Health & Retirement Services of Illinois

Newsletter January 2015

OUR NEWS LETTER HRSI

NEW REALITIES CHANGING YOUR RETIREMENT

By Tom Sightings December 3, 2014

We no longer have our grandfather's retirement. Pensions are a distant memory for many of us. We all worry about the future of Social Security and the escalating cost of health care. Meanwhile, our life expectancies have increased, and we can look forward to a longer, healthier and more expensive old age.

But Americans are practical. We adjust our lives to deal with changing times. Here are some of the new realities of retirement and how Americans are coping with them.

1. The traditional career path is a relic of the past. The experience of a decades-long full-time job that is followed by full-time retirement is now the exception rather than the rule. Instead, many employees are leaving work in their 50s and taking lower paying temporary jobs for several years before full retirement. People in this stage of their working life have different attitudes and expectations compared to full-time employees, which presents new challenges and opportunities for both management and workers.

2. Employees have less control over the timing of their retirement. Age discrimination is illegal. Yet, many workers in their

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50s and early 60s have lost their jobs and been passed over for new positions. Other people jump into retirement, even if they can't really afford it, because they are sick of their jobs and dream of an easier life -- if only they could survive without a paycheck.

3. More people choose semi-retirement. Due to economic uncertainties, a significant number of retirees now hold part-time jobs. Just over a third (35 percent) of Americans work full time at age 62 and about 14 percent work part time, according to the National Institute on Aging, By age 68, only about 13 percent work full time while 19 percent work part time. Retirement is not an all-or-nothing proposition. The downside of a part-time job is that you're still working. But for many people a part-time job cushions the blow of a layoff, or allows them to leave behind the drudgery of an old job to try something new and more interesting. A part-time job also supplements income from Social Security and a pension and extends the life of their retirement savings.

4. Many people enjoy more flexibility. In 1970, Social Security introduced the delayed retirement credit, meaning that employees working beyond normal retirement age continue to build up Social Security credits. Now workers have the flexibility to retire anywhere between ages 62 and 70 without financial penalty. Theoretically, no matter when you retire, you collect the same amount of Social Security benefits (depending, of course, on how long you live). Also, the decline in defined-benefit pension plans may have a silver lining. Today, fewer companies require workers to retire at a specific age, so you can often stay on the job longer if you want to. The net result is more choice for workers. You can keep working, but if you harbor a dream to do something different -- try a new job, open your own business, make your own crafts or pick up some extra cash as a dog sitter or house sitter -- then early retirement is more feasible today than ever before.

5. People who are semi-retired spend more time in part-time careers. Those who leave the full-time workforce early need to make more income, largely because they have spent fewer years earning a salary.Therefore, instead of taking full retirement at 66, many people keep their part-time jobs until age 70 or beyond to make up for lost wages earlier in their career. So, if you do take a part-time job later in life, make sure you really enjoy what you're doing.

Some people question: If you're still working, how can you say you're retired? The answer is not to think of retirement as a time to sit around and do nothing. Instead, it is a time, at last, to do what you want. For increasing numbers of Americans this means scaling back and working fewer hours on a less stressful basis, either for your old company or in an entirely new environment.

Working in retirement can provide the best of both worlds. You're free from the daily obligations you've been shouldering for years, but you're still making money. You have some structure in your life, and you're meeting new people. You are also doing something useful and making a difference in the world.

20 Filling Foods That Help You Lose Weight

by Nicole Cherie Jones, Health.com Health December 7, 2014

If the theme song for every diet you've tried would be "I Can't Get No Satisfaction," you should keep reading. "One of the biggest challenges when you're trying to lose weight is combating hunger and the desire to eat," says Cynthia Sass, MPH, RD, and Health's contributing nutrition editor. The simple solution: eat filling foods that stick with you. "Foods that contain fiber, protein, and plant-based fat tend to be the most satiating," Sass says. These nutrients slow down digestion and the absorption of nutrients, a process that helps you feel physically full for longer, and also means no blood sugar or insulin spikes.

While you might find some of the research that follows surprising, there are no magic potions or super bars on this list. They're all nutrient-rich whole foods, which a recent study revealed increase calorie burning by roughly 50% compared to processed foods, adds Sass. Eating less without feeling like you're on a diet and burning more calories? We'll take it.

Potatoes

"Many people still think that because potatoes have a high glycemic index they will induce cravings and weight gain, but research shows this isn't the case," says Joy Dubost, PhD, RD, spokesperson for the Academy of Nutrition and Dietetics. In fact, potatoes ranked number one on the famous satiety index, which was published in the *European Journal of Clinical Nutrition* in 1995. During the low-carb years, they fell out of favor, but lately there's been a renewed interest in studying their effect on diet and weight loss. After all, even though a potato is carb-heavy, it is a vegetable—one medium spud contains 168 calories with 5 grams of protein and 3 grams of fiber. Some experts argue that they are particularly satisfying because of they contain resistant starch—complex starch molecules that we can't digest.

Apples and Pears

With a satisfying crunch—or in the case of certain softer varieties, a sweet, juicy bite—pears provide a lot of bang for your buck (the dollar kind and nutritional kind). For less than $1 and around 100 calories, you get between 4 and 6 grams of appetite-suppressing fiber, plus lots of antioxidants. A recent study from Washington State University suggests that Granny Smiths are the most beneficial for our gut bacteria due to their high content of non-digestible compounds, including dietary fiber. Researchers believe that re-establishing a healthy balance of bacteria in the colon stabilizes metabolic processes, helping to increase satiety and reduce inflammation, which has been associated with chronic health problems like heart disease and diabetes.

Almonds

If you're looking for the perfect on-the-go snack, almonds might just be it. Several recent studies have found that snacking on them helps you stay satiated throughout the day, and eat less at meals. A small handful is the ideal portion size (about 1 ounce, or 22 almonds)—for 160 calories, you get a healthy dose of monounsaturated fat, 3 grams of fiber, and 6 grams of protein. Bonus: they're loaded with vitamin E, which is essential for healthy hair, skin, and nails.

Lentils

No surprise here. People have been filling their belly with hearty lentils for thousands of years, and staying full for hours thanks to 13 grams of protein and 11 grams of fiber per serving (3/4 cup). A recent study published in the journal *Obesity*reviewed nine randomized, controlled trials that measured the effect of pulses (such as lentils, black beans, and chickpeas) on post-meal satiety. Participants felt 31% fuller after eating one serving of pulses compared to the control meals of quickly digested foods such as bread and pasta. One study published earlier this year in *The FASEB Journal* even found that beans were as satisfying as beef.

Cacao nibs

You've probably heard that dark chocolate is heart-healthy and packed with antioxidants. But why is it so satisfying? It contains happy-making brain chemicals such as serotonin. Its health benefits come from cacao beans, but most chocolate also contains sugar. That's why some experts advise eating the beans themselves, in the form of less-processed cacao nibs (crunchy, broken up bean bits), which offer 9 grams of fiber per ounce (compared to none in 1 ounce of a typical milk chocolate bar). "I recommend cacao nibs or dark chocolate with more than 70% cacao to my clients," says dietitian Ashley Koff, RD, a New York-based dietitian. "You get a natural energy boost from its theobromine, a bitter alkaloid of the cacao plant, plus magnesium, which is mother nature's anti-stress mineral," she explains.

Hemp hearts

Also known as shelled hemp seeds, these have only recently made their way into mainstream grocery stores. Hemp—a relative ofmarijuana—is perfectly legal, and packs more protein than chia or flax, in addition to fiber. Since it contains a complete essential amino acid profile and is rich in essential fatty acids (EFAs) such as omega-3, it's a great option for vegans who want to add more staying power to their meals. These deliciously nutty little seeds can be eaten as a topping on oatmeal, yogurt, and salads, or blended into smoothies.

Kimchi

In addition to adding a satisfying complexity to meals, foods that have been fermented, like kimchi and sauerkraut, contain probiotics that aid digestion, says Koff. And when you keep your gut happy, it has vast positive effects on your health. One recent study published in the *Proceedings of the National Academy of Science* found that maintaining healthy bacteria levels in the gut improve the functioning of the gut lining, and may help reduce fat mass, inflammation, and insulin resistance. Another study from the Department of Endocrinology and Metabolism at Ajou University School of Medicine in Korea, which focused specifically on kimchi, had similar findings.

Lemons

Add the juice and pulp of this citrus fruit to pump up the flavor of everything from your ice water to salads, smoothies, and cooked fish, for almost no calories, recommends Koff. In addition to making the food taste better, the pectin fiber in this citrus fruit may help you fight off hunger cravings. "Lemons are also an alkaline-forming food that helps promote an optimal pH in the intestines," she explains, which some say can help with digestion and aid in weight loss, though these claims have not yet been proven with scientific research.

Greek yogurt

Dubost recommends dairy foods of all types to her clients, but especially higher protein options like Greek yogurt and cottage cheese. The satiating effects of yogurt are especially well researched. In one study published last year in the journal Appetite, participants were given a 160-calorie yogurt snack three hours after lunch that contained either low protein, moderate protein, or high protein. Those who ate the high-protein yogurt (a Greek yogurt containing 24 grams of protein) felt full the longest, and ate dinner later than the other subjects. Some studies also suggest that the acids produced during yogurt fermentation increase satiety.

