Health & Retirement Services Of Illinois

July 2010 Newsletter

OUR NEWS LETTER

CONGRESSIONAL HEARINGS-TYLENOL RECALL

Children's Tylenol, Motrin, Zyrtec, and Benadryl Being Recalled may be Linked to 100s of Adverse Reactions.
Date Published: Thursday, May 27th, 2010

On April 30, McNeil, a unit of Johnson & Johnson (J&J), recalled 43 varieties of Tylenol Infant Drops, Children's Tylenol Suspensions, Children's Tylenol Plus Suspensions, Motrin Infant Drops, Children's Motrin Suspensions, Children's Zyrtec Liquid in Bottles, and Children's Benadryl Allergy Liquid in Bottles in the U.S. and 11 other countries. At the time, the company said some drugs might contain a higher concentration of active ingredients than is specified; others may contain inactive ingredients that may not meet internal testing requirements; and others may contain tiny particles.

J&J removed the questionable OTC products from store shelves in what Congressional staff described as "the largest recall of children's medicine in the history of the U.S. Food & Drug Administration (FDA)," quoted Reuters from a May 24 memo to committee lawmakers. Now, Reuters reports that the FDA has received over 700 complaints about adverse reactions in children and infants given J&J medications. The reports include 30 deaths. Direct links have not yet been made with to J&J drugs, said Reuters citing a Congressional memo.

Recently, we wrote that the Wall Street Journal obtained a copy of a letter McNeil sent to doctors and poison control centers on May 1 providing information about the recall in which it said that some samples of recalled infants' Tylenol were found to contain as much as 24% more active ingredient than shown on the label. Also, the Journal recently published new details about McNeil Consumer Healthcare's recent recall of over-the-counter (OTC) medicines. Much of what the Journal reports is disturbing.

Meanwhile, members of the House Oversight and Government Reform Committee released details of the FDA's investigation this week and a U.S. House of Representatives hearing to review the manufacturing issues at J&J plants that led to the recall is scheduled for today, said Reuters. The FDA is investigating manufacturing procedures at the Fort Washington, PA manufacturing facility where the recalled medicines were made and is also investigating McNeil's manufacturing company wide. McNeil also makes drugs at plants in Lancaster, PA, and Las Piedras, Puerto Rico. Since the recall, the Fort Washington plant has been closed until McNeil can assure quality production and the FDA clears the site.

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Written testimony, authored by Joshua Sharfstein, the FDA's principal deputy commissioner and prepared for today's House committee meeting discussed the broad recall and said the agency is working with the firm "to address its systemic quality issues," quoted the Journal. "FDA is also considering additional enforcement actions against the company for its pattern of noncompliance which may include seizure, injunction, or criminal penalties," Mr. Sharfstein said, wrote the Journal. "Over the last several years, FDA has had growing concerns about the quality of the company's manufacturing process," Sharfstein added.

According to Reuters, FDA inspectors found a variety of problems at the plant in late April, such as "bacterial contamination of ingredients and filthy equipment … some medications … were overly concentrated and 'had the potential to be superpotent,' citing the Congressional memo. The Journal noted that the bacterial contamination was found in a raw ingredient used to manufacturer Tylenol and another problem resulted in some drugs to have higher levels of active ingredients while some products contained metallic particles.

Walgreens-CVS dispute may put dent in drug discounts

Here are tips on how to save money on prescriptions
By Gregory Karp, Tribune Newspapers
7:27 p.m. CDT, June 10, 2010

A high-profile spat between the parent companies of the nation's two largest drugstore chains could mean some people who have their drug coverage managed by CVS Caremark Corp. soon might be unable to get their prescriptions filled at Walgreen Co. stores at a discount.

Analysts anticipate the two sides will resolve their dispute by renegotiating the payments Walgreens would receive from CVS Caremark, an outcome that raises a question or two for all consumers: How much wiggle room is there on prescription drug prices? What can I do to pay the lowest prices possible?

Americans spend about $250 billion a year on prescription drugs, according to the most recent numbers from the National Association of Chain Drug Stores.

"If people spend too much money on their medications of any kind, but particularly for chronic issues, they're a lot less likely when a recession hits or they lose a job to continue taking them," said Lisa Gill, editor for prescription drugs for Consumer Reports' Health.org.

Here is some advice to save you money on medications from Consumer Reports' Health.org, the Kaiser Family Foundation and other sources. Check with your doctor before attempting any of these strategies.

Substitute. Ask your doctor about taking a less-expensive medication for your ailment. You may be able to switch to a cheaper name-brand drug or a generic drug. Despite the name, generics are not inferior to name brands, but they can cost 20 percent to 80 percent less. On average, the cost of a brand-name prescription in 2008 was about $138, while generics cost about $35, according to the drugstore association. Generics are available for drugs with expired patents. Instead of thinking of generics as second-rate, think of them as safe, tried-and-true medications that have withstood the test of time. Insurance co-payments for generics often are less than for brand-name drugs.

Buy in batches. Most health-insurance plans through employers offer a mail-order option for ordering larger quantities of pills at a discount. A three-month supply by mail can cost nearly the same as a one- or two-month supply at a retail drugstore. Savings on generics are even greater. To compare prices accurately, figure out the cost per pill by dividing the total price by the number of pills. For those with prescription insurance, buying larger quantities means shelling out fewer insurance co-pays.

Shop around. Drug prices can vary widely among pharmacies, so compare prices among online, mail-order and bricks-and-mortar retailers, especially if you take the medication regularly. Wal-Mart, Costco, Kmart and other mass merchandisers now offer low-cost generic drugs, often about $4 a month. Price comparisons are available at such Web sites as DestinationRx.com, PharmacyChecker.com and PillBot.com.

