Health & Retirement Services Of Illinois
March 2013 Newsletter

OUR NEWS LETTER

Avoid These 10 Common Tax-Filing Mistakes

By Kay Bell | Bankrate.com

Bankrate, Inc.

Thanks to tax preparation software, more of us are making fewer mistakes on our annual tax returns. But still, just one slip in entering information on your computer could end up costing you, either in the form of a larger tax bill or a smaller refund.

And even if a mistake -- either on your computer or paper forms -- doesn't cost you cash, it could delay the receipt of any refund you're expecting.

To get exactly what you should from the Internal Revenue Service, as quickly as possible, look out for these tax-filing pitfalls. A few are new, thanks to recent law changes. Others are perennial problems taxpayers face each filing season. With a little care, you can avoid them all.

1. Pay your Roth conversion taxes

A lot of taxpayers have taken advantage of the tax law change that now allows anyone, regardless of income, to convert a traditional individual retirement account to a Roth IRA. But if you made such a change in 2010 when this conversion was first allowed, you have a tax task to take care of on your 2012 return. A special provision allowed individuals who moved their money into a Roth IRA in 2010 to spread the taxes due on converted amounts equally over the 2011 and 2012 tax years. The first half of those conversion taxes was due with your 2011 tax return. Make sure you pay the rest of the taxes with your 2012 return.

2. Homebuyer tax credit complications

Since its creation, the first-time homebuyer credit went through significant changes. It started as a $7,500 interest-free loan from Uncle Sam, changed into a true tax credit of up to $8,000 for a first-time buyer and added a $6,500 tax credit for a previous homeowner moving up to another house.

All the revisions to eligible buyer guidelines, purchase time frames, income thresholds, home price restrictions and payback requirements are a tax-filing minefield. If you're not careful, a mistake here could end up costing you the credit or at least slowing down the processing of your return.

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If you're paying back the original $7,500 tax credit, the IRS has made the repayment process a bit simpler by eliminating in many cases the requirement that taxpayers file Form 5405. Now some individuals who are repaying the credit can just write the repayment amount they are including with their taxes directly on Form 1040.

3. Math miscalculations

The most common error on tax returns, year after year, is bad math. Mistakes in arithmetic or in transferring figures from one schedule to another will get you an immediate correction notice. Math mistakes also can reduce your tax refund or result in you owing more tax than you thought.

Using a tax software program to file your return can help reduce math errors. The built-in calculators do the work for you, adding, subtracting and inserting numbers on additional forms as needed. But you still have to make sure your initial numbers are correct. Entering $3,500 when the real figure is $5,300 makes a lot of tax difference. Getting the numbers right is crucial because you can be sure the IRS will be double-checking numerical entries against its copies of your tax statements (W-2, 1099s and the like). When IRS examiners find a discrepancy, they'll definitely let you know and, in many cases, will correct your mistake and refigure your taxes for you. Don't give them the chance. Make sure your math entries are right.

4. Direct deposit dangers

Taxpayers can have a refund directly deposited into multiple bank accounts. This option is a great way to save your refund money, but the more numbers you enter on a tax form, the more chances you have to enter them incorrectly. And a wrong account or routing number could cause you to lose your refund entirely.

You can divide your refund into three accounts by filing Form 8888 along with your individual return. It's not a difficult document to complete, but if you put in wrong account numbers, your refund could end up in someone else's account or be sent back to the IRS. Either way, you might not be able to retrieve your refund because there is no IRS procedure for replacing lost electronically transferred funds.

Incorrect account numbers aren't just a problem when a refund is split multiple ways. Even if your refund is going to just one account, make very sure you enter your account and bank routing numbers correctly.

5. Additional income, additional filing work

Did you have a side job this year? If so, as a contractor you probably received a Form 1099-MISC detailing the extra earnings.

What about savings and investment accounts? For these, you should have received Form 1099-INT and Form 1099 DIV statements.

In each 1099 instance, the IRS knows precisely how much extra money, either as wages or unearned investment income, you made as soon as you did, thanks to the copies of your 1099 forms that went to the tax agency.

If you forget to include any of these earnings on your return, the IRS examiners will let you know you owe taxes on it, too. And depending on when your oversight is discovered, you also could owe penalties and interest on the unreported earnings.

6. Filing status errors

Make sure you choose the correct filing status for your situation. You have five options, and each could make a difference in your ultimate tax bill.

If this is the first tax-filing season you've been divorced and you now are a single parent, head-of-household probably will be more beneficial. And you're still married, but you and your spouse are thinking about filing separate tax returns? That works in some cases, but not all.

Make sure you know what each tax-filing status entails, and choose the one that best fits your personal and tax situation.

7. Social Security number oversights

Because the IRS stopped putting taxpayer Social Security numbers on tax package labels in response to privacy concerns, some taxpayers forget to write in their identification numbers. Your tax ID number is crucial because there are so many transactions -- income statements, savings account interest, retirement plan contributions -- keyed to this number.

The nine-digit sequence also is vital to claim several tax credits, such as the child tax and additional child tax credits as well as ones for educational expenses and dependent care costs.

And make sure the names associated with the Social Security numbers match Social Security Administration records. A difference here also will cause the IRS to kick out or slow down your return.