Eggs

Two large hardboiled eggs only set you back 140 calories and provide 12 grams of complete protein, which means it contains all 9 essential amino acids that your body

needs but can't make itself, says Dubost (all animal proteins offer a "complete" amino acid profile). A study published in the journal*Nutrition Research* found that eating eggs at breakfast helped dieters feel less hungry for a full 24 hours, while also stabilizing their blood sugar levels and helping them eat fewer calories over the course of the day.

Lean beef

Lean cuts of beef such as sirloin, tenderloin, and top round are high in protein and offer a complete amino acid profile, which make them extremely satiating. A healthy 4-ounce portion of as sirloin steak contains 200 calories and 32 grams of protein. Just don't go overboard—even lean cuts of red meat are relatively high in saturated fat, and eating a lot of it has been associated with heart disease, cancer, and type 2 diabetes. Limit yourself to one serving a week.

Broth-based soup

"Based on the latest research the most satiating foods pack plenty of protein and fiber, along with high water content," says Dubost. Finding a food with all three of those can be tough, but a broth-based soup with vegetables and lentils or beans does it, she says. It's well known that fiber-rich vegetables help you stay full longer for few calories and if you need a reminder about lentils see number TK. Many previous studies have demonstrated the satiating effect of soups compared to solid meals, but an interesting study published in the European Journal of Clinical Nutrition found that smooth soups actually result in more fullness because they digest more slowly than chunky soups. Bring on the blender!

Hot oatmeal

When your mom told you to eat your oats, she was right. Just make sure they're cooked. One recent study published in *Nutrition Journal* found that calorie-for-calorie, oatmeal cooked with nonfat milk was more satisfying than oat-based cold cereal with nonfat milk. Participants who ate about 220 calories of the hot kind for breakfast reported less hunger and increased fullness compared to the cereal eaters—possibly because satiety is enhanced by the higher viscosity of the beta-glucan in the cooked oatmeal. Another new study suggests that its resistant starch may boost beneficial gut bacteria, which—according to mounting evidence—keep the good mood brain chemicals flowing.

Avocado

Just *thinking* about rich, creamy avocado is satisfying. Yes, it's high in fat—but the good kind. Its plant-based fatty acids have anti-inflammatory benefits, which can help ease arthritis and lower risk of heart disease. Plus, half an avocado packs 7 grams of fiber. In a study published in *Nutrition Journal*, researchers found that adding half an avocado to lunch increased subjects' satisfaction by 26% and reducedtheir desire to eat by 40% for

3 hours. Like olive oil, it increases absorption of fat-soluble nutrients, making diced avocado the perfect way to ensure your salad is delicious, filling, and fully utilized by your bod.

Raspberries

Berries can be pricier than other fruits, which ups their indulgence factor and may cause you to slow down and savor, which can increase food satisfaction. Sun-ripened raspberries taste sweet, but are surprisingly low in sugar (5 grams for a whole cup) and high in fiber (8 grams per cup). Translation: a sweet tooth fix without the blood sugar spike. In a study published in the *Journal of Nutrition*, researchers found that polyphenol-rich berries like raspberries may even reduce the digestion of starch in bread—and the typical insulin spike response.

Leeks

New research indicates that gut health—which influences mood, satiety, and metabolism—is closely related to the diversity of your gut bacteria, known as your microbiome. The bacteria in your colon need to be fed dietary fiber to flourish, but most of the fiber we eat is short-chain. Only fructan and cellulose fibers (types of prebiotics) are long enough to survive all the way down the GI tract, according to Jeff Leach, founder of the American Gut Project. Leeks are one of the top sources of fructan (10 grams per leek) and cellulose. One caveat: Cooking shortens the fiber chain, so to reap the maximum benefits, eat raw or lightly sauteed.

Quinoa

Even though it's categorized as a grain, and treated like one in recipes, quinoa is technically the seed of a plant related to spinach, beets, and chard. Ever since it was first stocked at Whole Foods and Trader Joe's in 2007, it has exploded in popularity as a gluten-free, vegan source of "complete" protein, with 8 grams per cup cooked. It also has almost double the fiber of brown rice, which gives it extra hunger-squashing power, says Sass.

Fish

Fish is another very efficient source of protein. Many types of white fish are extremely lean, and fattier varieties such as salmon pack healthy omega-3 fats. Some studies suggest that fish protein may be slightly more satiating than beef protein, but more research is needed to explain why. One possible explanation is that fish are naturally high in the amino acid L-glutamate, which is associated with umami, a savory-rich taste linked to satiety.

Popcorn

Did you know popcorn is a whole grain? Yep. Four cups contain 3 grams of fiber and

protein each. But its biggest trick is volume. Four cups takes up a lot of room in your stomach and as long as you eat it with only a little salt and tiny bit of oil, that size serving will set you back less than 150 calories. One study found that snacking on popcorn helped dieters satisfy their hunger while staying on track with their weight-loss plan.

Flaxseed

"In my experience, both personally and with my clients, seeds are incredibly filling and satiating," says Sass. One study from the University of Copenhagen in Denmark found that meals supplemented with 2.4 grams of flaxseed fiber promoted a greater feeling of satiety and fullness in men compared to meals without the fiber. One tablespoon of ground flaxseed contains 37 calories, 2 grams of polyunsaturated fatty acids, which includes omega-3s and 2 grams of fiber. Note: whole flaxseeds will pass through your system without being digested, so buy them ground or do it yourself using a spice grinder.

Feds recover $5B in healthcare waste

By Sarah Ferris - 12/10/14

The federal government has recovered nearly $5 billion in misspent healthcare dollars over the last fiscal year, about 15 percent less than the same period last year.

Investigations within the Department of Health and Human Services (HHS) led to roughly 1,000 criminal charges and 500 civil charges, according to a report Wednesday. The department also barred more than 4,000 people from federal healthcare programs.

The wasted money was found across 100 departments in HHS, which is one of the largest spenders of federal dollars. It is also the government's largest distributor of grants.

The report also found that HHS saved about $15.7 billion by using funds "more efficiently" based on previous recommendations from the Office of the Inspector General.

Analysis: Shoppers should look at all health plan costs

By Elise Viebeck - 12/10/14

People shopping for medical coverage on ObamaCare's exchanges should look at costs other than the monthly premium, a new analysis urged Wednesday.

Researchers with Avalere Health, a consulting firm, found that 74 percent of silver plans on the exchanges have out-of-pocket cost limits that are lower than what is required under the healthcare law next year.

Additionally, deductibles in the silver tier rose 7 percent on average for next year. Policyholders in that group will have to pay $2,700 on average before their coverage begins to help with the cost of care.

Avalere officials urged consumers to look carefully at these figures as they choose a health plan.

"Consumers with complex health conditions should closely consider factors other than premiums," said Caroline Pearson, vice president at Avalere Health, in a statement.

"Out-of-pocket limits and deductibles will also play a critical role in determining the total cost of coverage for many enrollees."

The analysis echoes calls from federal health officials, who are calling on ObamaCare enrollees to return to the exchanges to see if they can find a better deal for 2015.

Still, experts believe it will be difficult to persuade consumers to actively shop again for coverage, even if their costs are rising.

People shopping for health insurance are typically most attentive to the monthly premium cost as opposed to deductibles and out-of-pocket limits.

Under the Affordable Care Act, insurers are required to limit out-of-pocket costs for individual enrollees to $6,600 and families to $13,200 next year.

Consumers May Miss Out On Subsidies Due To Uncertainty About Job-Based Coverage

By **Michelle Andrews** December 9, 2014

Confusion about whether some types of job-based coverage disqualify consumers from signing up for subsidized insurance through the health law's marketplaces may lead some people to buy skimpier employer plans instead.

In recent weeks, some assisters who help consumers find coverage say people are being told by their employers that their bare-bones plans – which, for example, may cover preventive benefits only — meet "minimum essential coverage" requirements. That's the type of coverage most people must have to satisfy the health law's requirement that they have health insurance.

The problem is that consumers mistakenly think that having access to such coverage means they don't qualify for subsidies if they want to buy a policy on the exchanges instead.

But that's not necessarily the case.

Rather, they would be ineligible for subsidies if their employer plan is deemed affordable under the law and pays for 60 percent of allowed medical charges, on average. Coverage is considered affordable if it costs no more than 9.5 percent of an employee's income for self-only coverage.

Some of the confusion relates to the similar-sounding bureaucratic names for these different health law standards. Minimum value coverage means the plan pays for 60 percent of allowed medical charges, on average.

Minimum essential coverage, which can include a range of things from grandfathered health plans to some of the prevention-only plans being offered by large employers,

refers to what large employers must offer to avoid paying penalties for not offering coverage, as well as what individuals must carry to comply with the law's coverage requirement.

Some consultants have reportedly developed job-based plans that cover very little other than preventive benefits. Unlike small group and individual plans, which are required to provide comprehensive coverage under the health law, no such requirements exist for large group plans.

"It's hard for consumers to understand how a plan that is lousy in their eyes could somehow prevent them from getting subsidies on the exchange," says JoAnn Volk, a senior research fellow at Georgetown University's Center On Health Insurance Reforms.

The federal government recently released guidance saying that plans that don't include coverage of hospitalization services and doctor's visits don't satisfy the minimum value standard even if they manage to meet the 60 percent actuarial value threshold without those benefits. Until final regulations are released next year, workers who are offered such plans won't be barred from qualifying for premium tax credits on the exchanges, the guidance said.

The vast majority of plans are believed to meet the minimum value standard, however. No more than 2 percent of people covered by employer-sponsored insurance — 3.2 million people — are enrolled in plans with an actuarial value of less than 60 percent, according to a 2011 estimate by the federal Department of Health and Human Services. Those affected are more likely to be in low-wage jobs and may not have had health insurance before.

