Health & Retirement Services of Illinois

Newsletter March & April 2015

OUR NEWS LETTER

IRS offers ObamaCare relief

By Bernie Becker - 01/26/15 05:00 PM EST

The IRS said Monday that it would offer some taxpayers relief if they received too much of a subsidy for purchasing healthcare.

Taxpayers who received a premium tax credit to purchase health insurance are required on their tax return this year to reconcile the tax break they received with the amount they were supposed to get based on their actual income.

Because of that requirement, some taxpayers who received the premium tax credit are likely to face an unexpected expense on their return this year.

Under the deal the IRS offered Monday, taxpayers who ask for a waiver by April 15, are otherwise current on their taxes and report the excess payment won't face a penalty for not paying the IRS back on time. Those taxpayers do still have to eventually pay back taxes for the credit, with interest.

In Our Newsletter

Consumers' out-of-pocket health costs increase; new report shows wide variation in prices

Angela Townsend, The Plain Dealer

on February 03, 2015, updated February 03, 2015

Out-of-pocket health care costs for people who have health insurance through their employer continue to go up, according to a report by the Washington, D.C.-based Health Care Cost Institute.

Ohioans with health insurance from their jobs are spending an average of $715 of their own money before their coverage kicks in, according to a new data brief released Tuesday by the Health Care Cost Institute, which conducts independent research on health costs in the United States.

Nationally, adults ages 18-64 paid more than 15 percent of their health bill, an average of $707 in 2013, up from $662 in 2012.

The report also looked at the variation in cost of what people pay out of pocket for five common procedures and services - new doctor visits, lower leg MRI, cataract removal, colonoscopy and ultrasound for pregnancy - nationally and in nine states, including Ohio.

The price of cataract removal in Ohio varies by $386, while the cost of a colonoscopy varies less - $124 - according to the report, which analyzed data from Aetna, UnitedHealth, and Humana. The unidentified data represents more than 50 million claims and is based on actual amounts paid.

Go to healthcostinstitute.org to see the entire report.

What does the report show?

The report shows the variation in cost of a service or procedure - the difference between the highest and lowest prices - not the actual price.

Snapshot of the medical expenses landscape in Ohio

The Health Care Cost Institute looked at how much consumers who get health insurance through their jobs spent out of pocket on health care in 2013, nationally and in every state. They also looked at the variation in cost (the difference between the lowest and highest prices) for five common health care expenses.

PROCEDURE	U.S. AVERAGE VARIATION	OHIO AVERAGE VARIATION
New patient visit	$19	$14
Colonoscopy	$130	$124
Cataract removal	$444	$386
Lower-leg MRI	$342	$141
Ultrasound for pregnancy	$78	$38
Annual health-care spending	$707	$715

SOURCE: Health Care Cost Institute (www.healthcostinstitute.org/)

THE PLAIN DEALER

"We couldn't report prices directly," HCCI Senior Researcher Eric Barrette told The Plain Dealer. "That gets into some of the privacy. But we can report consumer variations on price."

"For a new patient visit, if the difference is around 15 or 20 dollars, it might not matter," he said. "But for something like an MRI, maybe you care less about how friendly the tech is and more about the difference in prices."

What a person pays out-of-pocket for a new doctor visit varies by $10 in Arizona, but as much as $35 in Wisconsin. And whereas the price of cataract removal in Ohio varies by $386, the variation is more than twice that in Wisconsin. Cataract removal, the sole surgical procedure highlighted in the report, had the highest variation in price than anything else.

Why is there such a variation in cost?

There are many factors - the type of insurance plans offered, or the health of the population - that may impact cost between states or within a state.

How should consumers use the report's findings?

"It's akin to a public service announcement," Barrette said. "There are differences in prices between providers and places of care. Although there's been a lot in the news about excessive costs, this data brief looks specifically at what consumers pay. Everyone will be at different place, and will need different services. This is not supposed to be a reference to go and say, 'Here's how much I can save.'

"But if [consumers] ask questions, if they talk to two physician offices, they could save enough money that can be cost effective for them," he said.

But what about people who are in health plans with narrow provider networks?

"The analysis is not restricted to in-network claims only," he said. "It's not necessarily that within a network, every price is the same."

Why was Ohio chosen to illustrate the cost variations?

Ohio was chosen because it was one of the states that had a large sample size, and a sufficient amount of data that researchers could rely on for usable estimates.

Even so, not all big insurance companies are represented, HCCI Executive Director David Newman said. Once that happens - and he expects it will in time - the estimates will get better, he said.

Is there anything else that consumers can use?

In February HCCI will launch what it's calling a new "transparency tool" that will help consumers shop for health care.

"Our belief is that consumers need to focus on buying value in health care," Newman said. The new tool, he said, will allow people to look at price and quality information for opportunities to save money.

The new website, a collaboration between HCCI and the insurance companies, have been in the works for nearly a year, Newman said.

"The first part of the website will look like Edmonds.com [a car-buying website]," he said. It will give an average price for a service or procedure, based on national data from 3 billion insurance claims, for major metropolitan areas across the country. That part of the website, expected to go up later this month, will be accessible to everyone.

The second part of the website, which will launch by the end of the year, will provide additional information that is more specific to individual consumers, assuming that their insurance company participates. They can log in and find out how much in out-of-pocket costs to expect at different providers, according to what their plan and deductible looks like.

Medicare to pay for lung cancer screenings

By Elise Viebeck - 02/05/15

Medicare is moving to cover lung cancer screenings for older people who have a history of smoking at least one pack of cigarettes per day.

The Centers for Medicare and Medicaid Services (CMS) had previously announced its decision to provide the CT scan coverage in November. The agency issued its final national coverage determination on Thursday, prompting praise from advocates who said thousands of lives would be saved.

"This is the first time that Medicare has covered lung cancer screening," said CMS Chief Medical Officer Dr. Patrick Conway in a statement. "This is an important new Medicare preventive benefit since lung cancer is the third most common cancer and the leading cause of cancer deaths in the United States."

Medicare beneficiaries will have to meet specific criteria in order to qualify for screenings, which will cost nothing to recipients: they must be between ages 55 and 77, receive a written order from a physician, and have a history of smoking at least one pack a day for 30 years.

While Medicare is typically only available to people 65 and older, some people receive it earlier due to disabilities and will also qualify for the screenings.

The Medical Imaging and Technology Alliance, a trade group, praised the decision as a "triumph" for Medicare beneficiaries.

“Given the high bar CMS holds in making national coverage determinations, it is clear that the benefits of [CT] scans for those at high risk of lung cancer are indisputable," said Gail Rodriguez, executive director of MITA, in a statement.

6 Things That Will Make Your Hard-Earned Money Vanish

Just about any person with a job will tell you they work hard for their money. And if you're like just about everyone on the planet, you probably want to hold on to the money you've earned. But there are a number of things that could cause your hard earned money to vanish. Here are 6 things that could make your money go poof!

Poor Spending Habits

One of the most common things that will make your money vanish is wasting it on things you don't need and can't afford. Expensive coffee, cigarettes, alcohol, brand-name fashion items, the latest technology, restaurants, gym memberships, and expensive cars are all things

people waste money on.

When it comes to spending, always cover your basics, then set aside money for retirement and emergency (and kid's college funds), and THEN treat yourself to things in moderation.

High credit card interest rates

The average American household with at least one credit card has nearly $16,000 in credit card debt. With interest rates in the high-teens, you could flush a lot of money down the toilet every month on credit card interest payments. However, it's possible to save hundreds of dollars a year by reducing your credit card interest rate through debt consolidation.

One website called Prosper Marketplacelet's you borrow between $2,000 and $35,000 towards debt consolidation or other personal expenses. Your interest rate could be as low as 6.73% with payback terms of 3 or 5 years. You can get a free loan rate-quote here. Consolidating your high interest credit card debt into a lower rate could save you quite a bit in the long run.

Overpriced insurance

Everyone knows that having car insurance is required by law. But there's nothing in the law about having overpriced car insurance! Many people are over-paying for their car insurance every month and don't even know it. Have you shopped around for rates recently? If not, you could be wasting money every month.

Websites like eSurance.com make it easy to compare multiple car insurance quotes in just a few minutes so you can compare rates and save.

Of course, not having the right insurance is even worse than overpaying for insurance. Make sure you know what your insurance covers. For example, many people have home insurance but don't

realize it does not cover certain types of flood damage. Next thing they know they're out tens of thousand of dollars in damages.

Bad investments or not enough diversification

One way to lose a lot of money fast is by making poor investment decisions. While there may always be a correlation between risk and reward, you should never make an investment that you can't afford to lose entirely.

But more importantly, you should never have all of your eggs in one basket. You should always diversify your investments so if one goes south, you do not lose everything. Here are a few platforms you can use to diversify your investments and increase your returns:

An easy way to diversify stocks and reduce trading fees

The stock market is obviously a top choice for many investors. But picking the right stocks can be challenging. Even if you can spot trends in the market and economy, finding all of the companies that will be impacted by those trends is exceedingly difficult.

Enter Motif Investing. Motif is a new service that aggregates portfolios of 20-30 stocks based around an idea, belief, or trend. So instead of worrying about finding the right companies, you can focus on investing in the ideas you believe in and let Motif do the rest. And whereas most stock trading platforms charge you anywhere from $5-$10 per stock trade, Motif only charges $9.99 for trading an entire motif of stocks.

A new high-return alternative to stocks

Since its inception just a few years ago, the popularity of peer-2-peer lending platforms continues to skyrocket. These platforms work by allowing investors to fund consumer notes. Prosper Marketplace has proven to be great investment and diversification tools for investors over the past few years, with season returns averaging as high as 11.35%. In fact, every investor who has invested in at least 100 notes on Prosper has experienced positive returns! You can invest as little as $25 per note…

High interest home mortgage payments

While it may not always make sense to refinance, there are a few good reasons to consider doing it, such as shortening the term of your loan, getting out of an ARM (Adjustable Rate Mortgage), consolidating debt or taking out home equity, or a general interest savings of at least 2% (some experts say 1%).

