

Insurers forcing patients to pay more for costly specialty drugs

Anthem Blue Cross, Aetna and other health insurers are increasingly shifting more prescriptions for complex conditions to a new category requiring customers to shoulder a larger share of the medication's cost.



Nationwide, an estimated 57 million Americans rely on specialty drugs for complex conditions. These medications account for only 1% of total drug use, but 17% of drug spending by insurers because of the high prices, according to IMS Health, which tracks medical data. Above, prescription drugs at a community health center in Aurora, Colo. (John Moore, Getty Images / May 28, 2012)

By Chad Terhune, Los Angeles Times *May 29, 2012*

Thousands of patients in California and across the nation who take expensive prescription drugs every month for cancer, rheumatoid arthritis and other ailments are facing sticker shock at the pharmacy.

Until recently, most of these patients typically paid modest co-pays for the advanced drugs. But increasingly, Anthem Blue Cross, Aetna and other insurers are shifting more prescriptions to a new category requiring patients to shoulder a larger share of the drug's cost.

The result: Pharmacy bills are going up by hundreds of dollars a month — on top of insurance premiums.

Robert Gomer, who owns an interior plant business in Rancho Mirage, saw his cost for three HIV drugs soar to \$450 a month on a new Anthem Blue Cross plan this year from \$80 a month on a previous plan.

"All of a sudden you're starting to count pills and asking friends to borrow some," Gomer said. "It was a very stressful situation to be faced with."

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Anthem, the state's largest for-profit insurer and a unit of WellPoint Inc., adjusted its prescription drug coverage early this year. It said it shifted more medications to the most expensive tier for many of its employer plans to keep premiums more affordable.

"Because high-cost pharmaceuticals reduce the affordability of health insurance, Anthem moved some of these drugs from a co-pay tier to a cost-sharing tier," said company spokesman Darrel Ng. "We continue to evaluate and refine the drug classifications in our four-tier plans to enhance value and affordability."

Robert Galle, Aetna's head of pharmacy benefit management operations, said his company is responding to employers' concerns about escalating costs from these specialty drugs. "As new drugs are brought to the market, we are generally adding them to these tiers," he said.

Consumer advocates and some benefit consultants argue this trend could backfire as a cost-saving tool if workers stop taking needed medications and require even more costly medical care down the road.

Proposed state legislation would cap out-of-pocket expenses for prescriptions and other medical costs, but the insurance industry is fighting that move. Insurers say those caps will drive up premiums for all customers and that state rules are unnecessary because the federal Affordable Care Act establishes out-of-pocket spending limits in 2014. Insurers also note that caps don't address the underlying increase in drug prices.

Nationwide, an estimated 57 million Americans rely on specialty drugs for complex conditions. These medications account for only 1% of total drug use, but 17% of drug spending by insurers because of the high prices, according to IMS Health, which tracks medical data.

What's more, the struggle over drug spending is projected to intensify as the number of biological drugs and the conditions they can treat is expected to soar in the years ahead. Healthcare researchers say they could account for 40% of overall drug spending by 2020.

In most cases, cheaper generic substitutes don't exist for these drugs because many are derived from living organisms, not chemical compounds that can easily be copied.

The average annual cost for multiple sclerosis drugs was \$24,116 in 2010, according to Express Scripts, a pharmacy benefit manager. The average for pulmonary hypertension was \$32,570. Employers and insurers are picking up most of that tab now.

To help lower their costs, health plans are changing their approach to drug coverage, often expanding from a three-tier to a four-tier plan. The first tier would be generic drugs at a \$10 co-payment, for instance, the second tier preferred brand-name drugs at a \$30 co-pay, the next tier non-preferred brand-name drugs for \$50, and the top tier would be dozens of specialty drugs costing patients 10% to 30% co-insurance or \$150 co-pays.

Nationwide, 14% of workers are in a plan with four or more tiers of cost sharing for prescription drugs, compared with 7% five years ago, according to the Kaiser Family Foundation.

Melanie Rowen, a 34-year-old career counselor in Berkeley, racked up thousands of dollars of credit card debt to pay for her multiple sclerosis drug. She was responsible for 30% of the price of a medication called Rebif, which initially cost her \$680 a month and jumped to nearly \$900 a month in a year's time — until she recently switched jobs.