In addition, because the 9.5 percent affordability standard is based on the cost of employee-only coverage rather than family coverage, most plans will be considered affordable, says Judith Solomon, vice president for health policy at the Center on Budget and Policy Priorities.

Having said that, "we know there were some pretty shabby plans being offered out there," Solomon says.

During open enrollment, health plans are all supposed to provide a “summary of benefits and coverage” that explains the details of the plan and also states whether it provides minimum essential coverage and meets minimum value standards.

“We were hearing from assisters that people were having trouble understanding this employer coverage information,” says Cheryl Fish-Parcham, private insurance program director at Families USA, a consumer advocacy organization.

Families USA and other advocacy groups sent a letter to the administration requesting that it amend the summary of benefits and coverage requirements to add language informing people that they could be eligible for premium assistance on the marketplace if their employer plan doesn’t meet the minimum value standard, Fish-Parcham says.

Workers who are filling out an application for a marketplace plan and are uncertain about whether their on-the-job coverage meets minimum value standards can download an “employer coverage tool” from healthcare.gov and ask their employer to complete it.

However, employers aren’t required to fill out the form.

“It’s a bewildering process,” says Fish-Parcham.

Cost of Job-Based Health Insurance Outpaces Family Income: Report

Workers are paying more for health plans, could be getting less financial protection

By Karen Pallarito Health Day Reporter

TUESDAY, Dec. 9, 2014 (HealthDay News) -- Americans who get job-based health insurance are spending a bigger chunk of their paychecks on health care than they were a decade ago, and they may be getting less financial protection for the money, a new report suggests.

Premium increases sharply outpaced wage growth between 2003 and 2013, researchers at the Commonwealth Fund reported Tuesday.

Family health plan premiums jumped 73 percent, to $16,029, while median family income increased by just 16 percent, according to the report. The study shows a similar discrepancy for individuals.

Employers also shifted more of the cost of coverage to their workers.

Employees' share of health plan premiums rose from $606 in 2003 to $1,170 for single coverage in 2013 -- a 93 percent increase, the study found.

At the same time, deductibles for single and family coverage more than doubled. And the percentage of workers in health plans that require deductibles swelled to 81 percent in 2013, from 52 percent in 2003.

"People with middle and lower incomes are very likely feeling very pinched by the increase in insurance and the cost of their care when they go to the doctor or fill a prescription," said report author Sara Collins, the Commonwealth Fund's vice president for health care coverage and access.

"They simply have less income to spread across all life necessities, which include health insurance and care," she noted.

But a group that represents the 400 largest employers in the United States noted that employers are still paying the majority of employees' health care costs.

"As costs go up, so do theirs [employers]," said Karen Marlo, a vice president at the National Business Group on Health, in Washington, D.C.

The challenge for employers, she said, is assuring not only that employees are getting good coverage, but finding ways to "make it affordable for the company and the employees."

More than 150 million people, or well over half of the under-65 population, have health insurance through their job or a family member's job, the report noted.

By contrast, only about 7 million people are enrolled in health insurance plans sold through the federal and state marketplaces created as a result of the Affordable Care Act.

The Commonwealth Fund, a private New York-based health care foundation, used data from the Medical Expenditure Panel Survey to assess changes in employer-sponsored health insurance.

The study shows that working adults and their families are spending more on health insurance despite a recent slowdown in the growth of health care costs.

The rate of growth in premiums for employee-only coverage rose just 4 percent per year, on average, between 2010 and 2013, the period following passage of the health-reform law. That compared to an average of 5 percent per year between 2003 and 2010.

The slowdown is "promising" but hasn't "translated into relief for workers," Commonwealth Fund President Dr. David Blumenthal said in a news release on the study findings.

What's more, employer surveys suggest that shifting costs to workers will continue in the coming years as a strategy for managing health insurance costs.

The Affordable Care Act provided a bit of financial relief to consumers by requiring most health plans, including many employer-sponsored health plans, to cover preventive services for free. But the law doesn't waive the ongoing out-of-pocket cost of medications or physician visits for people managing chronic conditions, such as high cholesterol, diabetes or high blood pressure.

"That worries me that when they face large cost-sharing, they may just decide to forgo that care," said Sarah Thomas, director of research at the Deloitte Center for Health Solutions in Washington, D.C.

Thomas co-authored a recent report examining out-of-pocket costs to consumers with all kinds of coverage, including Medicare, Medicaid, marketplace health plans and employer-sponsored health insurance. That report noted that out-of-pocket health expenses are almost twice as much as what people spend on new motor vehicles but about half of much as their grocery budget.

Rising out-of-pocket expenses means consumers must become savvy shoppers, Thomas said. "They need to start looking for good value and the way that they get care."

Insurance BUSINESS AMERICA

Should ACA's open enrollment period be moved?

by Caitlin Bronson | Dec 19, 2014

Health insurance producers have long argued that a shift in the open enrollment period—currently slated to continue through February 2015—would benefit their clients' schedules and pocketbooks, not to mention their own long work hours and bottom line.

Now, there is researched proof.

A recent study published on HealthAffairs.org argues that there is "considerable seasonality in measures of financial stress" and as a result, the most opportune time for scheduling open enrollment may be between February 15 and April 15—after most Americans have received their income tax refunds.

As it currently stands, the open enrollment period is dissuading many low-income families from purchasing health insurance.

"[The current open enrollment period occurs] just when many lower-income people are financially stressed by demands of the holiday season," wrote study authors Katherine Swartz and John Graves. "When people's decisions-making capacity is stretched thin, either they cannot make decisions or they make poor choices."

Swartz and Graves even went so far as to call the current open enrollment season "a mistake," and suggested that based on Google data, searches related to health insurance drop significantly between Thanksgiving and Christmas, resurfacing in early January. Similarly, plan choices are more likely to be made with "tunnel vision," when stressed-out shoppers think only of the bottom line given their forthcoming holiday obligations.

"The ACA's goals of maximizing enrollment in the health plans and maintaining a healthy balance of enrollees with low and high risks of having high medical expenses are more likely to be achieved if the open enrollment season is shifted to the two months between February 15 and April 15 each year," they said.

The move would also be favorable for producers.

Susan Lundy, owner of Benefits By Design in Larkspur, Calif., serves clients for both their health insurance and Medicare needs. One of her biggest complaints with this year's open enrollment period is the fact that it coincided with that of Medicare.

"Obviously no one's asked an agent who's been selling for a long time what would happen if they have open enrollment for everybody under the age of 65 at the same time as open enrollment for everyone over the age of 65," she said.

Orange County agency owner Patrick Freeman agreed, suggesting that the government move either the open enrollment period for Medicare or the larger period for Obamacare.

"Otherwise," he said, "I'm going to make the choice to serve my Medicare clients."

5 most egregious examples of government waste this year

THE Fiscal TIMES

By Brianna Ehley 22 hours ago

. 5 Most Egregious Examples of Government Waste This Year

Every year the federal government loses tens of billions of dollars to waste, fraud and abuse. Unfortunately, 2014 was no exception.

Federal auditors issued plenty of scathing reports this year flagging programs and projects that were inefficient or wasteful. They also identified numerous costly instances of wrongdoing by federal employees.

Drawing on much of our reporting throughout the year, *The Fiscal Times* identified 5 of the most egregious examples of government waste in 2014.

Afghanistan Reconstruction: It's basically been standard operating procedure for John Sopko, the Special Inspector General for Afghanistan Reconstruction (SIGAR), to warn Congress about the failing $104 billion reconstruction effort in that country. Numerous projects have gone well over budget and been left finished, while millions of dollars have vanished and likely ended up in the wrong hands. In 2010, auditors said they could only account for about 10 percent of the total money spent repairing the war-torn country. Read more about the vast amounts squandered in Afghanistan.

$100 Billion in Improper Payments

Entitlement Programs: Government agencies in charge of major federal programs such as Medicare, Medicaid and Social Security have doled out about $100 million in improper payments each year for the last five years. The payments include everything from outright fraud to errors made by the agencies or errors made by people claiming the payments. Between 2002 and 2012, federal agencies gave out about $688 billion to the wrong people.

Agencies are required to estimate the payment error rate of their programs. For example, Medicare's Fee for Service program had an error rate of 10.1 percent in 2013 –about $33.2 billion of the program's total payments were improper. Read more about it.

$3.1 Billion in Administrative Leave for Federal Workers

Rewarded for Bad Behavior:
The Government Accountability Office revealed this year that the federal government paid $3.1 billion to federal workers on administrative leave over the last three years. Of this amount, $775 million went to 57,000 employees who were off work for a month or longer.

Though not all of this money can be considered waste, lawmakers have questioned federal agencies' use of administrative leave – especially when the departments place those employees accused of wrongdoing on leave for extended periods of time while they collect government salaries. Rep. Darrell Issa (R-CA) had referred to these instances as "taxpayer-funded vacations." Sen. Tom Coburn (R-OK) said in an interview earlier this year, "Instead of firing misbehaving employees, Washington rewards those who have broken the law or engaged in misconduct by paying them to do nothing – sometimes for many years."

In one example, Veterans Affairs executives at a Phoenix, Virginia health care center – caught covering up hidden wait lists – were put on administrative leave in May and continue to receive their annual government salaries of $85,000. Read more.