8. Complete charitable contributions

Did you give to charitable groups last year? All types of donations, from cash to cars, could be valuable tax deductions, so make sure you count them all when you file. Be sure to follow the donation tax rules, the most important being that you give to a qualified organization -- that is, one that has tax-exempt status with the IRS. Also be careful when calculating any gifts of clothing and household items. Tax law now requires that these donations be in good or better condition or the deduction is disallowed.

9. Signature required

Sign and date your return. The IRS won't process it if it's missing a John Hancock, and that means on e-filed returns, too. Taxpayers filing electronically must sign the return electronically using a personal identification number, or PIN. To verify your identity, you'll have to provide the PIN you used last year or your adjusted gross income from your previous year's tax return.

Your tax software should walk you through the e-signature process, but if you're still mailing your return, don't be in such a hurry that you stuff your 1040 in the preaddressed IRS envelope without signing it. And if it's a joint filing, you and your spouse must sign.

10. Missing the deadline

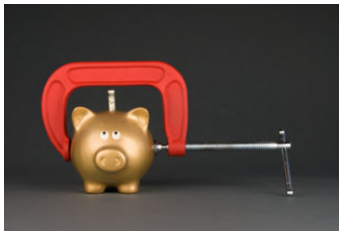
Don't miss the impending April 15 tax deadline. If you owe the IRS and that's the reason you're thinking of not filing, that's a bad idea. If you don't file a return, you'll face even stiffer penalties. So send in the paperwork, pay what you cann and talk with the IRS or your tax professional about the next steps.

Signs You're Living Beyond Your Means

By Lisa Scherzer | The Exchange – Wed, Feb 6, 2013

"There is no dignity quite so impressive, and no independence quite so important, as living within your means." — Calvin Coolidge

Living within one's means is the bedrock of financial stability. But for consumers still facing the lingering effects of years of frenzied borrowing and spending that preceded the recession, the sage counsel of our 30th president remains a lofty aspiration — and one out of many people's grasp.



Financial difficulties rose last month for middle-income households, according to the Consumer Reports Index, an overall measure of Americans' personal financial health. The Trouble Tracker, a measure of financial difficulties, climbed to 37.5 from 32.7 for middle-income Americans. The areas that saw the greatest increase were missed payments on a major bill (other than mortgage) and the inability to afford medical bills or medications.

Whether the trouble stems from the increase in the Social Security payroll tax that hit paychecks in January or a holiday spending hangover, it doesn't bode well for consumers trying to get their finances under control in 2013.

So how do you know if you're living above your means — in other words, spending more than you're bringing in? Not being able to cover the bare necessities is an obvious red flag. But there are some other tell-tale signs you're in over your head.

1. You couldn't survive financially without your job's income for at least six months.
This is the universally touted emergency fund financial advisors love to talk about. In its 2012 annual financial literacy report, the National Foundation for Credit Counseling (NFCC) found that two out of every five adults (40%) said they were saving less than the prior year, and 39% didn't have any nonretirement savings. Whether you call it a rainy day fund, emergency fund or cash reserve fund, it needs to be established and replenished over time, says Sheryl Garrett, founder of Garrett Planning Network, a group of fee-only financial planners. And she knows it's boring: "I've met very few people who enjoy saving money in their cash reserve account. It's not interesting, fascinating, or complicated. Yet, it's one of the most critical and fundamental concepts in personal finance," says Garrett.

Generally, cash reserve need is based on how long you expect to be unemployed if you lose your job. Three months of expenses is reasonable, six months is ideal – particularly for self-employed people and those with volatile incomes, Garrett says. But it could also come in handy for other emergencies like a major medical expense or expensive home repair. How much do you need to meet your ongoing monthly living expenses, including mortgage, food, insurance, car maintenance, utilities, etc. -- should you lose your job or need to pay a major medical expense? That's how much you should set aside.

"Bottom line, based on your skills (presuming the individual is not already retired) how long would it take in this market to find another position with similar income," Garrett says.

2. You're saving less than 10% of your pay.
Financial advisers differ on the ideal savings rate, this is a general guideline. "If you haven't been saving at least 10% of your income for retirement since age 25, you're not saving enough," Garrett says. And if you're over 35, you should tuck away more than that.

To put this in some context, a 2011 paper published by the Center for Retirement Research at Boston College, "How Much to Save for a Secure Retirement," tried to calculate the savings rates required to maintain pre-retirement living standards. The authors found that, assuming a 4% withdrawal rate during retirement, someone who starts saving at 25 and retires at 70 needs to save 7% of earnings to achieve an 80% replacement rate at retirement. But if you're planning to retire at 65, you'd need to save 15% of your income.

3. Your mortgage payment is more than one week's salary.
This one answers, in part, the all-important question, how much home can you afford? The one-week salary figure is a rough guide and "means that your mortgage payment would not be more than one-quarter of your income," says Harold Evensky, certified financial planner and president of Evensky& Katz Wealth Management in Coral Gables, Fla.

Another way to think about this one is you're probably living above your means if more than 35% of your income (a more-forgiving number) goes to into your home (rent, maintenance, upkeep, mortgage), says Rick Kahler, a CFP in South Dakota. "It's a general rule of thumb; some lenders may say 30% and others 40%," he says.