"It blew my mind," Rowen said. "I felt like I was staring into the financial abyss."

Assemblywoman Fiona Ma, a San Francisco Democrat, is pushing a bill that seeks to limit consumers' financial exposure to high drug costs and other medical bills. The proposed legislation would cap annual out-of-pocket medical costs at \$5,950 for an individual and \$11,900 for a family.

Lawmakers in more than 20 states have introduced similar measures to limit bills for expensive medications. In 2010, New York banned four-tier and higher pharmacy plans.

The California Assn. of Health Plans is fighting the proposed legislation on the grounds that it curtails ways to keep premiums affordable and the federal healthcare law addresses the issue. "Capping out-of-pocket costs doesn't make healthcare less expensive. It just shifts costs into premiums," said Charles Bacchi, executive vice president of the industry group.

But supporters say the uncertainty of whether the federal healthcare law will survive a constitutional challenge gives even more reason to enact these consumer protections at the state level.

"It doesn't take a lot to push a whole range of families into medical debt and bankruptcy," said Anthony Wright, executive director of Health Access, a consumer advocacy group.

Carrie Thorpe, a 52-year-old event planner in Temecula, pays \$150 each month for an injectable drug to treat her multiple sclerosis that costs \$4,000 per month overall. She said she couldn't afford her share without help from a patient assistance program.

"I can't function without this medication," she said. "I'm at the mercy of whatever the cost is."

The biggest challenge for retirees today: Being unaware of the challenges.

By Neal Halaway
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At the risk of going out on a proverbial limb, I'm going to start this article by making a bold statement:

We have a serious issue emerging in America today, and it's called *retirement preparedness*. Recent figures from the Employee Benefit Research Institute reveal that 47% of Americans, ages 56-62, would run out of funds necessary to pay for basic retirement expenditures if they retire at age 65. And 6 in 10 Americans express significant concern about their retirement savings and investments.¹ So, why are people so unprepared? Of course, the recent market downturn played an enormous role. But the truth is, investors could have been more prepared had they a better understanding of today's changing retirement landscape and the unprecedented challenges it poses.

Two overarching issues

The future of Social Security is in question. Every day more and more of the 78 million baby boomers approach retirement age. The Census Bureau estimates that the ratio of people in their retirement years, 65 and older, versus those in their working years, 20 to 64, will rise from 20.6% in 2005 to over 35% in 2030. That, of course, will put an enormous strain on the Social Security system and also put the benefits of future retirees in question. In fact, the government predicts that by 2037, Social Security's scheduled payout will be reduced by 24%, according to the 2009 OASDI Trustees Report.

Pension plans are waning. In addition to Social Security, defined benefit plans, such as pensions, have long been relied upon as an important source of income in retirement. But, here too, a challenge is emerging as traditional employer-sponsored pensions seem to be going the way of the dinosaur. The number of defined pension plans being offered to employees has been shrinking steadily since the 1980s. As of 2007, only 36% of workers were covered by a traditional pension, according to the Center for Retirement Research at Boston College. This number is down from 88% in 1983.

Defined contribution plans, such as 401(k)s and 403(b)s, have become the default vehicles for helping to fund retirement. But the problem – which became painfully evident over the last few years – is that these plans leave investors highly vulnerable to market volatility.

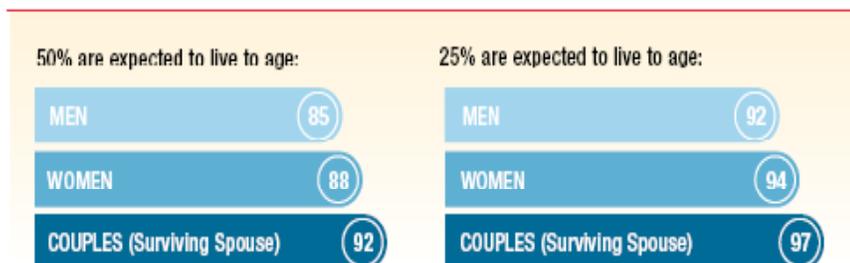
The shift ahead

With the future solvency of Social Security uncertain and traditional pensions becoming a luxury of the past, the burden of financing retirement is shifting squarely to the shoulders of individuals. Adding to this burden are three financial risks that make retiring today more challenging than ever. Preparing for these risks – and the impact they can have on your retirement portfolio – is the first crucial step in addressing them.