$550 Million for the FBI's Faulty IT System

I.T. Failures Cost Taxpayers a Fortune:
The Federal Bureau of Investigation's new case filing system, "Sentinel," is just the latest chapter in federal IT flops. The system, ridden with problems, has spiraled $100 million over budget – and it still barely works. Auditors say the system, which is supposed to make it easier to search case files, is so flawed it actually makes the process more time consuming and difficult. Read more.

$240 Million FEMA Disaster Management System

FEMA Fumbles Funding and Fails:
FEMA spent $240 million building a high-tech system to help deliver supplies and coordinate the multi-agency response to national disasters. But a review by the Department of Homeland Security's Inspector General found the Logistics Supply Chain Management System so riddled with errors that it can't "interface" with other agencies – making it nearly impossible to locate and deliver emergency supplies.

The IG also said that even if the system worked, agency employees have not been trained properly to use it. Overall, auditors concluded, "Despite spending about $247 million over nine years, FEMA cannot be certain its supply chain management system will be effective during a catastrophic disaster."

This is a huge problem: FEMA is notorious for botching its delivery of disaster relief. Just ask Hurricane Sandy victims.

How to pay off your credit cards in 2015

credit.com

By Jason Steele December 29, 2014

If you are ringing in the new year with substantial credit card debt, then now is the time to create a strategy for paying it off in 2015. Doing so will allow you to save tremendously on interest charges while likely increasing your credit score and reducing your stress levels.

So here are five ways to pay off your credit cards in 2015 and be debt-free by the time you go to your next New Year's Eve party:

1. Stop Using Credit Cards for New Purchases

As the saying goes, when you find yourself in a hole, the first thing to do is stop digging. The fact that credit cards are so easy to use makes it so easy to get into debt. Furthermore, each new charge adds to your average daily balance, increasing the interest charges. So the first step is to leave your credit cards at home and switch to a different method of payment for your daily expenses, such as a debit card, cash or checks. Then, focus on using your remaining funds available to you each month to pay off your debt.

2. Get a 0% APR Balance Transfer Offer

There are many credit cards that offer interest-free promotional financing on balance transfers, but usually with a 3% balance transfer fee. However, the Chase Slate is currently the only credit card offered with 0% APR financing on balance transfers, and no balance transfer fee. These 0% APR balance transfer offers allow cardholders to take a break from interest payments for 15 months. Avoiding interest charges will not only allow you to save money, it will also give you the opportunity to pay more of your debt off sooner.

3. Create a Budget

Cardholders with debt need to sit down and create a realistic spending plan while setting goals for debt repayment. Once you have a clear picture of your income and expenses, you can make the choices necessary to reach your goal.

4. Develop a Schedule

Figure out how much you can pay per month, or check to see how much you will need to pay each month to be debt-free this time next year. (Credit.com has a debt payoff calculator that can help — and you can plug in varying interest rates, balances or payment times to find one that makes sense for you.)

5. Pay Down Your Debt Early & Often

Whether or not you have your debt covered by a 0% APR promotional financing offer, it's smart to make frequent payments when you are able. For example, you could schedule payments shortly after you receive your paycheck, or when your tax refund arrives, rather than waiting for the next due date. If your debt is accruing interest charges, paying before the due date reduces your account's average daily balance, which will minimize interest charges. And even if interest is not being charged, paying early will prevent you from changing your mind and using the money for something else.

Note: It's important to remember that interest rates, fees and terms for credit cards, loans and other financial products frequently change. As a result, rates, fees and terms for credit cards, loans and other financial products cited in these articles may have changed since the date of publication. Please be sure to verify current rates, fees and terms with credit card issuers, banks or other financial institutions directly.

Medicare To Offer Help To Some Seniors When Advantage Plans Drop Doctors

By **Susan Jaffe** December 22, 2014

Starting next year, the government will offer some seniors enrolled in private Medicare Advantage insurance an opportunity to leave those plans if they lose their doctors or other health care providers.

Last year, thousands of seniors in at least 10 states were left stranded or assigned new doctors when insurers discontinued contracts with the physicians.

The Medicare Advantage policies cover 16 million seniors and are an alternative to the government-run Medicare program. Medicare Advantage members can only get care from a network of providers under contract to participate in their plan. They must remain in their plans for the calendar year, with some rare exceptions, but losing their doctor has not been among the permitted reasons.

But if certain conditions are met, officials at the Centers for Medicare & Medicaid Services will create a special three-month enrollment period following network changes "considered significant based on the [effect] or potential to affect, current plan enrollees," according to an update to Medicare's Managed Care Manual. During that time, they could join traditional Medicare or another Medicare Advantage plan whose provider network includes their doctors.

"If CMS does not prohibit midyear network terminations then a special enrollment period is the next best thing for beneficiaries," said David Lipschutz, senior policy attorney at the Center for Medicare Advocacy, a nonprofit law firm that works on behalf of Medicare patients.

This KHN story also ran in USA Today. It can be republished for free.

Clare Krusing, a spokeswoman for the trade group America's Health Insurance Plans, said banning network changes would hamper provider contract negotiations, which occur throughout the year, and could ultimately reduce the variety of available plans.

She said "CMS has taken a balanced approach" in dealing with seniors' needs while assuring flexibility for health plans.

But Lipschutz said no one seems to know what the "significant" network changes are that will trigger the special enrollment opportunity.

Medicare spokesman Raymond Thorn said the agency will make that "case-by-case" determination based on the number of beneficiaries affected and whether they received adequate and timely advance notice, the size of the plan's service area, when during the year the provider terminations occur and other factors. He declined to provide details on the minimum number of beneficiaries, providers or service area size that would be

necessary. Once Medicare decides that plan members should be allowed to leave their plan, the agency will require the plan to notify its members about their new options.

Only CMS will make a determination of the need for this provision. Individual beneficiaries who are concerned after their doctor is dropped from a plan cannot request the special enrollment period, Thorn said. That is different from how Medicare handles some other mid-year changes in these policies. Beneficiaries can request a special enrollment if they move into an area where their plan is not available, become eligible for Medicaid, or move into a nursing home, among other reasons.

Last year, UnitedHealthcare cut thousands of physicians from its Medicare Advantage plans across the country, including 2,200 physicians in Connecticut. At town hall meetings held by the Fairfield County, Conn., Medical Association, executive director Mark Thompson said angry and fearful patients told "heart-wrenching" stories about their experience.

"They were being forced to leave their doctors and there wasn't anything they could do about it," he said. "They couldn't go to another plan and they couldn't go back to traditional Medicare."

The only option at the time, he said, "was to go to another doctor who they had no history with."

UnitedHealthcare spokesman Terence O'Hara said next year its enrollees "nationally will continue to enjoy a broad selection of doctors that can provide the right care where and when it is needed."

The special enrollment option comes after officials established stricter notification rules for network changes that also take effect Jan. 1, 2015. Insurers must tell CMS at least 90 days before instituting network "significant" changes. The rules also recommend that insurers provide more than the required 30 days' advance notice to beneficiaries. It should include the name of the provider being terminated and how members can request continuation of ongoing medical treatment from that provider.

This article was produced by Kaiser Health News with support from The SCAN Foundation.

HHS proposes changes to O-Care benefit summaries

By Elise Viebeck - 12/22/14

Federal officials are proposing to make the benefit summaries required for health plans on ObamaCare's marketplaces more user-friendly.

The Department of Health and Human Services (HHS) announced plans to streamline the documents while adding new information that will help consumers better understand cost-sharing.

The changes follow tests that indicate what information matters most to consumers as they shop for health insurance, the proposal stated.

"Our goal is to improve consumers' access to concise and comparable health plan information to help them better understand their coverage options and make informed choices when shopping for a plan," said Centers for Medicare and Medicaid Services Administrator Marilyn Tavenner in a statement.

Tavenner said the changes would enhance clarity. In one example, the summaries will now list how a plan's cost-sharing terms apply in an emergency medical situation, in addition to pregnancy and managing diabetes.

If finalized, the proposal would be implemented on or after Sept. 1, 2015.

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Share the Wellness: Protecting Yourself from the Cold and Flu Viruses

January 7, 2015

The Centers for Disease Control and Prevention (CDC) recently declared a flu epidemic. While the current flu season is in full swing, there are still steps you can take to help protect yourself from the cold and flu viruses.

Different Viruses, Different Symptoms
Colds and the flu do have a lot in common. They both can cause coughing, a runny nose, sneezing and watery eyes. But they aren't the same.

A cold usually:

- Causes symptoms two-to-three days after infection
- Lasts a week
- Causes headache or only a mild fever

However, the flu often:

- Comes on quickly
- Lasts as long as two-to-three weeks
- Raises your temperature to 100-to-102 degrees Fahrenheit
- Causes a headache, as well as other aches and pains

There is no medicine to cure a cold, but bed rest, drinking fluids and using a humidifier can help tame symptoms.

If you think you might have the flu, however, don't go it alone. See your doctor. This is especially important if you are in a high-risk group (young children, people over 65, pregnant women and people with certain medical conditions)..

When It's Something More Serious
Occasionally, a cold or flu can lead to another type of lung infection, such as bacterial pneumonia. This can be mild or quite serious. See your doctor right away for treatment if you have signs of pneumonia, including a high fever, "shaking" chills, chest pain when you cough or breathe, or cold or flu symptoms that suddenly get worse.