Websites like LendingTree.com all you to compare refinancing rates for your home or car loan so you can see if you can get a better rate than the one you have now. The service is free and there are no obligations to any specific lenders.

Hidden 401k Fees

Many people think they're all set once they start setting aside money for retirement. But what many people don't know is that hidden fees in their retirement accounts could be costing them tens of thousands of dollars over the life of the investment.

Be sure to review your retirement plan statement in detail to see what fees you're being charged. You may even want to consult an expert or search on the internet to see if certain fees are normal. (If you see a fee, Google it).

Conclusion

You work hard for your money and you deserve to keep it. Don't make these common mistakes that have caused so many to see their funds vanish before their very eyes.

If you need some extra help planning your finances, check out LearnVest.com.They have a free service that helps regular people take control of their finances.

Affordable Care Act poses new challenges for tax preparation, taxpayers

Kevin Ruiz, left, and Jorge Rodriguez get their Statue of Liberty outfits in order before dancing and waving to passing motorists for Liberty Tax Service in Winnetka, Tuesday, January 20, 2015. Michael Owen Baker — Staff photographer

By Neil Nisperos, Inland Valley Daily Bulletin ,and Susan Abram, Los Angeles Daily News Posted: 02/12/15

Evan Bybee, 24, of San Bernardino receives free tax help from accounting student NycoleLotz, 23, at California State University San Bernardino Wednesday. Micah Escamilla — Staff photographer

Accountant Ken Dewan's office has been swamped with phone calls lately, and he's got the U.S. government to thank for it.

The questions and the confusion about the Affordable Health Care Act just keep coming, and it's made for some late nights.

"You cannot believe the number of questions we're getting on the phone," said Dewan, office manager and owner of two Liberty Tax Services in Los Angeles. "We have been very, very busy. We've been closing at 11 p.m."

Even as new healthcare consumers rush to meet a Sunday deadline to sign up for coverage under Obamacare, those who've signed up already are scrambling to understand what accountants from the San Fernando Valley to the South Bay to the Inland Empire say are its sweeping tax effects.

While April 15 is still weeks away, confusion and questions about certain themes are emerging, with even seasoned taxpayers, used to filing on their own, have questions.

As Kiak Tae, a tax specialist at ITS Financial Group in Gardena said Wednesday: "It's a mess. Everything is so new that each scenario is different, and a lot of people are really clueless."

Another way of saying it is that the reality of the penalties for not having insurance seem to be setting in.

The most-asked question has to do with the penalty a qualified uninsured person must pay for not signing up for health insurance, Dewan said.

Most people think it's $95. But in reality, the penalty is $95 per adult and $47.50 per child, with a family maximum of $285, or — for 2014 — 1 percent of the annual household income, whichever is greater. (That 1 percent changes to 2 perent for next year's filers).

Of the 1.2 million Californians who enrolled into a health plan through Covered California, the state's health insurance market exchange, 800,000 of them received federal subsidies to help them pay for their coverage. Covered California officials estimated that federal money paid out an average of $5,200 per household per year, or about $436 per month.

But some people may have to pay those subsidies back. Those who received the 1095-A forms to file federal tax returns this year will learn if what they received was appropriate.

"For many consumers, their tax credit will need to be adjusted, because their income is different than what they estimated it would be for 2014," Peter Lee, executive director of Covered California said last month. "As a result, consumers will see their tax credit adjusted upward or downward in their tax return based on their actual income as reported to the IRS for 2014."

In California, at least 100,000 people received 1095-A's that had incorrect information. Covered California offials said this week that new forms will be mailed out before the end of the month.

A major challenge is that most taxpayers in California have yet to receive a 1095-A form from the state in order to report whether they are covered through the state health insurance marketplace under the Affordable Care Act, Courts said.

"They haven't received it in the mail yet," said Janet Courts, a Cal State San Bernardino accounting lecturer and coordinator of the university's Volunteer Income Tax Assistance, or VITA, program. "And most taxpayers don't know what they're looking at, so they're not familiar with it."

Gerald Kominski, the director of the UCLA Center for Health Policy and Research, said the document reporting required to the IRS has increased.

"It has increased the amount of record-keeping for anyone receiving a subsidy," Kominski said. "It's increased their record-keeping for tax purposes, because now they have to track the subsidies they received and the number of months they were insured for tax purposes."

Kominski said that because the subsidies for healthcare are now administered through the tax system, subsidies can change as a result of very small changes in income, and recipients may not receive what they had applied for in an earlier application form. Or, they may owe more in taxes because their actual income did not match the income they had provided in an earlier form.

"Over time, this may lead to a need for some administrative simplification so that people don't have to recalculate their subsidy based on small changes in their income," Kominski said. "What it would mean is that we would use wider income categories rather than now, where basically, your income is calculated in a continuous line or a continuous function as a separate category."

IRS officials acknowledge there's a need to "navigate these changes."

In a help sheet sent out Thursday, they urged taxpayers to note that along with a few new lines on existing forms, two new forms will need to be included in returns. Most taxpayers under the ACA will need only to check a box on their return, showing they had health coverage for all of 2014, officials said in the help sheet.

Regardless, Courts said tax preparers are gearing up.

“This year, the ACA is our biggest challenge,” Courts said.

And Tae is seeing it, adding that it’s taking him about 20 minutes longer to file taxes for people who signed up for insurance on the public exchanges.

As for taxpayers, San Bernardino resident Evan Bybee, 24, seemed to be doing his best to take the questions and scope of the new tax structure in stride.

He just signed up to get health insurance through Covered California, but since he’s started to file his tax returns for the first time, he doesn’t see the additional paperwork as an issue. Bybee was getting his returns done through student volunteers at Cal State San Bernardinoon Wednesday.

“For my generation, and people in my exact situation .... I’m not getting too much of a grip of it,” Bybee said. “I’m learning a new system so it’s not that bad.”

Dewan hoped that the learning continues, because taxpayers need a lot more help.

“This is a game-changer,” he said of the law and its tax ramifcations. “Tax preparation has become a lot more complicated, because it’s not a single flow, but a multiple flow. On the taxpayer side, I think there’s a lot more education that needs to be done.”

Is Your Brain Telling You to Make a Bad Decision on Social Security?

By John Reeves | February 13, 2015

Financial professionals often recommend that you wait until full retirement or even later before applying for social security benefits. An individual who'd receive $1,000 per month at full retirement age would get a mere $750 by claiming early at age 62. And that same person could get as much as $1,320 per month by waiting until age 70. For many Americans, it *appears* to make a lot of sense to wait.

As a general rule of thumb, if you expect to live beyond your late 70s, waiting until at least full retirement might be the smart choice. According to the Social Security Administration, a man reaching 65 today can expect to live until 84.3. And a woman turning 65 can expect to live until age 86.6. Given that one out of every four 65-year olds today lives past age 90, you'd assume that most folks would hang on until full retirement before applying for benefits.

That assumption would be wrong, however. In practice, many Americans seem to be ignoring the data. According to *The New York Times*, 41% of men and 46% of women choose to take their benefits at 62 -- the earliest age possible. Why aren't they listening to the experts?

Your social security and your brain

Obviously, there are some very rational reasons for claiming your benefits at 62. For example, you might have some serious health concerns. Or you may just really need the money. Sometimes real life is more complicated than insurance data and actuarial tables.

There might be another powerful reason that people aren't even aware of, however. According to psychological research, we are all hardwired to lock in certain gains, even if such a decision has a lower expected value. In other words, our psychology could be leading us to make suboptimal financial choices when it comes to social security.

The price of certainty

The underlying principle involved here, which was highlighted in the work of Daniel Kahnemanand Amos Tversky, is called the "certainty effect." This idea is actually quite easy to understand. Essentially, everyone tends to over-weigh a sure gain compared with a slightly riskier gain, even if the expected value of the certain gain is lower.

Here's an illustration of how it works. Suppose there are two options. Option 1 gives you a chance to win $9,500 with 100% certainty. Option 2, on the other hand, provides you with the opportunity to win $10,000 with 97% certainty, though there's a 3% chance you will win nothing.

Even though the expected value of Option 2 is higher ($9,700 compared to $9,500), the "certainty effect" would predict that more individuals would choose Option 1 than Option 2. According to Kahneman:

People are averse to risk when they consider prospects with a substantial chance to achieve a large gain. They are willing to accept less than the expected value of a gamble to lock in a sure gain.

A team of academics recently tested this theory, and reported their findings in a paper titled "Risk preferences and aging: The 'Certainty Effect' in older adults' decision making". They discovered that "older adults were more likely than younger adults to select the sure-thing option when it was available -- even if it had a lower expect value." In other words, they not only found evidence supporting the "certainty effect," they found that older adults were *more* susceptible to it than younger ones. The overall conclusion of the study is very instructive:

... [W]hen it comes to the important decision whether to claim social security benefits at the earliest retirement age (i.e., 62 years old) and receive a sure but lower-dollar payout (i.e., up to 20% less) versus a higher-dollar payout a few years later at full (between 65--67 years old) or after full retirement age (at 70 years age at the latest, with a benefit increase between 4% and 8% for each year after full retirement age until age 70) at the risk of not being alive, older adults might sub-optimally go for the sure payout at the earliest possible age rather than delaying their retirement benefits; thus, permanently reducing their benefits.

Clearly, our instincts can inadvertently lead us astray on financial matters. As Jason Zweig notes in his classic book *Your Money and Your Brain*, "[I]nvestors habitually are their own worst enemies, even when they know better." When deciding when to apply for social security benefits, it might be wise to remember how our brains are wired. Otherwise, you could be leaving a lot of money on the table.

The $60K Social Security bonus most retirees completely overlook

If you're like most Americans, you're a few years (or more) behind on your retirement savings. But a handful of little-known "Social Security secrets" could ensure a boost in your retirement income of as much as $60,000. In fact, one MarketWatch reporter argues that if more Americans used them, the government would have to shell out an extra $10 billion... every year! And once you learn how to take advantage of these loopholes, you could retire confidently with the peace of mind we're all after.

The 25 Highest Paying Jobs in America That You Can Actually Get

BY Laurie KulikowskiFollow| 02/17/15

NEW YORK (TheStreet) -- Wouldn't it be nice if you could have a career where the salary was high and there were plenty of jobs available, so that you could essentially choose who you worked for?