Challenge #1: We're Living Longer

It seems that, as a society, we have indeed discovered the elusive fountain of youth. Over the last 60 years alone, average life expectancy has increased by more than 10 years,² and most experts see that trend continuing. This means that you could be preparing for retirements that last 30 years or more. While you may view this as welcome news, there is a catch. Somehow you need to fund this "newly extended" retirement. You'll need an income source that can help you reconcile the notion of *longer* life with *quality of life*.

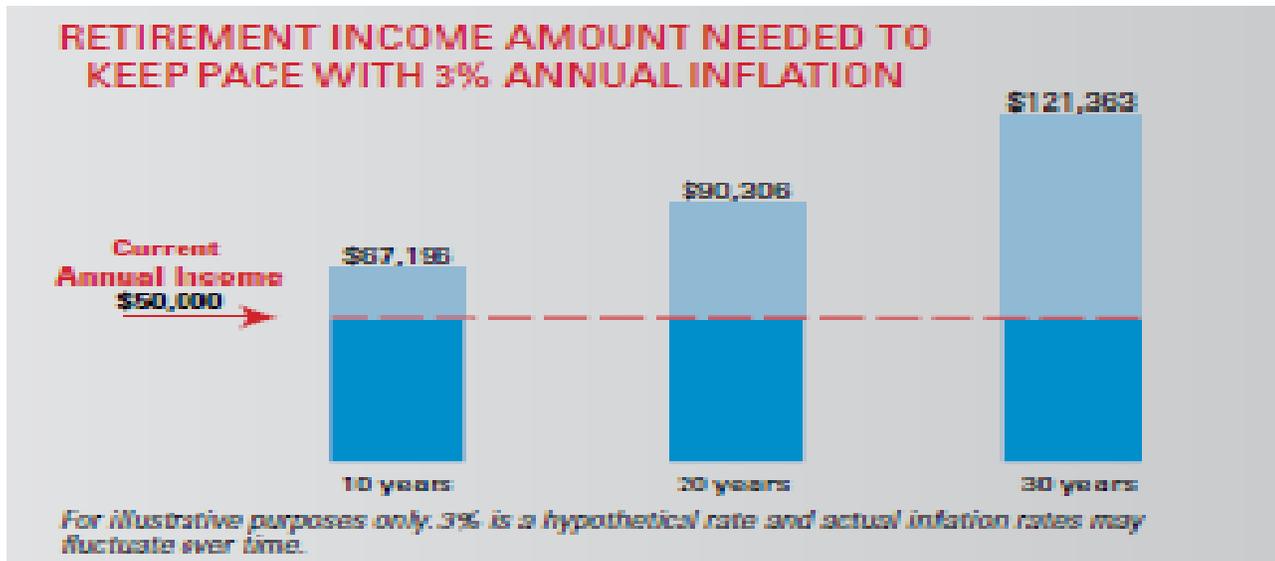
Expected life span of individuals and couples age 65¹



Challenge #2: Rising Costs

When referring to costs of living, the old adage, “what goes up, must come down,” is generally not a very good rule of thumb. Expenses in retirement will tend to keep rising, which means you will need a well-conceived retirement income plan to help account for these increases. Specifically, there are three key, cost-related issues that can erode your purchasing power over time.

The first is **inflation**. Most people underestimate the cumulative impact inflation can have on their standard of living in retirement. During our working years, wages typically rise as consumer prices increase, so normal inflation is not generally a big concern. But for someone who is living off of retirement savings, inflation can become a significant risk. Over the last 40 years, costs for basic necessities such as food, housing, transportation and utilities have risen at between 1% and 13% annually.³ But even at a relatively modest rate of 3%, inflation can diminish your purchasing power considerably over time.



Taxes are another key issue that retirees must be prepared to address. Although federal taxes do fluctuate up and down, a soaring deficit of over \$1.4 trillion⁴ means there’s a fair chance that taxes could be moving upward. According to the Tax Foundation, federal income taxes would need to double – that’s right, *double* – across the income spectrum in order to close the deficit.