Consider independents. Consumers report high satisfaction with independent local pharmacies but have a perception that they're too expensive, according to a Consumer Reports survey. Many local pharmacies will "almost always" match prices with bigger pharmacies when a customer asks, Gill said. "If feel like that's a huge unspoken, unknown tip," she said.

Split pills. Buy medications at double strength and split the pill in half. The price of medication is often the same regardless of dosage so you end up paying half-price and forking over half as many co-pays. Pill-splitting is safest when using a plastic pill-splitting tool, also called a tablet cutter, which can cost about $5 at a drugstore. The pharmacist might also split pills for you.

Be aware that some pills cannot be split, including time-release drugs and capsules. And the patient must be able to split pills and be dedicated to doing it. Pill-splitting is perfect for the family of cholesterol-lowering drugs called statins, Gill said.

Get loyal. Insured or not, get a pharmacy loyalty card, which can save up to 20 percent, Consumer Reports said.

Use tax-free money. If you participate in a flexible spending account (FSA) or health savings account (HSA), use that tax-free money to pay for drugs and co-pays.

Canada? Buying brand-name drugs from Canada or other foreign countries can be cheaper, but it's not legal.

Get help. People with low incomes and without insurance may qualify for a variety of programs that offer free or discounted prescription drugs. Among them are Partnership for Prescription Assistance (pparx.org); Rx Outreach (rxoutreach.com.); TogetherRxAccess (togetherrxaccess.com); along with federal, state, and local government programs.

Qualifying income levels can be generous. For example, a family of four with income of $90,000 would qualify for TogetherRxAccess.

WHAT TO DO WHEN YOUR BANK FAILS

By Jon Yates, Tribune Newspapers 5:49 p.m. CDT, June 3, 2010

It might seem like the entire financial industry has gone a bit haywire. The stock market is all over the place, corporate bigwigs are reaping huge bonuses despite the ongoing recession, and banks are failing at an alarming rate.

Last year, 140 banks went under, and the number appears to be accelerating this year. Through May 21, 73 banks in the U.S. and Puerto Rico had failed, leaving rattled consumers in their wake.

But experts say there is no reason to panic. In most cases, if your bank goes under, you will barely notice.

"When a bank fails, it's a seamless process for depositors," said Greg Hernandez, spokesman for the

Federal Deposit Insurance Corporation. "The only thing they're going to notice is their bank has a new name."

Most failed banks are bought out by another bank. When that happens, the bank remains open for business, but certain aspects of your accounts could change. If you have a certificate of deposit, the new bank could give you the option of cashing it out or transferring the money to a new CD with different terms.

If you're concerned about your money, don't be. As long as your bank's deposits are covered by deposit insurance, you do not risk losing it. The FDIC insures deposits up to $250,000, but Greg McBride, a senior financial analyst for Bankrate.com, said there are several ways to increase that limit.

If you have a joint account with your spouse, that account is insured for $500,000. You could also have a separate, individual account in which you can keep another $250,000. Between different accounts and joint accounts with family members, you can actually insure millions of dollars in one bank, McBride said.

In most cases, you'll have no contact with the FDIC. Hernandez said that of the 140 banks that failed last year, the FDIC reimbursed depositors from six banks.

"The FDIC literally sends checks to depositors because they couldn't find any acquiring banks," Hernandez said.

How can you tell if your bank is at risk of failure? The FDIC compiles a list of banks it thinks could be in trouble, but it does not publish the list for fear of creating a run on the bank's assets. Remember that scene in "It's a Wonderful Life" where half of Bedford Falls descends on the Bailey Brothers Building & Loan to withdraw their money amid rumors that the institution might fail? Well, that's what the FDIC is trying to avoid.

You can do a quick Google search of your bank and see what has been written about it recently.

Bankrate.com, an online aggregator of financial information, offers its own bank rating system. The Web site allows you to type in your bank's name and see how many stars it got, from five stars for "superior" to its lowest rating of one star.

"It lets you kick the tires and look under the hood just to make sure you're comfortable," McBride said.

As long as your money is FDIC insured, the rating probably doesn't matter. Still, if your bank receives a low rating, you might consider transferring to another bank, if only for peace of mind.

"The money you put in the bank is the money that's supposed to help you sleep at night, not keep you awake," McBride said. If you're not feeling comfortable with your bank, move your money.

Even if your bank does get a low rating, there generally is no way of knowing ahead of time whether it will fail.

When it happens, it happens quickly.

"By the time you find out about it, you're now the customer of another bank," McBride said. "In terms of access to your money, payments clearing, deposits being posted — everything happens seamlessly. It feels more like a bank merger than a bank failure."

Why you should know this

Was your bank one of the 140 that failed last year? Banks are still folding at an alarming rate. Be prepared in case yours joins the fallen.

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COMPARE COST OF LONG TERM CARE ACROSS

THE NATION.

http://www.genworth.com/content/genworth/genworth/coc_landing.html?WT.mc_id=COC03

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MEDICARE PART D REBATES

By ANNA PRIOR, June 20, 2010

Some participants in Medicare Part D prescription-drug plans should be on the lookout for a check in the mail.

The U.S. Department of Health and Human Services started sending out $250 rebate checks late last week.

The one-time rebate, which is part of the health-care reform bill signed into law by President Obama earlier this year, applies to Part D participants who fall into the drug-coverage gap commonly known as the "doughnut hole." The rebate is meant to help alleviate the costs people incur during the gap.