Guard Your Health
You can give viruses the slip in the months to come by following these tips:

- Get a flu vaccine. If you haven't gotten one yet, now's the time.
- Cut your risk of germs by washing your hands often. Lather up with soap and warm water for 15 seconds every time.
- Avoid touching eyes, nose and mouth with unwashed hands. Cover your nose and mouth with a tissue when you cough or sneeze. Throw the tissue in the trash after you use it.
- Use common sense; try to avoid sick people.
- Take care of your body. Eat well, exercise regularly, get enough sleep and keep your stress in check.
- Don't smoke.
- Disinfect frequently touched surfaces, such as toys and doorknobs, especially if someone is sick.

*Sources:*Centers for Disease Control and Prevention*;* Washington Post, Dec. 31, 2014

All Markets

Be Scam Smart[SM]: Health Insurers Battle Fraud from Within

January 7, 2015

This is the fourth in a series of six anti-fraud articles that will also be published in employer and member newsletters. Please share this article with your clients to help them – or their family and friends – avoid becoming victims of health care fraud.

Fair warning to health care cheats: You face a formidable army of top-flight "scam busters" working directly for health insurance companies nationwide to track you down. When they do, you could do jail time, pay back what you stole, and be fined. Is it worth it? You better think twice.

Blue Cross and Blue Shield (BCBS) Plans across the U.S. fight fraud, waste and abuse. The Special Investigations Departments (SID) at the Illinois, Montana, New Mexico, Oklahoma and Texas Plans are aggressive, early anti-fraud leaders.

"At any time, we have 300 active cases," says William Monroe, a 23-year FBI veteran and vice president of fraud and security for the SID. "Not all pan out, but we do follow each case to the investigative end. Right now, we have a couple boiling up that look like they could be very serious, widespread schemes." Monroe's FBI work included public corruption, terrorism and health care fraud.

"It's wonderful to keep after health care cheaters at a company with such a well-deserved reputation for honesty and integrity." Besides former federal agents and other former law enforcement personnel, the SID team now includes medical personnel, highly trained analysts, and a well-regarded former federal prosecutor.

SID's Work

The team investigates health care fraud, refers cases for criminal prosecution, recovers fraud losses, and takes steps to deter others from committing health care fraud. All this investigation protects the company, its customers and providers. What does SID look for? Typical schemes:

- **Double billing.** Providers submit two-or-more claims for the same procedure.
- **Unlicensed providers.** These people never got a medical license or practice while it's suspended.
- **"Free" screenings.** Providers offer services without charge to get patients' medical information. Then they turn around and bill insurance companies for unwanted or unneeded services.
- **Upcoding.** This is claiming a more expensive service than was actually provided.

"I don't want people to think there's rampant fraud among providers. There isn't. Most are honest and honorable," says Monroe. "But that tiny percentage of rotten apples can get away with a whole lot and give the profession a bad name. We aim to root out that small percentage of bad actors."

Three Key Anti-fraud Goals

1. Look for new fraud schemes or new wrinkles on old ones.
2. Try to slow health care payments just enough to ensure payments are legitimate. Otherwise, SID and other "scam busters" spend time chasing improper payments after the fact, instead of stopping them before they go out.
3. Streamline participation with all law enforcement, regulatory and national anti-fraud groups to "connect the dots" and stop would-be scammers in their tracks.

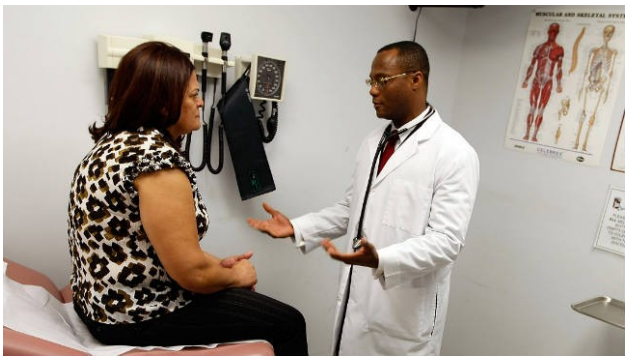
Monroe specifically works to strengthen ties with the "big three" national fraud-busting groups:

- Blue Cross's own National Anti-Fraud Advisory Board or NAAB
- The National Health Care Anti-Fraud Association (NHCAA), which is a private-public partnership with some 100 members including many health insurers and public agencies

- The Healthcare Fraud Prevention Partnership (HFPP) formed in 2012 and including the U.S. Department of Justice, and Health and Human Services and its Centers for Medicare & Medicaid Services division, and a small number of private entities

“While doing this, we make sure those making simple mistakes aren’t penalized,” Monroe says. “But we sure do want to put the bad guys out of business.” Finally, he says every citizen can help, too. If you see things on bills that weren’t done, for example, call the BCBSIL Provider Fraud Hotline at **877-272-9741**.

ObamaCare's 2015 challenges



By Sarah Ferris - 01/01/15

As ObamaCare enters its fifth year, there are still major components of the law to be worked out for the first time.

Both the individual mandate and the employer mandate – which are considered vital pillars of the president's landmark healthcare law – will confront new challenges in 2015. Doctors and hospitals will also face new penalties for failing to comply with federal rules such as those requiring the use of e-records.

The stakes are high in 2015. The administration will be hoping that ObamaCare regains ground after a muddy patch over the last few weeks that included controversies around the administration's famously blunt former adviser Jonathan Gruber, an inflated enrollment tally and a new legal threat to the law's subsidies.

Employer mandate goes into effect

After years of delays, businesses with at least 100 employees will be forced to offer insurance for the first time in 2015.

Business groups have lobbied hard against the controversial rule, which they have called a major headache that will force layoffs and less hours for workers.

The twice-delayed penalty has also been tweaked over the last two years to require less paperwork for employers. Medium-sized companies, with staffs of between 50 and 100, will have until 2016 to offer coverage.

The GOP-led House has voted numerous times to delay – and ultimately repeal – the employer mandate. The Senate's incoming Republican leadership has also floated the same approach as part of its battle plan in 2015.

Fines levied for individual mandate

Most Americans have been required to have health insurance since January 2014, but the financial penalties for those who ignored the mandate will only go into effect during tax season this spring.

Each person without insurance will pay $95 or 1 percent of their income, whichever is higher.

The mandate is a crucial part of ObamaCare, meant to push people of all ages and health conditions to seek coverage – and balance the influx of older and sicker people who were expected to flood the marketplaces with younger, healthier counterparts.

Implementing the new fines next year will require full attention from the Internal Revenue Service. It will likely be a major challenge for the already cash-strapped agency that is dealing with sharp budget cuts and new responsibilities such as the employer mandate.

Primary care doctors face pay cut

Family doctors who treat Medicaid patients will see steep drops in payments from the federal government that could make it tougher for millions of low-income people to find care.

Reimbursements from Medicaid will shrink an average of 43 percent starting in January, when the federal government's temporary raise for primary care doctors is set to expire.

The federal government had raised its reimbursement rates to entice more doctors to accept Medicaid patients under ObamaCare. Patients with Medicaid have been historically known to cost healthcare providers far more than they are repaid for the treatment, causing some doctors to turn away patients.

Medicaid has added 10 million people to its rolls under ObamaCare, reaching a total of 63 million enrollees this year. While Congress decided not to make the hikes permanent, at least 15 states will keep at least a portion of the new payment rates to help Medicaid patients.

Medicare doctors fined for not using e-records

More than 270,000 doctors and 200 hospitals nationwide will see funding cuts from Medicare next year for failing to meet new government requirements for electronic medical records.

The Obama administration has sought to encourage “meaningful use” of e-records and e-prescribing systems to make healthcare providers more efficient and cut down on communication errors that can harm patients.

But the effort has come under fire from some providers who say patients are harmed by the cuts to their reimbursement rates. The cuts will increase to 3 percent within three years.

Electronic medical records have been increasingly adopted by healthcare providers across the country, though the steep investment costs – about $165,000 for an average five-person practice in the first year – continue to be a burden.

CHIP funding set to expire

A 27-year program that has helped millions of children gain insurance is set to end next year without new steps from Congress.

Under ObamaCare, the Children’s Health Insurance Program, or CHIP, is reauthorized until 2019 but only funded through September of next year.

The program provides coverage to about 8 million children annually and has been praised by lawmakers of both parties.

Still, members of Congress have failed to take steps to fund the program despite urgent pleas from governors who say they need to know immediately whether the program will end.

While some of the children currently enrolled could now find other options under ObamaCare, the program’s coverage tends to be more generous with deductibles and copays, as well as wider doctor networks, than cheaper plans on the exchanges.

Dilemma over deductibles: Costs crippling middle class

Rather than pay so much out-of-pocket, many skip checkups, scrimp on care

Laura Ungar and Jayne O'Donnell , USA TODAY

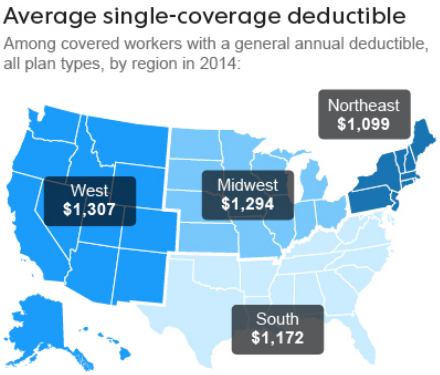
Gold standard sullied?

Employees' deductibles balloon to 80%

Physician Praveen Arla is witnessing a reversal of health care fortunes: Poor, long-uninsured patients are getting Medicaid through Obamacare and finally coming to his office for care. But middle-class workers are increasingly staying away.