A new report by Glassdoor, an online job review Web site, could be a guide for turning that dream into reality.

The report identifies 25 jobs that have the highest average annual base salary and are in high demand by employers nationwide. That means jobs that have high salaries and ones that have the most job openings.

For a position to be considered, it had to receive at least 75 salary reports shared on Glassdoor by employees during the past year (through Jan. 25). The job must also have been in the top 50th percentile for number of openings. Job openings represents active listings or jobs posted within the last three months, as of Feb. 2, or both, Glassdoor said.

Not surprisingly, technology and health care are the two industries with the most jobs represented, but there are plenty of other industries also listed. Still, it's worth nothing that while these jobs pay handsomely, most also require a high level of experience, skills and education.

Software engineer is the position with the most job availability with 99,055 openings, although it ranked No. 23 on the list because of its annual salary of $96,392, according to the report.

Check out other positions that made the list.

25. Sales Engineer

Sales engineers are experts in scientific processes and technical knowledge to sell complex products or services to businesses. They typically have bachelor's degrees in engineering or a related field.

Average Base Salary: $90,899
Number of Job Openings: 5,508

Obamacare subsidies slash costs for low-income consumers

Jayne O'Donnell, USA TODAY February 11, 2015

In this Aug. 6, 2014 photo, Dr. FaranBokhari, head of the trauma department at Cook CountyísStroger Hospital in Chicago, second from right, and Dr. Jared Bernard, a lieutenant commander and trauma surgeon in the U.S. Navy, third from left, work together during surgery of a gunshot victim.(Photo: Nam Y. Huh, AP)

Lower-income insurance shoppers can slash their share of healthcare costs to an average of $14 in co-payments when they visit their primary care doctors, and the percentage of costs they have to share for emergency room visits can be as low as 19%, according to a report out today from the Kaiser Family Foundation.

As the deadline for Obamacare open enrollment nears on Sunday, the Kaiser report and a federal study out earlier this week on premium tax credits show how little many lower-income consumers would have to pay out of pocket for coverage.The earlier report from the Department of Health and Human Services found advanced premium tax credits paid directly to insurance companies for lower income consumers cut their premiums, on average, to $105.

Those two reports should help convince leery consumers that the cost of coverage may be less than they expect, and the cost of not having it – including tax penalties and health issues – far higher. "If we want people to have coverage.it has to be something they can afford to have," says Gary Claxton, a Kaiser vice president and co-author of the new cost-sharing report. "Most of the people who were uninsured before, even if they signed up, would have trouble paying for the care." Cost sharing includes deductibles that have to be paid by consumers before insurance kicks in, as well as co-payments and co-insurance. Co-payments are a set amount consumers pay at the time of appointments; co-insurance is the percentage patients pay for certain services, such as hospitalization.

How cost sharing subsidies stack up:

• For plans with a combined deductible for medical and prescription expenses, costs range from $229 for those eligible for plans with the most generous coverage of 94% of costs to $2,559 for standard unsubsidized plans.

• For primary care office visits, the average co-payment amount ranges from $14 for the 94% plans to $28 for plans without cost sharing reductions.

•The average out-of-pocket limit for single coverage ranges from $879 for the 94% plans to $5,824 for standard plans.

Kaiser notes that those eligible for any of the plans with cost sharing reductions -- those earning between 100% and 250% of the federal poverty level -- can save thousands of dollars if they have serious ongoing or onetime medical needs.

The federal poverty level is $11,770 for an individual and $24,250 for a family of four.

Share the Wellness: The Heart and Mouth Connection

Sure, healthy gums are important for your smile – without them, you can lose your teeth. Here's another fact to chew on: More and more research suggests that gum disease may boost the chances of developing cardiovascular problems.

Explaining the Connection
Several studies have shown a link between gum disease and heart attack, heart disease and stroke. In one study, those with severe gum disease were almost 10 times more likely to have coronary artery disease than their peers with healthy gums.

Some researchers think bacteria are the culprits behind gum disease and explain the connection. Chewing, talking and swallowing seem to pump bacteria out of the gums of people with gum disease. These germs may then enter the blood through sores in the gums, a frequent annoyance for those with severe gum disease.

Experts believe that when these bacteria enter the blood, the body produces proteins that cause swelling in the arteries. One of these, C-reactive protein, is linked to plaque buildup in the arteries.

What about people who already have heart disease? Based on the research so far, scientists don't think gum disease raises future heart risks in these people.

Despite these recent findings, experts can't say for sure that gum disease causes heart disease or stroke on its own. There may be other explanations that need to be explored. For this reason, more research is underway.

Strategies for Good Oral Hygiene

- Brush at least two times a day, and floss once a day.
- Don't use tobacco in any form.
- Eat a healthy diet. Limit foods high in sugar.
- Visit your dentist for regular checkups and cleanings.

It's important to be on the lookout for signs of gum disease. These include tender or bleeding gums, loose teeth, bad breath or a bad taste in your mouth. If you have gum disease, medicine or other treatments can help preserve your smile and possibly your heart health.

Sources: Mouthhealthy.org; Heart.org

Immigration Changes Wouldn't Solve Health Issues

February 26, 2015, By Tim Henderson

Community activists rally during an event on Deferred Action for Childhood Arrivals (DACA) and Deferred Action for Parental Accountability (DAPA), in downtown Los Angeles. For states, the controversy over deferred deportation for millions of unauthorized immigrants has raised thorny health care questions. (AP)

This story has been updated to correct the name of the National Conference of State Legislatures.

President Barack Obama's controversial executive action on immigration has highlighted a thorny health care issue for states: Potentially millions of immigrants could legally stay here and work, but still lack health insurance.

Unauthorized immigrants have limited access to health care coverage, and the president's action likely will make them ineligible for most Medicaid services and bar them from purchasing insurance on the federal and state exchanges created under the Affordable Care Act (ACA).

Some states have sought to solve the problem for low-income immigrants with separate state-funded insurance programs. Those that have not are wrestling with the consequences of a population that is going without routine care, which can drive up costs when preventable illnesses become serious health emergencies.

Treating kidney disease as an emergency condition, for instance, costs almost five times what it would with routine care denied to unauthorized immigrants, according to a Baylor College of Medicine study published by the Texas Medical Association last year.

Unauthorized immigrants without health insurance present other problems for states. In Maryland, for instance, state attorneys face cases of criminally insane defendants who are no longer deportable but can't get the follow-up care required for release into the community.

The issues arise from what the Annenberg Public Policy Center calls "a curious intersection" between the ACA and the president's executive action that defers deportation for many unauthorized immigrants: The action allows them to live and work here legally, but not to get insurance under the ACA.

The president's action, Deferred Action for Parental Accountability (DAPA), defers deportation for immigrant parents of U.S. citizens and it expands the 2012 program, Deferred Action for Childhood Arrivals (DACA), which deferred deportation for immigrants who arrived unlawfully before they turned age 16.

The action is on hold because of an injunction issued Feb. 16 by a federal judge in Texas after 26 states filed suit. The Obama administration is appealing. But even if the president wins, the health care issue likely remains for the immigrants who are allowed to stay and work.

“People granted DAPA or expanded DACA will not be eligible for federal health coverage programs,” the Georgetown University Health Policy Institute recently wrote on its policy blog.

Only states with state-funded alternatives, such as California’s Medi-Cal, are considering plans to accept expanded DACA/DAPA recipients. California, along with Washington, Massachusetts, Minnesota, New York and the District of Columbia use state or local funds to offer some health insurance to DACA recipients, according to the National Conference of State Legislatures.

California and New York have been the most successful in bridging the gap, according to a Migration Policy Institute study of unauthorized immigrants. In both states, unauthorized immigrants are more likely to have health insurance than the general population.

Illinois was planning a state-funded insurance exchange open to all, including unauthorized immigrants, under Democratic Gov. Pat Quinn. Republican Gov. Bruce Rauner, who replaced Quinn in January, has not said whether he will continue the plan.

Many immigration and health care advocates hope the situation will change nationally, and DACA and DAPA recipients will be allowed to purchase insurance on all exchanges and be covered by employer plans under the ACA. Dozens of state and local advocacy groups have asked the federal government to open up more health insurance options for DACA and future DAPA recipients.

“There is some hope that the work authorization will allow people granted DACA or DAPA to obtain jobs that provide health insurance benefits,” Georgetown’s Health Policy Institute said. “However, many people in low-wage, part-time and seasonal jobs will continue to be left out of employer-sponsored health insurance or unable to afford their required share of the premiums.”

State Headaches

More than half of unauthorized immigrant adults have no health insurance, and one in five lives in poverty, according to Pew Hispanic Center estimates (Pew also funds *Stateline*). That creates problems, even in criminal cases.

At a meeting of the National Association of Attorneys General in Washington, D.C., this week, Assistant Attorney General Rhonda Edwards of Maryland said she’s finding it increasingly hard to deal with mental hospital inmates who are unauthorized immigrants because of their lack of insurance.

Without insurance, it’s difficult or impossible to release patients from mental hospitals and free the beds for other patients, she said.

“Treatment for mental illness is afforded to illegal mentally ill immigrants who are court-committed to state-run facilities at governmental expense,” Edwards wrote in a paper on the subject. “However, once these individuals are

released, no governmental funding is allocated for their care and treatment for mental illness symptoms that may cause them to be a danger in the community."

Unauthorized immigrants without insurance are entitled to emergency care, including childbirth care, through a federal-state Medicaid safety net fund costing $2 billion a year, according to a 2013 report from Kaiser Health News. Routine care is often left to safety net clinics that also get federal funding, but politically sensitive care like birth control can be inconsistent from state to state.

A recent University of Kentucky study found that lack of insurance drives many immigrant women to cross the border into Mexico to get oral contraceptives.

"If you're an undocumented woman, you're really reliant on these clinics," said Kinsey Hasstedt, a public policy associate for the Guttmacher Institute, a reproductive health advocacy group.

An Employment Advantage?