The doughnut hole kicks in after a person's annual prescription-drug cost -- covered at 75% -- reaches a set dollar amount. For 2010, it's typically $2,830. The insured is then on the hook for 100% of his or her medication costs until catastrophic coverage kicks in, typically when total drug costs for the year reach $6,440.

Rebate checks are mailed within 45 days of Medicare Part D participants hitting the doughnut hole. The checks are mailed automatically and there are no forms to fill out. For more information or to find out if you're eligible for the rebate go to medicare.gov or call 1-800-633-4227.

To further help close the gap, starting in 2011 people in the doughnut hole will get discounts on drugs, which will increase through 2020, when the gap is eliminated and the standard 75% coverage applies.

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WALGREEN, CVS CAREMARK – NEW CONTRACT

The New York Times (6/19, B3, Abelson, Singer) reported, "After an unusually public showdown that

threatened to restrict where millions of consumers could fill their prescriptions, Walgreen and CVS Caremark said on Friday that they had agreed to a new contract." As a result of Friday's deal, "people enrolled in those drug benefit plans will be able to continue shopping at Walgreen, which operates about 7,500 drugstores across the country, the two companies said. The two did not disclose the terms of the new contract and neither would elaborate beyond the joint statement they issued."

The AP (6/19) reported, "CVS Caremark Corp....said Walgreens' participation means the CVS Caremark national pharmacy network will have more than 64,000 participating pharmacies."

Bloomberg News (6/19, Wolf, Sherman) reported, "The accord means CVS Caremark...will deflect complaints from customers of its pharmacy-benefits management, or PBM, living in areas mainly served by Walgreen, the biggest drugstore chain," while "Walgreen will avoid losing almost $5 billion in annual sales."

Focusing on the events leading up to the agreement, Modern Healthcare (6/19, Rhea, subscription required) reported, "In early June, Walgreen, the US's largest pharmacy chain, said it would no longer accept CVS Caremark reimbursement for customers covered under new and renewing pharmacy benefits plans because the rates were too low. Walgreen also accused...CVS Caremark of engaging in tactics aimed at driving its pharmacy benefits members to CVS pharmacies for fulfillment of their prescriptions." For its part, "CVS Caremark countered by announcing that it would discontinue all of its reimbursement arrangements with...Walgreen, even those covering existing customers." Forbes (6/18, Gutierrez) and Dow Jones Newswire (6/19, Cummings) also covered the story.

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JOBS BILL BLOCKED IN SENATE

By Lori Montgomery and Brady Dennis, Washington Post Staff Writer, Friday, June 18, 2010

The Senate effectively rejected a slimmed-down package of jobless benefits and state aid late Thursday, rebuffing President Obama's call for urgent action to bolster the economic recovery.

Sens. Ben Nelson (D-Neb.) and Joseph I. Lieberman (I-Conn.) voted with a united Republican caucus to block the approximately $120 billion package. The measure needed 60 votes to advance, but garnered only 56.

Democratic leaders, who had predicted victory less than 24 hours earlier, vowed not to give up on the measure, but acknowledged that they have no clear path to securing the one or two Republican votes needed to push it to final passage. Though the sprawling package contains a number of must-pass provisions, Republicans have been steadfast in their opposition, insisting that the full cost of the measure be covered by cutting existing government programs.

"Americans are frustrated with the amount of spending and borrowing around here," Senate Minority Leader Mitch McConnell (R-Ky.) said after the vote. "Let's not wave on through legislation that is going to worsen the deficit and dig an even deeper hole than we are in."

With midterm elections looming this fall, conservative Democrats also had voiced opposition to the size of the package and its impact on deficits, already driven to record levels by government spending to combat the recession. But congressional leaders have struggled to pare the legislation back.

The measure would protect doctors from a steep cut in Medicare rates scheduled to take effect Friday and extend emergency unemployment benefits that support more than 5 million people. Without congressional action, an estimated 1.2 million people will stop receiving checks by the end of the month, according to independent estimates.

The package also would extend some expired tax breaks for businesses and individuals, including the hugely popular research and development tax credit. And it would raise taxes on oil companies, multinational corporations and investment partnerships.

During the past month, Democratic leaders have winnowed the overall price tag down from $200 billion and reduced its impact on the deficit by two-thirds. The House narrowly approved the package and sent it

to the Senate, where Majority Leader Harry M. Reid (D-Nev.) has been trying to add $24 billion in aid to state governments, a top Obama priority designed to avert thousands of state layoffs and prevent the 9.7 percent unemployment rate from shooting even higher.

To squeeze in that extra cash, Reid has hacked away at other pieces of the package. The latest version would protect doctors from the Medicare pay cut for six months rather than the 19 months approved by the House, for example, and it would dock $25 from the checks of all 15 million people who receive unemployment benefits, repealing a boost approved in last year's stimulus legislation.

The resulting measure, unveiled late Wednesday, would add $55 billion to deficits over the next 10 years, according to the Congressional Budget Office. And with that, Democrats believed they had secured the votes of at least two Republicans: Sens. Olympia J. Snowe (Maine) and Scott Brown (Mass.).

But any deal unraveled during a long day of talks Thursday, leaving Democrats frustrated and perplexed.

"We thought we had enough votes to pass this," Reid told reporters, adding that Lieberman had been prepared to come on board. He and Senate Finance Committee Chairman Max Baucus (D-Mont.) said they would regroup Friday. But aides said the path forward would not become clear until next week at the earliest.

