# Health & Retirement Services of Illinois

Newsletter December 2018

OUR NEWS LETTER

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## COMPARE ESTIMATED OUT OF POCKET COSTS

Health and drug costs not covered by Medicare have a big impact on how much you spend each year. **Now you can visit Medicare.gov to quickly see how the coverage choices you make may affect your out-of-pocket costs**.

Based on your ZIP code and basic health status, you can get an idea of what your 2019 out-of-pocket spending may be for Original Medicare (Part A & Part B) vs. Medicare Advantage. This includes plan deductibles and prescription drug copays (if you choose drug coverage).

## NEED SOMEONE TO CONTACT MEDICARE ON YOUR BEHALF?

Would you like for a family member or caregiver to call Medicare on your behalf?

Medicare can't give personal health information about you to anyone unless you give permission in writing first. To do this, fill out **form CMS-10106: "Authorization to Disclose Personal Health Information.**"

You can fill out and submit the form online simply by **logging into your MyMedicare.gov account and following these steps:**

1. Navigate to the "My Account" tab.
2. Click "Authorized Representative."
3. Click "Medicare Authorization to Disclose Personal Health Information form."
4. Enter the requested information and click the "Continue" button.

# SOCIAL SECURITY BENEFIT INCREASE FOR 2019

Social Security Announces 2.8 Percent Benefit Increase for 2019

Social Security and Supplemental Security Income (SSI) benefits for more than 67 million Americans will increase 2.8 percent in 2019, the Social Security Administration announced today.

The 2.8 percent cost-of-living adjustment (COLA) will begin with benefits payable to more than 62 million Social Security beneficiaries in January 2019. Increased payments to more than 8 million SSI beneficiaries will begin on December 31, 2018. (Note: some people receive both Social Security and SSI benefits). The Social Security Act ties the annual COLA to the increase in the Consumer Price Index as determined by the Department of Labor's Bureau of Labor Statistics.

Some other adjustments that take effect in January of each year are based on the increase in average wages. Based on that increase, the maximum amount of earnings subject to the Social Security tax (taxable maximum) will increase to $132,900 from $128,400.

Social Security and SSI beneficiaries are normally notified by mail in early December about their new benefit amount. This year, for the first time, most people who receive Social Security payments will be able to view their COLA notice online through their ***my* Social Security** account. People may create or access their ***my* Social Security** account online at www.socialsecurity.gov/myaccount.

Information about Medicare changes for 2019, when announced, will be available at www.medicare.gov. For Social Security beneficiaries receiving Medicare, Social Security will not be able to compute their new benefit amount until after the Medicare premium amounts for 2019 are announced. Final 2019 benefit amounts will be communicated to beneficiaries in December through the mailed COLA notice and ***my* Social Security** Message Center.

The Social Security Act provides for how the COLA is calculated. To read more, please visit www.socialsecurity.gov/cola.

## How can I get a Social Security Statement that shows a record of my earnings and an estimate of my future benefits?

You can get your personal *Social Security Statement* online by using your *my* Social Security account. If you don't yet have an account, you can easily create one. Your online *Statement* gives you secure and convenient access to your earnings records. It also shows estimates for retirement, disability and survivors benefits you and your family may be eligible for.

To set up or use your account to get your online *Social Security Statement*, go to *Sign In Or Create An Account.*

We also mail paper *Statements* to workers age 60 and older three months before their birthday if they don't receive Social Security benefits and don't yet have a *my* Social Security account. Workers who don't want to wait for their scheduled mailing can request their *Social Security Statement* by following these instructions. The *Statement* will arrive by mail in four to six weeks.

# 2019 Medicare Parts A & B Premiums and Deductibles

On October 12, 2018, the Centers for Medicare & Medicaid Services (CMS) released the 2019 premiums, deductibles, and coinsurance amounts for the Medicare Part A and Part B programs.

**Medicare Part B Premiums/Deductibles**

Medicare Part B covers physician services, outpatient hospital services, certain home health services, durable medical equipment, and certain other medical and health services not covered by Medicare Part A.