"It's flip-flopped," says Arla, who helps his father run a family practice in Hillview, Ky. Patients with job-based plans, he says, will say: " 'My deductible is so high. I'm trying to come to the doctor as little as possible. … What is the minimum I can get done?' They're really worried about cost."

It's a deep and common concern across the USA, where employer plans cover 60% of working-age Americans, or about 150 million people. Coverage long considered the gold standard of health insurance now often requires workers to pay so much out-of-pocket that many feel they must skip doctor visits, put off medical procedures, avoid filling prescriptions and ration pills — much as the uninsured have done.



A recent Commonwealth Fund survey found that four in 10 working-age adults skipped some kind of care because of the cost, and other surveys have found much the same. The portion of workers with annual deductibles — what consumers must pay before insurance kicks in — rose from 55% eight years ago to 80% today, according to research by the Kaiser Family Foundation. And a Mercer study showed that 2014 saw the largest one-year increase in enrollment in "high-deductible plans" — from 18% to 23% of all covered employees.

“People put off care or they split their pills. They do without.”

Karen Pollitz, a senior fellow at Kaiser

Meanwhile the size of the average deductible more than doubled in eight years, from $584 to $1,217 for individual coverage. Add to this co-pays, co-insurance and the price of drugs or procedures not covered by plans — and it's all too much for many Americans.

Holly Wilson of Denver, a communications company fraud investigator who has congestive heart failure and high blood pressure, recently went without her blood pressure pills for three months because she couldn't afford them, given her $2,500 deductible. Her blood pressure shot so high, her doctor told her she risked a stroke.

And LaRita Jacobs of Seminole, Fla., who gets insurance through her husband's job and has an annual family income of $70,000, says $7,500 a year in out-of-pocket costs kept her from dealing with an arthritis-related neck problem until it got so bad she couldn't lift a fork. She's now putting off shoulder surgery.

"How did we get to this crazy life?" asks Jacobs, 54. "We're struggling to pay our bills like we were struggling when we first got started."

Why is this happening? Many patients and doctors blame corporate greed — a view insurers and business leaders reject. Some employers in turn blame the Affordable Care Act, saying it has forced them to pare down generous plans so they don't have to pay a "Cadillac tax" on high-cost coverage in 2018. But health care researchers point to a convergence of trends building for years: the steep rise in deductibles even as premiums stabilize, corporate belt-tightening since the economic downturn and stagnant middle-class wages.

LaRita Jacobs has severe arthritis and delayed a neck surgery until it got so bad she couldn’t lift a fork. Now, she is delaying shoulder surgery that her doctor recommends and opting for less expensive physical therapy and enduring the pain. Here, she readies the needle for her weekly injection of Methotrexate, a type of chemotherapy regularly used for people with autoimmune diseases like rheumatoid arthritis.
(Photo: Melissa Lyttle for USA TODAY)

"It's a case of companies trying to offer workers health insurance and still generate profit," said Eric Wright, a professor of sociology and public health at Georgia State University. "But whenever costs go up for the consumers across the board … it promotes a delay in care."

Others disagree, saying that when people pay for their care, they shop more intelligently. Chris Riedl, Aetna's head of product strategy for its national accounts, says her company's research does not indicate that insured patients are showing up sick in emergency rooms with long-neglected illnesses — which to her means, "intuitively, they're not avoiding care."

But many doctors contend it's only a matter of time before the middle class begins crowding ERs. They say putting off care can be dangerous, exponentially more costly and, if it continues and spreads, can threaten the health of the nation.

Monitoring the trend

'Can I stop taking this medication?'

Praveen's father, MohanaArla, says being forced to pay so much out-of-pocket "is as good as not having insurance" in an era of ever-rising health care costs. Inpatient care last year averaged $17,553, and insurance plans require people to pay a portion of that even after meeting their deductibles, up to an out-of-pocket maximum that can easily exceed $10,000 a year for families. Median household income in the U.S. is around $53,000, and the average American has less than $6,000 in savings, according to a 2012 report by Pitney-Bowes Software. A quarter have no emergency savings at all, Bankrate.com reported in June.

Bullitt County, Ky., family practitioner MohanaArla, right, and intern Dominique Rhymes examine Lee Curry, 54. Curry was injured while working to pull a passenger from a wrecked vehicle as a Sheriff's Department employee when his wrist was slammed in a truck door by a wind gust on Oct. 31, 2014.
(Photo: Alton Strupp for USA TODAY)

"Health expenses tend to come up unexpectedly, or if you have a chronic condition, they come up relentlessly," adds Karen Pollitz, a senior fellow at Kaiser. "People put off care or they split their pills. They do without."

Mounting evidence backs that up:

• Nearly 30% of privately insured, working-age Americans with deductibles of at least 5% of their income had a medical problem but didn't go to the doctor, the Commonwealth Fund found. Around the same percentage skipped doctor-recommended medical tests, treatments or follow-ups.

• Nearly half of middle-class workers skipped health care services or fell into financial hardship because of health expenses, according to a survey by the Associated Press and NORC Center for Public Affairs Research.

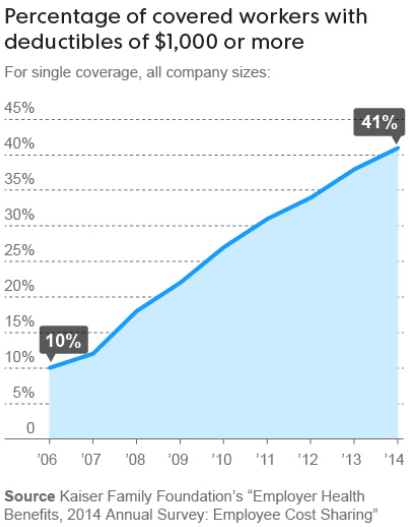
• Use of hospital care among insured workers has been dropping since 2010, and use of outpatient care, such as doctor visits, dropped slightly for the first time from 2012 to 2013, according to insurance claim data analyzed by the Health Care Cost Institute.

• Medical professionals across the USA see the reality behind the research. The Arlas' patient load used to be 45% commercially insured and 25% Medicaid; those percentages are now reversed. Stan Brock, founder of Remote Area Medical, which runs free clinics around the nation, says the group's volunteer workers found that around 7% of patients who came to one of the clinics had job-provided insurance — and some waited for days just to keep a prime spot in line.

Patients often do a sort of medical and financial triage when they get sick. Jacobs, a former college professor, says every time a doctor suggests a new test, procedure or medication for her severe arthritis, she asks herself: " 'Is it critical?' You're always playing the odds. ... And I'm constantly asking my doctor: Can I stop taking this medication?"

When her shoulder started hurting a couple of years ago, she had an X-ray but put off the recommended MRI for two years. It worsened, and she couldn't move her arm without pain or lift her right hand above her head. She finally got that surgery in October but is now forgoing a shoulder procedure, opting for less expensive physical therapy and planning to "tough out the pain."

"You don't want another surgery … another bill," she says. "It may be more of a problem later, but that's the risk you take."



While all out-of-pocket expenses play a role in such decisions, experts say the driving factor is the deductible, which averages $2,000 or more for single coverage for nearly one in five workers and from around $2,000 to $4,500 for families, depending on the type of plan. Companies may help fund health-savings accounts to pay some of these costs, sometimes with only a few hundred dollars.

"I can remember when $1,000 was considered a high-deductible plan. Now that's become kind of the norm," Pollitz says. "We're kind of in high-deductible land."

The cost shift extends to workers in government jobs, long known for bountiful benefit packages. Lee Curry, a sheriff's deputy in Bullitt County, Ky., says his county health plan comes with a $1,500 deductible, which keeps him from going to the doctor at all.

"Health insurance doesn't cover much of anything until you cover your deductible," says Curry, 54. "It puts a burden on you. You've got to have the money to be seen."

Is Obamacare to blame?

Stagnant salaries also skew budgets

Since the ACA took effect, "there's been an accelerated movement" to these types of health plans, says Brian Marcotte, president and chief executive officer of the Washington, D.C.-based Business Group on Health.

Marcotte, whose group represents 400 large employers, says that the looming Cadillac tax is one factor but acknowledged that managing health care costs is another.

Companies have cited the ACA for cutting medical benefits in other ways. For example, United Parcel Service partly blamed the law when it removed thousands of spouses from its plan because they are eligible for medical coverage elsewhere.

But DeAnnFriedholm, director of health reform for Consumers Union, says she's skeptical when employers point to the ACA. "This isn't new," she says. "Companies have been cutting back on benefits and cutting costs for decades."

Sara Collins, vice president for Health Care Coverage and Access at the Commonwealth Fund, says two ACA requirements — keeping children under 26 on their parents' plans and covering preventive care — didn't add much to companies' health care tabs, partly because most already covered preventive care such as physicals and mammograms. Pollitz says the ACA actually holds down the consumer burden by capping out-of-pocket expenses at $6,300 a person — which, although that amount is "more than most people have in the bank," is better than no cap at all.

Experts point out that the ACA requires preventive care to be covered fully and exempt from deductibles — although surveys show many workers still forgo screenings and physicals because they're unaware of this or know they can't afford follow-ups if illnesses are found.

Several experts say the consumer crunch has less to do with the health system overhaul than stagnant salaries. The average hourly wage is nearly identical to what it was 50 years ago in today's dollars: $19.18 in 1964 compared with $20.67 in 2014, according to U.S. Bureau of Labor data analyzed by the Pew Research Center. Meanwhile, U.S. health spending ballooned from 5% of gross domestic product in 1960 to 17% in 2013.