"The vast majority of Americans want us to create jobs, to help pull us out of this recession," Baucus said. "The bottom line is we're going to keep trying, because that's what the American people want us to do."

White House spokeswoman Amy Brundage blamed Republican obstructionism for the bill's failure. "These measures are vital to our nation's families and our economic recovery, and the President urges those opposing these measures to end this obstruction and stand on the side of the American people," Brundage said.

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Doctors Recouped Cuts in Medicare Pay, Study Finds.

By REED ABELSON Published: June 16, 2010

When Congress aims to reduce Medicare spending, lawmakers often rely on cutting the prices they pay doctors and hospitals.

But a new study shows how that approach may have limited success, if doctors respond by simply treating more patients to make up for the lost income.

That is what happened, according to the study, after Congress tried to reduce Medicare spending on cancer chemotherapy drugs that doctors administer to patients in their offices. Many doctors ended up prescribing chemotherapy for more of their patients, to make up for the lower prices.
The study, being published Thursday on the Web site of the academic journal Health Affairs, suggests that any significant changes in medical payment rates must be done carefully, said Joseph P. Newhouse, a health policy professor at Harvard who is one of the study's authors.

"Hospitals and doctors will respond to changes in how they are paid," Professor Newhouse said.

The study, which will be published in the July issue of Health Affairs, examined changes in payments for certain cancer drugs as part of Congress's 2003 overhaul of Medicare.

The issue was the large sums that cancer specialists made from the difference between what they paid for the chemotherapy drugs they gave to patients and how much Medicare reimbursed them for those drugs. In some cases, a doctor could buy the drugs for about 20 percent below the price Medicare set for the drugs, which are given intravenously in a doctor's office.

Critics at the time were concerned that doctors had a financial incentive to provide chemotherapy to patients when there was little likelihood that they would benefit from the treatment. But when the cuts

went into effect, there was a new concern — that many cancer specialists would stop treating patients, sending them instead to hospital clinics for their chemotherapy.

"At the time, I think we were legitimately concerned about that," said Dr. Craig C. Earle, a cancer specialist who is now the director of health services research at Cancer Care Ontario and the Ontario Institute for Cancer Research in Toronto, which oversees cancer care for Canadians in the province of Ontario.

But doctors ended up treating more patients, not fewer, according to the study, which analyzed Medicare claims for 222,478 patients who were found to have lung cancer from 2003 to 2005.

On average, within a month of the diagnosis, chemotherapy treatment increased to 18.9 percent of patients, compared with 16.5 percent before the law went into effect in 2005.

"In sum, far from limiting access," the changes under the law "actually increased the likelihood that lung cancer patients received chemotherapy," the study concluded.

Doctors responded by treating more patients because they had been making so much money under the old system, Professor Newhouse said. "These markups were a substantial portion of their income," he said.

The study could not determine whether some doctors had cut back or stopped their use of chemotherapy drugs.

Because the study was limited to lung cancer patients, the findings may also not be true of the price cuts that affected other patients undergoing chemotherapy, the authors said. Nor did the study address the question of whether the increased use of chemotherapy was benefiting patients.

The reason the authors limited the study to lung cancer was to be able to better test the idea of whether doctors might also change types of chemotherapy, based on their relative profitability. Doctors tend to view the different chemotherapy options for lung cancer as offering essentially the same benefits to patients, unlike treatments for some other cancers, Dr. Earle said.

Under the government's reimbursement formula, which is based on percentages of the drug's price, doctors using the most expensive chemotherapy drugs still make more money than those who choose a less expensive drug.

The study found that doctors frequently switched to more expensive options, like increasing their reliance on drugs like docetaxel, where doctors were paid roughly $2,500 for giving a standard monthly amount. "The financial incentive seemed to have an effect where there's not strong evidence or more than one equally good treatment option," Dr. Earle said.

But at the same time, Dr. Earle said, he thinks some cancer doctors left private practice for positions in hospitals because of the lower reimbursement rates, which made them no longer able to afford being independent.

"When you squeeze the system in a little place, there is a lot of change," he said, "but not always the way one would expect."

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Medicare Advantage: You Get What You Pay For

AUSTIN FRAKT, Assistant Professor of Health Policy and Management
Boston University's School of Public Health, JUN 14, 2010

The Obama administration seems worried. In an election year, any change to Medicare that adversely affects beneficiaries is a political liability for incumbents. And big changes to Medicare are coming,

beginning with Medicare Advantage, the program that provides private insurance alternatives to traditional fee-for-service Medicare, the program's public option.

Last Monday, private insurers that offer Advantage plans submitted their 2011 bids, estimates of the cost of providing a fixed set of basic Medicare benefits next year. It is through this annual bidding process that the generosity of coverage and level of cost-sharing for each plan is established. With 2011 government payments to plans fixed at 2010 levels by the new health overhaul law, it is likely that beneficiaries will pay more to get less from Advantage plans next year. The bids will reveal how much.

According to the Wall Street Journal, in advance of the bid deadline, Department of Health and Human Services Secretary Kathleen Sebelius sent a letter to insurance companies warning them not to dramatically increase premiums or cost-sharing of Advantage plans. If they do, they run the risk that Sebelius will reject their proposals.

Despite the secretary's threat, it's inevitable that Advantage plans will adjust their premiums and cost-sharing upward in the long run, if not in the short run. Over the next few years, the new health law gradually reduces Advantage payments from today's generous levels that are about 15% above fee-for-service costs. The lower levels will depend on local costs and plan quality.

