



## Hospitals charging fees for facility use

By Ben Sutherly

*The Columbus Dispatch* Tuesday October 23, 2012

If your doctor is employed by a hospital system, chances are you've paid a facility fee.

Ohio State University's Wexner Medical Center alone collects about \$17 million each year in facility fees from payers and patients, according to data provided to *The Dispatch*.

Those fees were based on 370,000 patient encounters, for an average of about \$46 per encounter. Facility fees, also called "provider-based billing," allow hospitals that own physician practices and outpatient clinics that meet certain federal requirements to bill separately for the facility, in addition to the physician services.

The fees, which have been allowed by Medicare for more than a decade, are becoming more common as hospitals employ more physicians, perform more outpatient procedures and look to shore up their finances. "We get paid more," said Debra Lowe, administrative director of revenue cycle at Wexner Medical Center.

"That's the impetus" for charging facility fees. The university health system charges facility fees only in outpatient settings that it owns or leases, though it doesn't charge facility fees for any care provided by its employed primary-care doctors.

"Any physicians that have an off-site facility and see patients at the main hospital, there's a facility fee for the care you receive from them," Lowe said. She said the fees help offset the cost of nursing services, clinical support and medical education.

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“It very well could be that we transition more physicians into this model” of charging facility fees, Lowe said.

Such business considerations come as health systems extend their reach by employing more doctors. OhioHealth, for example, now employs more than 400 doctors — three times the 135 doctors it employed five years ago. As of July, Wexner Medical Center had 858 employed physicians, an increase of more than 20 percent from the 706 it employed in 2008.

Nationwide Children’s employs 528 doctors, up from 381 in 2008. Mount Carmel Health System has about 140, up from 130 five years ago.

Facility fees for outpatient care frequently take patients by surprise. And such care is becoming more common. Franklin County’s hospitals performed 4.46 million outpatient procedures in 2011, up 38 percent from 2007. During that same period, the number of inpatient admissions at county hospitals grew by 10 percent.

Private-sector health insurers are concerned that facility fees add to the cost of health care without supplying any real value for consumers, said Miranda Motter, president and CEO of the Ohio Association of Health Plans, which represents the state’s health-insurance industry.

“It is even more troubling if cost-conscious consumers are discouraged from seeking primary care from employed physicians because of the potential of additional facility-fee costs,” Motter said.

Facility fees can range from \$140 to \$375 at Wexner Medical Center, and from \$30 to \$200 at Nationwide Children’s facilities, officials said. In many cases, commercial insurers negotiate lower charges, Lowe said. Medicare pays Wexner Medical Center \$50 for facility fees, she said. OhioHealth and Mount Carmel Health System say they don’t charge facility fees.

But for certain outpatient procedures — cardiology and vascular care, for example — their billing often is the same for off-campus care as it would be at the hospital itself. Hospitals say that’s because such services were previously provided in hospital settings and are still subject to hospital-accreditation policies and regulatory requirements.

Another reason: Hospitals often shift costs, charging private-sector insurance and their patients more to compensate for their losses on Medicare and, especially, Medicaid patients. In some cases, OhioHealth and Mount Carmel officials said, patients are billed by an employed physician’s practice for the care they receive from a specialist in one part of an off-site building, and no facility fee is included.

They also get a separate bill from the hospital for any testing they receive elsewhere in the same building. The charges in that bill are comparable to what they would be at the main hospital.

If a doctor’s offices are part of a hospital’s outpatient department and a facility fee is charged, Medicare requires that hospital to explain the fees upfront.

A Nationwide Children's official said the fees are necessary because 53 percent of the hospital's patient revenue comes from Medicaid.

"It's not viable for private-practice physicians to see that high of a Medicaid mix without charging some fees," said Tim Robinson, executive vice president and chief financial officer.

Families of patients at Nationwide Children's won't see facility-fee charges on their bills because it's included as part of the professional fee, Robinson said.

Robinson said the fees help pay for "wrap-around services" provided by translators, dietitians, social workers and asthma coordinators, for example, that are meant not only to get patients better, but to keep them well.

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# Future of long-term care insurance in flux

By Christine Dugas, @christinedugas, USA TODAY

As Americans are living longer, they are facing the staggering cost of nursing homes and assisted-living care, often without a financial safety net. Long-term care insurance is one way to prepare for the growing expenses, but the industry is undergoing changes and the products are confusing and costly.

The long-term care insurance industry did not have many carriers to begin with. And now the industry is shrinking, prices are rising and carriers are limiting their coverage. Since 2010, five key insurance carriers have exited the market, according to a recent Moody's Investors Service report.

"As the market stands, currently there is considerable uncertainty as to its future," says Laura Bazer, Moody's vice president. "The question is, will new players come in and fill their shoes and will the products that the players are selling be useful to policyholders?"