The issue of health insurance came up in arguments before U.S. District Court Judge Andrew Hanen, who issued the injunction which blocked DAPA and the expansion of DACA.

States argued that DACA and DAPA recipients would have an unfair advantage over citizens in competing for jobs because employers wouldn't have to buy insurance for them.

Expanding deferred deportation could "create a discriminatory employment environment that will encourage employers to hire DAPA beneficiaries instead of those with lawful permanent status in the United States," Hanen wrote in a memorandum opinion in issuing the injunction. "If an employer hires a DACA beneficiary, it does not have to offer that individual healthcare nor does it incur a monetary penalty for the failure to do so."

But employment experts said such a tactic is not as easy as it sounds. Any employer of more than 50 people must provide health insurance for all employees unless every single one is exempt, said Ken Jacobs of the University of California, Berkeley Labor Center.

"There is a penalty that applies to employers that do not provide affordable coverage," Jacobs said. "That rule applies to all workers."

Angel Padilla, a health policy analyst at National Immigration Law Center, agreed. He pointed to a brief released in December by the Annenberg Public Policy Center debunking the idea.

"It would be extremely unlikely for DACA and DAPA grantees to allow an employer to skirt the employer mandate and there are a number of existing protections to keep this from happening," he said.

States Can Step In

States have always been free to make their own health care provisions for unauthorized and other immigrants, who are generally barred from government health benefits such as Medicaid for five years after they attain legal status.

Several states, such as Alaska and Massachusetts, provide state funding for selected unauthorized immigrants (such as children and pregnant women) for some services, according to a Pew report released last year. But other states, such as Alabama, Mississippi, North Dakota, Ohio, Texas, Virginia and Wyoming, deny Medicaid even to some immigrants with green cards who have been legal for five years.

Many states are opposed to providing help to unauthorized immigrants on ethical and financial grounds. Foes say it's wrong to reward illegal entry into the country, and that more demand on health care resources will strain budgets and harm the quality of care. Opinion polls often favor withholding health care subsidies from illegal immigrants, according to a review by the Federation for American Immigration Reform (FAIR), a group seeking to stop illegal immigration.

But without affordable health insurance, advocates say unauthorized immigrants will continue to have health issues.

"With a growing undocumented immigrant population in Texas, our state legislators must be aware of and address this problem before it evolves into a health care crisis," researchers warned in last year's Baylor College of Medicine study on health care for undocumented immigrants.

April 2015 Newsletter starts

Why it would be hard for Obamacare to recover from a Supreme Court loss

By Jason Millman March 2

(Photo by Mark Wilson/Getty Images)

The Supreme Court on Wednesday will hear about the potential disruption in health insurance coverage for millions of people if Obamacare subsidies are struck down in the nearly three dozen states that didn't set up their own exchanges. Behind the scenes in these states, insurers are scrambling to keep the subsidies in place, as I and my colleagues wrote over the weekend.

Without the subsidies, the situation would quickly become pretty chaotic for insurers, who've largely benefited from the law so far. Most of the uninsured would no longer be subject to Obamacare's individual mandate requiring people to have health insurance because they wouldn't then have access to "affordable" coverage, as the Affordable Care Act defines affordability. But all of the law's other features that increase the cost of health insurance, such as guaranteed coverage regardless of preexisting conditions, would remain in place. The history of similar state-level health reform efforts that enacted these consumer protections without the mandate and financial assistance shows health insurance rates skyrocketed and healthier people dropped out of the insurance markets.

The timing of the Supreme Court decision could make a tough situation for insurers selling on the ACA exchanges even tougher. They're going to be filing 2016 rates over the next few weeks and months, before the Supreme Court is expected to issue its decision in late June. If the subsidies are struck, it's expected that healthier and low-income people would be the first to drop coverage — and quickly — after their monthly premiums increased on average by nearly 75 percent. That would then drastically alter the insurers' assumptions about who would sign up for 2016 health plans — they'd have a costlier population to cover, but the 2016 rates would already be locked in.

Neither Republicans nor Democrats have offered much hope that Washington could come up with a quick and workable fix if the subsidies are suddenly stripped from millions of people. The Obama administration

— which doesn't want to give the Supreme Court any reason to think that an adverse ruling wouldn't cause chaos — says there's nothing it could do administratively.

Republicans, on the other hand, want to show the court that a ruling against the Obama administration would not be disruptive. A trio of senior Republican senators wrote in a Washington Post op-ed Sunday that they had a plan to offer temporary financial assistance to those who would lose the subsidies. But they didn't provide key details -- such as how long they'd provide the aid, and what it would be worth -- and their offices haven't said when they might release more details. It's also questionable how much support there would be for such a measure among Republican lawmakers.

Actuaries, who work for the insurers, are pushing for the Obama administration to let insurers to change their 2016 rates this summer if the subsidies are invalidated in the federal exchange states. They've also suggested allowing insurers to now propose two sets of rates — one if the federal subsidies survive, and another if they don't. "Otherwise, insurer solvency could be threatened," a professional society representing actuaries recently wrote to Health and Human Services Secretary Sylvia Mathews Burwell.

It might be easier for insurers to drop out of these exchanges entirely. The ACA contains a provision that would discourage this behavior, locking out insurers from the exchanges for five years if they leave the marketplace. However, the threat of losing the exchange business might not be enough to keep insurers in the market if there's no immediate fix on the horizon, said Larry Levitt of the Kaiser Family Foundation.

"A lot of it will hinge on insurers' perceptions of whether a fix is coming and when," Levitt said. "They would immediately start losing money, as healthy people drop out and sick people stay in."

The most obvious solution, and the one insurers are lobbying for, would be for states to set up their own exchanges, since those subsidies aren't being threatened in the lawsuit, *King v. Burwell*. But there are huge political and logistical challenges to making that happen.

Jesse Thomas, chief executive of a start-up health insurer in Ohio that received $130 million in federal loans, said his group is working to build support for a bill establishing a state-run exchange if the federal subsidies are struck. Thomas, who runs InHealth Mutual, also said he's thinking of how to further expand the business into the small group market if the Supreme Court rules against the government. Thomas estimates that about half of the 22,000 people his company enrolled in 2015 health plans are in Ohio's exchange.

"We've pivoted before," said Thomas of InHealth Mutual, referring to the Obama administration's 2013 decision to allow people to stay longer in their existing health plans. "We'll pivot this time, and we'll get a broader spread of our risk."

Joel Ario, who previously ran the HHS office overseeing exchanges, said he would expect the battle over state-run exchanges to mirror the Medicaid expansion. Some Republican states would establish an exchange, while others would refuse. The Obamacare divide among the states would grow even deeper.

"It would be pretty ugly and divisive for the country," Ario said.

Employees not benefiting from slower growth in healthcare costs

While employees' insurance premiums and out-of pocket medical expenses shot up 21% from 2007 to 2013 to an average of $3,273 a year, employers' total healthcare costs rose only 14.5%. (Brent Lewis, Denver Post via Getty Images)

By NOAM N. LEVEY *contact the reporter*

Overall healthcare spending in the U.S. has risen at the slowest pace on record in recent years

American workers already struggling with stagnant wages are being saddled with higher medical bills even as employers reap the benefits of a sustained slowdown in the growth of healthcare costs, a new report indicates.

BUSINESS

Obamacare sign-ups expected to top 10 million amid sizable expansion

While employees' insurance premiums and out-of pocket medical expenses shot up 21% from 2007 to 2013 to an average of $3,273 a year, employers' total healthcare costs rose only 14.5%.

Samantha Allen always dreamed of being a photographer. (Noam N. Levey)

"Almost everyone in the health system is realizing savings, but employees' costs are rising," noted the new report from the Center for American Progress, a left-leaning Washington think tank.

Public opinion surveys regularly show affordability as a top healthcare concern for Americans. That is one of the reasons many policymakers hoped the slowdown in healthcare costs would bring some relief.

Overall healthcare spending in the U.S. has risen at the slowest pace on record in recent years.

The Center for American Progress report, provided exclusively to the Los Angeles Times, offers additional evidence this slowdown is not helping workers, however.

Researchers analyzed national survey data from the federal Agency for Healthcare Research and Quality that measure how much employers and employees pay for health plans that workers get through their jobs.

They also looked at data gathered from major health plans by the Health Care Cost Institute on how much employees pay in co-pays, deductibles and other out-of-pocket health spending.

America's uninsured rate plummeted last year, with the improvement driven by states that have fully implemented the Affordable Care Act, a new nationwide Gallup survey indicates. (Noam N. Levey)

Employers still pick up the lion's share of workers' health costs, paying more than two-thirds of the average worker's insurance premium in 2013, or $7,238, according to the report.

But the employer share is shrinking.

At the same time, workers' out-of-pocket costs are rising as employers boost deductibles and co-pays in the health plans they offer.

From 2007 to 2013, the average worker's annual out-of-pocket medical spending rose to $800 from $665, researchers found.

This trend is particularly troublesome at a time when paychecks are stagnating, said Topher Spiro, the center's vice president for health policy and lead author of the report. "This issue is critically important to address the squeeze middle-class families are facing," he said in an interview.

The report suggests three potential responses. These include: requiring employers to more clearly tell employees how costs are rising in their health plans; mandating that employers return some savings to workers if employers' costs rise more slowly than overall healthcare costs; and expanding employees' access to primary care visits that are not subject to cost-sharing.

Spiro acknowledged that large employers and major employer groups are unlikely to back any additional requirements.

But he said that increased focus on the issue may put pressure on employers, just as sustained calls to raise the minimum wage may have influenced decisions by Wal-Mart Stores Inc. and other businesses to boost pay.

"This is an issue that needs to be on the table," Spiro said.

A To-Do List for the Year You Retire

By David Ning

Ed Slott and Co. Retirement Consultant Jeff Levine on how the Obama Administration's proposed budget would impact Americans' retirement savings.

Many workers face a dilemma very close to their planned retirement date. They want to keep working and saving to be sure they won't ever run out of money, but work frustrations and a desire to do other things keep reminding them they can probably get by quitting. Here are some things you should do in the final few months before you retire

Start speaking up at work. Don't be offensive and disrespectful, but start saying what everyone is thinking about in meetings and afraid to say. After all, the consequences of possibly alternating your career trajectory don't matter to you much anymore, and voicing your concerns could lead to changes within the organization. By being a voice of reason, you will likely feel less frustrated at work. Plus, you'll probably find that people from all levels of the organization will start appreciating and respecting you more for the points you bring up.