That's good news for taxpayers, even if it isn't welcome news to Medicare beneficiaries. According to the Congressional Budget Office, the reduction in plan payments is expected to save over $100 billion in the next decade. The lower spending on Advantage plans inevitably will lead to reductions in plan availability. Some beneficiaries will have access to fewer plans, some to none at all, a fact illustrated by a Health Care Financing Review paper I co-authored.

Our earlier paper in the International Journal of Health Care Finance and Economics indicates that even where plans continue to be offered, their benefits will be less generous as government payments decrease. Though beneficiaries will object to the loss of benefits, they actually don't value those benefits anywhere near their full cost to taxpayers. In a study published last year, also in the International Journal of Health Care Finance and Economics, we found that for the benefits provided by each additional dollar paid to Advantage HMOs since 2003, beneficiaries would have paid just $0.14 out of their own pocket. In monetized terms, a dollar saved makes a Medicare beneficiary worse off, but by far less than one dollar.

This relatively poor return of value on taxpayer dollars is why I support reductions in Advantage payments. The administration and congressional Democrats have chosen the right path for Advantage payment policy. Having done so, they are now faced with a political problem. How can they avoid the potential ire of disgruntled Medicare beneficiaries? It will be hard, if not impossible.

Sebelius' letter is a good try. It's an attempt to bully plans into self-subsidizing their products or finding creative ways to hide the reduction in generosity this year. If she succeeds, then she'll have achieved a short-term political victory. But she's facing an uphill battle.

In the long run, there's no getting around the fact that Advantage plans will shrink in generosity and availability. Anything else would defy a fundamental law of economics that also happens to be a fundamental law of politics: you get what you pay for.

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Drug spending in U.S., Canada about same: report

CBC News:

A new report suggests that despite federal government controls on the price of prescription drugs, the burden of paying for medications in Canada differs little from the United States.

The report by the economic think-tank the Fraser Institute says that per capita spending on prescription drugs is nearly identical for Americans and Canadians.

In both the U.S. and Canada, consumers spent 1.7 per cent of their gross per capita income on prescription drugs. Looked at in terms of after-tax income the rate is 2.6 per cent for Canadians compared with 2.3 per cent for Americans.

Americans.

That rate is based on Canadians being written an average of 14.2 prescriptions per year, compared with 12.7 for Americans.

Name-brand drugs in Canada are substantially cheaper than in the U.S., at an average of 53 per cent lower.

The major difference is in the cost of generic substitutes, which come in 112 per cent cheaper in the United States. Americans also purchase more of the inexpensive generics instead of brand-name drugs.

'**These policies have not resulted in personal advantages for Canadians**.'—Mark Rovere, lead author of study

A shopper walks toward the pharmacy at a Little Rock, Ark., Wal-Mart. A new study by the Fraser Institute suggests prescription drug costs differ little between the U.S. and Canada. (Danny Johnston/Associated Press)

The Fraser Institute frames the study as showing a failure in Canada's interventionist model in prescription drug costs.

"Much of Canada's prescription drug policy is based on the assumption that greater government intervention in the market such as regulation of drug prices will provide more affordable access to drugs," notes Mark Rovere, lead author of the study.

"But our research finds that on average these policies have not resulted in personal advantages for Canadians compared to the United States," he said.

The Ontario government is currently facing a major battle with pharmacists as it attempts to bring down the cost of generic drugs in that province.

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www.healthcareil.com

SMALL BUSINESSES SAY HEALTHCARE LAW MAKES IT DIFFICULT TO SHOP FOR NEW PLANS.

Firms Find Changing Insurance Is Trickier
By AVERY JOHNSON

Many small-business owners are caught in a bind created by the federal health-care overhaul that has made choosing health-insurance plans for their workers a trickier calculation.

Companies whose health plans are up for renewal are seeing sharp increases for the coming year. In years past, they could simply seek other bids. But this year, the new health-care law complicates the decision to switch plans.

Under the health-care overhaul, companies that keep their existing health plans will be exempt from some of the new law's requirements, such as providing yearly physical exams and other benefits that could add up to substantially higher costs starting in 2014.

The U.S. Chamber of Commerce estimates that 20 or so new rules could raise companies' health bills by 1% to 3% each. Companies forfeit "grandfathered" status if they change their health plans.

Last week, new regulations outlined limits on the changes that can be made to a plan before it is subject to the requirements that will take effect in 2014. For example, increasing a plan's deductible by more than a certain amount could trigger the forfeiture of grandfathered status. Even grandfathered plans, though, will have to comply with many of the law's reforms, such as covering adult children up to age 26.

Many small businesses would like to keep their grandfathered status but can't afford the premium increases. Benefits consulting firm Mercer LLC says increases are averaging about 10% in 2010, and a Deloitte LLP estimate puts the range between 11% and 15%.

In California, Blue Shield California's small-business quotes rose an average of 18%. In New York, WellPoint Inc.'s Empire BlueCross BlueShield unit says it has raised prices for some small companies 17%. Mark Wagar, chief executive at Empire BlueCross BlueShield, attributed the higher premiums to increasing hospital prices and taxes.

The insurers argue that they have to increase prices because of mushrooming costs for hospital care, drugs and doctors. They say that the health overhaul did little to address the rising costs and that the health overhaul law's new coverage requirements could push prices up further.

Tom Epstein, the vice president for public affairs for Blue Shield of California, says that up to 75% of the increases stem from higher-than-anticipated patient use of plans with few limits on cost sharing.

Mike Sumner, who runs Case Automotive in Woodburn, Ore., found out recently that he would have to pay a 24% premium increase to renew his policy with Regence, a Blue Cross Blue Shield plan in the Northwest.

