Health & Retirement Services of Illinois
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OUR NEWS LETTER

Large Medicare Premium Increase Projected In 2017

07/12/2016 Diane Archer_Founder of JustCareUSA.org

The Medicare Trustees' June 2016 report signals a projected 2017 Medicare Part B premium increase of 20 percent for some people. However, Congress could still intervene this fall to prevent it. **Out-of-pocket costs for people with Medicare are already extremely high.**

The Medicare Part B premium, generally deducted from your Social Security check, is tied to the cost of delivering medical services — doctors' visits, therapy services, lab tests and medical equipment. Medicare covers 75 percent of the cost of that care, and the premium covers the remaining 25 percent.

As many as one in three people who pay $121.80 a month for Medicare Part B in 2016 could see their premium increase to as much as $149. Because that's such a large increase, Congress may decide to reduce it some.

Wealthier people with Medicare are also likely to see a sizable premium increase. For the last decade, people with annual incomes above $85,000 (couples above $170,000) — about six percent of the Medicare population — pay much higher premiums than others with Medicare. **In 2016, depending on their income, they pay between $170.50 and $389.80.**

To learn more about the **Trustees' projections over the next several years, click here**. **Here are some tips for choosing between traditional Medicare and a Medicare Advantage private insurance plan**. For help understanding what to do if you're eligible for Medicare, **here's a simple checklist**.

In Our Newsletter

The End of Social Security (Leaked Evidence Stumps Obama, Stuns Retirees.)

- BY J.L. YASTINE August 1, 2016

American seniors have been worried about our nation's ability to continue to pay out Social Security.

As one retirement-bound Los Angeles resident puts it, "The money that I put aside now, it's not like that money is going to be waiting for me."

Unfortunately, several leaked reports now confirm that these fears will become an ugly reality, very soon.

Doug Bandow, a former special assistant to President Ronald Reagan, and a senior fellow at the Cato Institute, warns that seniors must plan for "Social Security's coming crash."

And in an alarming article, *U.S. News & World Report* argues that payouts will inevitably end, and says you must learn how to "prepare for the end of Social Security" now.

How could this happen?

As you know, Social Security operates as a classic Ponzi scheme — new contributions are used to pay off earlier contributors.

The problem is twofold: Our government tapped into Social Security savings, and there are not enough new contributors to pay those who already funded the system.

And the problem is worse than any government agency wants to admit.

However, one famous economist, James Dale Davidson, boldly states…

"We could see the end of Social Security as soon as 2016,

and there is nothing President Obama, Congress or

any other government agency can do to stop it."

Yes, Social Security as we know it could end in 2016.

Before you dismiss Davidson's warning, know that he has a remarkable track record of calling nearly every major economic shift over the last three decades.

For example, Davidson predicted the stock market collapse of 1999 and 2007, along with the fall of the Soviet Union and Japan's economic downfall, to name just a few.

And his predictions have been so accurate, he's been invited to shake hands and counsel the likes of former presidents Ronald Reagan and Bill Clinton — and he's had the good fortune to befriend and convene with George Bush Sr., Steve Forbes, Donald Trump, Margaret Thatcher, Sir Roger Douglas and even Boris Yeltsin.

So, how can Davidson be so sure that Social Security will end in 2016?

As Davidson explains in a newly released video, "Right now, there are five massive cracks in the American economy's foundation that are converging for the first time in history. This is a landmark development that I am convinced will trigger the greatest depression we've ever seen. Yes, worse than the 1929 Great Depression."

Davidson's new video is causing a controversy, not just because of what he says, but because the evidence he provides is irrefutable (he uses over 20 unquestionable charts to prove his point).

"I know that everywhere you turn things look pretty good," Davidson goes on to say, "The market is near all-time highs, the dollar is strong and real estate is booming again. But remember, the exact same scenario played out in 1999 and 2007. The economy is unraveling right now, and fast. Very fast."

Davidson warns that a 50% stock market collapse is looming, that "real estate will plummet by 40%, savings accounts will lose 30% and unemployment will triple."

And although our future may seem bleak, as Davidson says, "There is no need to fall victim to the future. If you are on the right side of what's ahead, you can seize opportunities that come along once, maybe twice, in a lifetime."

Indeed, in his video, Davidson reveals what he and his family are doing to prepare right now, and even profit. (It's unconventional and even controversial, but proven to work.)

While Davidson intended his video for a private audience only, original viewers leaked it out and now tens of thousands are downloading the video every day.