But perhaps the most pressing concern for today’s retirees is the rising cost of **healthcare**. It’s a topic that has certainly garnered its share of attention from politicians and the media over the last few years, and based on the numbers, the attention may be warranted. Healthcare costs have risen 149% between 2000 and 2009 – over four times greater than workers’ incomes.² And these increases pose an even bigger concern if you’re entering retirement, a time when health issues are more likely to arise.

It is estimated that an average, healthy, 65-year-old couple will need \$260,000 to pay for healthcare costs for the remainder of their lives.⁵

Challenge #3: Market Uncertainty

The third risk to your financial security in retirement is *market uncertainty*. The last few years have been a sobering reminder of how short-term volatility can affect retirement portfolios. Between 2007 and 2009 alone, the S&P 500 had an unprecedented 39 days with a movement of 4% or more in either direction.⁶ Volatility poses one of the biggest threats to your retirement savings because a downturn just before or after retirement can be devastating to your portfolio. It can literally take years to recover from losses; precious time that you may not have. This is why protecting your portfolio is so important.

Potential income solutions for retirement

There are a number of different options for generating income in retirement, including fixed income investments such as government bonds and municipal bonds, lower yielding FDIC-insured investments such as money market accounts and CDs, and guaranteed income vehicles such as annuities. You generally have two options with annuities: fixed annuities and variable annuities.

With a fixed annuity, you make an initial payment to an insurance company and they guarantee you a fixed monthly or annual payment (in most cases, for as long as you live). With a variable annuity, the insurance company allocates your funds to professionally managed investments that you select (typically various types of mutual funds). Your lifetime income payments will then fluctuate with the performance of these investments. In addition, today's variable annuities offer what are called *optional living benefits*. Available for an additional fee, these benefits are designed to help further grow your income for retirement while protecting it against market downturns.

Work with a financial professional

It's important to find a licensed financial professional who will work with you to create an income plan that meets your needs and goals for retirement. Armed with knowledge, foresight and the guidance of a reputable advisor, you can address today's retirement challenges and work toward securing a more comfortable and rewarding future.

Presented by

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¹ Prudential's Four Pillars of Retirement Series, Sept 2009

² Towers Watson Health Care Cost Survey 2010 (active employee data) and Bureau of Labor Statistics, seasonally adjusted data from the Current Employment Statistics Survey August to August, 2000-2009

³ Inflationdata.com

⁴ The Wall Street Journal, June 10, 2010

⁵ 2010 study conducted by the Center for Retirement Research at Boston College; healthcare and nursing home costs may vary by state

⁶ By the Numbers Research, March 22, 2010

[†] U.S. Annuity 2000 Mortality table, Society of Actuaries, lifespan for couples refers to the surviving spouse

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CAN YOU RAISE YOUR SSI BY REAPPLYING FOR BENEFITS?

Social Security has closed a popular loophole, but all is not lost.

Presented by **Neal Halaway**, HRSI Family Wealth Adviser

The “reset button” has been removed. A few years back, the distinguished economist Laurence Kotlikoff alerted people to a loophole in the Social Security framework: retirees could dramatically increase their Social Security benefits by reapplying for them years after they first applied.

It worked like this: upon paying back the equivalent of the Social Security benefits they had received to the federal government, retirees could fill out some simple paperwork to reapply for federal retirement benefits at a later age, thereby increasing the size of their Social Security checks. Figuratively speaking, they could boost their SSI after repaying an interest-free loan from Uncle Sam.

You can't do this any longer.

In late 2010, the Social Security Administration closed the loophole. Too many retirees were using the repayment tactic, and the SSA's tolerance had worn thin. (The Center for Retirement Research at Boston College figured that the strategy had cost the Social Security system between \$5.5-8.7 billion.)^{1, 2}

Today, accumulated Social Security benefits can no longer be repaid with the goal of having the SSA recalculate benefits based on the retiree's current age. You can only withdraw your request for Social Security benefits once, and you are only allowed to reapply for benefits within 12 months of the first month of entitlement.^{1, 3}

Couples can still potentially increase their SSI. This involves using the “file and suspend” strategy once one spouse has reached full retirement age (FRA).