The increase in rates will not only affect new policyholders. Even existing policyholders will see sharp increases in their premiums, although their carriers must seek permission from state insurance departments.

Currently, long-term care insurance costs average about \$2,000 a year for a single person age 55 and more than \$2,400 a year for a couple who are also 55, says the American Association of Long-Term Care Insurance.

Long-term care insurance is not for everyone. Consumers who have not saved much money don't need it because they would qualify for Medicaid. And those who have more than \$5 million do not need long-term care insurance because they can self-insure their assets, says Byron Udell, founder and CEO of AccuQuote.

It is those in the middle who have the most to lose if they don't have long-term care insurance. It is especially important if they want to be able to leave behind assets for their children, Udell says.

Typically long-term care insurance plans have a waiting period, such as 90 days, before policyholders would begin to receive benefits. And although nursing home care is very expensive, in California, for instance, a large percentage of elderly people are in nursing homes for 90 days or less.

Today more than 85% of care is received outside of nursing homes, says Deb Newman, chairman of the Life Foundation. And people may not need as much long-term care insurance if they are being cared for at home.

One of the biggest complaints among consumers is that they may die without ever using long-term care insurance. That is why the industry is starting to come up with some new products to address those concerns. Among them:

- Shared care products that allow a married couple to take out separate plans that are connected. "If the first person passes away without using it, the benefit transfers to the spouse," Newman says.
- Hybrid products that are a life insurance policy that has a rider for long-term care insurance. Only a handful of companies offer it now, and it is being perfected, Udell says. But the hybrid provides a way to set up a pot of assets that can be used for long-term care. And if it is never needed for that, the family will receive a life insurance benefit.

•Long-term care partnership programs, which are offered in about 40 states. The advantage: Americans who have a state-approved, private long-term care insurance policy will be able to hold onto more of their assets if they later need to apply for Medicaid.

Americans can expect to live longer, and at some point many may need to be taken care of, and long-term care insurance could be useful. But as the industry seeks to reduce its risks, "at what point does long-term care become too costly for an individual or not have enough benefits to make it worth purchasing?"Bazer asks.

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# WOLF: Obamacare taxes mean Obamacare layoffs

800,000 jobs at risk

By Dr. Milton R. Wolf

The Washington Times



Monday, November 12, 2012

Illustration Crushing Obamacare Taxes by Alexander Hunter for The Washington Times

America's race toward the so-called "fiscal cliff" of automatic, massive tax increases is only part of the problem. This Thelma has her Louise — the Obamacare taxes — and hand-in-hand, these two terrors are racing toward Jan. 1.

The only thing worse than President Obama's broken Obamacare promises are the promises he intends to keep: the tax hikes. Remember when Mr. Obama promised he'd never raise taxes on families earning less than \$250,000 a year? He'd prefer you didn't, but when Chief Justice John G. Roberts Jr. and the Supreme Court put its stamp of approval on Obamacare, Mr. Obama became a court-certified tax-raiser.

Most of the president's health care takeover won't begin until 2014, but Democrats just couldn't wait that long to start taxing you. The "Top Five Worst Obamacare Taxes Coming in 2013," compiled by Americans for Tax Reform, is worth reviewing.

**Obamacare Medical Device Tax.** From pacemakers to MRI machines, if your health depends on a medical device, you will pay more. Manufacturers will face difficult decisions to compensate for the 2.3 percent excise tax on gross sales — levied even if a firm is not profitable. Will these firms charge you more, lay off workers or sacrifice research and development? Answer: Yes, yes and yes.

**Obamacare "Special Needs Kids Tax."** The newly imposed \$2,500 cap on flexible spending accounts is "particularly cruel and onerous" to families of special needs kids whose expenses can be many times that amount.

**Obamacare Investment Income Surtax.** What do your investments have to do with health care? It doesn't matter. If it moves, the Democrats will tax it. Capital gains taxes will increase by more than half and dividend taxes will nearly double. A hostile investment climate will starve business of capital and is a recipe for a double-dip recession.

**Obamacare "Haircut" for Medical Itemized Deductions.** Limiting the amount of medical expense deductions will impact families with sizable medical expenses — chief among them, near-retirees.

Obamacare Medicare Payroll-Tax Hike. An increase in the payroll tax by nearly a third just made you more expensive for your employer to keep around.

Of course, this is just the start. The labyrinth of new Obamacare regulations will kill businesses. The 2,700-page law has already generated tens of thousands of pages of regulations, and it's growing. Here's one example: The president's crackerjack bureaucrats required an impressive 18 pages just to define what a full-time employee is. Businesses will need to hire their own in-house bureaucracies to stay in compliance with the Washington bureaucracies.

It gets worse — much worse. Obamacare imposes a \$40,000 fine for daring to hire a 50th employee without providing government-sanctioned health insurance. Small businesses will start to resemble the television show "Survivor" as anyone above the magic number is voted off the island. Think this won't have an impact? There are already 2.4 times as many businesses in America with 49 employees as those with 50. Good luck.