Humana profit plunges on higher provisions for Obamacare business

BY AMRUTHA PENUMUDI Wed Aug 3, 2016

Humana Inc (HUM.N) reported a 28 percent drop in quarterly profit as it set aside more money to cover losses in its Obamacare business, and the company said it would discontinue next year most of these plans sold off public exchanges.

The U.S. health insurer, whose acquisition by rival Aetna Inc (AET.N) has been challenged by U.S. antitrust authorities, said it planned to shrink its individual commercial business to 156 counties next year from 1,351 currently.

Under the business, Humana offers individual insurance plans both on and off the public exchanges set up under President Barack Obama's Affordable Care Act.

The company said it expected premiums of $750 million-$1 billion in 2017 from its Obamacare plans, way lower than the $3.4 billion estimated for 2016.

U.S. health insurers, including Anthem Inc (ANTM.N) and UnitedHealth Group Inc (UNH.N), have been losing money in their Obamacare businesses due to high medical costs.

Humana set aside about $208 million more in the second quarter to cover losses in the business, which it currently operates in 15 U.S. states.

The company said it would shrink the business to 11 states next year and had already limited memberships in the four states where it no longer intended to offer the plans.

Humana had said in May it would exit the Obamacare business in some states.

The company and Aetna announced a deal on Tuesday to sell a portfolio of about 290,000 of their Medicare Advantage members in 21 states to Molina Healthcare Inc (MOH.N) to win U.S. antitrust approval for their merger.

Humana's individual commercial memberships fell by nearly a quarter in the three months ended June 30.

Net income fell to $311 million, or $2.06 per share.

Excluding items, the company earned $2.30 per share, beating the average analyst estimate of $2.23, according to Thomson Reuters I/B/E/S.

Revenue rose 2 percent to $14.01 billion, topping the average estimate of $13.59 billion.

Big Companies Expect Moderate Increases In 2017 Employee Health Care Costs

By **Jay Hancock** August 9, 2016

Big employers expect health costs to continue rising by about 6 percent in 2017, a moderate increase compared with historical trends that nevertheless far outpaces growth in the economy, two new surveys show.

“These cost increases, while stable, are both unsustainable and unacceptable,” said Brian Marcotte, CEO of the National Business Group on Health, a coalition of very large employers that got responses from 133 companies.

Employers are changing tactics to address the trend, slowing the shift to worker cost sharing and instead offering video or telephone links to doctors, scrutinizing specialty-drug costs and steering patients to hospitals with records of lower costs and better results.

Most large-company employees should expect a 5 percent increase in their premiums next year and, in contrast to previous years, “minimal changes” to plan designs, NBGH said.

The portion of employers offering high-deductible health plans next year — 84 percent — is essentially unchanged from 2016, according to the NBGH report. So is the percentage of companies offering high-deductible plans — 35 percent — as the only choice for workers and families.

Patients with high-deductible coverage pay thousands of dollars in medical costs before the insurance kicks in.

The idea is that sharing the pain makes employees smarter shoppers, prompting them to forego unneeded tests and find the best price. But critics say available tools to shop for care are grossly inadequate.

Counting cost-control measures, companies responding to NBGH’s survey expect their net health expenses to rise by 5 percent next year. A survey of hundreds of employers by consultants Willis Towers Watson showed similar results.

“This is well above the cost-of-living increase,” said Julie Stone, health care practice leader at Willis Towers Watson. To control costs, “our clients are willing to do things that a few years ago employers might have been reluctant to do,” she said.

Five or 6 percent is moderate compared with medical-cost growth in the early 2000s, when annual percentage increases reached double digits.

But it's still far greater than recent increases in corporate profits and economic output. Economists partly blame the skimpy raises workers have received over the past decade on the ballooning resources employers had to devote to health spending.

Moderate cost trends in the large-employer market seemingly contrast with those in the Affordable Care Act's online marketplaces, where plans sold to individuals are seeking premium increases of 10 percent or more.

But the variation has more to do with volatility in how insurance companies price their plans than with big differences in underlying costs, said Larry Levitt, a senior vice president with the Kaiser Family Foundation. (Kaiser Health News is an editorially independent program of the foundation.)

Many marketplace plans underestimated costs for their members this year, forcing catch-up increases for 2017, he said.

New kinds of spending are driving health cost increases.

Even as hospital use has moderated, employers point to specialty drugs to fight cancer or hepatitis C that can cost tens or hundreds of thousands of dollars per patient as a new major contributor to health expense.

Nearly 1 in 3 companies said specialty drugs are the main factor in cost increases, according to the NBGH survey. Nine of 10 employers plan to install programs to manage specialty-drug costs, according to the Willis Towers Watson study.