"Being grandfathered would be great, and I do like my plan," he says, "But 2014 is too far out. We've got health-care problems now." Instead of paying the new rate, he plans to shop for a new plan for himself and his six employees.

A spokeswoman for Regence says the rate increase is the result of rising medical and prescription costs.

The Chamber of Commerce and the National Federation of Independent Business say they are receiving calls nonstop from employers worried about keeping down health costs and wondering how much they can change their plan design.

"This is the most timely issue for them right now," says Amanda Austin, who is the policy director for the NFIB, a small-business group.

Cigna Inc. Chief Executive David Cordani says he has also been fielding a lot of questions from corporate customers, including small businesses, about maintaining their grandfathered status.

Last week, about 3,000 employers and brokers dialed in to the company's conference call and chiefly asked about the grandfathering rules. The majority are "playing it safe and making very little changes," says Mr. Cordani, whose company covers 632,000 people in companies with fewer that 250 employees.

Tim Sledz, manager of Windwalker Aviation Services in Romeoville, Ill., is so worried about the future that he has elected to hang onto his six-person business's grandfathered status. UnitedHealth Group Inc.'s UnitedHealthcare unit offered him a renewal-rate increase of roughly 15% to stay with the plan starting June 1.

A spokesman for UnitedHealth Group confirms that Windwalker is a client and says the rate increase reflects rising health-care costs and the group's previous health-care needs.

Nicholas Papas, a spokesman for the White House Office of Health Reform, says that the health-care law gives companies the flexibility to respond to rising costs. The new rules allow changes to deductibles, for instance, that adjust for medical inflation plus 15%.

Tax credits of up to 35% should help small businesses with 25 or fewer workers offset rising costs, and eventually health-insurance exchanges—the new marketplaces where consumers can shop for coverage— will help push prices down.

The law will also allow a grace period during which plans can undo changes that may have unwittingly triggered the

forfeiture of grandfathering, Mr. Papas says. And, he adds, it will even acknowledge good-faith efforts to comply that nonetheless resulted in changes that are "modestly" over the new limits.

Last month, Kevin Harriman, managing partner at Pro Star Aviation, which provides engineering services for corporate aircraft in Londonderry, N.H., got a renewal notice for his plan, which covers about 50 employees. He was advised that the price would increase roughly 18%, up from the usual single-digit boosts of the past.

To keep costs down on his plan through Harvard Pilgrim, Mr. Harriman raised the deductible for all employees to $2,500 from $1,500.

"Obviously we don't want to fall into the trap where to save ourselves an increase we end up in a place where we're out of luck and we could have stayed in a nice plan," says Mr. Harriman. But "we had no choice."

Harvard Pilgrim confirms the numbers but declines to comment further.

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More Americans purchasing travel insurance.

Planning for Volcanoes and Other Vacation Jams
By NANCY MATSUMOTO

When volcanic ash clouds darkened a large swath of Northern Europe in April and resulted in an unprecedented number of flight delays and cancellations, many travelers who had once pooh-poohed travel insurance decided to take a second look.

"Any type of event like the volcanic ash event really creates heightened awareness of the need for travel insurance," says Michael J. Ambrose, president of Travelex Insurance Services. "Our calls shot up 20% to 30%."

Although no figures detailing the increased popularity of travel insurance since the volcano eruption are available, Wayne Nelson, senior manager of industry affairs for the American Society of Travel Agents, says, "When events like this … occur, most [in the industry] agree that sales at least double."

In 2008, Americans spent nearly $1.6 billion on travel insurance, according to the U.S. Travel Insurance Association, reflecting a growth of about 13% over the past two years. Sales are increasing in part because travelers realize the importance of health care and medical evacuation. "When you leave the country in some incidences your health-insurance plans might not cover you," says Mr. Ambrose. Also, he adds, "trip interruption and cancellation coverage has become more important in recent years due to travelers worried about losing their travel investment."

We compared comprehensive travel insurance plans from four online providers. Each website featured easy-to-use quote calculators that quickly provided a cost estimate based on country and state of residence, destination, trip cost and duration, and age of each family member traveling. Prices for comparable plans didn't vary much; the time-consuming aspect of the process was parsing the details of coverage.

Each plan offered similar 100% to 150% flight cancellation or interruption coverage, but varied in what is deemed "acceptable reasons for cancellation," and coverage for delayed flights, missed connections and lost baggage. Most plans cover cancellations due to medical illnesses, weather-related shutdowns by carriers, or the death of a family member. Yet there is enough variability in covered reasons (ranging from jury duty to employer mergers and acquisitions) to warrant a close look at the fine print. Medical care and evacuation coverage varied considerably as well.

In the case of the Icelandic volcano eruption, most insurers have been covering cancellations and delays

under their adverse weather clauses. Insurance must be purchased before an eruption is declared a foreseeable event or after common carrier schedules return to normal in order to be covered by most plans.

Worried that the giant British Petroleum oil slick will ruin your Gulf of Mexico vacation? None of the plans covered this event outside of "cancel for any reason" policies—deluxe plans that are generally 30% to 40% more expensive than more restrictive plans, according to Alex Velinov, president of Total Travel Insurance. Mr. Velinov adds that certain plans will cover cancellation if the oil slick shuts down the hotel or resort you booked.

Travelex's no-frills Basic plan clocked in with the lowest quotes for two trips we planned this summer, one to Atlanta and one to London. We liked the site's uncluttered home page and went directly to the "Get a Quote" box. After inputting our travel details, it was easy to compare the four plans offered. A chart spelled out each plan's benefits in 10 categories, such as trip cancellation, medical evacuation and accidental death and dismemberment coverage.