Get one-time expenses out of the way while you still have income. You should go on that lifelong dream vacation, fix the nagging house repair you've been putting off and even upgrade aging cars before you retire. If an expense costs more than you anticipate, you can always compensate by working another few months to pay for it. Tackling large costs while you are working is a much better strategy than taking a big chunk of money from your nest egg that can't be easily replaced once you leave your job.

Max out your retirement accounts. Many people claim they don't earn enough to contribute the maximum amount to their retirement accounts, but the year leading up to retirement is the perfect time to stash away as much cash as you can. As you approach retirement, you should put a significant percentage of your paycheck away for retirement so that the stash can grow tax-deferred. Or you could put the money in a Roth account and pay the tax now so that you can take tax-free withdrawals later on in retirement.

Test-drive your budget. Use this time to start trying out your retirement spending plan. Can you actually live on the proposed monthly budget? Have you missed a few infrequent but inevitable expenses? By trying out your budget, you will feel more confident about your finances. And if you find that you can't get by on your allotted monthly income, there's still time to alter your original plan and retire a bit later.

Really start exercising. Many stressed out people have low energy and live an unhealthy life. Now is the time to prioritize your health by making the effort to start exercising. It will be tough at the beginning, but you'll feel great once your body adapts to the new routine. You'll have richer conversations because your energy levels will increase, and you'll feel younger and more alive than ever.

Simplify your financial picture. Start to consolidate your financial accounts and consider simplifying your investments. Just remember to consider the tax consequences before you sell investments that have large capital gains. This way, you won't need to spend as much time managing specific investments in retirement, and it will help cut down on the chances you will make a mistake that hurts your finances down the road.

Explore part-time retirement. Talk to your boss and see if there are opportunities to work part-time as a consultant. By working less, your stress level will go way down, helping you hang on to your job for a few more years. If that's not an option, ask the management to consider letting you work from home at least part of the time. It's amazing just how much stress a daily commute can add to our lives, and how eliminating it can help you stay more motivated to work. You may even want to start a small business on the side. While not all businesses are successful, there's certainly the hope that a side gig will start making you enough money to help you retire a little sooner or finance a better lifestyle.

It's exciting to be close to the retirement finish line, but there are lots of things to do in your final year of work. Taking care of these things will help you decide if you are really ready to retire or should hold on to your job for a few more months.

Social Security Q&A: At 62, How Can We Maximize Our Benefits?

Laurence Kotlikoff Contributor 3/04/2015

Social Security may be your largest or one of your largest assets. How you manage it, by deciding which benefits to collect and when, can make an absolutely huge difference to your lifetime benefits. And those with the highest past covered earnings have the most to gain from maximizing their Social Security.

I've been answering questions and writing columns about Social Security each week for the past two years on PBS NEWSHOUR's website. The editors at Forbes asked me to post a Q&A each day from those columns. To see all my columns, please go to my software company's site, www.maximizemysocialsecurity.com, and click More Press below the WSJ quote.

Today's question asks how a couple can maximize their benefits when turning 62. The answer reviews a likely potential strategy and then considers how best to file in a possible alternative scenario.

Question: I just turned 62 in May 2014. My wife turns 62 in December 2016. When and what do we need to file?

On the few calls we have made to Social Security advisers or the Social Security Administration, we don't seem to get straight answers. I would like to work until 64-65 just for the medical insurance. I have other investments and a 401K, but want to get the most possible out of Social Security. My wife does not work any longer; she is a stay-at-home wife primarily to take care of her mother. I just want to make the right decisions to maximize our retirement earnings and make sure I/we apply for Social Security and Medicare at the right times.

Answer: There are some great technical experts at the local Social Security offices, but sometimes getting advice from Social Security can be tricky, especially if you're not exactly sure what information you're looking for. Plenty of people have written me about wrong advice they've received, so make sure to check your answers with several different advisers.

Your best strategy is, I believe, to file for your retirement benefit when you reach full retirement age and suspend its collection. When you reach 70, you'll start collecting your retirement benefit. This will permit your wife to file just for her spousal benefit at her full retirement age and also wait until 70 to collect her retirement benefit. By filing at your full retirement age, you give yourself the option to collect all suspended benefits in a lump sum check in the case of an urgent need for cash. Requesting suspended benefits will, however, mean you will lose the delayed retirement credits for all the months during which you suspended your benefit.

If your wife was a much higher earner when she worked, it's possible (remotely possible) that your best strategy is for her to file early (before full retirement age) to enable you to collect just your spousal benefit

until you reach 70, when you'll flip onto your retirement benefit. She'd collect a reduced retirement benefit and then suspend it at full retirement age and start it up again at 70.

6 Filling Foods to Eat on a Diet

Catherine Northington

Learning to control your appetite is a fundamental step toward maintaining a healthy diet. As it turns out, this ability is influenced just as much by what you eat as it is by how much you eat. Individuals looking to lose weight should focus their diets on lean proteins and high-volume — that is, high fiber and water content — foods, Dr. Wayne Campbell said to WebMD; high-volume foods bulk up your meals and help your stomach feel fuller.

These six foods incorporate these nutritional values in a way that will appease your appetite without costing too many calories.

1. Cottage cheese

One half-cup of cottage cheese costs you just 103 calories while packing in an impressive 11.7 grams of lean protein, and that same serving contains just 4.5 grams of fat, according to USDA data. Insufficient protein levels have been linked to the desire to eat, Campbell told WebMD, and snacking on high-protein, low-calorie foods like cottage cheese will stave off serious food cravings until meal time. A glass of milk can offer similar benefits, but these same studies indicate that eating solid foods can help your stomach feel fuller. Try some cottage cheese mixed with honey or berries for a low-calorie and satisfying snack.

2. Watermelon

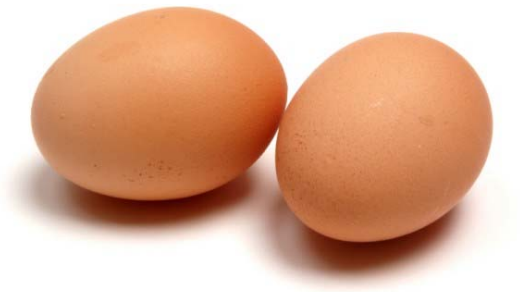
A full cup of diced watermelon consists of just 46 calories, says the United States Department of Agriculture (USDA), and it also offers a high water content per serving. Snacking on two cups of the refreshing fruit will cost you fewer than 100 calories, providing you with sufficient water and fiber levels to keep you satisfied until your next meal. Dailyburn adds that those two cups will also have you halfway toward your recommended daily Vitamin C intake! In fact, high fiber and low calorie contents are a common quality in the fruit family — all the more reason for adding apples, oranges, and berries to your snack-time rotation.

3. Popcorn

No, we're not talking the movie theater kind. Calorie for calorie, this snack food is one of the best sources of fiber: three cups of air-popped popcorn contain 93 calories and 3.5 grams of fiber, and given how quickly we tend to down the stuff, those fiber levels add up quickly. Time magazine adds that because popcorn takes up more room in your stomach than, say, potato chips, you'll feel much fuller after snacking on the air-popped snack. Pro tip: Sprinkle some red pepper on your popped treat before eating — one Purdue University study showed that people who added just a half-teaspoon of the spice reported feeling fuller after eating.

4. Spinach

Leafy greens such as spinach and kale offer huge nutritional benefits along with low calorie contents. Per two-cup serving, raw spinach contains 14 calories, 1.7 grams of protein, and 1.3 grams of fiber, reports the USDA. For a satisfying snack low in calories but heavy on nutritional advantages, try a bed of leafy greens with a light, low-fat dressing and a portion of lean meat. Sites like Dailyburn also recommend switching up your leafy green intake with a "Green Smoothie," which combines various leafy greens with fruits, vegetables, and milk or milk substitutes for a nutrient-rich on-the-go snack.



5. Eggs

Eggs are versatile, tasty, and nutritionally advantageous. One egg contains 78 calories and 6.3 grams of protein, reports the USDA. In fact, “Eggs are one of the few foods that are a complete protein, meaning they contain all nine essential amino acids that your body can’t make itself,” Joy Dubost, a spokeswoman for the Academy of Nutrition and Dietetics, told Time. A study at St. Louis University found that subjects who ate eggs for breakfast consumed 330 fewer calories throughout the day than the subjects who ate bagels, Time reports, suggesting a link between those amino acids and the suppression of hunger hormones.

6. Turkey

Lean meats such as turkey offer high-protein solutions for the low-calorie dieter. For example, the USDA says that a three-ounce serving of roasted skinless turkey breast contains just 116 calories while offering an incredible 25.1 grams of protein and just 1.7 grams of fat. Similarly, a half-chicken breast contains 142 calories, 26.7 grams of protein, and 3.1 grams of fat, making it another nutritionally excellent choice in the lean meats category.

Be Scam Smart[SM]: How to Protect Your Personal Information

March 4, 2015

Warning: Make sure you don't give hustlers who scam health care systems any personal medical or other data that lets them get away with it. You've heard this message before and you will again, for good reason.

When health care programs or new laws like the **Affordable Care Act** (ACA) come along that require people or business owners to make decisions about their money, sneaky cheaters are right there to make money from them. Too often, they succeed. Don't be among their victims.

With just a little extra care, everybody using health care services can help cut the cost of health care fraud. Here are some ways to do so:

- **Don't give anyone your Social Security, credit card, bank account and phone numbers to get an ACA "card."** No member cards are issued under ACA. That is just a sneaky way to convince you to hand over private information. Don't do it!
- **Don't believe anyone who says ACA requires you to buy a new health insurance policy.** It's true the law says nearly everyone must have health insurance. But if you already have health insurance through work or government programs like Medicare and Medicaid, you won't have to make any changes in most cases.
- **Don't give out your personal data to anyone who phones or comes to the door to talk about health policies.** Instead, tell them to mail information or provide a website.
- **Send away people who claim to be "government workers" checking your health insurance information so they can "update" it.** No such government workers exist. If you need to update your information, you'll have to make a call to the number provided by your insurance company or the government when you enrolled.
- **Choose an insurance company you trust, even if prices seem lower elsewhere.** Why? These could be made-up companies offering no health coverage at all. They'll walk off with your money and your private information. And you'll end up without insurance and without the money you had set aside to pay for it.