4. Your credit card balance has remained the same for the past year.
Simply holding your own (where your balance remains the same) is a good sign you're living beyond your means, and if your balance grows each month, you're way out of bounds. "I believe those are good leading indicators because credit card debt is very expensive, not tax deductible and, unlike mortgage debt, does not finance a potentially growing asset," says Evensky. (Credit card debt typically funds either a depreciating asset, like a car, or a lifestyle event, like a vacation.)

5. You buy big-ticket items through interest-free, deferred-payment offers because you think you'll be able to afford it next year.
Whether these deals are of the "Buy now and pay no interest until next year" or "No monthly payments for six months" variety for a furniture set or new washer and dryer, they sound enticing but can be deadly. These retailer deals involve no monthly payments for a certain period of time (usually a year) or no interest on payments made during the promotional period. But if you fail to pay for your item in full by the set deadline, you'll get hit with sky-high interest charges. And it's common for interest to be charged to your account from the date of purchase. If you can't afford to buy it now, will you be able to later?

6. You use one credit card to pay another credit card's balance.
Another symptom of living above your means: You're always looking for new cards to transfer the balance to "but never seem to get ahead," says Erin Baehr, a CFP in Stroudsburg, Pa. If you've racked up debt on a high-interest card, moving the balance to one with a lower interest rate will save you money in the long run. But if you're doing a balance transfer because you need to raise your personal debt ceiling, that's not good, says Scott Bilker, founder of DebtSmart.com and author of "Talk Your Way Out of Credit Card Debt."

7. You pay an overdraft fee on your checking account every three to four months or more.
Overdraft fees — or "non-sufficient funds fee" in bank-speak — are charged when there's not enough money in your account to cover a check or debit card payment. And consumers might not even know they could get hit: A May 2012 survey of consumers commissioned by Pew's Safe Checking in the Electronic Age Project found that nearly one-fifth (18%) of consumers incurred an overdraft penalty fee in the previous year, and more than one-third of survey respondents weren't aware their bank offered overdraft coverage until they incurred a penalty, which range from $30 to $35.

“One-off overdraft situations aren’t necessarily an indicator [of living beyond your means]. It’s the ongoing, repetitive nature of overdraft fees that will signal a problem,” says Mary Beth Storjohann, CFP with wealth adviser Hoyle Cohen in San Diego.

8. Before buying something, you often think, “I know I shouldn’t, but…”
"I know things are tight, but I need to take that vacation, it's for my mental health," or “I work so hard, I deserve that new flat-screen TV.” Sound familiar? “That's really rationalizing what you know is not a good idea for you… Like a spa day or expensive dinners out. I don't often hear that from people who are comfortable financially, but more so from those who are struggling,” Baehr says.

Part-Time Employee Health Care Rare Ahead Of Obamacare: Study

Posted: 02/04/2013

Just 8 percent of part-time workers are enrolled in their company health insurance plans, according to a report released Monday that underscores the reasons for and the challenges created by President Barack Obama's health care reform law.

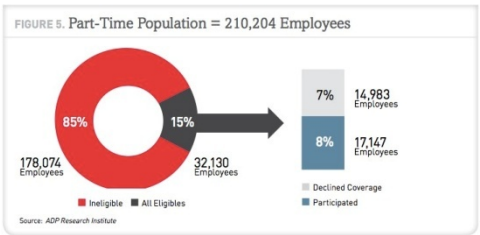
Low-income workers are the primary target of Obamacare's expansion of health insurance to as many as 30 million people through Medicaid, subsidized private plans and new job-based health coverage. But the law's requirements for employers are leading some to consider cutting part-time workers' hours, raising questions about whether these workers will be better or worse off.

The report, conducted by the payroll and benefits manager Automatic Data Processing's ADP Research Institute, partly illustrates why 47 million Americans have no health insurance.

The ADP Research Institute analyzed data from about 300 large employers covering 2 million workers and dependents. Among the employers studied, 23 percent of their workers are part-time but only 8 percent get company-sponsored health benefits. Just 15 percent of part-time workers are even offered health insurance.

Cost is the main reason part-time workers don't enroll in company health plans when they're available, especially among those who earn less than $30,000 a year, said Tim Clifford, the president of ADP Benefit Services. That group is due to receive the largest financial assistance under health care reform.

"Part-time coverage has always been pretty low," Clifford said. "There's no question that the law will extend coverage to millions of Americans," he said. But it also will create some disruption within the realm of employer-sponsored health benefits as companies decide whether to open their insurance plans to more workers or devise strategies to avoid Obamacare's new rules and costs, he said.



Source: ADP Research Institute

Seventy-seven percent of workers at the companies studied in the report are full-time. Among those full-time employees, 88 percent were eligible for health benefits, and 77 percent of those who were offered health insurance signed up.

Jobs are the most common source of health insurance coverage in America, with more than 150 million workers and dependents getting coverage from their employers. Although higher-income and full-time employees aren't likely to see major changes when the biggest parts of the health care reform law take effect next year, the impact on lower-income people could be mixed.

The law's individual mandate will require nearly all legal U.S. residents to obtain health insurance whether they want it or not, with certain exceptions. And while lower-income workers should have access to more affordable health care coverage, employer response to the law could reduce the hours they work.

The core goal of the health care reform law is to extend health insurance coverage to those who currently go without, a large proportion of whom are workers who can't afford it, said Ethan Rome, the executive director of Health Care for America Now, an advocacy organization that campaigned for the law.