800,000 Jobs. That's what Congressional Budget Office Director Doug Elmendorf estimated in 2011 that Obamacare will destroy, and the day of reckoning has begun. In the wake of Mr. Obama's re-election, companies large and small have already begun announcing layoffs, 45 so far, including (but certainly not limited to): Boeing, Hawker Beechcraft, U.S. Cellular, Husqvarna, Caterpillar, Bristol-Myers and on and on. Expect more — lots more.

Small businesses are especially vulnerable, particularly without the resources for throngs of lobbyists and lawyers. A recurring theme is unfolding: "Elections have consequences," said one Las Vegas business owner as he explained that the survival of his company demands that he lay off 22 of his 114 employees. The Twitter aggregator website Twitchy.com has compiled distraught business owners facing the new normal. One user tweeted: "I own a small business ... as of today. I will be laying off 10 of my 60 employees ... Thanks Obamacare."

These tragic stories are accumulating, and the human toll is devastating despite the administration's assertions of a recovery. "The private sector is doing fine," claimed the president earlier this year. This is fine? Mr. Obama came into office promising us change, and now he's delivering it: 800,000 layoffs and lost jobs during a "recovery" would indeed be some kind of change.

Be sure to thank a Democrat.

*Dr. Milton R. Wolf, a Washington Times columnist, is a radiologist and President Obama's cousin. He blogs at [miltonwolf.com](http://miltonwolf.com).*

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# Medicare asks some to make plan changes

By Susan Jaffe, Kaiser Health News, 11/5/2012

Medicare officials are trying a novel approach during this enrollment season to gently nudge a half-million beneficiaries out of 26 private drug and medical plans that have performed poorly in the past three years.

It starts with letters telling seniors they're enrolled in a low-rated plan. "We encourage you to compare this plan to other options in your area and decide if it is still the right choice for you," the letter urges. About 375,000 Medicare Advantage plan members got letters, as did 150,000 drug plan members in 48 states. The effort is the first time that Medicare officials have tried to steer beneficiaries away from some private drug and medical plans, while still allowing the plans to operate. Officials have also warned the plans that they might be canceled in the future.

Instead of a typical government form letter, each was addressed to the individual by name and tells the beneficiary that her plan "has been rated 'poor' or 'below average'" because it earned less than three stars under Medicare's five-star rating system for three consecutive years.

Yet, that might not be enough to catch their attention.

"Some people don't change no matter how many letters you send them," says Leta Blank, program director for the Montgomery County, Md., Senior Health Insurance Assistance Program, which helps seniors evaluate coverage options. There are dozens of plans for sale in most counties. Even if a different plan is cheaper, studies have shown, few seniors change plans. "They are paralyzed. It's a very difficult issue," Blank says.

For many beneficiaries, plan ratings are not as important as price, restrictions on drugs and whether their doctors participate, she says.

In addition to the letters, Medicare is making it harder for people to sign up for one of the 26 plans. If consumers search for plans on Medicare's plan-finder website, they can access and join other, better-performing plans electronically. But to join one of the 26, they must contact that company directly. Those plans also have a warning symbol next to their names to highlight their low ratings.

Seniors who pick plans with poor track records will have one chance to switch next year into a better plan. Medicare officials are considering mailing a reminder in February. Most of the roughly 13.3 million Medicare Advantage members and about 19 million drug plan enrollees are locked into plans for a year. But if beneficiaries stay in a low-rated plan, they eventually could be forced out.

"We want to make it easy for beneficiaries to find and select the highest-quality plans, and discourage people from staying in chronically low-performing plans," said Isabella Leung, a Medicare spokeswoman. Notices don't explain that plans might be in trouble. In April, the Centers for Medicare & Medicaid Services, which oversees Medicare, warned insurers that plans scoring less than three stars over three years "have ignored their obligation to meet program requirements and (are) substantially out of compliance with their Medicare contracts over a period of time." Such plans can expect greater scrutiny, the letter says. "They should also expect CMS to initiate action to terminate their contract" after CMS confirms the low scores reflect violations of Medicare rules. CMS has prohibited one plan from enrolling new members.



Robert Zirkelbach, of America's Health Insurance Plans, an industry group, said the letter is "premature" because the ratings system is flawed. He says it's based on measures that don't sufficiently take into account, for example, plans serving a disproportionate number of beneficiaries with many chronic conditions or special needs, or who live in underserved areas. "It's important to make sure we get the measures right before we move on to these other steps."

Leslie Fried, director for policy and programs at the National Council on Aging, an advocacy group, said the letter didn't have to mention potential plan terminations. "The letter tells people what they need to know about the quality of their plan and that they should consider changing to a higher performing plan," she said. If seniors ignore the warning, that's their choice, she said.