The standard monthly premium for Medicare Part B enrollees will be $135.50 for 2019, an increase of $1.50 from $134 in 2018. An estimated 2 million Medicare beneficiaries (about 3.5%) will pay less than the full Part B standard monthly premium amount in 2019 due to the statutory hold harmless provision, which limits certain beneficiaries' increase in their Part B premium to be no greater than the increase in their Social Security benefits. The annual deductible for all Medicare Part B beneficiaries is $185 in 2019, an increase of $2 from the annual deductible $183 in 2018. Premiums and deductibles for Medicare Advantage and Medicare Prescription Drug plans are already finalized and are unaffected by this announcement.

Since 2007, a beneficiary's Part B monthly premium is based on his or her income. These income-related monthly adjustment amounts (IRMAA) affect roughly 5 percent of people with Medicare Part B. The total premiums for high income beneficiaries for 2019 are shown in the following table:

| Beneficiaries who file individual tax returns with income: | Beneficiaries who file joint tax returns with income: | Income-related monthly adjustment amount | Total monthly premium amount |
|---|---|---|---|
| Less than or equal to $85,000 | Less than or equal to $170,000 | $0.00 | $135.50 |
| Greater than $85,000 and less than or equal to $107,000 | Greater than $170,000 and less than or equal to $214,000 | $54.10 | $189.60 |
| Greater than $107,000 and less than or equal to | Greater than $214,000 and less than or equal | $135.40 | $270.90 |

| | | | |
|---|---|---|---|
| $133,500 | to $267,000 | | |
| Greater than $133,500 and less than or equal to $160,000 | Greater than $267,000 and less than or equal to $320,000 | $216.70 | $352.20 |
| Greater than $160,000 and less than $500,000 | Greater than $320,000 and less than $750,000 | $297.90 | $433.40 |
| Greater than or equal to $500,000 | Greater than or equal to $750,000 | $325.00 | $460.50 |

Premiums for high-income beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate return, are as follows:

| Beneficiaries who are married and lived with their spouses at any time during the year, but who file separate tax returns from their spouses: | Income-related monthly adjustment amount | Total monthly premium amount |
|---|---|---|
| Less than or equal to $85,000 | $0.00 | $135.50 |
| Greater than $85,000 and less than $415,000 | $297.90 | $433.40 |
| Greater than or equal to $415,000 | $325.00 | $460.50 |

**Medicare Part A Premiums/Deductibles**

Medicare Part A covers inpatient hospital, skilled nursing facility, and some home health care services. About 99 percent of Medicare beneficiaries do not have a Part A premium since they have at least 40 quarters of Medicare-covered employment.

The Medicare Part A inpatient hospital deductible that beneficiaries will pay when admitted to the hospital will be $1,364 in 2019, an increase of $24 from $1,340 in 2018. The Part A inpatient hospital deductible covers beneficiaries' share of costs for the first 60 days of Medicare-covered inpatient hospital care in a benefit period. In 2019, beneficiaries must pay a coinsurance amount of $341 per day for the 61st through 90th day of a hospitalization ($335 in 2018) in a benefit period and $682 per day for lifetime reserve days ($670 in 2018). For beneficiaries in skilled

nursing facilities, the daily coinsurance for days 21 through 100 of extended care services in a benefit period will be $170.50 in 2019 ($167.50 in 2018).

| Part A Deductible and Coinsurance Amounts for Calendar Years 2018 and 2019 by Type of Cost Sharing | | |
|---|---|---|
| | 2018 | 2019 |
| Inpatient hospital deductible | $1,340 | $1,364 |
| Daily coinsurance for 61st–90th Day | 335 | 341 |
| Daily coinsurance for lifetime reserve days | 670 | 682 |
| Skilled Nursing Facility coinsurance | 167.50 | 170.50 |

Enrollees age 65 and over who have fewer than 40 quarters of coverage and certain persons with disabilities pay a monthly premium in order to voluntarily enroll in Medicare Part A. Individuals who had at least 30 quarters of coverage or were married to someone with at least 30 quarters of coverage may buy into Part A at a reduced monthly premium rate, which will be $240 in 2019, an $8 increase from 2018. Certain uninsured aged individuals who have less than 30 quarters of coverage and certain individuals with disabilities who have exhausted other entitlement will pay the full premium, which will be $437 a month, a $15 increase from 2018.