"From the perspective of the employee, the question is: are folks going to get affordable coverage? And the answer is yes," Rome said. "They're going to get offered health insurance when they otherwise wouldn't get it," whether it's from their employers or via new benefits created by the health care law, he said.

Obamacare will provide Medicaid coverage to anyone who earns up to 133 percent of the federal poverty level, which is $15,282 for a single person this year, if the individual lives in a state that opts into an expansion of the program. People who earn between the poverty level, $11,490 for an individual in 2013, and four times that amount will be eligible for tax credits to defray the cost of private insurance if their employers don't provide health benefits.

There may be trade-offs, however. Employers that can't or don't want to add low-wage and part-time workers to their employee health plans are considering their options.

Companies don't always offer fringe benefits to low-wage workers, especially part-timers, because doing so traditionally hasn't been considered necessary for hiring and retention, Clifford said. By contrast, higher-skilled, higher-paid workers expect their employers to provide health insurance as part of their compensation.

Under the health care reform, law, however, employers with at least 50 full-time workers must offer health insurance coverage to employees or face penalties that start at $2,000 per uncovered worker.

One way to avoid the law's requirements is to reduce employees' hours to below the 30-hour threshold that marks them as full-time. Retail and food-service firms like Darden Restaurants, which owns the Olive Garden and other chains, have publicly weighed this approach, as have some universities and other employers.

IRS Rule Could Leave Some Families Without Affordable Health Insurance or Subsidies

By Sara Hansard Tuesday, February 5, 2013

The Internal Revenue Service (IRS) disappointed consumer groups and unions when it released a final rule Jan. 30 that could leave some families without affordable health insurance coverage or premium tax credit subsidies to help pay for it.

Timothy Jost, a law professor at Washington and Lee University in Lexington, Va., and consumer representative to the National Association of Insurance Commissioners, told BNA that he had hoped IRS would allow families to receive the subsidies in situations where a family member has coverage that meets the Affordable Care Act requirement for "affordable" employer-sponsored coverage but the family cannot afford family coverage. Instead, IRS went with a stricter reading of the statute that does not allow families to receive premium tax credits through the online health insurance exchange markets that will begin operating in 2014.

"It just seems to me that you can't have it both ways," Jost said. ACA requires employers to provide qualified coverage that costs employees no more than 9.5 of their income for self-only coverage. If employers with at least 50 full time employees do not provide such coverage, they are liable for steep penalties under the law.

A 2012 Government Accountability Report estimated that 460,000 children would be ineligible for coverage under the interpretation of the statute adopted by the IRS. A spokesman for the American Academy of Pediatrics said the final rule makes it imperative that Congress reauthorize the Children's Health Insurance Program.

Public can see pharmacy payments to doctors starting in 2014

Revisions in the final transparency rule will give physicians more time to resolve payment amounts and won't require disclosure of indirect pay from accredited education programs.

By CHARLES FIEGL, amednews staff.*Posted Feb. 11, 2013.*

Washington After numerous missed deadlines, new regulations require that data on the payments and gifts that drug and medical device companies make to physicians will become available publicly in a searchable database beginning in September 2014.

The long-awaited final rule for the implementation of the Physician Payment Sunshine Act — a 2010 law requiring financial ties between manufacturers and medicine to be disclosed — was released on Feb. 1. The Centers for Medicare & Medicaid Services addressed several issues pertaining to the reporting of fees, meals, travel expenses and other transfers of value. Those issues were raised by the American Medical Association and other organized medicine groups over an earlier proposed version of the rule. For instance, CMS will allow doctors additional time to resolve disputes over any inaccurate data and will not require certain indirect payments from continued medical education programs to be reported on the database.

Under the law, manufacturers already should have started collecting information about the payments and gifts they make to physicians. The Affordable Care Act mandated that data collection for transparency reports was to start in 2012, but the Obama administration delayed finalizing regulations for more than a year as stakeholders debated aspects of the program.

Data collection now will begin on Aug. 1 for applicable manufacturers. Companies will be required to collect data from August through December during the first year, 2013. The data will be sent to CMS by March 31, 2014, and become available to the public on Sept. 30, 2014.

Manufacturers are not required to track buffet meals, snacks or cups of coffee they provide to physicians, but the value of other meals must be recorded. Transfers of value under $10 also do not need to be reported unless the cumulative amount to an individual doctor totals $100 or more in a calendar year.

Fines up to $100,000 possible

CMS can levy $10,000 fines on manufacturers for failing to report gifts. The penalty climbs to $100,000 when a manufacturer is found to have knowingly omitted payment information.

"You should know when your doctor has a financial relationship with the companies that manufacture or supply the medicines or medical devices you may need," said Peter Budetti, MD, CMS deputy administrator for program integrity. "Disclosure of these relationships allows patients to have more informed discussions with their doctors."

The AMA supported the concept of the Sunshine Act and will review the final regulation carefully to determine if its earlier concerns about the details of the program have been addressed, said AMA President Jeremy A. Lazarus, MD.

"Physicians' relationships with the pharmaceutical industry should be transparent and focused on benefits to patients," Dr. Lazarus said. "Our feedback during this rulemaking process was aimed at ensuring the new registry will provide a meaningful picture of physician-industry interactions and give physicians an easy way to correct any inaccuracies. As the rule is implemented, we will work to make sure physicians have up-to-date information about the new reporting process."