An example: Eric applies for Social Security at age 66 (his FRA). Immediately after filing for Social Security benefits, he elects to have his benefit checks stopped or postponed. As he has technically filed for benefits at full retirement age, his wife Fiona can begin receiving spousal benefits - a combination of her own benefits plus the extra benefits coming to her as a spouse, both reduced by a small percentage for each month that she is short of her FRA. (If she is younger than her FRA, she cannot apply to only receive a spousal benefit.)⁴

Meanwhile, Eric's Social Security benefits are poised to increase as long as his checks are halted or deferred. As Eric has hit FRA, he now has the chance to accrue delayed retirement credits (DRCs) and have his benefits enhanced by COLAs between today and the month in which he turns 70.⁴

Before you claim Social Security benefits, run the numbers. Knowing when to apply for Social Security is crucial. As it may be one of the most important financial decisions you make for retirement, it cannot be made casually. Be sure to consult the financial professional you know and trust before you apply.

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Citations.

- 1 - www.socialsecurity.gov/pressoffice/pr/withdrawal-policy-pr.html [12/8/10]
 - 2 - www.cbsnews.com/8301-505123_162-37841858/the-end-of-social-securitys-interest-free-loan/ [12/9/10]
 - 3 - www.financial-planning.com/fp_issues/2011_3/under-the-radar-2671684-1.html [3/1/11]
 - 4 - www.foxbusiness.com/personal-finance/2012/01/30/social-security-qa-how-to-maximize-benefits/ [1/30/12]
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Medical data breaches raising alarm

By David Schultz, Published: June 2 [The Washington Post](#)

As more doctors and hospitals go digital with medical records, the size and frequency of data breaches are alarming privacy advocates and public health officials.

Keeping records secure is a challenge that doctors, public health officials and federal regulators are just beginning to grasp. And, as two recent incidents at Howard University Hospital show, inadequate data security can affect huge numbers of people.

On May 14, federal prosecutors charged one of the hospital's medical technicians with violating the Health Insurance Portability and Accountability Act (HIPAA). Prosecutors allege that over a 17-month period, Laurie Napper used her position at the hospital to gain access to patients' names, addresses and Medicare numbers to sell their information. A plea hearing has been set for June 12. Napper's attorney declined to comment.

Just a few weeks earlier, the hospital notified more than 34,000 patients that their medical data had been compromised. A contractor working with the hospital had downloaded the patients' files onto a personal laptop, which was stolen from the contractor's car. The data on the laptop was password-protected but unencrypted, which means anyone who guessed the password could have accessed the patient files without a randomly generated key. According to a hospital news release, those files included names, addresses and Social Security numbers — and, in a few cases, “diagnosis-related information.”

Howard University spokesman Ronald J. Harris said in an e-mail that the two incidents are unrelated but declined to answer further questions. In its news release about the stolen laptop, the hospital said it will set new requirements for all laptops used by contractors and those issued to hospital personnel to help protect data.

Just days after Howard University contacted its patients about the stolen laptop, the Utah Department of Health announced that hackers based in Eastern Europe had broken into one of its servers and stolen medical information for almost 800,000 people — more than one of every four residents of the state.

And in November, TRICARE, which handles health insurance for the military, announced that a trove of its backup computer tapes had been stolen from one of its contractors in Virginia. The tapes contained names, Social Security numbers, home addresses and, in some cases, clinical notes and lab test results for nearly 5 million patients, making it the largest medical data breach since the Department of Health and Human Services began tracking incidents 2½ years ago.

As recently as five years ago, it's possible no one outside Howard University would have known about the incidents there. But reporting rules adopted as part of the 2009 stimulus ensure that the public knows far more about medical data breaches than in the past. When a breach occurs that affects 500 or more patients, health-care providers must notify not only HHS but also the news media.

According to an HHS database, more than 40 percent of medical data breaches in the past 2½ years involved portable media devices such as laptops or hard drives. Deven McGraw, head of the health privacy project at the Washington-based Internet advocacy group Center for Democracy & Technology, said many of these incidents were avoidable. “We have technology that can help save us when we're all too human,” she said.

Cloud storage, password protection and encryption are all measures health-care providers could be taking to make portable electronic health records more secure, McGraw said.

Another thing that might make health-care providers tighten their security is the potential of facing hefty fines if their patients' data are breached. But until recently, providers haven't had to worry much about this.

Since the enactment of HIPAA in 2003 until late last year, there were more than 22,000 complaints about violations of the law's privacy rule. HHS assessed a monetary penalty only once, according to a report it gave to Congress. Although the department has the power to issue subpoenas when enforcing HIPAA, it has only used that power twice since 2003.