We opted for the least expensive Basic plan, which covered our family of three's $800 Atlanta flight for $76. In addition to 100% trip cancellation and delay coverage, the plan offered $500 a person in lost-baggage coverage; $100 a person for baggage delay; $15,000 in medical benefits for either sickness or accident; and $100,000 in medical evacuation. Adding the "cancel for any reason" clause would have bumped the price up to $110. For our five-day $4,500 London flight, the same two plans were priced at $110 and $161.

While Travelex's plan was the least expensive, Travel Guard offered better coverage for the Atlanta trip for just $2 more. This plan provided flight-interruption protection worth 150% of the cost of the flight, $1,000 and $300 a day in lost or delayed baggage coverage, $25,000 in medical insurance, and $500,000 in medical-evacuation coverage. When we tried to add on "cancel for any reason," a Travel Guard agent we contacted said this feature wasn't available to New York state residents.

Before we finalized our purchase, we got to review the plan's terms and conditions, and click on a link for alerts and strike notifications. A list of nine striking airlines and 54 travel suppliers in default came up, informing us that these carriers wouldn't be covered for trip cancellation/interruption after certain dates.

At the Access America's site, we liked how easy it was to compare coverage between the company's three plans. The site also let us save our quotes for later purchase. We were puzzled to see the economy "Basic" plan for our London trip was $11 higher than the more generous "Classic Comprehensive" plan. A spokesman for Access America accounted for the difference by explaining that the Classic Comprehensive plan includes a "kids are free" feature that the Basic plan doesn't.

For our Atlanta trip, Access' basic plan was $76, $2 less than the Classic Comprehensive with a free kids feature. But it only offered $150 for missed connections (compared with $500 and $750 for Travelex and Travel Guard), $10,000 in medical coverage and $50,000 for medical evacuation.

For comparison, we tried Total Travel Insurance, an aggregator site that pulls together price quotes from major travel insurers. The home page looked too chaotic, but the FAQ on trip cancellation insurance was extremely informative (especially its entries on terrorism and inclement weather coverage).

The site's quote calculator came up with four plans, telling us the cost, percentage of total trip cost, provider and the underwriter. We were surprised that Total Travel didn't pop up with the lowest price. But Mr. Velinov says, "Some plans have such limited cancellation [coverage] that we don't think those plans are worth introducing to customers."

We liked the site's detailed analysis of each plan, and the function that let us view two plans' benefits in side-by-side charts. Another plus: the automatic inclusion of two "cancel for any reason" plans in our menu of choices. On a total airfare cost of $4,500 for our London trip, the least expensive plan Total Travel offered was $168, compared with the lowest-priced "cancel for any reason" plan at $362.

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EXERCISE AS A TONIC FOR AGING.

Fit, Not Frail: Exercise As A Tonic For Aging

Provided By: NewYorkTimes, Posted: Thursday, June 10th, 2010

Fact: Every hour of every day, 330 Americans turn 60.

Fact: By 2030, one in five Americans will be older than 65.

Fact: The number of people over 100 doubles every decade.

Fact: As they age, people lose muscle mass and strength, flexibility and bone.

Fact: The resulting frailty leads to a loss of mobility and independence.

The last two facts may sound discouraging. But they can be countered by another. Regular participation in aerobics, strength training and balance and flexibility exercises can delay and may even prevent a life-limiting loss of physical abilities into one's 90s and beyond.

This last fact has given rise to a new group of professionals who specialize in what they call "active aging" and an updated series of physical activity recommendations for older adults from the American Heart Association and the American College of Sports Medicine. These recommendations are expected to match new federal activity guidelines due in October from the United States Health and Human Services Department.

But you need not — indeed should not — wait for the government. Even if you have a chronic health problem or physical limitation, there are safe ways to improve fitness and well-being. Any delay can increase the risk of injury and make it harder to recoup your losses.

Miriam E. Nelson, director of the John Hancock Center for Physical Activity and Nutrition at Tufts University in Boston and lead author of the new recommendations, observed last fall in The Journal on Active Aging that "with every increasing decade of age, people become less and less active."

"But," Dr. Nelson said, "the evidence shows that with every increasing decade, exercise becomes more important in terms of quality of life, independence and having a full life. So as of now, Americans are not on the right path."

Jim Concotelli of the Horizon Bay Senior Communities in Tampa, who oversees fitness and wellness program development for communities for the elderly in several states, noted this year in The Journal on Active Aging that many older Americans were unfamiliar with exercise activities and feared that they would cause injury and pain, especially if they have arthritis or other chronic problems. Yet by strengthening muscles, he said, they can improve joints and bones and function with less pain and less risk of injury.

The key is start slowly and build gradually as ability and strength improve. Most important is simply to start — now— perhaps under the guidance of a fitness professional or by creating a program based on the guidelines outlined here.

Although medical clearance may not be necessary for everyone for the moderate level of activity suggested, those with a known or possible problem would be wise to consult a doctor. And a few sessions with a trainer can help assure that the exercises are being done correctly and not likely to cause injury.