Organized medicine groups, manufacturers and CMS will need to increase efforts to educate physicians about the details of the Sunshine Act, said MichaelineDaboul, president and CEO of MMIS, a health technology company that develops health information exchanges. An MMIS survey of 1,000 physicians found that about half were not aware of the transparency report program. Many also were concerned about the accuracy of data gathered by companies. The survey said 43% of respondents indicated that the program would affect their relationships with drug and device firms.

Daboul suggested that physicians work directly with the companies to see their financial relationship data before the information is sent to the government. Doctors and companies need to be proactive and prepared to work together to prevent any misinformation from making its way into the public database, she said.

"If I'm a physician, I want to protect my reputation," she said. "I want my patients to understand my relationships with industry."

Concessions in the final rule

In the draft version of the rule, CMS had proposed a 45-day period in which physicians could review and correct their individual payment and gift data compiled by drug and device companies. The AMA had recommended that data be corrected on an ongoing basis. Other commenters called for an additional 60 to 90 days to resolve disputes after the 45-day review period.

Extended or rolling periods to address objections raised by physicians are not feasible, CMS stated in the final rule. However, the agency did agree that a distinct period should be available in which to resolve incorrect data after the 45-day window. Manufacturers and other organizations will have 15 days to correct any erroneous information following the review period, CMS said. The agency is developing a secure website for data submission, review and correction.

Organized medicine groups and others also had recommended that accredited or certified continuing medical education payments to speakers should not be reported on the database. Existing safeguards and standards regarding such compensation are in place, the groups said, and public reporting of payments or transfers of value related to educational activities would harm such programs. That reporting would lead to decreased funding for education and a falloff in attendance, they said. Furthermore, Congress did not intend for those payments to be included in transparency reports.

CMS agreed that an indirect payment made by a drug or device company to a speaker at a continuing education program does not need to be reported under certain conditions. First, the program must meet accreditation or certification standards of the AMA, the American Osteopathic Assn., the American Academy of Family Physicians, the Accreditation Council for Continuing Medical Education or the American Dental Assn. Continuing Education Recognition Program. The manufacturer cannot select the speaker or provide a third-party vendor with a list of experts for consideration to speak. Finally, the manufacturer must not pay the speaker directly.

"We believe that when applicable manufacturers suggest speakers, they are directing or targeting their funding to the speakers, so these payments will be considered indirect payments for purposes of this rule," CMS stated. "Conversely, when they do not suggest speakers, they are allowing the continuing education provider full discretion over the [education] programming, so the payment or other transfer of value will not be considered an indirect payment for purposes of these reporting requirements."

Murray Kopelow, MD, president and CEO of the Accreditation Council for Continuing Medical Education, applauded CMS for recognizing the value of continuing education and for agreeing that current accrediting standards are sufficient. "The standards are designed to ensure that accredited CME activities are independent, free of commercial bias, based on valid content, and contribute to health care improvement," he said.

Unaccredited and noncertified education program payments must be reported, CMS added.

Rule stands firm in some areas

CMS disagreed with arguments that all indirect payments or other indirect transfers of value should be excluded from reporting requirements. This type of transaction occurs when a manufacturer requires, instructs or directs payment to a particular recipient regardless of whether the company specified that physician.

For example, a drug manufacturer might make a general payment to a clinic for a physician to review materials without stating the name of the physician. Because the company had directed the payment to be provided to a physician, it would be a reportable indirect payment under the final rule.

Indirect payments can be excluded from reporting requirements when manufacturers do not know the identity of the recipient. This may occur, for example, when a device manufacturer hires a research firm to conduct a double-blind market research study that pays physicians to respond to a survey.

If the exception did not apply in such a case, a manufacturer might feel obligated to track down the identity of the recipients, the rule stated. CMS' intention is to prevent companies from directing payments to recipients whose identities can be obtained easily.

"We agree that applicable manufacturers should not be responsible for tracking and reporting indirect payments or other transfers of value indefinitely," CMS said. At the same time, if a company determines the identity of a recipient, it is obligated to report it. Recipients discovered on or before June 30 of the year after a payment made by a third party are required to be reported on the database.

Hospital Observation Units Fill Gaps, But Patients May Foot The Bill

By Michelle Andrews February 12, 2013

Partner content from: KHN

About a third of U.S. hospitals have an observation unit, and most hospitals will eventually have one, the industry predicts.

iStockphoto.com

If you find yourself in the emergency department and the doctor says he wants to keep you at the hospital for "observation," take heed. Depending on the hospital, observation can mean very different things for both your medical care and your wallet.

At its best, placing patients on observation allows hospital staff to closely monitor and intensively treat patients whose condition is unstable or unclear. They might have chest pain, for example, or need a little time to recover from a migraine or an asthma attack before being sent home.

This type of outpatient care is sometimes provided in a special observation unit with a dedicated team that follows clearly defined treatment protocols. About one third of hospitals have them. Within 24 hours they can generally determine whether a patient needs to be admitted to the hospital or can be sent home.

But other times patients who are kept for observation don't get special care – they are simply sent to a regular hospital bed and treated no differently than someone who's been admitted. In those cases, "observation" may be no more than a billing designation that allows hospitals to move patients out of crowded emergency departments and avoid potential insurance reimbursement problems for inappropriate admissions.