# Why Do Short-Term Health Insurance Plans Have Lower Premiums Than Plans That Comply with the ACA?

Larry Levitt

The Trump administration earlier this year issued a regulation that expands the availability of "short-term" health insurance plans that do not have to comply with any of the rules in the Affordable Care Act (ACA) for plans sold in the individual market. Specifically, the regulation allows short-term plans to be offered for up to 364 days and renewed at the discretion of the insurer for up to three years. Short-term plans are also expected to be more attractive now that ACA's individual mandate penalty has been repealed, since people previously enrolling in these plans were liable for the penalty.

Short-term plans pose tradeoffs for consumers. On the one hand, they typically have substantially lower premiums than ACA plans. On the other hand, they exclude people with pre-existing conditions — an estimated 27% of all non-elderly adults — and offer more limited benefits than ACA plans.

In this analysis, we quantify the effects of the eligibility rules and more limited benefits generally found in short-term plans on the premiums in those plans. We estimate that by screening out people with pre-existing conditions and providing less comprehensive benefits, insurers may be able to offer short-term plans at premiums 54% lower than ACA-compliant plans.

**Denial of Coverage to People with Pre-Existing Conditions**

Short-term plans generally limit coverage of pre-existing conditions in two ways: by denying insurance altogether to people with pre-existing conditions, and by excluding coverage of pre-existing conditions for people who are offered a policy. By covering primarily people who are healthy at the time they apply, short-term plans have much lower claims costs than ACA-compliant plans and can charge substantially lower premiums.

We estimate conservatively that excluding coverage of pre-existing conditions results in 38% lower premiums relative to ACA-compliant plans.

Our estimate is derived by comparing average health care expenses paid by insurance for people with private health insurance overall – which includes a mix of both healthy and sick people in individual and employer-based plans – to average expenses for people who do not have a pre-existing condition that would have led to a denial of insurance before the ACA. The estimate is conservative because it assumes that the ACA's risk pool includes a proportionate mix of healthy and sick enrollees, while it is likely that actual enrollment in ACA individual market plans are disproportionately sick. To the extent the current ACA risk pool is sicker than average,

the potential reduction in premiums in short-term plans that exclude people with pre-existing conditions could be greater. If insurers start to offer guaranteed renewable short-term policies, the premium advantage would moderate as some enrollees develop health conditions over time. However, our review of products now on the market suggests that insurers are generally not yet offering a renewal option.

## Limited Benefits

Short-term plans often exclude or severely limit benefits that ACA-compliant plans are required to cover, including prescription drugs, maternity care, mental health, and substance use treatment. Excluding people with pre-existing conditions eliminates a substantial amount of expenses in each of these benefit categories, but excluding the categories altogether further reduces spending and premiums.

Eliminating prescription drug coverage reduces premiums by an estimated 13%, after accounting for the reduction from excluding people with pre-existing conditions. This estimate is based on analysis of prescription drug expenses paid by private insurance for people without pre-existing conditions. Since the survey data on which this estimate is based do not account for rebates provided by drug manufacturers to insurance companies, it is likely slightly overstated.

Maternity expenses account for an estimated 3.4% of claims expenses in private insurance plans. However, because women who are pregnant at the time they apply for coverage would be excluded, the effect on premiums would be approximately one-quarter of that amount, or about 0.85%.

Mental health and substance abuse treatment account for 4.2% of claims expenses. It is difficult to estimate how much an insurance plan would pay for mental health and substance abuse, once people with pre-existing conditions (e.g., severe mental illness or a history of alcohol or substance abuse with recent treatment) are excluded. We assume half of the claims expenses for these services, or 2.1% total expenses, would be eliminated if plans did not cover mental health and substance abuse treatment.

In total, we estimate that the benefits often excluded or limited in short-term plans could reduce premiums by about 16%.

## Other Factors Affecting Premiums

Short-term plans can be purchased with a variety of features, which will also affect the premiums they charge, including:

- **Deductibles, coinsurance, and copays.** Higher or lower levels of patient cost-sharing than in standard ACA-compliant plans (i.e., bronze, silver, and gold) will result in different premiums. Since short-term plans do not have to cap patient out-of-pocket costs

like ACA-compliant plans, they can be purchased with very high deductibles and lower premiums.