Physician Praveen Arla says he's seen a role reversal since the implementation of the Affordable Care Act. Middle-class patients are now avoiding regular care due to high-deductible plans and out-of-pocket expenses. VPC

"People are very close to the line in terms of their budgets," Collins says. "What consumers are really seeing is their incomes have grown even slower than the slower growth in health care costs" in the past few years.

Insurers also blame the cost of care, saying that can't be absorbed just by premiums. But Wilson and other patients put much of the blame on insurers.

"Insurance is all about the dollar," Wilson says. The never-ending cost shift to consumers "is something that basically all kinds of people screwed up. … Obamacare is a step in the right direction. But it's not enough. I expected more out of it than I got."

The ugly side effects

A spiral of painful debt

When consumers skip care, they enter a downward spiral that imperils their physical and financial health.

Jennifer Ross, an arthritis sufferer in Florida insured through her husband's job, says she recently made the wrenching decision not to take a medication that might allow her to get around without her wheelchair. The $2,400-a-month medicine would cost her $600 a month out-of-pocket even with insurance, and she simply can't swing it. To make matters worse, Ross' 12-year-old daughter was recently diagnosed with arthritis, too.

"It's a no-win situation," Ross says.

Surgeon Paul Ruggieri of Fall River, Mass., says his patients with high-deductible plans often blanch at the out-of-pocket cost to electively treat two common ailments he sees regularly — gallstones and hernias — until they become potentially dangerous and costly emergencies.

If the procedures are done electively, patients are required to pay half of the cost upfront; a hernia repair done laparoscopically would cost about $4,000 at a surgery center. That's often about the amount of some patients' deductibles, so they would have to pay the full bill out-of-pocket. If the procedure is done at a hospital, even laparoscopically, it can cost as much as $17,000. If patients delay and are rushed to the emergency room for the procedure, the hospital would charge at least two to three times the amount of the surgery, Ruggieri says. It would also mean a two- to three-day hospital stay vs. two hours for the elective procedure, and much longer at-home recuperation.

Paul Ruggieri, with medical assistant Monica DePonte, is a surgeon who sees a lot of hernia and gall bladder patients who put off care until it becomes an emergency.
(Photo: Josh T. Reynolds for USA TODAY)

Ruggieri sees the same issues with gallstones, which are simple to treat electively before they get so painful a patient can't stand it anymore and heads to the ER.

When patients do get needed care, some find themselves in massive debt. Kim Brown, an administrative assistant in Louisville who was earning about $40,000 a year, owes many thousands — the bills are still coming, so she doesn't know exactly how much — after battling thyroid cancer. She says her annual out-of-pocket costs are $7,500, and she also has to pay 15% for things like hospital stays. No longer able to work because of her illness, she reluctantly signed up for Medicaid and will likely declare bankruptcy.

'Skin in the game'

The push for preventive care

"I've worked for 35 years. I never wanted to go on Medicaid," says Brown, 50. "It's horrible. I paid for insurance for all those years, and still ended up in this situation."

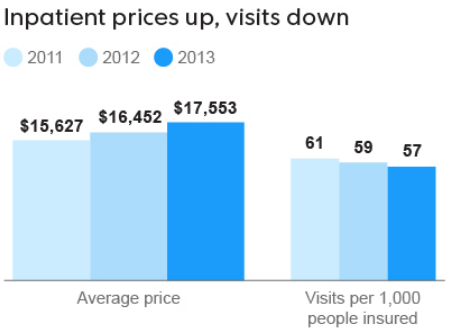
But insurers, employers and others say that such stories are the exception and that high deductibles generally encourage consumers to seek the best value for their dollar.

"By having deductibles, it puts skin in the game," says Divya Cantor, senior clinical director for the insurer Anthem in Kentucky.

Joel Diamond, a Pittsburgh primary care doctor, thinks high-deductible plans are a smart choice for people who can't afford higher premiums and are generally in good health.

He cites the case of a young woman who couldn't afford insurance on her own who stopped having periods and went to the emergency room with severe headaches. Diamond discussed doing testing for possible ovarian and endocrine problems. When blood work showed abnormal levels of the hormone prolactin, he recommended an MRI to rule out a pituitary tumor. Her bill for just a few hours in the emergency room was $15,000, something that will take her years to pay off.

If she had had a high-deductible plan, he says, it would have paid for a large chunk of the cost, and her debt could have been a third to half as much.



Source Health Care Cost Institute's "2013 Health Care Cost and Utilization Report," October 2014

"We don't have car insurance for windshield wipers and oil changes, but we need it for the catastrophic stuff, just like our health care," says Diamond, who is also chief medical officer for the health care IT company dbMotion.

Aetna's Reidl says her company allows people to compare prices easily on its website. Some tests, for example, could cost hundreds of dollars or less at some hospitals and thousands at others.

Aetna, the first national insurer to move to high-deductible plans — which it coined "consumer-directed plans" — more than a decade ago, says the plans help employees and employers save money.

Reidl says she has heard the criticism that they "may cause some individuals to put off care," but counters that Aetna members with these plans get routine preventive care and screenings at higher rates than those with other plans. And their employers save an average of $208 per employee per year after they switch to high-deductible plans.

"We've seen that over 10 years consistently," she says.

Aetna recommends companies pair the plans with health reimbursement or savings accounts — which allow employees to set aside tax-free money to use for cost sharing — to ease the burden of out-of-pocket costs on employees.

But Wendell Potter, who used to work in public relations in the insurance industry and has since written a book about the experience called *Deadly Spin*, says insurers who study high-deductible plans are "not disclosing everything they find."

"They do these reports based on their populations to try to sell more of these plans to employers," he says. Population-based reports don't necessarily reflect the fact that "individuals and families are having to file for bankruptcy because they are in their plans."

Potter left his public relations job at Cigna in 2008 in part because "I was expected to be a champion" of high-deductible plans. He says these plans are "taking us in the wrong direction ... back to a system that we would have thought the ACA prevented."

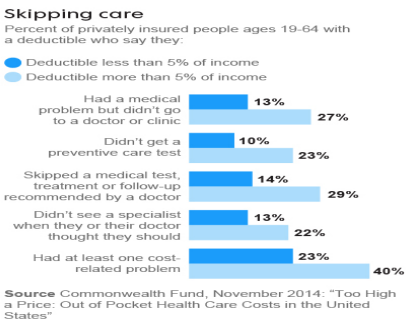
The future

Will time heal all?

There are no signs high deductibles are going away.The Centers for Medicare and Medicaid Services last month cited these plans as one of the reasons health care spending hit a record low in 2013. But CMS statistician Micah Hartman says his office is "not looking forward to what the impact would be going forward" if consumers who delay care need far more expensive emergency care later.

Meanwhile, experts say Americans will need to take further steps to control their health costs.

Wilson, the Denver patient, says that after her doctor scolded her for stopping her blood pressure pills, she now takes them daily. But keeping up with her six medications is a constant struggle given her $33,000-a-year income, so she copes by asking for samples from the doctor, using a prescription discount plan and sometimes buying just a few pills at a time.



Doctors and doctor groups say such individual coping strategies can be helpful, but action is needed on a national level. The American Academy of Pediatrics recently came out with a policy statement saying high-deductible plans "may be a less desirable way to lower health care costs than other means … even if 'other means' require more work by government, insurance companies and other health policy participants."

They say policymakers should consider requiring that the plans cover only adults, not children, as adults may suffer more from reduced care. The group also suggests exempting outpatient care from deductibles and requiring employers to put a lot more money in health-savings accounts that go with the plans.

Oncologist Ezekiel Emanuel, the former special adviser for health care policy to the director of the Office of Management and Budget, says insurers and employers moved to high-deductible plans rather than trying to come up with "a more intelligent plan design."

Emanuel, who is considered an architect of Obamacare, says that he is "not a fan of high-deductible plans" and that what's needed are "smart deductibles" that don't discourage people from using the services they really need to stay healthy. He cites the preventive care visits that aren't subject to deductibles under the ACA.

Higher deductibles, he says, should apply to "discretionary services" like knee replacements and low or no deductibles should be for important treatment such as for insulin or ophthalmologist visits.

But Wright, the Georgia professor, says he doesn't see any major changes on the near horizon.

"I wish I could be optimistic, but I'm not sure," he says. "There's a lot of reason to be worried about the future."

Seniors switching to Medicare Advantage, study finds

By Elise Viebeck - 01/05/15

Medicare Advantage is a popular choice for seniors already enrolled in traditional Medicare. That's the conclusion of a new study released Monday, which found that a majority of beneficiaries who enrolled in private Medicare plans between 2006 and 2011 were switching from the main program.

This choice was most common among seniors in their late sixties, who switched from the traditional program at "higher-than-average rates," according to researchers.

Published in the journal Health Affairs, the study challenges the notion that the rise in Medicare Advantage enrollment is primarily due to new beneficiaries choosing private plans at the outset.

"In 2011, 52 percent of new Medicare Advantage enrollees had switched from traditional Medicare, down from 78 percent in 2006," the study stated.

"Conversely, people new to Medicare accounted for 48 percent of new Medicare Advantage enrollees in 2011, rising from 22 percent in 2006."

Medicare Advantage enrollment is projected to increase to a new all-time high in 2015, according to the Centers for Medicare and Medicaid Services, and private insurance companies are pushing the administration not to cut payments in February.