Those patients who are kept for observation sometimes find themselves with hefty bills, according to a recent article in the *Annals of Emergency Medicine*. That's because observation care is considered outpatient care and many insurance plans charge a la carte for every blood test, X-ray or scan. In contrast, patients may owe just a single copayment if they're admitted to the hospital, regardless of the specific services received.

"If you're not in a dedicated unit, you should be having your hand on your wallet and really pushing back hard if you're there longer than 12 hours," says Arthur Kellermann, a physician and senior researcher at Rand, a public policy research organization.

So if the emergency department doctor says he wants to keep you around for observation, it behooves you — or a family member — to ask a few questions:

- Am I going to a separate "observation unit" or will I be placed on "observation status" somewhere else in the hospital?
- Am I going to be an inpatient at the hospital or cared for as an outpatient? Even though you can't control how you're cared for by hospital staff or what you're billed, forewarned is forearmed.

"A lot of the patients that are very angry about this are those that are getting bills months later with no communication," says Christopher Baugh, the medical director of the emergency department observation unit at Brigham and Women's hospital in Boston. "These discussions need to happen in real time."

Drug prices jump again

By Dennis Cauchon, USA TODAY,

After dropping during the recession, drug prices have reignited in the past four years, returning to growth rates of a decade ago. In 2012, prescription drug prices rose 3.6%, twice the 1.7% inflation rate, Bureau of Economic Analysis data show.

The trend is in sharp contrast to other health costs. Prices for a doctor's visit, lab test and nursing home room all fell below the rate of inflation for the past two years.

What's driving drug costs up: brand-name drugs paid for by insurance and often heavily advertised.

The price escalation on patented drugs has offset enormous savings that have occurred simultaneously from the growing use of inexpensive generic drugs. Generic drugs can be made by multiple companies, which compete on price. Four of every five prescriptions are for generics, which can cost one-fourth or less than the brand-name version.

This blend -- expensive brands and cheap generics after patents expire -- lets consumers buy drugs at low cost while providing profits for drug research. The Food and Drug Administration has approved 70 new drugs in the past two years, including a breakthrough treatment of cystic fibrosis and the first drug for a common form of skin cancer.

The top-selling drugs reflect the strategy of the $310 billion annual drug industry:

•No. 1 Nexium, a heartburn drug, had a 7.8% price hike to a $262 average prescription in the first nine months of 2012, IMS Health reports.

•No. 2 Abilify, for bipolar disorder and depression, increased 10.4% to $642 per prescription.

•No. 3 Crestor, a cholesterol-lowering drug, went up 9.7% to $193 per prescription.

"Pricing decisions are based on many factors that reflect our obligations to patients and shareholders," says Stephanie Andrzejewski of AstraZeneca, which makes Nexium.

"This price system is a blessing as well as a frustration," says N. Lee Rucker, a pharmaceutical expert at AARP, which represents seniors. High prices create a robust market for innovative drugs, she says, but the patents can be too long and physicians may be poorly informed about a drug's cost and effectiveness.

Most consumers are protected from rising drug prices. The Medicare drug benefit, started in 2006, means the government pays most costs that once fell on seniors.

There's a Reason You're Always Late

By YouBeauty.com | Secrets to Your Success – Fri, Feb 15 2013

Disney/YouBeautyBefore writing her book, "Never Be Late Again,"management consultant Diana DeLonzor was always, always late. "It didn't matter what time I got up. I could get up at six and still be late for work at nine," she recalls. She was reprimanded at work, lost friendships and her timely husband was always mad at her. She couldn't stand being late, yet she just couldn't change.

"Most people really hate being late and have tried many times to fix it," DeLonzor says. "Punctual people misunderstand. They think you're doing it as a control thing, or that you're selfish or inconsiderate. But it really is a much more complex problem than it seems."

In a study she led at San Francisco State University of 225 people, she found that about 17 percent were chronically late. Among them, there were clear patterns. Late people tended to procrastinate more, demonstrated trouble with self-control (were more prone to habits such as overeating, drinking too much, gambling and impulse shopping), showed an affinity for thrill-seeking and displayed ADD-like symptoms-restlessness, trouble focusing and attention issues.

"People who are chronically late are often wrestling with anxiety, distraction, ambivalence or other internal psychological states," says Pauline Wallin, Ph.D., a psychologist in Camp Hill, Pennsylvania.

Jeff Conte, Ph.D., an associate professor of psychology at San Diego State University who has studied lateness in the workplace, says that there are deep-rooted personality characteristics at play, making lateness a very difficult habit to break. DeLonzor quips that telling a late person to be on time is like telling a dieter not to eat so much. "If it were that easy, we wouldn't have Weight Watchers."

With the right approach, however, the eternally tardy can change their ways.

What Kind of Late Are You?

The first step toward timeliness, says DeLonzor, is self-awareness. Sit down and go over your history and patterns. Are you late to everything or just some things? How do you feel when you're late? What causes you to run behind?

Julie Morgenstern is a professional organizer and productivity expert. When meeting a new client she always starts with the same question: Are you always late by the same amount of time or does it vary? If it's always the same, that is indicative of a psychological hurdle. Maybe you're afraid of downtime, or feel that you have to fit as much as humanly possible into your day (even if it's not humanly possible). If you arrive late by 10 minutes to one thing and 30 minutes to another, the problem is likely mechanical. Your time management skills need work.

