a totally free government program, and it helps qualified homeowners get better, more affordable mortgages. Homeowners have used HARP to eliminate up to 15 years of mortgage payments, cut their interest rates in half, or even to just simply lower their monthly payments and save up to $4,100 a year.

How To Get A HARP Loan

To help homeowners find banks that offer HARP refinances, services such as LowerMyBills are available. LowerMyBills is a completely free service that many homeowners love because it helps them easily compare multiple lenders at once. It only takes about three minutes to use their easy online form, and their network of lenders can help you calculate your new house payment and see if you qualify for HARP.

Banks don't want homeowners to know about it because they hate what this program could do to them. HARP helps homeowners refinance at today's historically low rates and switch to 15 year fixed rate mortgages. That helps homeowners save up to $190,000, which means homeowners who use HARP could take as much as $190,000 out of banks pockets and put it back into theirs. Calculate your new house payment and see if you qualify from our lenders

Health insurance rates could jump nearly 50 percent for some

BY GABRIELLA DUNN *gdunn@wichitaeagle.com*

Health insurance rates for people who buy coverage on their own or with a small business will see rates increases by up to 47.41 percent next year.

This comes after a year of rate increases that ranged up to 25 percent for those groups – people who work for a small business or who purchase health policies directly from an insurance company or from the government's health exchange created through the Affordable Care Act, called HealthCare.gov.

But despite the increases, many people won't pay higher premiums each month because federal subsidies and tax credits often pick up the additional costs.

Nonetheless, health insurance plans now have yearly out-of-pocket costs that can range up to $6,550 for single person, or $13,700 for a family.

$6,550yearly maximum out-of-pocket costs for a single person

$13,700yearly maximum out-of-pocket costs for a family

In Kansas, insurance companies proposed rate changes ranging from a decrease of 1.37 percent to an increase of 49.4 percent for plans that begin Jan. 1, 2017. Open enrollment begins Nov. 1.

The Insurance Department approved all rate changes at the amounts requested by insurance companies. And in the cases of three plans, the department approved rate increases higher than what the companies proposed.

"The rates that were submitted were actually less than the companies could have submitted, said Cindy Hermes, director of public outreach for the Kansas Insurance Department.

"The companies were justified in their rate increases and could have asked for more."

Nationwide, when the Affordable Care Act went into effect, insurance companies underestimated how sick consumers would be who purchased coverage. And companies, under the Affordable Care Act, can only calculate a person's insurance premium using the individual's age, location and tobacco use.

For people with family plans, the size of the family and ages of each family member also factor in.

THE COMPANIES WERE JUSTIFIED IN THEIR RATE INCREASES AND COULD HAVE ASKED FOR MORE.

Cindy Hermes, Kansas Insurance Department

Hermes said insurance companies also saw an uptick in the number of people who purchased insurance during the height of a serious illness and dropped the insurance after treatment.

"We're not the only state that is experiencing this, she said. "It's a nationwide phenomenon."

Large employers saw big hikes

Because of that, the Kansas Insurance Department reviews insurance companies' actuarial data and assumptions, then chooses to accept, revise or deny each proposed hike for individuals and small businesses.

Employees of large companies typically don't find out the cost of their health insurance plans until later in the fall. Last year, many companies with more than 100 full-time employees saw rate hikes of around 15 to 20 percent.

Three companies will provide individual plans in Kansas: BlueCross BlueShield Kansas Solutions, BlueCross BlueShield of Kansas City and Medica. United Healthcare announced in May that it would bow out of the individual market in Kansas and Aetna, which owns Coventry Health and Life, backed out of 11 states where it previously offered plans, including Kansas.

Social Security checks are about get a little bit bigger. Very little.

Checks for 66 million beneficiaries will rise between 0.2% to 0.5% in 2017. That works out to between $2.61 and $6.53 a month more for the typical retiree, according to the American Institute for Economic Research, a nonpartisan think tank.

The average retirement benefit check is currently $1,305.30, according to government figures.

This is by far the the smallest percentage increase of any year in which benefits did rise.

But it's better than 2016, when Social Security checks didn't increase at all. There have only been three years without any increase at all since Social Security's cost-of-living adjustment was put in place in 1975 -- 2010, 2011 and 2016.

n all three of those years, falling gasoline prices played a big role in capping inflation, which is the measure that Social Security increases are tied to.