Kaiser Health News is an editorially independent program of the Henry J. Kaiser Family Foundation, a non-profit, non-partisan health policy research and communication organization not affiliated with Kaiser Permanente.

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# Retirement 'Perfect Storm' Coming in 2013

 By Mark Koba / CNBC – Thu, Nov 15, 2012  
[@cnbc](#) on Twitter

An estimated 7 million Americans will reach the age of 65 by the start of 2013, and many will no doubt be thinking about retiring.

But even if falling off the "**fiscal cliff**" is avoided, some financial experts are warning anyone thinking about trading in their paycheck for a retirement fund next year.

"It's kind of a perfect storm in 2013 when you think about it," said Jason Wheeler, CEO of Pathfinder Wealth Consulting.

"With questions about taxes, spending cuts, the markets, health care-and then put those together with the number of seniors wanting to retire or will lose their jobs-the year could be a rough one when it comes to retirement," he said.

Topping Wheeler's worry list seniors are taxes.

"The magnitude of what a retiree will pay on their investments could really hurt their finances," he said. "And right now we don't know what that will be."

If no deal is reached to solve the fiscal cliff by Dec. 31, the Bush tax cuts end and rates go higher on capital gains and dividends.

As it stands now, the top tax rate on capital gains will jump to 23.8 percent from 15 percent and the top tax rate on dividends nearly triples to 43.4 percent from 15 percent. And any fiscal deal will likely include higher tax rates so seniors had better count on that when they plan for their retirement, said John O. McManus, CEO of McManus & Associates, a trust estates law firm.

"Many seniors may want to postpone retirement in 2013 because they just don't know what their tax rates will be," McManus said. "If the markets don't perform well and tax rates go higher, seniors will have a lot less money to spend. There's a lot of uncertainty about where this will all end."

But McManus said even planning for tax increases won't be easy.

"If someone retires in January but a deal isn't reached until March, will tax rates be re-retroactive? That's a big risk for someone thinking about retirement," said McManus.

More seniors than ever are depending on defined contribution plans to fund their retirement as traditional pension programs decline. Only one in five people in the private sector actually have a pension plan in place, according to the National Institute on Retirement Security.

And though the most recent IRS data show that more than 63 percent of taxpayers with qualified dividend income are age 50 and older, some 23 percent of workers don't participate in a retirement plan-leaving many seniors unprepared for their golden years.

"The vast majority of people don't have the money to retire," said financial planner Bill Losey, president of Bill Losey Retirement Solutions. "For instance, they don't max out the contributions to their 401(k)'s. I think people need to have two to five years' worth of expected income before they can think about retiring."

Another part of the storm facing seniors in 2013 is Social Security. Retirees will see an increase in their payments-but only by 1.7 percent, less than the 3.6 percent they got in 2012. That's because the payments are adjusted to inflation-which Wheeler said is low but not low enough.

"Food, clothing, gas, everything is inching up in price while salaries remain low," he said. "Seniors will feel the pinch if they retire next year."

Inflation hurts those seniors who looked to fixed income investments like bonds, for retirement funds, said Chris DeGrace, first vice president for private wealth management at SunTrust Investment Services.

"Given how low interest rates are and will be for the next few year with what the Federal Reserve is doing, it's going to be hard for seniors to generate needed income," DeGrace said. "There will be more stress on them to find other types of guaranteed income streams."

If their incomes are going down, seniors face rising health care costs in 2013. A report from Fidelity Investments found that a 65-year-old couple in 2012 would need an estimated \$240,000 to cover medical costs through their retirement-a 50 percent increase from 2002. That figure will likely increase to \$260,000 next year.

And those on Medicare will see their monthly premiums go up from \$104.20 in 2012 to \$120.00 in 2013-as well as increased taxes on the wealthy to help pay for Obamacare.

"More and more people are going to be responsible for their health care costs as they get older," Wheeler said. "Even with Medicare, and as companies stop providing coverage to their retirees, those costs loom large for seniors."

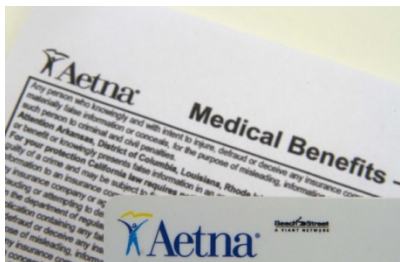
While 2013 presents unique problems, analysts say that in the end, planning for retirement never comes at an easy time, fiscal cliff or not.

"Seniors need to think about that if they leave the workforce, can they get back in, no matter what the year?" said Losey. "Are they retiring because they need a break? I've had clients say three to six months later that they want to work again because they are bored. And these days it's difficult for seniors to get jobs that pay well when companies are hiring younger people at lower salaries."

"It's not to say that 2014 will be a better year to retire," said McManus. "There are always a lot of things people can't control, like the markets and global issues. I'm just saying that if you think about retiring in 2013 you need to take care and take caution."