The five worst states to grow old in

By Thomas C. Frohlich and Alexander Kent

The U.S. elderly population has grown dramatically in recent decades. The number of Americans 65 and older grew from 35 million in 2000 to 41.4 million in 2011 and to an estimated 44.7 million in 2013. This trend is expected to continue as members of the baby boomer generation reach retirement age.

The United States will face increasingly large challenges. In the coming years, state officials, families, and individuals will need to pay more attention to the needs of the elderly — to improve medical care, access to services, infrastructure, or other factors that become more necessary late in life.

HelpAge International evaluates the social and economic well-being of the elderly in its annual Global AgeWatch Index. Last year, the United States was among the better places to grow old in the world, at eighth place. However, domestically, each state offers a very different quality of life for its older residents. Based on an independent analysis by 24/7 Wall St., which incorporated a range of income, health, labor, and environmental indicators, the following states are the five worst in which to grow old. To see the rest of the 10 worst, visit 247WallSt.com:

To be considered among the worst states to grow old, senior citizens in the states had to have relatively weak income security, as measured by several indicators. The 2013 median income among families with a head of household 65 and older, for example, did not exceed the comparable national figure of $37,847 in nine of the worst states to grow old. A typical elderly household in Mississippi earned less than $30,000, the least nationwide.

Retirees often have fixed income as they begin to tap into their savings and collect Social Security. Kate Bunting, CEO of AgeWatch USA, explained that, “It’s really important for older people to have reliable access to a guaranteed income.” More than 90% of Americans 65 and older in the vast majority of states received Social Security income in 2013. Yet, the average monthly Social Security benefit of $1,294 was likely not enough for many seniors.

Many older Americans also had non-Social Security income, such as withdrawals from 401Ks and savings as a supplement. In 2013, 47.9% of Americans 65 and older had such supplemental retirement incomes. Comparable figures in a majority of the worst states to grow old actually exceeded the national figure. Even with the supplemental retirement income many elderly residents had, it was frequently not enough to offset their financial burdens. At stake, according to Bunting, is the elderly’s “ability to eat nutritious foods, which impacts their health, and their ability to access other critical services.”

With lower, and often fixed, incomes, elderly Americans are vulnerable financially. In addition, age often brings a host of health problems, causing greater reliance on medical and accessibility services. To determine how the states fared when it comes to health care, we examined health services and outcomes. Among the worst states, for example, life expectancy was relatively low. In all of the 10 worst states, it was less than 80 years. Life expectancy at birth in 2011 did not exceed 76 years in four of the states.

A good education, which can lead to employment opportunities and higher incomes, is also an indication of well-being. More than 24% of Americans 65 and older had at least a bachelor's degree as of 2013. In seven of the 10 worst states to grow old, however, less than 20% of elderly residents had attained at least a bachelor's degree. In Mississippi, just 14.2% did, the lowest rate nationwide.

Safety often becomes a greater concern for aging Americans, as older people are often targeted by criminals. Residents of any age in the worst states to grow old also did not feel particularly safe. On a recent survey, less than 70% of residents in nine of the 10 states told Gallup they felt safe walking home alone at night. The violent crime rate in four of the worst states was also greater than 500 violent crimes reported per 100,000 residents, all among the higher violent crime rates in the nation.

In addition, policies often shape the quality of life of a state's elderly population, particularly in terms of accessibility to services. Based on a survey by the Organization for Economic Cooperation and Development (OECD), all of the worst states for old people had worse accessibility to services than the majority of states. Bunting said that the aging population is growing, and it will become increasingly "important that [states] have the right kinds of policies in place that help support a quality old age." Adapting to these demographic patterns through age-friendly policy, Bunting continued, is "important and worthwhile to do, no matter what age you are."

These are the worst states to grow old in.

5. NEVADA
Median household income (65+): $41,491 (13th highest)
Percentage with a disability (65+): 36.2% (23rd highest)
Percentage with a bachelor's degree or higher (65+): 22.5% (20th lowest)
Violent crime rate: 591.2 per 100,000 residents (3rd highest)

The collapse of Nevada's economy as a result of the housing crisis in 2009 is likely still having an effect on the state's residents, including its elderly population. Only 91% of Nevadans aged 55 to 64 were employed in 2013, the lowest rate in the country. Additionally, Nevada had the country's highest rate of residents 65 and older who did not have health insurance, which may have contributed to only 66.1% of all residents having a personal doctor, the lowest rate in the country. Senior citizens in Nevada were also among the country's least likely to have access to healthy and affordable food, with food insecurity identified among 10.4% of older residents. Food insecurity was far

from Nevada residents' only problem, as the state also had one of the highest violent crime rates in the country in 2013.

4. ARKANSAS
Median household income (65+): $31,959 (4th lowest)
Percentage with a disability (65+): 42.4% (4th highest)
Percentage with a bachelor's degree or higher (65+): 16.8% (3rd lowest)
Violent crime rate: 445.7 per 100,000 residents (10th highest)

More than 94% of elderly Arkansas residents received Social Security benefits in 2013, the highest rate among all states. Yet, this income frequently did not meet the financial needs of many older Arkansans, as nearly 13% did not have adequate access to nutritious and affordable food in 2011, the highest rate in the nation. While it is often expected that Americans entering retirement have savings of some kind, just 41.5% of the age group in the state had any retirement income to supplement Social Security, nearly the lowest figure. As a result, the state had among the higher poverty rates among its elderly population, at 10.5%. In addition, older state residents had low educational attainment rates. Less than 17% had at least a bachelor's degree in 2013, the third lowest rate nationally.

3. WEST VIRGINIA
Median household income (65+): $31,542 (3rd lowest)
Percentage with a disability (65+): 45.5% (the highest)
Percentage with a bachelor's degree or higher (65+): 14.2% (the lowest)
Violent crime rate: 289.7 per 100,000 residents (23rd lowest) Just over 14% of West Virginia's elderly population had at least a bachelor's degree in 2013, 10 percentage points below the national figure and the lowest in the country. Poor educational outcomes often lead to low incomes. Among the state's senior citizens, a typical household earned $31,542 in 2013, the third lowest figure in the country. Additionally, West Virginia's elderlies

were the most likely in the country to have some kind of disability in 2013, with nearly half indicating they were disabled. Low incomes and a high share of disabled residents may prohibit some older residents from taking advantage of services. According to a 2013 OECD report, services in West Virginia were less accessible than all but a few other states.

2. LOUISIANA
Median household income (65+): $31,230 (2nd lowest)
Percentage with a disability (65+): 41.7% (7th highest)
Percentage with a bachelor's degree or higher (65+): 18.8% (8th lowest)
Violent crime rate: 510.4 per 100,000 residents (5th highest) Older Louisiana residents are among the nation's most financially insecure. A typical household with older occupants had an income of $31,230 in 2013, second only to Mississippi. Compared to seniors in other states, seniors in Louisiana were also some of the least likely to receive Social Security benefits or other forms of retirement income. Perhaps as a result, nearly 13% of the age group in the state lived in poverty in 2013, the second highest rate in the country. Older Louisiana residents also fared poorly in terms of health. For example, life expectancy at birth was less than 76 years as of 2011, one of the lowest figures. A 2013 assessment of city infrastructure design found that policies implemented in Louisiana in recent years better considered the needs of elderly people and others requiring greater access than most states, which bodes well for the state's future elderly populations.

1. MISSISSIPPI
Median household income (65+): $29,511 (the lowest)
Percentage with a disability (65+): 45.1% (2nd highest)
Percentage with a bachelor's degree or higher (65+): 18.2% (6th lowest)
Violent crime rate: 267.4 per 100,000 residents (18th lowest) Mississippi's older population fares poorly based on a wide range of measures, making it the worst state in the nation in which to grow old. Mississippi's elderly population had by many measures the worst income security nationwide. The median income among elderly households was less than $30,000 in 2013, the lowest in the country. Nearly 15% of residents 65 and older lived in

poverty that year, also the worst rate. Perhaps as a result of financial burdens, elderly residents had worse health outcomes. More than 45% had a disability, the second highest rate in the country. In addition, accessibility to services in Mississippi was rated worse than in any other state by the OECD.

METHODOLOGY

To determine the best and worst states in which to grow old, 24/7 Wall St. compiled data from a variety of sources and grouped them into four broad categories: income, health, labor, and environment and access.

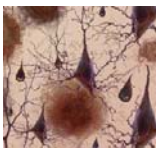
To construct our index we used the min-max normalization method. A similar methodology was used in constructing HelpAge International's Global AgeWatch Index and the United Nation's Human Development Index. First, all indicators were modified so that higher values indicated better outcomes. For example, rather than use the percentage of the population with a disability, our index used the percentage of people 65 and over without a disability. Second, each indicator was normalized to fall between 0 and 1 using the indicator's minimum and maximum values. Third, we calculated the geometric mean of the indicators in each category to obtain an index of each category. Geometric means were used to account for relationships between indicators that may be causal. Our final index was calculated as a geometric mean of the category-specific indices.

Included in the income category are data from the U.S. Census Bureau's 2013 American Community Survey (ACS) regarding the 65 and older population with retirement income, poverty rates, and median household income. The health category includes data from the Census Bureau on the percent of people 65 and over with a disability. Also included are data on the percentage of seniors insecure about food from Feeding America's 2013 report, Spotlight on Senior Hunger. We also included 2011 life expectancy at birth from the Organization for Economic Cooperation and Development, the OECD's health index, and a survey from Gallup on whether people have a personal doctor. The labor category incorporated data from the Census on the share of people 65 and over with a bachelor's degree or higher, as well as employment rates for people aged 55-64 from the Bureau of Labor Statistics. The environment and access category included data from the OECD on how accessible a variety of services are in each state. From Gallup, we considered how safe people feel walking alone at night and how satisfied people are with the places they live. Finally, we included data on violent crime rates from the Federal Bureau of Investigation.