The government won't release the official cost of living adjustment until after the September inflation reading, which is due on Oct. 18. But the AIER's estimates, which use government data, are typically on the mark.

The formula used to calculate Social Security benefits is somewhat flawed, since retirees typically do not drive as much as younger workers who commute to work. So they don't benefit as much from the lower gas prices. And retirees often spend a bigger proportion of their money on health care, which has seen prices rise faster than overall inflation.

At the same time, retirees get hurt by low interest rates, since many depend on savings for at least part of their living expenses.

Between ACA and Medicare, some Americans may have too much health coverage

By Susan Jaffe | Kaiser Health News October 11

Ever since the Affordable Care Act's insurance marketplaces opened for business in 2014, the Obama administration has worked hard to get Americans to sign up. Yet officials now are telling some older people that they might have too much insurance and should cancel their marketplace policies.

Each month, the Centers for Medicare and Medicaid Services (CMS) is sending emails to about 15,000 people with subsidized marketplace coverage. The message arrives a few weeks before their 65th birthday, which is when most become eligible for Medicare.

"In most cases you won't want to keep your Marketplace plan because once your Medicare coverage starts, you'll no longer be eligible for any premium tax credits or other cost savings you may be getting," says the email, which goes to enrollees in the 38 states using the federal HealthCare.gov. "To avoid an unwanted overlap in Marketplace and Medicare coverage . . . tell us you want to end your Marketplace plan."

And last month, CMS also began mailing letters to people already covered by Medicare as well as enrolled on the marketplace and getting financial assistance. That notice, required under the health-care law, says that they can keep dual coverage — without subsidies — but urges them to discontinue their marketplace policy since in most cases it duplicates their Medicare benefits.

Enrollees who do not follow that advice — and only the individual can terminate marketplace coverage in this situation — will have their subsidies cut. Inaction also means paying back any coverage assistance received after they should have joined Medicare.

The 13 state-operated marketplaces also must find and alert people with such overlapping coverage, although they are not required to contact beneficiaries nearing Medicare eligibility.

A CMS official said the agency has found a small number of consumers with double coverage by comparing marketplace and Medicare enrollment data but declined to say how many.

Advocates have praised federal officials for the new efforts to help seniors avoid costly enrollment headaches — something that nearly four dozen health insurers, unions and consumer groups pushed for in December.

“People ages 55 to 64 are the largest segment of marketplace enrollees,” said Stacy Sanders, federal policy director at the Medicare Rights Center. “So we want CMS, as much as possible, to get in front of any problems that might result from mismanaged transitions.”

Beneficiaries shoulder a lot of responsibility, given that neither the marketplace nor Medicare is required to provide advance notification. After turning 65, people who missed their enrollment period have to pay for insurance on their own or go without coverage while they wait for Medicare to kick in. They also are stuck paying a late-enrollment penalty — for the rest of their lives.

Without a reminder, it is easy to become tangled in problems that cannot easily be unwound, as Beth Taxter, 66, learned last year.

The self-employed Taxter, who lives outside Portland, Maine, thought she could keep her marketplace policy and did not have to sign up for Medicare because she was still working. Six months after turning 65, she went to a Southern Maine Agency on Aging meeting about Medicare. “Much to my dismay, I heard things that made me think there might be some trouble,” she said.

An agency representative told Taxter that her marketplace plan did not exempt her from Medicare’s fines for signing up late for Part B coverage, which pays for doctor visits and other outpatient services. She moved to rectify her insurance status but still faced consequences.

Seniors who don’t enroll in Part B three months before or after their 65th birthday will be hit with that permanent penalty — 10 percent of the monthly premium for each 12-month period they were late. (People who continue working after 65 for firms with more than 20 employees can delay getting Part B until they leave their job. They then have an eight-month window for signing up.)

But that is not all. By law, seniors who are late enrolling can do so only during January through March for coverage that begins the following July. While Taxter waited months for

her coverage to kick in, she had no other option but to keep her marketplace plan, although minus the subsidies the federal government had been providing to make it affordable.

“When I turned 65, neither the marketplace, the federal government nor the insurance company . . . let me know that I needed to sign up for Medicare” she said last week. “People get clobbered for not knowing what they don’t know.”

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