DeLonzor describes seven types of late people. Most fall into the top three categories:

The Deadliner enjoys the rush of the last minute. She thrives on urgency and often claims to work best under pressure. Sometimes it's difficult for Deadliners to motivate unless there's a crisis (even if that means creating crises of their own). Rushing from here to there serves as a way to relieve boredom.

The Producer needs to get as much done in as little time as possible. She feels better about herself when she's checking things off a massive to-do list. Producers tend to engage in "magical thinking," consistently underestimating the amount of time their tasks will take. They hate wasting time, so they schedule themselves to make use of every minute of the day.

The Absent-Minded Professor is easily distracted. Distractibility is thought to have a genetic basis and can range from full-blown attention deficit disorder to innocent flakiness. Absent-Minded Professors often lose track of time, misplace car keys and forget appointments.

People typically identify with more than one lateness personality. The other four are: the Rationalizer, who never fully admits to her lateness (many late people are at least one part Rationalizer); the Indulger, who generally lacks self-control; the Evader, who tries to control feelings of anxiety and low self-esteem by being late; and the Rebel, who arrives late to assert power (Rebels are usually men).

What Is Making You Late?

Watch yourself carefully to identify what is actually making you late. Producers often schedule more tasks, chores and appointments than they can get done in a day (without a Star Trek transporter and a time machine). Perhaps you suffer from what Morgenstern calls the One More Task Syndrome. "I think this is a technical fix for a psychologically-driven behavior. You feel you have to be productive, so you shove one more thing in before you have to leave," she says. DeLonzor says many late people- including herself-have an aversion to leaving the house, and suddenly feel the need to straighten the blinds or open the mail when they should be heading out the door. To combat this she uses a mantra of sorts: "When I catch myself doing this, I'll snap or clap and say 'This can wait.'"

A note to late-leavers: Texting that you're "five minutes behind!" doesn't absolve you-or buy you extra time for one last thing. Allow us to reimagine an old adage. Stop (yourself). Drop (what you're doing). And roll (on outa there).

Overcoming Lateness

Transforming yourself from chronically late to perfectly punctual is a big task. Wallin says it is important to make deadlines non-negotiable, "like a promise to yourself." Start with something easily attainable, like vowing not to hit snooze tomorrow-not even once. "If you can't commit to a small inconvenience like that," she cautions, "you are not ready to tackle your chronic lateness." Before jumping in, try an experiment: Get somewhere on time. Just once. Just to see how it feels. Note your reaction. Are you relieved or anxious? Proud or bored as hell? Then work your way up from there.

Step 1:Relearn to Tell Time. Every day for two weeks, write down each task you have to do and how long you think it will take. Time yourself as you go through your list-showering and dressing, eating breakfast, driving to work, picking up the dry cleaning, doing the dishes-and write the actual time next to your estimate. Many people have certain time frames cemented in their brains that aren't realistic. Just because once, five years ago, you made it to work in 12 minutes flat doesn't mean it takes 12 minutes to get to work.

Step 2:Never Plan to Be On Time. Late people always aim to arrive to the minute, leaving no room for contingency. Say you need to get to work at 9:00. You assume it takes exactly 12 minutes to get to work, so you leave at 8:48. If you miss one traffic light or have to run back inside to grab an umbrella, it becomes impossible to make it in on time. Don't chance it. Both DeLonzor and Morgentern say you should plan to be everywhere 15 minutes early.

Step 3:Welcome the Wait. If the thought of getting anywhere ahead of time freaks you out, plan an activity to do in the interim. Bring a magazine, call a friend you haven't spoken to in a while, or go over your schedule for the week. Make the activity specific and compelling, so you'll be motivated get there early and do it.

Finally, if you have a friend or family member that's always late, remember that it's not about you. Tricking her by saying something starts a half hour earlier doesn't work; she'll eventually catch on. And scolding her won't make you feel any better about her lateness. In fact, it will probably just amplify your bad feelings. Instead, have an honest discussion-before you're totally fed up-and set some guidelines. Try this: Every time your friend is late by 15 minutes or more, she pays for dessert. If it doesn't get her butt in gear, at least it sweetens the deal for you.

Medicare says drug refills shouldn't be done without patient's OK

Medicare says patients' approval should be required before drugstores refill prescriptions. (Mysupplementmedicare.com)

By David Lazarus *February 15, 2013,*

Medicare called Friday for administrators of its Part D prescription-drug program to ensure that drugstores refill prescriptions only after receiving patient approval.

The move follows a series of columns in the Los Angeles Times revealing how CVS and other drugstore chains were routinely refilling prescriptions and billing insurers, including Medicare, without authorization.

In a lengthy document detailing proposed updates for companies participating in Medicare plans, the Centers for Medicare & Medicaid Services said it had received "complaints that beneficiaries have had medications delivered that had been previously discontinued or were otherwise unwanted and unnecessary at the time of delivery."

"Automatic delivery practices are potentially generating significant waste and unnecessary additional costs for beneficiaries and the Part D program overall," Medicare said. "While proponents of these programs tout improved adherence, it remains unclear to us that permitting such programs would be cost-effective."

Medicare is proposing that "Part D sponsors should require their network retail and mail pharmacies to obtain patient consent to deliver a prescription, new or refill, prior to each delivery."