Approaches include shifting drug coverage to large pharmacy benefit firms, which can deploy better buying power against the manufacturers, and infusing drugs at patients' homes rather than in expensive hospitals, Stone said.

Employers are increasingly steering workers toward hospitals with records of higher quality results and fewer complications for expensive procedures such as fertility treatments and bariatric surgery. Until now companies have promoted such "centers of excellence" mainly for organ transplants.

They're also encouraging remotely delivered preventive care by offering nurse coaches for the chronically ill via telephone and video conferencing to extend the hours of primary care clinicians.

Nine out of 10 large employers will offer such telehealth services next year in states that allow it, up from 70 percent this year, the NBGH survey shows.

Employers continue to shrink coverage for workers' spouses, especially if spouses have access to a medical plan through their own workplace.

By 2018 Willis Towers Watson expects nearly half of large companies to charge an extra $100 or so a month to carry a working spouse on the plan — in addition to the regular premium contributions.

CMS steps up enforcement on Medicaid users getting marketplace tax credits

By Virgil Dickson | August 5, 2016

The CMS is stepping up enforcement action against Medicaid consumers who received tax credits to purchase insurance through the Affordable Care Act marketplace—a move that could mean lost coverage for some.

The CMS first began to alert states relying on Healthcare.gov about the problem last September. Previously, consumers in this situation would receive a notice that they must terminate their marketplace coverage or else be on the hook repaying the credit.

Consumers are finding themselves being dually enrolled if they have experienced a life change, such as a drop in income that made them eligible for Medicaid after they had purchased marketplace coverage.

Similarly, consumers enrolled in marketplace coverage may have applied and been awarded Medicaid coverage while failing to terminate a marketplace plan.

To help find these people, the CMS is enlisting periodic data matching, which uses existing non-employer sponsored coverage data to check whether a consumer who is enrolled in Marketplace coverage with tax credits is also enrolled in Medicaid or Children's Health Insurance Program coverage.

Now the CMS is stepping up enforcement action by voiding the enrollee's tax credits if they don't end their marketplace coverage on their own after being warned, it said in a new notice to states.

There is a chance that this change in policy could lead to a loss in coverage for some as the agency acknowledges some people receiving the warnings may not actually be in Medicaid as its records indicate.

It's unclear how many people will be receiving the notices. A CMS spokeswoman would say only that it was a “small number” of people.

As a result of the new enforcement action, actions are being taken to mitigate the possibility of someone wrongly losing their tax credits, the spokeswoman said.

Consumers in these situation will now receive two notices after having been found dually enrolled in Marketplace coverage and Medicaid. If that person either doesn't void their

marketplace coverage or attest they are not in Medicaid after the second notice, the CMS will step in and void the person's tax credits.

This extra step may not help avoid loss of coverage as many low income families tend to move often, so many addresses may be inaccurate, said Kip Piper, a Washington-area consultant and former senior official at the CMS.

Long-term care insurance rates soaring

Lynn Arenella, a professor at Bentley University, will see her annual premium for long-term health insurance double.

By Deirdre Fernandes GLOBE STAFF AUGUST 08, 2016

The cost of long-term health insurance for Bentley University biotechnology professor Lynn Arenella will double in the next year, to about $2,600 annually.

This wasn't supposed to happen. Legislators passed a law in 2012 aimed at protecting consumers from such steep increases. But nearly four years later, amid a tussle between industry and consumer groups, state insurance regulators still haven't issued final rules for implementing the law, leaving insurance companies to raise certain rates at will.

The delay has allowed Arenella's insurer, Chicago-based CNA Financial Corp., to raise premiums by close to 100 percent for Massachusetts consumers who bought their policies through their employers, unions, or associations — known as group coverage — with no regulatory review. Hundreds of Massachusetts residents will see their premiums rise by 95 percent over two years, CNA has told customers.

And nearly 100,000 Massachusetts residents who purchased long-term care insurance through other group plans face potentially skyrocketing premiums.

"This is a stunningly large increase," said Arenella, who bought her policy about 15 years ago, when Bentley participated in a consortium with Babson College, Brandeis University, Wellesley College, and Wheaton College to offer employees long-term care insurance at cheaper group rates.

State regulators, college officials, and the Boston Consortium for Higher Education, which initially recommended CNA to the colleges, all say there is little they can do to stop the increases.

"That's a whopper of a rate hike, without question," said Chris Goetcheus, a spokesman for the state Division of Insurance.