Alzheimer's Diagnostic Tests Inch Forward, but Treatments Are Still Lacking

Researchers are trying to develop ways to more quickly and accurately diagnose Alzheimer's, which might lead to better treatments and understanding in the future

February 27, 2015 |By Rebecca Harrington



Clinical diagnoses from specialists can be accurate up to 90 percent of the time but the only way to absolutely verify that someone has Alzheimer's is to examine their brain in a postmortem autopsy.

Kathy Stack's memory loss began with the little things: losing her wallet, taking a wrong turn, forgetting someone's name. In 2013 at the age of 68, she visited her neurologist, who sent her to a memory loss specialist. He told her she had a 50–50 chance of developing full-blown Alzheimer's disease within five years.

Two years later, Stack, who was the first female department director of community services for Saint Paul, Minn., has made lifestyle changes such as working out regularly and doing daily brain exercises to stave off the disease. She is prepared for what the next stages of Alzheimer's may bring, but says she has noticed her symptoms worsening.

More than five million people in the U.S. currently have Alzheimer's, and that number is increasing with the aging population. Clinical diagnoses from specialists can be accurate up to 90 percent of the time but currently the only way to confirm that an individual has the disease is to examine the brain after death. Researchers are working to develop tests that diagnose Alzheimer's earlier and more reliably. But with limited treatment options available, some experts worry that better tests may do more harm than good.

A number of diagnostic tests are now in various stages of development in the research pipeline. Researchers described one such test on Feb. 24 that will be presented at a meeting of the American Academy of Neurology in Washington, D.C. in April. It analyzes skin samples, using antibodies to look for proteins associated with Alzheimer's and Parkinson's diseases. Because skin and brain cells originate in the same place in the embryo, the researchers hypothesized that they'd find similar levels of tau—a protein that forms distinctive tangles in the brains of Alzheimer's patients—in both cell types. Early results suggest that Alzheimer's and Parkinson's patients have elevated levels of tau in their skin. Lead investigator Ildefonso Rodriguez Leyva of the Autonomous University of San Luis Potosi in Mexico says they also found higher levels of the protein alpha-synuclein in the skin cells of Parkinson's patients but not those with Alzheimer's, which allowed them to distinguish one dementia from the other. The next step is to ramp up the study to include more subjects; these early results came from only 65 people. Rodriguez Leyva says he hopes they can offer the test within two years.

Other tests in development look for different possible markers of disease. Daniel Alkon of the Blanchette Rockefeller Neurosciences Institute in Morgantown, West Virginia and his group have developed a skin test that measures so-called protein kinase C, epsilon (PKCE) levels. PKCE promotes the growth of synapses in the brain and destroys tau protein. It decreases in patients with Alzheimer's. In clinical trials, Alkon and his group were able to predict which patients would get Alzheimer's more than 95 percent of the time by measuring PKCE levels in their skin cells. They validated their diagnoses with autopsies years later. But they only studied about 140 patients, and thus will require more findings in later-phase clinical trials. Alkon said he hopes to be able to offer the test to the

public in about two years through what is known as a Clinical Laboratory Improvement Amendments-certified lab, and then will seek U.S. Food and Drug Administration approval after that.

The lone reliable genetic test for Alzheimer's can only identify the familial form of the disease, which accounts for about 5 percent of cases. This type of Alzheimer's arises from a mutation in one of three genes that encode proteins involved in the production and processing of amyloid-beta, which, when abnormal, can build up in the brain and form plaques characteristic of the disease. Another gene variant can warn of a predisposition to Alzheimer's, although having this mutation does not guarantee an individual will develop the disease. The single biggest risk factor is age.

In current diagnoses people usually go to the doctor only if they are concerned they have memory loss. To determine if the dementia is likely Alzheimer's a physician will typically administer memory tests, ask about family history and do a neurological exam. If physicians encounter an unusual type of dementia that they can't distinguish, says Keith Fargo, director of scientific programs for the Alzheimer's Association, they can give patients a PET (positron emission tomography) scan to detect amyloid plaques in the brain. The Alzheimer's Association, however, does not recommend it for all patients because amyloid buildup doesn't necessarily mean they have the disease. Patients could have plaques and no signs of the disease. It takes this suite of examinations to reach the final diagnosis, which is partly what is motivating researchers to develop one single test.

Seeking an early diagnosis can rule out other causes of dementia such as Parkinson's, multi-infarct dementia or vitamin B deficiencies, some of which are treatable. Edward J. Goetzl, a senior clinical investigator at the National Institute on Aging who developed a promising blood test that will soon be available via a CLIA-certified lab, says early diagnoses could lead to better results from existing drugs. By the time many patients start taking drugs aimed at reducing the damage the disease has caused, he says, it's often too late for therapeutics to have much effect. "I think there are hundreds of great drugs out there," Goetzl says, "but by the time they start them, the cells are dead."

Finding a test that can diagnose Alzheimer's sooner could eventually mean that patients receive the news years before severe symptoms set in. At the very worst, Goetzl says, early diagnosis could mean having to retire or lose freedoms such as car privileges. It can also lead to depression, however. "Diagnosing before [symptoms worsen] presents all kinds of ethical and personal challenges that, in my opinion, we aren't really prepared to deal with," Alkon says. "In the absence of a definitive curative therapy, getting to know that you may get this disease 20 years from now might not do you any good, in fact it may cause you harm."

But in a 2014 GE Healthcare survey (pdf) of 10,000 people worldwide, nearly three quarters of respondents said they would want to know if they had a neurological disorder, even if it had no cure. In this age when so much health information is readily available, from genetic sequencing to early disease diagnoses, it now seems that knowing what could come is preferable to finding out when it happens.

For Stack, the diagnosis was a chance to make decisions before she could not make them for herself. In the weeks following her diagnosis she met with her lawyer, financial planner and visited long-term care facilities. "It's not as dire as it sounded two years ago when [my doctor] just kind of laid it out for me. I didn't think 50–50 sounded like good odds at the time," Stack says. "I think that we are slowing down the progression of the disease, so I can be hopeful."

High court decision on health insurance subsidies could trigger price spike, market meltdown

BY JULIE APPLEBY KAISER HEALTH NEWS

Making health insurance available and affordable to millions of people who buy their own coverage was a key goal for backers of the federal health law known as Obamacare.

But if the Supreme Court strikes down the insurance subsidies of millions of Americans who rely on the federal insurance marketplace, including an estimated 1.18 million Floridians, it could leave many worse off than they were before the law took effect, say experts.

“The doomsday scenario could materialize and it does impact everyone” — those getting subsidies, as well as those paying the full cost of their plans on the individual market in states using the federal exchange, said Christopher Condeluci, an attorney who worked for Iowa Republican Charles Grassley on the Senate Finance staff during the drafting of the law.

That’s because millions of consumers likely would drop their policies, which they could no longer afford without subsidies.

In Florida, where the uninsured rate was among the highest in the country before the Affordable Care Act, record numbers of consumers signed up for coverage — many becoming insured for the first time — through the state’s federally-facilitated marketplace. In 2015, 1.6 million Floridians obtained health insurance under the plan, more than any other state in the nation.

According to a recent report by the Urban Institute, 1.07 million of those Florida consumers would become uninsured if the court rules to remove the subsidies.

“The hundreds of thousands of low- and middle-income Florida individuals and families who currently benefit from the financial help will suffer most, because the harm they would suffer would be more than just financial,” said Greg Mellowe, policy director at the consumer advocacy group Florida CHAIN. “They would once again be uninsured or under-insured and without meaningful access to real health coverage.”

Most insurers could not drop plans without giving one-to-three months’ notice. But the companies remaining in the market would likely seek sharp increases in premiums for the following year, anticipating that the consumers most likely to hold onto their plans would be those needing medical care. One Rand analysis projects that unsubsidized premiums could increase by almost half — an average annual increase of $1,600 for a 40-year-old — and that 70 percent of consumers would cancel their policies.

Those price increases, in turn, would drive more people to drop coverage, spurring further price hikes and potentially leading to what insurance experts call “a market death spiral.”

“It’s not the subsidy market that will fall apart, it’s the whole market” for everyone who doesn’t get job-based insurance coverage, said Robert Laszewski, a consultant for the insurance industry who is no fan of the health law. “There will be millions of Republicans who are not subsidy-eligible who are also going to get screwed.”

Legal Arguments

At issue in King v. Burwell — slated to be argued before the Supreme Court March 4 — is the basis of subsidies that go to millions of low- and moderate-income Americans in the states that rely on the federal marketplace. More than 85 percent of the 8.6 million people who purchased plans in those states qualified for subsidies, administration officials say.

The law’s challengers point to four words in the ACA that say subsidies shall be distributed through marketplaces “established by the state.” They argue that that wording bars the government from subsidizing insurance purchased through a federally administered exchange. Supporters of the law argue that Congress intended the subsidies be available through both federally run and state-run markets, which they say is clear in reading the overall bill.

The ruling would have no effect on the subsidies provided to residents through 13 state-run markets, such as those in California, New York and Washington.

The Obama administration has declined to discuss contingency plans, expressing confidence that it will prevail with the justices. “Congress would not pass a law that 87 percent of folks would not get subsidies, but people in say, New York, would,” Health and Human Services Secretary Sylvia Mathews Burwell said.

Experts say Congress could also apply “fixes,” such as voting to allow subsidies to continue through the rest of the year.

But whether a Republican-controlled Congress that has pledged itself to the law’s repeal would agree to that is uncertain.

Aetna spokeswoman Cynthia Michener said the insurer is talking with lawmakers from both parties “about how to make a grand bargain should the Supreme Court decide against federal exchange subsidies.” A decision to strike the subsidies would likely “spur bipartisan action to resolve the issue promptly,” she added.

At the state level, officials could decide to establish state-run marketplaces, but they would have to move fast before the start of open enrollment for 2016, tentatively set to begin Nov. 1. And lawmakers in many GOP-led states are likely to resist such steps, citing opposition to the law.