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# Time to elect a health-care plan



Wilfredo Lee/AP - Aetna has some tips to help during open enrollment for health-care benefits.

By [Michelle Singletary](#), Nov 06, 2012

## The Washington Post Published: November 6

Thank goodness the election is over because there is another election you need to focus on now.

This time of year, your employer gives you an opportunity to make changes to your workplace benefits next year. Yes, it's open-enrollment season again.

## Electing a health-care plan



Michelle Singletary NOV 6

Can I be honest with you?

I've been trifling in the past when it comes to open enrollment. There have been times when I waited until the night before the deadline to review my benefit information. Or life got in the way and I just forgot to review my choices. Usually, I just went with what I already had, which is good. But I could have made some costly mistakes.

Fifty-six percent of employees estimate they waste up to \$750 annually because of their errors during open enrollment, according to a survey of 2,500 consumers conducted for insurance provider Aflac. Participants said they elected the wrong level of insurance coverage or took benefit options they didn't need.

Take heed from the mistakes the Aflac survey found:

- Sixty-one percent of those polled said they are only sometimes or not at all aware of changes to their insurance policies each year.
- Eighty-nine percent default to the same options every year.
- Only 16 percent contribute the right amount to flexible spending accounts.

If you can't focus on the dizzying amount of information, I understand. You are not alone. A health survey by Aetna found that workers rank choosing health-care benefits as the second most difficult major life decision behind saving for retirement. Further, survey respondents said that choosing health-care benefits is more difficult than purchasing a car, making decisions about medical tests or treatments, parenting and selecting other forms of insurance.

So why do we dread it so much?

Overwhelmingly, employees said they found decisions on their health-care benefits to be difficult because the information they are given is confusing and complicated, there is conflicting data and it's hard to determine which plan is the right for them, according to the Aetna survey.

First — and this may sound obvious — don't treat your open enrollment package like junk mail. Open it. Or go online and read through the materials provided by your employer. You will likely find tools to help you compare health-care costs, insurance plans or other benefits. Even if you aren't planning to make any changes to your choices, look at everything that is being offered. The health insurance plan that has worked for you in the past may have undergone some major changes or service deletions. How do you know if you've got the best plan for you or your family if you don't know what else is being offered?

You have to do some math. I know. It's a pain. But you may have a Cadillac health insurance plan when you only need Chevy coverage. Take some time to add up your yearly medical expenses so you can elect the right coverage for your needs. Aetna found that 43 percent of its survey participants rarely or never track how much they spend on out-of-pocket health-care costs.

Maybe self-help isn't best for you. Some people are comfortable reviewing materials on their own. But in the Aflac survey, half of employees said they would feel more informed if they sat down with an insurance consultant during enrollment. If you fit within this group, go to the open enrollment meeting at your place of work.

Aetna has some additional tips to help during open enrollment. Go to [www.planforyourhealth.com](http://www.planforyourhealth.com) and look for “(Benefits) Decisions 2012: Top 10 Tips.” Here are a few of the tips, pulled together by Wendy Shanahan-Richards, co-author of “Navigating Your Health Benefits for Dummies” and national medical director for Aetna:

- Make a list of your current and future health-care needs. Include prescription medications or any planned surgeries or health-care procedures for the upcoming year.
- Review any problems you had with previous benefits plans. This is a good time to try to learn more about coverage you wish you had in the past. One of the reasons I'll probably stick with my current provider is because the company added my regular health facility to its list of centers designated to handle urgent-care problems. If my children get sick after-hours, I don't have to drive as far as I've had to in the past.
- Don't just focus on the plan premiums. Take note of out-of-pocket expenses such as co-payments, deductibles and any additional charges.
- Pay attention to your open enrollment deadlines so you don't have to rush to make a decision for your elections.

Don't be trifling. Not now. Not when health-care costs are going up and your money is so stretched.

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## For Business Owners, the Health Care Details Begin to Emerge

By PAUL DOWNS November 14, 2012

The struggles of a business trying to survive.

Last week, before the election, I received a fat envelope from Independence Blue Cross with our health insurance renewal rates for 2013. This happens about this time each fall, and it is not something I look forward to.

I've had a couple of good years — my rates fell in 2010 and 2011 — but this was preceded by a long string of years with double-digit increases. Which is discouraging, because the astronomic rise in costs wasn't accompanied by any apparent rise in the quality of the health care we have been getting. Co-pays have gone up. Drugs have gotten more expensive. At the doctor's office they still hand me that stupid clipboard with the paper questionnaire to fill out, then they make me wait another 30 minutes to see the doctor. Most problematic, in my opinion: I still can't find a price list for any of the doctor's routine services. So I have no way to compare the costs.