While CNA had a courtesy meeting with state insurance officials last fall and informed them of the increase, the agency has no authority to review or approve rates for long-term care policies in group plans, he said.

CNA made the move “after extensive review” of its expected claims and the life expectancy of its clients, said Brandon Davis, a spokesman for the company.

State officials are hoping to have rules in place soon to regulate the group market, but exactly when remains unclear. That is leaving consumers vulnerable, said Al Norman, executive director of Mass Home Care, a network of nonprofit agencies that manage patient care.

Group plans have always been a weak spot in the long-term care insurance market, usually flying under the regulatory radar, Norman said.

“This shows how group purchasers who thought they could leverage a better rate by pooling their members, ended up vulnerable to massive rate hikes,” Norman said. “These group plans were one of the major loopholes in the old regs, and now the Division of Insurance is leaving consumers prey.”

CNA is one of several companies to nearly double the premiums on group policyholders of long-term care plans.

Boston-based John Hancock Financial is raising premiums on federal employees and retirees nationwide who purchased its group long-term care insurance policies by as much as 126 percent in some cases.

On a website for government employees, a John Hancock subsidiary said an analysis of the plan “indicates that the current . . . premiums are not sufficient to meet the program’s future, projected claims costs.”

It is difficult to pinpoint how many Massachusetts consumers are being hit with rate increases and how high those increases are, because the state doesn’t oversee that part of the market.

Insurance companies, including CNA and John Hancock, have argued that they need these steep increases to cover the costs of future claims as people live longer and health care costs rise.

Long-term care insurance was designed to fill the gap between Medicare, the health insurance for the elderly that covers short-term rehabilitation and recovery services, and Medicaid, the program for the poor that pays for long-term care after a senior exhausts assets and meets income requirements. In addition to group plans, the policies are sold to individuals directly.

The insurance was pitched to baby boomers and was popular for a while. But in recent years, rates have risen rapidly for individual and group plans nationwide, in part because insurers set

prices too low when they launched the policies, underestimating how long people would live and need nursing home care, and overestimating how many people would drop their plans before collecting benefits.

Insurance companies also expected to earn much more in interest on premiums they invest to pay future claims.

Several companies have stopped writing new policies.

Massachusetts insurance regulators have been grappling with rate increases for both group and individual plans. Regulators must approve rate increases for individual plans and have rejected proposals from insurance companies to double premiums on individual long-term care policies, keeping increases more modest.

Earlier this summer, John Hancock informed nearly 6,000 Massachusetts long-term care insurance policyholders that their premiums would increase by 20 percent.

Still, these increases have left consumers angry. Under pressure to address rate increases for all long-term policies, the Legislature in 2012 passed a law that expanded consumer protections and attempted to control prices. The law also gave state regulators the authority to review group rates and policies and write rules.

Work on the regulations began under the administration of Governor Deval Patrick and has continued since in fits and starts.

The agency created working groups, held a hearing about draft rules, and more recently met privately with insurance companies, health care law experts, and consumer advocates to restart the process and reach some agreement on how to regulate the market, Goetcheus said.

At the same time, the Division of Insurance has been addressing other priorities, such as ensuring that outdated and cumbersome regulations are removed, he said.

Goetcheus said that while consumer advocates have pushed to cap annual rate increases, insurance companies have balked at such restrictions.

“We have a delicate balance to ensure that carriers can pay their claims down the road while ensuring their rates are justifiable,” Goetcheus said.

How to save big on Medicare? Know when to sign up

By Sam Wood, STAFF WRITER POSTED: AUGUST 04, 2016

Enrolling in Medicare can be stressful and confusing, but delay signing up and it can also set you back a bundle. Late enrollment penaltiescan hike a monthly premium by 10 percent or more - for the rest of your life.

More than 750,000 Medicare beneficiaries have made that mistake, boosting their Part B premiums, on average, by 30 percent, or an extra $440 a year. The problem is getting worse, too. With more people working past their 65th birthday and still getting health care coverage through their employers, they may not ask about Medicare until they miss their deadline.

Now a bipartisan bill introduced in Congress last month aims to reduce the number of seniors who get caught in that expensive trap - by simply telling people when to sign up.

More than 10,000 baby boomers turn 65 every day and become eligible for the federal insurance program that covers both seniors and the disabled, according to the Medicare Rights Center, a nonprofit national advocacy group. Most retirees, when they sign up for Social Security, are automatically enrolled in Medicare Part A, which pays for inpatient hospital care and rehab in a skilled nursing facility or nursing home.

Medicare Part B isn't an automatic thing, however. Though optional, this is the plan that covers medical services that people need more often, such as doctor visits, outpatient hospital services, x-rays, lab tests and mental health care.