Coffee May Protect Against Some Skin Cancers

Live Science January 21, 2015

(Photo: Getty Images)

Go ahead, enjoy that morning mug. A new study suggests that people who are in the habit of drinking coffee regularly may be protected against malignant melanoma, the leading cause of skin-cancer death in the United States.

People in the study who drank four or more cups of coffee daily were 20 percent less likely to develop malignant melanoma than non-coffee drinkers, according to the study published today (Jan. 20) in JNCI: Journal of the National Cancer Institute.

Of course, the findings don't give you license to fire up the Mr. Coffee and then spend your day lounging in the sun without any sunscreen — the best way to prevent skin cancer remains avoiding sun exposure and ultraviolet radiation, said study researcher ErikkaLoftfield, a doctoral student at the Yale School of Public Health and a fellow at the National Cancer Institute.

"Our results, and some from other recent studies, should provide reassurance to coffee consumers that drinking coffee is not a risky thing to do," Loftfield told Live Science in an email. "However, our results do not indicate that individuals should alter their coffee intake." [Top 10 Anti-Cancer Foods]

Measuring java's effect

Previous studies had found hints that drinking coffee might be linked tolower rates of nonmelanoma skin cancers, but the findings were mixed when researchers looked at coffee and melanoma, the deadliest form of skin cancer. Melanomas arise from pigment cells in the skin called melanocytes. According to the National Cancer Institute, 76,100 new cases were diagnosed in the United States in 2014, and 9,710 people died of the disease.

Loftfield and her team pulled data from a huge study run jointly by the National Institutes of Health and the American Association of Retired Persons, which tracked 447,357 retirees over 10 years, on average. Ultimately, in this group, there were 2,904 cases of malignant melanoma (a cancer that has spread beyond the top layer of the skin), and 1,874 cases of early-stage melanoma, which remains only on the top layer of the skin.

"Our study is the largest to date to evaluate this relationship" between melanoma and coffee drinking, Loftfield said.

The participants reported their coffee consumption as well as other factors that might influence their cancer risk, including exercise, alcohol intake and body-mass index. To estimate people's UV exposure, the researchers used NASA data on the amount of sunlight in each participant's hometown.

Perky protection?

After the researchers controlled for the other factors, coffee drinking turned out to be a boon: There were 55.9 cases of melanoma yearly per 100,000 people among those who drank at least four cups a day, versus 77.64 cases yearly per 100,000 people among the people who didn't drink coffee, the researchers wrote.

The findings specifically applied to caffeinated coffee, not decaf. It's possible that caffeine itself could be the protective factor, but there could also be some other compound in coffee that protects against malignant melanoma that is more abundant in caffeinated coffee than in the decaffeinated variety, the researchers said.

The lack of a link with decaf could be due to chance, Loftfield noted.

The researchers plan to look for evidence of this protective effect in other groups of people, but Loftfield warns that the research is limited: The scientists had no way of knowing about the sunscreen habits of their respondents, or their skin coloring (lighter-pigmented and freckled people are more prone to melanoma). Nor is it clear what coffee contains that could help save the skin.

RETIREMENTSOCIAL SECURITY

The Best Way to Claim Social Security After Losing a Spouse

Q. My husband recently passed away at age 65. I'll be 62 in July, and I'm working full time. I went to the Social Security office and was told I could file for survivor benefits now, but would lose most of the income since my salary is about $37,000 a year. They told me to wait as long as possible to start collecting. My

own Social Security benefits would be about $1,200 per month at 62, but since I'll keep working, I will forfeit most of it. I don't want to give up most of the benefits. But if there's money I can collect until I turn 66, I'd like to get it. —Deanna

A. Please accept my condolences at the loss of your husband. I am so sorry. As for your Social Security situation, let me explain a few things that I hope will make your decision clearer.

First off, it's true that the Earnings Test will reduce any benefits you receive before what's called your Full Retirement Age (66 for you). However, these benefit reductions are only temporary—you do not forfeit this income. When you reach 66, any amounts lost by the Earnings Test will be restored to you in the form of higher benefit payments.

The real consequence of taking benefits "early"—before your FRA—is that the amount you receive will be reduced. There are different early reduction amounts for retirement benefits and widow's benefits.

That said, you can file for a reduced retirement benefit at 62 and then switch to your widow's benefit at 66, when it will reach

its maximum value to you. This makes sense if you are sure that your widow's benefit will always be larger than your own retirement benefit; more on that in moment.

One caveat: if you take your retirement benefits early, the restoration of Earnings Test reductions probably will be lost to you once you switch later to a widow's benefit. But if the widow's benefit is larger anyway, this should not bother you.

To find out more precisely what you'll get in retirement benefits, set up an online account at Social Security—you'll see the income you'll receive at different claiming ages. To get the comparable values of your survivor's benefit as a widow, however, you will need to get help from a Social Security representative.

Once you see those numbers, it could change your thinking. For

example, what if your own retirement benefit is larger than your widow's benefit? It could happen, especially if you defer claiming until age 70 and earn delayed retirement credits. In that scenario, you would do better to claim your widow's benefit—and perhaps even take it early if you need the money. You can then switch to your retirement benefit at age 70.

These claiming choices can be very complicated. Economist Larry Kotlikoff, who is a friend and co-author of my new book on Social Security, developed a good software program, Maximize My Social Security ($40), which can take all your variables and plot your best claiming strategy. But I'm not trying to sell his software, believe me; there are other programs

you can check out, which are mentioned here. Some are free, but paying a small fee for a comprehensive program may be worth it, when you consider the thousands of benefit dollars that are at stake.

RETIREMENTASK THE EXPERT

How To Tame The Unexpected Costs of Medicare

Donna Rosato@RosatoDonnaRobert A. Di Ieso, Jr.

Q: I got my annual notice from Social Security this week for

2015 and was surprised to find out that the Medicare premiums for me and my wife were going up for this year because of the amount of money I made in 2013. I did not know Medicare premiums were adjusted based on income. I am 71. Is there anything I can do? – Norman Medlen

A: You won't be able to change your premiums for this year, but there are moves that can help lower your future costs.

First, though, realize that your confusion is understandable. Many people don't know that Medicare premiums are calculated based on income, says Nicole Duritz, vice president of Health and Family Education and Outreach for AARP. Some people even believe that Medicare, which most Americans are eligible to receive when they turn 65, is completely free. It's true that most people don't pay for Medicare Part A, which covers hospitalization, but that's because they have contributed to Medicare throughout their careers through payroll taxes.

But your income determines how much you pay for Medicare Part B, which covers routine medical care, including doctor visits and outpatient services, such as physical therapy and X-rays. Under the rules, your income can include a salary from working, as well as proceeds from the sale of a house or withdrawals from a portfolio.

Granted, the income thresholds are relatively high. If an individual earns $85,000 or less, or a married couple earns $170,000 or less, the premium is $104.90 a month. People earning more than $85,000, or a couple earning more than $170,000, will pay $146.90 to $335.70 a month depending on their income. Only an estimated 5% of Medicare recipients pay more than the basic $104.90 level. The premiums are deducted from your Social Security check.

Premiums for Medicare Part D, which is for prescription drug coverage, are also income-based, which add anywhere from $12.30 to $70.80 a month to the premiums charged by the plan you select.

Still, there's good news: your premiums are re-evaluated each year based on your most recent tax return. So if the money you received was a one-time windfall, your premiums will drop back down the following year.

To make sure your premiums stay affordable, do some advance planning, says Rich Paul, president of investment advisory firm Richard W. Paul and Associates. That's especially true if you think you may have more windfalls ahead. "It's not just your Medicare premiums that will go up—the additional income may bump you into a higher tax bracket and your income taxes will go up too," says Paul.

For example, if you are converting a traditional IRA to a Roth, consider spreading the amounts over several years. That way, you won't have a large one-time jump in your income. Or make a large charitable contribution at the same time as you convert, since the deduction will offset some of your tax bill.

In addition to the premiums, the size of Medicare's out-of-pocket costs surprises many people, says Duritz. Medicare Part B covers roughly about 80% of your medical bills, but you have to pay the other 20%, including deductibles, co-insurance and co-pays. And unlike many employer plans, Medicare doesn't cover some major medical expenses, including glasses and dental work.

To cover those gaps, many people opt for a Medicare supplemental plan or Medicare Advantage. How much you pay depends on where you live and the status of your health, in addition to your income. "If you're healthy, you won't incur the same costs as someone with a chronic condition because you don't need as much care or medication," says Duritz.

Fortunately, there are a number of ways you can lower costs. She suggests getting regular health screenings to catch any problems early, exercising and maintaining healthy weight. If you are on medications, talk to your doctor about lower-cost options. "It doesn't have to be a generic—it could just be an older brand name," says Duritz. "We have had people cut their prescription drug costs by $1,000 or more using alternative medications."

It's also important to reevaluate your Medicare plans during annual open enrollment, which runs from October 15th to December 7th. Plans and costs change every year—and your medical needs may change too.

For help finding the best options, try AARP's "doughnut hole" calculator—named for the gap in prescription drug coverage under Medicare Part D—to find suggested drug alternatives to discuss with your doctor. AARP's Medicare Health Care Cost calculator will estimate your overall Medicare costs and suggest ways to minimize your spending. And AARP's Question and Answer tool walks you through all the costs of Medicare and how it works. With this information, you'll have a better idea of the costs to expect from Medicare.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