I open the envelope, wade through the pages of boilerplate and finally get to the heart of the matter. For the third year in a row, my rates have dropped. It's not a huge amount, about 5 percent, but it's better than another increase. The monthly charge for a single person has dropped from \$330.89 to \$315.23, and the rate for family coverage fell from \$971.26 a month to \$925.31. To put this in perspective, here are the rates for my cheapest policy options for the last seven years:

Year	Single	Family	% Change
2005	206.54	606.01	
2006	224.16	657.67	9%
2007	289.27	848.69	29%
2008	348.73	1023.17	21%
2009	351.46	1031.18	1%
2010	424.83	1246.74	21%
2011	352.64	1035.04	-17%
2012	330.89	971.26	-6%
2013	315.23	925.31	-5%

The drop from the peak in 2010 is significant, but I'm still paying 50 percent more for insurance that I was in 2005.

The envelope from Blue Cross was followed by an e-mail from our benefits administrator, with a spreadsheet attached that recapped all of the pricing information and added a whole lot more. Most of it was procedural, laying out the steps required for me to renew the policies for all my workers. But one of the tabs in the sheet was titled "Health Care Reform" and laid out all of the ways that the Affordable Care Act — a.k.a. Obamacare — would be changing the landscape. It's a long list, sorted by date, and progressing from now until the date of full implementation in 2014. This item in particular caught my eye:

"Effective March 2013: Employers must provide a new notice to all employees explaining the availability of Exchanges and whether or not the employee may be eligible for insurance affordability programs through the Exchange. The notice must be provided to new employees upon date of hire. Guidance is pending."

Scrolling further down the page, there was more:

“Effective January 1 2014: All U.S. citizens and legal residents must maintain ‘minimum essential coverage.’ Failure to obtain minimum essential coverage will result in financial penalties for groups with more than 50 employees. Some exceptions apply.”

And effective the same date, this:

“Health insurance will be available for purchase through the exchanges. Private and nonprofit insurers as well as states will offer small employers (up to 100 employees) the ability to purchase health insurance. Large employers (more than 100 employees) may purchase coverage through the exchanges beginning in 2017. Employers will not be required to purchase coverage through an exchange.”

Ah, the crux of the matter. Within a year I’ll have some idea of what it will save me (and cost my employees) to stop providing health insurance. I’ll have the option to let my workers get their own coverage, just the same way they get car and house insurance. I have not made up my mind whether this is a good idea or not, but soon I’ll have some real numbers to think about.

With President Obama’s re-election, the Affordable Care Act will be fully implemented. I voted for him, twice, partially in hope that something would be done about the health care mess. So this is what I get.

How about you? What has happened to your rates? What are you finding in your renewal packages? What do the health care changes mean for your company?

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Illinois plans to partner with the federal government on its health insurance exchange. (Image Bank / November 15, 2012)

By Peter Frost Tribune reporter *November 15, 2012*

Illinois plans to submit a blueprint of its health insurance exchange to the federal government on Friday, state health officials said Thursday afternoon.

By 2014, all states must have an active exchange where individuals and small businesses can shop for health insurance plans based on cost, provider networks and coverage options.

Illinois plans to partner with the federal government on the online marketplace mandated under the 2010 health care overhaul law.

States originally were required to submit their exchange blueprints by Friday, but federal health officials decided last week to extend the deadline to Dec. 14. All states still must notify the government Friday if they plan to set up their own exchange or to allow the federal government to do so for them.

Illinois chose to partner with the federal government for the first year of the exchanges, before taking over control in fall 2014, in time for open enrollment for 2015.

State insurance officials said they expect the marketplace to include several hundred health insurance plans offered by multiple providers.

The blueprint they plan to submit Friday will be "a living document" that's expected to evolve as federal and state governments set policy, said Colleen Burns of the Illinois Department of Insurance.

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# Medicare premiums going up \$5 a month for 2013

RICARDO ALONSO-ZALDIVAR , *The Associated Press*

POSTED: FRIDAY, NOVEMBER 16, 2012

WASHINGTON - Medicare premiums are going up \$5 a month in 2013, the government said Friday. It's less than expected, but still enough to eat up about one-fourth of a typical retiree's cost-of-living raise next year.

Medicare chief Marilyn Tavenner said the new "Part B" premium for outpatient care will be \$104.90 a month. In most cases, it's deducted directly from a beneficiary's monthly Social Security check. Currently the premium is \$99.90 a month.

Earlier this year, the government projected an increase of as much as \$9 for 2013, but health care inflation has remained modest.

Still, advocates for the elderly didn't see much to cheer about, particularly since Medicare cuts are on the table in budget negotiations between President Barack Obama and Republicans in Congress. Obama has promised to protect beneficiaries, but even his plan calls for upper-income retirees to pay more.

"These increases aren't as big as projected, but they are still increases," said Joe Baker, president of the Medicare Rights Center, a New York-based advocacy group. "Our fear is that as policymakers discuss deficit reduction, they'll pile even more costs on to seniors."