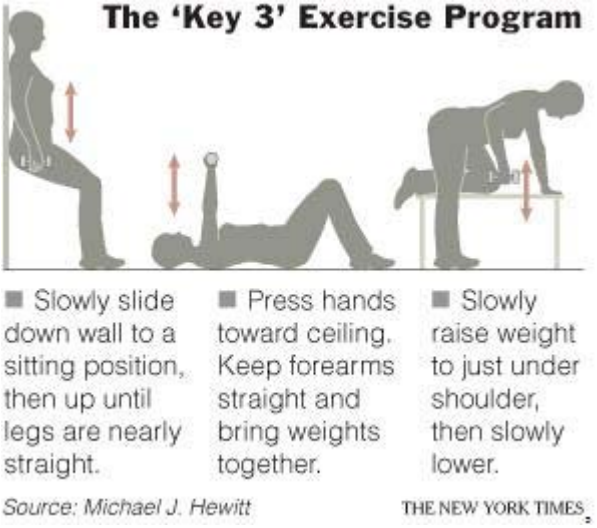
Until recently, physical activity recommendations for all ages have emphasized aerobics, or cardiovascular conditioning, through moderate to vigorous activities like brisk walking, cycling, lap swimming or jogging for half an hour a day five or more days a week. For those unable to do 30 minutes at a time, the activities can be broken up into three 10-minute intervals a day. If you have long been sedentary, start with even shorter intervals.

For people who prefer indoor workouts, a treadmill, cross-trainer, step machine or exercise bike can provide excellent aerobic training for the heart, lungs and circulation. Those unable to do weight-bearing

exercise might try swimming or water aerobics. Keep in mind that 30 minutes a day of aerobic activity five days a week is the minimum recommendation. More is better and can reduce the risk of chronic

disease related to inactivity.

Contrary to what many active adults seem to believe, physical fitness does not end with aerobics. Strength training has long been advocated by the National Institute on Aging, and the heart association has finally recognized the added value of muscle strength to reduce stress on joints, bones and soft tissues; enhance stability and reduce the risk of falls; and increase the ability to meet the demands of daily life, like rising from a chair, climbing stairs and opening jars.



Strength training can be done in a gym on a series of machines, each working a different set of major muscle groups: hips, legs, chest, back, shoulders, arms and abdomen. Or it can be done at home with resistance bands or tubes, hand-held barbells or dumbbells or even body weight. One program, the Key 3 program diagrammed here , was devised by Michael J. Hewitt, research director for exercise science at the Canyon Ranch Health Resort in Tucson. It can be completed in 10 minutes with practice.

As Dr. Hewitt explained in the International Longevity Center-USA newsletter, skeletal muscles can only contract and thus are always arranged in pairs. "One muscle of the pair pulls to bend the joint (flexion), and its antagonist pulls to straighten the joint (extension)." Thus, a strengthening program must be balanced, he said, "pairing every pulling lift with an opposite pushing action."

Dr. Hewitt emphasized that to reduce the risk of injury and premature muscle fatigue, the large muscles should be exercised first, followed by the smaller muscles, with the postural muscles exercised last. For example, one would start with chest and upper back muscles, then the arms and shoulders and finally the lower back and abdomen.

Muscles have to be overworked to grow stronger. The goal for each exercise is three sets of 8 to 12 repetitions to muscle fatigue. Muscles also need time to recover. So strength training should be done two or three times a week on nonconsecutive days.

The new recommendations add flexibility and balance to the mix. Improving balance and reducing the risk of falls is critical as you age — if you fall, break your hip and die of pneumonia, aerobic capacity will not save you. Ten minutes a day stretching legs, arms, shoulders, hips and trunk can help assure continued mobility, and daily exercises like standing on one foot and then the other, walking heel to toe or practicing tai chi can improve balance.

The recommendations, issued last August, are geared to healthy adults 18 to 64, with a companion set for those 65 and older or those 50 to 64 who have chronic health problems or physical limitations. Details can be found at http://www.acsm.org/. Under "Influence," click on Physical Activity Guidelines From ACSM and AHA.

The experts who made these recommendations urge all adults to adopt them now. As C. Jessie Jones, co-director of the Center for Successful Aging at California State University, Fullerton, said, "People can't wait until they're in residential or long-term care to get started."

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PLANNING FOR YOUR FUTURE.

With more Americans living longer lives, there's new interest in purchasing long-term care insurance to cover costs generally associated with aging.

Currently, 8.2 million Americans have purchased long-term care insurance that pays for home care, for assisted living or for care in a nursing home.

Such long-term health care costs are not usually covered by medical insurance, by Medicare supplement plans or group insurance. For seniors on Medicare, the long-term care benefits are limited–especially when considering the cost of a debilitating disease such as Alzheimer's.

Fortunately, long-term care insurance may be more affordable than you realize. Here are a few tips on how to save from the experts at NAIFA:

• Take advantage of the tax deduction. The Internal Revenue Service recently increased deductibility levels for long-term care policies. If you own a business, you may be able to deduct 100 percent of the cost. As an individual, your premiums may be partially tax deductible. Deductibles are based on age and range from $330 to $4,110.

• Compare policies. Each insurer sets rates based on the type of client it seeks to attract. The company with the lowest cost for a 55-year-old married couple may not be the least expensive for a 55-year-old single individual.

• Stay healthy. Individuals with few or no current health conditions pay less for their long-term care insurance.

• Involve your significant other. Discounts are offered to married adults and even unmarried adults who live together if both individuals purchase insurance coverage.

• Add a deductible. Deductibles on long-term care insurance policies are typically referred to as the Elimination Period, the number of days you choose to pay fully until your benefits for qualifying care begin. The longer the Elimination Period, the lower your annual premium.

• Set a defined benefit period. Deciding how long you will need the benefits could save you more than 50 percent of the cost.

• Share benefits. A shared care benefit gives couples a pool of money to work with.

• Pay your premium once a year. Monthly premiums typically cost 7-8 percent more.

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