Governors in at least five of the states using the federal exchange — Louisiana, Mississippi, Nebraska, South Carolina and Wisconsin — told Reuters they would not create their own exchanges if the court invalidated subsidies. In another four — Georgia, Missouri, Montana and Tennessee — politics could make it very difficult to set up a state program, Reuters reported.

In Florida and Texas, where there is strong opposition to the health law, but also large numbers of residents benefiting from subsidized coverage, officials would face even tougher decisions. “Florida has the highest number of enrollees in the federal marketplace and guess who is running for president? The former governor of Florida,” said Condeluci. (Gov. Rick Scott has not said he is running for president.)

Mellowe, of Florida CHAIN, said it is still unlikely Florida will consider establishing a state-based exchange due to the Legislature’s consistent opposition to the health law.

“Florida's track record suggests that we are nowhere near ready nor willing to take on that role at this juncture,” Mellowe said.

‘Nuclear Option’?

Insurers that sell plans in the federal-exchange states would find themselves in a drastically changed market.

Joel Ario, a managing director at consultancy Manatt Health Solutions, said insurers are already working on rates for 2016, which are scheduled for submission by April — two months before the court is expected to rule.

Some insurers have asked state regulators if they could submit two sets of rates for 2016, one that would reflect the subsidies being struck, he said. That idea was backed this week by the professional society of the nation’s actuaries, who help insurers set rates.

As for the states, Ario estimated that perhaps one third would set up their own markets fairly quickly.

Even if insurers wanted to drop coverage immediately in the event the high court struck the subsidies, most could not do so legally. State laws require anywhere from 30 days to 90 days’ notice for an insurer to exit a market. And, if they withdraw, they have to pull all their plans, not just those offered through the federal exchange. Under state rules, they may not be allowed back into the market for years, creating a disincentive to bail out, said Laszewski, whose clients include major insurers.

Many insurers don’t yet have contingency plans, he said, partly because it’s so hard to tell what may happen or what alternatives might be available.

“This is the nuclear option and there really isn’t a contingency plan for nuclear destruction,” Laszewski said.

Others don’t see a ruling against the administration in such dark terms.

“The Supreme Court generally doesn’t go out of its way to wreck the economy or the health system,” said Stuart Butler, a conservative scholar and senior fellow at the Brookings Institution.

He believes the court is likely to offer some temporary remedy, such as a grace period when the subsidies could continue to flow.

“The idea that there will be some cataclysm the day after is extremely unlikely,” Butler said. “We’ll see a number of states moving toward essentially setting up a state exchange. We could still see Texas and a few others saying no. But if two-thirds of states find a way to accommodate it, I don’t see that a critical mass for the collapse of the Affordable Care Act is there.”

The Home Refinance Plan Banks Don't Want You Knowing

- March 26, 2015

When visiting the American Value official website, homeowners will find out they may qualify for an insanely low home interest rate, especially if they purchased their home 5-20 years ago.

Although millions of Americans are eligible, most don't know the brilliant government program called the Home Affordable Refinance Plan (HARP). By refinancing their homes at lower interest rates, homeowners could easily **lower payments by as much as $4,264 each year.** [1]

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Re-Stimulating Middle Class America

Did you know if your mortgage is less than $625,000, your chances of qualifying for HARP could be high? The Government is pushing banks to cut your mortgage rates, which, as a homeowner, puts more money in your pocket while ultimately boosting the economy.

But the **banks are not happy** about this. Here's why:

1. Mortgage rates are already at a low[3] and this great program makes it even easier for you to qualify.
2. You'll see that you have a variety of options beyond your current mortgage holder. It pays to compare.

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- Homeowners can even take cash out for home improvements, pay off debt, or pay for their children's education.

Where Do I Start?

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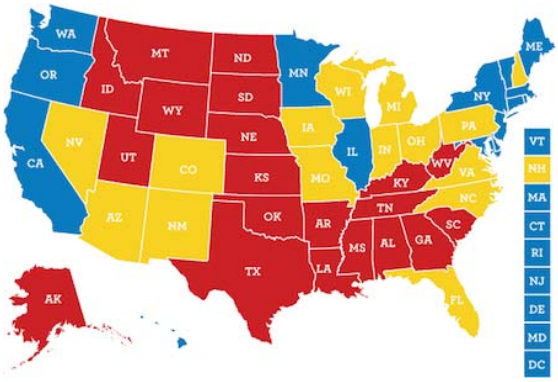
nation and what's better is that they work with HARP lenders to provide consumers with a comprehensive set of mortgage options.

There's no obligation to homeowners, and American Value offers easy and fast comparisons. It takes about five minutes, and the service is 100% free. You have nothing to lose, except for your money problems!

"Having an extra $300 - $400 every month makes a BIG difference."

Select Your State below:



Estimate My New Payment

Low-income people loved Obamacare, but the rest of us...

Dan Mangan | @_DanMangan

A health-care reform specialist helps people select insurance plans in Pasadena City College.

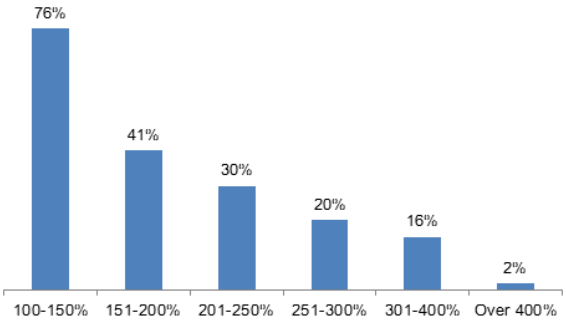
The carrots worked pretty well for Obamacare this year. The stick? Not so much.

People with higher incomes in 2015 were much less likely to enroll in Obamacare plans than lower-income earners—even when they were offered financial assistance to help pay for their health plans, according to an analysis released Wednesday.

And the differences in uptake of Obamacare were dramatic between income groups, with a sharp falloff as people's annual earnings increased and the amount of subsidies available decreased, the analysis by the Avalere Health consultancy found.

Those pronounced drops were particularly striking because they occurred even between groups who are eligible for the most generous kind of Obamacare private plan assistance.

Participation of eligible individuals enrolled in exchange plans, by income (poverty level)



A whopping 76 percent of Obamacare-eligible individuals who earned between $11,770 and $17,655 annually actually signed up for a plan this year on the federally run insurance exchange HealthCare.gov, which serves 37 states, Avalere found. That income group represents the low end for qualifying for Obamacare subsidies, and as a rule those people would receive the largest amount of financial aid.

But there were steep declines in the next two income groups, even though those people receive not only help paying their monthly premiums, but as with the lower earners remain eligible for financial assistance to cover out-of-pocket medical expenses.

Just 41 percent of eligible people earning between 151 and 200 percent of the federal poverty level bought HealthCare.gov plans. And just 30 percent of eligible people in the next income group, earning up to 250 percent of the poverty level, bought such a plan.

Only 16 percent of eligible people who earned between $35,427 and $47,080—the high-end Obamacare subsidy recipients—bought a HealthCare.gov plan.

And when the subsidies weren't available, because a person earned more than $47,080, the participation was far lower.

Just 2 percent of eligible people above that income enrolled in a HealthCare.gov plan, the Avalere analysis found.

"Virtually all of the people signing up for this are people who receive subsidies from the federal government," said Avalere Health CEO Dan Mendelson.

"A lot of the higher-income people are not participating in this," he said. "The exchanges are primarily a low-income benefit. ... The people signing up for these benefits are the ones that are heavily subsidized."

Mendelson said the findings are significant, because "it shows sort of a lukewarm embrace" of Obamacare among the people its meant to benefit.

The findings also suggest that the penalties for not having health coverage are less of an incentive for people buy Obamacare than the subsidies are.

The Affordable Care Act requires nearly all Americans to have some form of health coverage or be subject to a tax penalty.

In 2015, that penalty is the higher of $325 per individual or 2 percent of taxable household income.

The ACA also offers people who earn between 100 and 400 percent of the poverty level tax credits to help pay the premiums for plans they buy from a government-run Obamacare exchange. And people who earn between 100 and 250 percent of the poverty level can also qualify for financial aid to help pay their out-of-pocket medical costs.

Because of the value of premium and cost-sharing subsidies to low-income Obamacare customers, "In many cases, this is free insurance," said Mendelson.

The value of the premium subsidies tends to decrease the closer someone earns to 400 percent of the poverty level.

Mendelson said the low levels of participation seen among higher-income earners is due to "a lot of reasons."

In addition to lower subsidies, those people also may feel more comfortable facing a financial risk that could be mitigated if they had insurance, Mendelson said. "They probably don't have as much fear of going uninsured."

And, "undoubtedly, some of it is political and some of it is ideological" opposition to Obamacare, he said.

But, Mendelson added, "if just 2 percent of people over 400 percent of poverty are signing up, that's more than political."

Larry Levitt, senior vice president for special initiatives at the Kaiser Family Foundation, a health policy research organization, said at least a portion of the sharp differences in participation seen by Avalere may be explained by the fact that some higher-income earners bought ACA-compliant individual insurance plans outside HealthCare.gov.

But, Levitt said: "These results follow basic economic theory. ... The bigger a subsidy you give someone to buy health insurance, the more likely they are to sign up."

He added, "This may be one of the reasons that we've seen big enrollment numbers in some states that have not expanded Medicaid."

In those states, people who earn between 100 and 138 percent of poverty are eligible for Obamacare plan subsidies, whereas in states that expanded Medicaid they likely would enroll in that program.

Levitt said that "uninsured people with modest incomes may be a harder sell, since the subsidies they receive are small."

But he noted that "in the years ahead, as the penalties under the individual mandate ramp up, the stick to get people to buy coverage will grow stronger."

Next year, the Obamacare penalty for not having health coverage increases to the higher of $695 per adult or 2.5 percent of household income. In future years, the flat dollar amount will be indexed to the inflation rate.

Mendelson echoed Levitt, saying that he believes the future growth of Obamacare enrollment will come from higher-income groups "when the penalties grow."

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