- **Dollar limits on coverage.** Short-term plans can and generally do impose annual limits on benefits, which results in lower premiums. In some cases, an enrollee can choose the level of the limit. Short-term plans also in some cases cap what they will pay for a day in the hospital or a physician visit, which lowers premiums but could result in balance billing for patients.
- **Age and gender rating.** The ACA prohibits premiums from varying by gender and limits the variation in premiums due to age to a ratio of three to one. Short-term plans are not subject to those restrictions.
- **Medical loss ratio.** Individual market insurers must have a medical loss ratio of at least 80% — meaning 80% of premiums are spent on health care expenses – or pay rebates to consumers. Short-term plans can devote a larger share of premiums to overhead and profit, which may push premiums up.

## Conclusion

Short-term health insurance plans present a tradeoff to consumers – lower premiums in exchange for more limited coverage and less protection than ACA-compliant plans. Overall, we estimate that short-term plans could provide coverage with fewer benefits at premiums 54% lower than ACA-compliant plans. However, the bulk of these premium savings result from exclusion of people with pre-existing conditions, for whom short-term plans are not an option.

The lower premiums will likely prove attractive to people who are healthy, especially those buying their own coverage now who have incomes too high to qualify for ACA premium subsidies. If such individuals opt for short-term plans and then become seriously ill or injured, however, they could face higher out-of-pocket costs.

To the extent short-term plans siphon off healthy enrollees attracted by lower premiums, ACA-compliant plans will be left with a sicker pool of enrollees, and individuals with pre-existing conditions not eligible for subsidies will face higher premiums.

## Methods

Average total spending and prescription drug spending by private insurance come from the 2015 Medical Expenditure Panel Survey (MEPS). These spending averages are for people ages 18 to 64, with nine or more months of private insurance and zero months of Medicaid in 2015. For the purposes of this analysis, people with pre-existing conditions are those who have at least one declinable health condition, based on ICD9 codes, condition classification codes, and BMI data from MEPS.

# Could your anger be linked to lack of sleep?

© Provided by AFPRelaxNews A lack of sleep could be to blame for some increased feelings of anger according to new research.

New US research has found that even missing out on just a couple of hours sleep a night could make you angrier and diminish your ability to adapt to certain situations.

Carried out by researchers at Iowa State University, the new study looked at 142 participants who were randomly assigned to two groups.

One group was asked to maintain their normal sleep routine for a period of two days, while the other was asked to restrict their sleep by two to four hours each night for two nights.

Participants also rated their feelings of anger before and after sleep during a test in the lab, in which they were asked to rate products while listening to different background noises, designed to create frustrating situations which could provoke anger.

The findings, published in the Journal of Experimental Psychology: General, showed that those who maintained their regular sleep pattern got on average almost seven hours of sleep a night, while those in the restricted group got about four and a half hours each night, which the researchers say reflects the amount of sleep loss we regularly experience in everyday life.

In addition, the researchers also found that sleep restriction universally intensified feelings of anger, with co-author Zlatan Krizan adding that sleep loss was found to uniquely impact anger, rather than simply resulting from feeling more negative in that moment.

The study is one of the first to provide evidence that a lack of sleep can spark feelings of anger, with previous research finding a connection but not showing a causal relationship according to the researchers. Sleep loss has also been linked to an increase in negative emotions, such as anxiety and sadness, and a decrease in positive emotions, such as happiness and enthusiasm.

"In general, anger was substantially higher for those who were sleep restricted," Krizan said. "We manipulated how annoying the noise was during the task and as expected, people reported more anger when the noise was more unpleasant. When sleep was restricted, people reported even more anger, regardless of the noise."

"Despite typical tendencies to get somewhat used to irritating conditions -- an uncomfortable shirt or a barking dog -- sleep-restricted individuals actually showed a trend toward increased anger and distress, essentially reversing their ability to adapt to frustrating conditions over time. No one has shown this before."

Preliminary results from a separate study by the team also suggest that the experiments in the lab could also apply to real life, with the researchers finding that college students participating in the research also consistently report more anger than usual on the days when they are more sleep deprived.

The researchers are now beginning to collect data to see if sleep loss could even cause aggressive behavior toward others.

**To contact us: go to www.healthcareil.com or Call (800) 739-4700**