Most boomers celebrating their 65th birthdays this year will pay about $122 a month for Plan B coverage if they enroll three months before or after their birthday. Even if they're still working, it's up to each person to enroll within the window of eligibility or risk hefty surcharges, significant gaps in coverage and lack of access to health services.

For each year enrollment is delayed, the Part B premium jumps 10 percent. On average, retirees who miss their initial sign-up period wait three years to apply.

"It's costly to your health and your finances," said Deane Beebe, of the Medicare Rights Center. "Most people don't realize they have a problem until they see a doctor."

And the problem is getting more common, Beebe said, because people are working longer and the age for receiving Social Security benefits has climbed to 66 and no longer syncs up with Medicare eligibility.

The proposed bill, called the Beneficiary Enrollment Notification and Eligibility Simplication (BENES) Act, would twice alert people nearing retirement age by mail with a detailed notice explaining the Part B rules.

Right now, there is no notice.

Reps. Patrick Meehan (R-PA) and Raul Ruiz (D-CA) and Sens. Bob Casey (D-PA) and Chuck Schumer (D-NY) have sponsored the legislation in their respective houses.

"I've had seniors contact my office and say they simply had no idea of existing deadlines - or that they faced penalties down the road for missing them," Meehan said. "This commonsense legislation will fix that, and it will help Medicare more effectively serve Pennsylvania's seniors."

The bill would also streamline the enrollment process and protect people who unintentionally delay signing up or receive incorrect information about Part B from a federal employee.

4 Skills You Need for a Successful Retirement

Tom Sightings,U.S.News & World Report July 2016

You'd think that, by the time you retire, you no longer have to do all the things you did when you were working -- be responsible, pay attention to detail and respond to other people's demands. While it's true you may no longer employ your technical skills in retirement -- whether they're in construction, health care or administration -- you do need other skills that are critical in charting your way through a successful retirement. Here are four important ones.

1. The capacity to be independent and self-directed. You no longer have a work schedule or a place to commute to every morning. You do not have any goals or objectives that are set by your boss. Instead, you have to make up your own schedule and find your own reason for getting out of bed in the morning. You are now your own boss, possibly for the first time in your life. Can you set your own goals and find your own meaningful activities? I recently played golf with a man who retired at age 56. He reported that he was bored silly for the first year. He had to find something to do. So he invested in a couple of race horses, and he spent the next ten years of his life at the track and the horse farm. That solution may not be for everyone, but it worked for him.

2. Good people skills. Loneliness is an issue for many retirees. You may move to a haven in the sunbelt where you don't know anybody, and so you have to make new friends, develop new social groups and find your niche in a new community. Even if you've moved to the town where your children and grandchildren live, you can't always rely on them to provide your entire social life. They have their own lives, and they may move away for a new job opportunity. So you need to make your own way, as my brother-in-law did when he moved to a Boston suburb to be near his daughter and three grandchildren. Today, he and his wife babysit the grandkids once or twice a week, and they all get together on weekends. But my in-laws also joined a church where they sing in the choir, ride their bicycles with a group of seniors and met some neighbors they have an occasional barbecue with.

3. Financial confidence. You should have provided for your financial resources long before you actually retired. But even so, you're now on your own. You no longer have a human resources department to direct your 401(k) plan, and you likely do not enjoy the security and convenience of receiving a guaranteed monthly pension. You need to develop the confidence to manage your own money and turn your assets into income. Don't be shy about consulting a financial adviser if you feel you need one, but you must face the fact that instead of getting a paycheck you are now responsible for paying yourself out of your own resources. This involves some financial savvy. But more than that, it requires you to have confidence that you can control your own financial future, without the safety net of an old employer.

4. The ability to relax. I remember when my partner was approaching retirement. She was in a near-panic about what she was going to do with herself every day. She did not want to feel as if

she was simply on an extended vacation, playing tennis, having lunch and meeting other women for mahjong. She made fun of me because I wanted to learn how to play pickleball, a cross between tennis and badminton that a lot of seniors play because it's easier on the ankles and knees. She wanted to stay useful and wasn't sure how to do that in retirement. First, she had to accept the fact that people do slow down in retirement, and while you can still be helpful and important to other people, you no longer have to constantly strive to do better, feel the urge for self-improvement or feed the hunger of ambition. In short, you have to learn how to relax and enjoy life as someone who no longer has to grind out the days at work. My partner found her answer in volunteering at her church -- a place where she can contribute as much as she wants, but where there is no pressure to do more than she can.