High-income beneficiaries, those making above \$85,000 a year individually or \$170,000 for a couple, will face bigger increases. They will pay an additional \$42 to \$230.80 a month, depending on income. Most low-income beneficiaries have their premiums paid by Medicaid.

Tavenner also announced that Medicare's hospitalization deductible will increase by \$28, to \$1,184. The deductible is the amount a person must pay before health insurance kicks in. Many seniors have some form of additional coverage to handle their Medicare hospital deductible.

The annual deductible for outpatient care will increase by \$7, to \$147.

Coverage for outpatient care under Medicare Part B is optional, but more than 90 percent of the program's 52 million beneficiaries sign up. Medicare covers people 65 and older, the disabled and those with serious kidney disease.

Part B pays for office visits to doctors, preventive services and medical equipment. It's a good deal by any measure, since 75 percent of the cost is borne by taxpayers, with premiums set to cover the remaining 25 percent. Still, many beneficiaries are on tight budgets so the monthly premium is a closely watched indicator.

Last month the government announced a 1.7 percent cost-of-living increase for the 56 million Americans on Social Security. That works out to raises averaging \$19 a

month come January. The typical increase for retired workers will be slightly larger.

Obama's health care law reined in Medicare spending by curtailing payments to hospitals, insurers, drug companies and other service providers. Democrats want to focus the next round of cuts on providers, particularly pharmaceutical companies. But Republicans are looking for more significant changes in the program, such as increasing the eligibility age to 67.

The health care law improved preventive care for Medicare recipients and cut costs for people with high prescription drug bills. It also initiated a multitude of experiments on how to deliver quality care at lower cost for taxpayers. And it set up a cost control board to limit future increases in Medicare spending.

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# Can the IRS handle Obamacare?



IRS officials have promised everything will be ready in time, but there's a lot to do. | AP Photo

By [PAIGE WINFIELD CUNNINGHAM](#) | 11/20/12

Now that the health care law's future is finally secure, it's up to the Internal Revenue Service to make sure the money flows.

But only the right amount of money. And only to the people who are supposed to get it.

The agency is charged with shouldering some of the law's most nitty-gritty technical details, from making sure Americans receive the insurance premium tax credits they're eligible for, to incorporating more than 40 changes to the Tax Code, to collecting penalties from individuals and businesses that fail to meet the law's insurance requirements.

And there's plenty at stake as the agency faces the largest set of tax law changes in more than two decades and prepares to process returns from around 20 million Americans who are expected to enroll in subsidized health coverage.

IRS officials have promised they'll have everything ready in time, but the sheer scope of the workload has prompted fears that it's all just too much for the agency to handle and could cause error and fraud to skyrocket.

"They're going to be very strained," said Mark Everson, former IRS commissioner during George W. Bush's administration. "The main thing is the vast amount of information required for the IRS to collect and dispense. ... There's a lot of complexity to it."

The task is crucial, albeit unenviable, said Fred Goldberg, who served as IRS commissioner under President George H.W. Bush. "The IRS is like the guy who walks behind the elephant at the circus," he told POLITICO.

As the IRS marches onward, here's a rundown of how it's responsible for making the Affordable Care Act work as lawmakers intended.

## 1. Getting the tax credits out

To extend coverage to millions of uninsured Americans, the law largely depends on a system of income-based insurance subsidies, delivered through state-based exchanges. But all of that will be administered through the Tax Code — which means the IRS is facing a huge task.

When a low- to middle-income individual or family approaches an exchange to buy insurance, the IRS will have to release their tax returns so exchange workers can estimate how much of a credit they should get. When they enroll in a plan, the government will pay the credit directly to the insurers.

But because the credits will be based on two-year-old tax returns, there's a good chance the IRS will find them either too generous or too stingy when it totals things up at the end of the year. And if an enrollee's eligibility changes during the year — if they get divorced, have a child or even move to a different state — that could complicate things even more.

Some tax experts complain that the problem is aggravated by conflicting interests between the insurance exchanges and the IRS.

Since the exchanges will be regulated by the Department of Health and Human Services, they'll have an incentive to offer people the largest insurance credit possible to encourage them to enroll. But since the IRS has the job of balancing the books, any income miscalculations will just leave them with more work to do at the end of the year.

“HHS and the IRS have very different focuses and missions,” said Kathy Pickering, executive director of The Tax Institute at H&R Block. “HHS is very focused on making sure everyone has health care coverage whereas the IRS has to enforce the tax law and then reconcile that premium tax credit.”

## **2. Getting the overpayments back**

To save lower-income Americans from a big tax liability at the end of the year if they get too much in insurance subsidies, there's a limit on how much they'll have to pay back. (Congress has raised it twice.)