It said the requirement should be imposed for all coverage next year, but "we strongly encourage sponsors to make this a requirement of their network pharmacies that offer such automatic refill programs for 2013."

As I've reported, the U.S. Justice Department and regulators in California and New Jersey are investigating refill practices at CVS and other pharmacy chains. CVS has denied any wrongdoing.

HHS releases rule on insurers' essential health benefits

Kelly Kennedy, USA February 20, 2013

The release allows insurers and states to move forward on both the federal and state health exchanges.

"The Affordable Care Act helps people get the health insurance they need," said HHS Secretary Kathleen Sebelius.(Photo: Scott Olson, Getty Images)

Story Highlights

- Rule is critical to the creation of state and federal health exchanges
- Mental health benefits a key part of the new rule
- Health care exchanges start operating on Jan. 1

WASHINGTON —- The Department of Health and Human Services released its long-awaited final rule on essential health benefits today, allowing insurers and states to move forward on both the federal and state health exchanges.

The rule defines what must be covered in exchange plans, prohibits discrimination based on age or pre-existing conditions, describes prescription drug benefits and determines levels of coverage.

"The Affordable Care Act helps people get the health insurance they need," said HHS Secretary Kathleen Sebelius. "People all across the country will soon find it easier to compare and enroll in health plans with better coverage, greater quality and new benefits."

The states and insurers had been particularly interested in what kind of mental health and substance abuse coverage they would have to include. The new rule provides parity for both, and HHS released a report today that showed that could affect 62 million people.

"Americans accessing coverage through non-grandfathered plans in the individual and small group markets will now be able to count on mental health and substance use disorder coverage that is comparable to their general medical and surgical coverage," the report states.

But the rule doesn't include any surprises: A proposed rule released in November looks much the same as today's version.

"It's what many of us anticipated," said Ian Spatz, who advises states and providers about health policy as a senior adviser for the law firm Manatt, Phelps and Phillips. "It's good news for the states, because they've been moving forward based on the proposed rule."

State insurance commissioners and exchange directors have said they need to work quickly to meet deadlines to create an exchange, but without a final rule, they feared they might have to change direction on the work they have done so far.

"Over the summer, we'll get to see the what the plans look like and especially how much they will cost," Spatz said. Insurers have argued that having to provide all of the essential benefits would mean creating plans no one could afford, while patient advocates have argued for more coverage.

In the meantime, HHS has said there are mechanisms built in that would keep costs down for everyone, including subsidies for people whose incomes fall below 400% of the poverty line and preventive care that is expected to keep long-term health care costs down.

Some groups, such as the American Cancer Society Cancer Action Network, praised the section that said insurers may not charge a co-payment if a polyp is removed during a colonoscopy. A colonoscopy itself is preventive care; some insurers determined that if a polyp were removed during the procedure, it could be reclassified as "diagnostic," and the patient could be liable for part or all of the cost--often as much as $1,000. That's good news for patients who have a preventive exam and wake up to learn they had a procedure they must pay for, said Stephen Finan, senior director of policy for the American Cancer Society's Cancer Action Network.

"We specifically went to HHS with this issue a few months ago," Finan said.

Not everyone was pleased. National Retail Federation employee benefits policy counsel Neil Trautwein said that, though the administration has been "pretty reasonable and consistent with what they said they would be," his coalition of retailers is particularly sensitive to price and product. In his view, highlighting mental health parity after the shooting in Newtown, Conn., and applying it to small group and individual plans could prove to be a costly mistake.

"It's really an imperfect way to take on society's problems," he said. "We had argued against it. It's a cost question and a suitability issue."

The Mental Health Parity law came about because insurers and employers had implemented yearly and lifetime coverage caps for mental health care, as well as requiring employees to pay copays for treatment when that wasn't required for other chronic care issues, such as asthma or diabetes.

HHS has argued that addressing mental health issues in a stable way could cut health care costs in the long-term because people are less likely to end up hospitalized, are more likely to finish college or get good jobs, and are more apt to participate in their communities.

"Time will tell," Trautwein said. "We'll have a better idea in the fall."

The essential health benefits include ambulatory patient services; emergency care; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and rehabilitative services and devices; laboratory services; preventive and wellness services, and chronic disease management; and pediatric services, including dental and vision care.

Plans in the individual and small-group markets inside and outside of health care exchanges must cover essential health benefits beginning in 2014.

Health care exchanges, or marketplaces, allow consumers to go to a website and compare benefits and costs of different plans. HHS's essential rules are meant to make the categories comparable, though states may require more from the insurers that participate in the exchanges.

The rule also assigns "metal" ratings to different levels of plans, so a consumer will know that a bronze plan will have less generous benefits, but will cost less than a platinum plan.

Much of what will be included is similar to what is commonly covered by plans now, but there will be some changes in the small-group market, including coverage of mental health issues and substance abuse disorders, habilitative care, pediatric dental care and pediatric vision care.

But HHS also predicted in the rule that many individual market plans will not cover all 10 essential health benefits, which should help keep costs down.

The rule also states an insurer may not discriminate based on an "individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life or other health conditions."

HHS received about 11,000 comments before posting the final rule, including health insurance issuers, consumers, health providers, states, employers, employees and Congress members. Concerns included everything from coverage of lactation services and acupuncture to maternity coverage for dependents and cost-sharing for mental health care.