Under the current rules, married taxpayers earning less than 200 percent of the federal poverty level would have to pay back a maximum of \$600 in overpayments. That cap rises to \$1,500 for those between 200 percent and 300 percent of poverty, and \$2,500 for those with incomes higher than that.

But even with the caps, it will be a challenge for the IRS to get the money back since the agency is banned from using any of its traditional methods of collecting taxes. So if an individual still owes a \$3,000 total tax liability at the end of the year — and \$1,000 of that is an insurance subsidy repayment — the IRS can only charge interest or penalties or issue liens on the other \$2,000.

Tax experts say that could also leave the IRS with some big headaches.

“It complicates the IRS's job a lot if you think about it,” Goldberg said. “It's a separate bucket of liability.”

## **3. Collecting the new taxes**

The IRS is also facing the largest revamp of tax law in more than 20 years. From changing the medical expenses deduction to raising the Medicare payroll tax to creating entirely new revenue — like the tax on so-called Cadillac plans — the law makes more than 40 changes to the Tax Code.

And that includes the tax that could become the least popular of all: penalties for people who don't get health coverage after the individual mandate kicks in.

But implementing this part of the law may feel more natural to the IRS, which is used to navigating a complex tax system that contains thousands of different credits and deductions. The agency's inspector general concluded last summer that it has developed “appropriate plans” to put the new tax provisions in place.

Some of those, like a fee on branded drugs, have already gone into effect. Another handful are slated to become law on Jan. 1, including a higher Medicare payroll tax for high-income people and a medical device tax.

#### **4. Interpreting the law**

Along with implementing the law, the IRS must also lay out more specific guidelines on questions that have confused businesses as they try to figure out what the new law requires of them.

One of those questions is which employees count as full time under a new rule that requires most businesses to offer affordable coverage to workers. Another pressing question is how to calculate whether those plans are valuable enough to meet the requirements.

#### **5. Answering lots of questions**

And to top it all off, experts say the IRS is likely to be barraged at its call centers as people try to file tax returns that have suddenly become much more complicated. Right now, most Americans file relatively simple tax returns, especially those at the lower end of the income scale.

But once those folks enroll in subsidized health coverage, their filing process will be more complex as they try to calculate eligibility that may have changed mid-year.

“There’s so much the consumer still doesn’t understand,” Pickering said. “Clearly, there will be challenges with the call centers, and in the midst of a filing season where you’re dealing with much more fundamental issues such as ‘Where’s my refund,’ they have an enormous challenge in terms of being able to handle daily loads.”

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# GENERIC FORM OF LIPITOR RECALLED

no reason to action on cholesterol drug



Pfizer's Lipitor for treatment of high cholesterol is the best-selling drug. (Paul J. Richards/AFP/Getty Images / November 23, 2012)

**Reuters** November 23, 2012

Indian drugmaker Ranbaxy Laboratories Ltd. has voluntarily recalled its cholesterol-lowering drug atorvastatin in the United States, a development that could dent its image further in the world's biggest prescription drug market, where the company faced an earlier ban.

Ranbaxy did not specify the reason for the recall of the drug, which largely drove the company's sales in the first of half the year. Shares fell more than 4 percent after the announcement.

The recall of atorvastatin, a generic version of Pfizer Inc.'s Lipitor, will temporarily disrupt supplies in the U.S. market while the company conducts an investigation expected to take two weeks, it said. Lipitor is considered as the world's best-selling drug and at its peak generated \$13 billion in one year for Pfizer.

Ranbaxy was the first company to launch generic Lipitor in the United States after Pfizer's patent expired last year. The Indian company had marketing exclusivity for the first six months that generics were allowed to be sold along with U.S.-based Watson Pharmaceuticals Inc.

"The development will impact the company's credibility to an extent," said Bhagwan Singh Chaudhary, a research associate at the brokerage IndiaNivesh. "There have been issues in the past (about compliance) and a recall suggests, corrective measures suggested by the U.S. FDA are not being implemented."

Generic Lipitor generated nearly \$600 million in sales for Ranbaxy during its exclusive marketing period, Chaudhary said.

Other drugmakers including Indian rival Dr. Reddy's Laboratories Ltd have since launched their own generic atorvastatin versions in the United States.

Controlled by Japan's Daiichi Sankyo Co, Ranbaxy has had a troubled history in the United States where shipments from some of its manufacturing plants were banned from 2009 over a compliance-related probe.

The ban was troubling for Daiichi Sankyo, which acquired a majority stake in the Indian company for \$4.2 billion in 2008.

Early this year, Ranbaxy agreed to make broader changes at its plants and agreed to appoint an external auditor to resolve the dispute with the U.S. Food and Drug Administration.

It has also set aside \$500 million towards any settlement charges it might have to pay.

Shares of Ranbaxy, which is valued at \$3.93 billion, were down 3.5 percent at 494.85 rupees as of 0950 GMT, underperforming a 0.07 percent fall in the Mumbai market.

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