"The industry is very interested and responsive to correct the mistakes that they make and improve their privacy policies, so it's not necessary for us to resort to these types of penalties," said Susan McAndrew, deputy director for health information policy at HHS's Office of Civil Rights.

HHS was criticized for lax enforcement at a Senate hearing in November. In the six months that followed, the department reached settlements in several HIPAA cases with penalties totaling more than \$1.5 million.

McGraw said HHS was losing credibility on the enforcement issue, so she's pleased by the department's rapid response to its Senate grilling.

But, she said, federal regulators can only do so much. While the benefits of electronic health records far outweigh the risks, she said, those risks can only be mitigated — not eliminated.

"No matter how good you make the technology," McGraw said, "we'll never get the risk down to zero. But we can do a lot better than we have been doing."

Medical Tourism: Why More Boomers Are Going Abroad For Treatment

Posted: 06/04/2012 9:03 am Updated: 06/06/2012 3:25 pm



High medical costs and lack of insurance in the States have some boomers going abroad for treatment.

Fred Schuler is the type of guy you'd want to have a pitcher with within two minutes of speaking to him. He's affable and funny -- he laughs easily and regularly -- and seems like he'd have a lot of great stories, given his peripatetic lifestyle as a professional golf caddy on the PGA and LPGA tour circuit. But ask Schuler to describe the crippling pain that took him off the green and put him into a wheelchair for two months, and you can practically hear the 61-year-old wince.

"Other than excruciating?" Schuler asked gamely. "I was living on Aleve and Tylenol. I couldn't straighten up, I was hunched over. Toward the end I could walk 100 yards [with a cane] and then I was toast."

After living with the pain for almost four years, Schuler had few options: He was uninsured and out of a job, thanks to his debilitating disc problems. An orthopedic surgeon Schuler met at work offered to treat him for free. But upon examining his X-rays he realized Schuler's condition was far worse than he'd thought.

"I exercised every avenue I could in terms of getting public assistance to get some medical health here and kept running into dead ends," Schuler said.

That's when Schuler turned to a solution more post-50 Americans are considering as healthcare costs continue to rise: medical tourism.

Once only something done by the incredibly wealthy, medical tourism is "really turning into something people understand," said Josef Woodman, CEO of Patients Beyond Borders, which produces guidebooks on medical travel. The organization estimates that in 2012, 600,000 people will travel abroad for treatment -- a number anticipated to grow 15 to 20 percent annually as boomers age.

"Our population is continuing to age into financially challenging procedures," Woodman said. "Every month the insurance companies find a way to take benefits off the table. Each month there is a slightly bigger piece of the population pie that is going to find the cost savings very attractive."

"I would tend to say that 80 percent or more of the people using medical tourism are baby boomers," said Rajesh Rao, CEO of IndUSHealth, a medical travel program provider for patients and employer health care plans. "I would say the bulk of utilization happens with baby boomers just because they're at an age where they need more intervention."

Most of the people deciding to go abroad for treatments that are unaffordable in the United States are paying out of pocket. But with the cost of a round-trip ticket (or two, if they decide to bring along a companion), treatment and hotel accommodations, is it really that much cheaper?

The answer is a resounding yes, say experts, doctors and patients like Schuler.

A survey conducted by Patients Beyond Borders shows the jaw-dropping differences in cost. In 2011, you could pay \$88,000 for a coronary artery bypass graft in the U.S., or \$9,500 in India (which saw the highest average savings, at 65 to 90 percent). For a hip replacement in Mexico, it's \$12,500 instead of \$33,000 on average in the States.

And for those uninsured adults -- 16.5 percent of Americans between the ages of 45 and 64 in 2010 -- that extra "\$20,000-\$30,000 ... can be the difference between refinancing your home" and being out thousands, said Woodman.

So given all the cost benefits, why hasn't medical tourism taken off?

"We're so used to the adage that you get what you pay for, it takes a little thinking outside of the box," Rao said. "By just going outside, you end up getting a lot better quality and a lot better care for a lower cost. Until you actually see it, it's hard to believe."

Yet that same adage still may apply on a case-by-case basis, said Dr. Doug Lundy, an orthopedic trauma surgeon at [Resurgens Orthopaedics in Atlanta.

Some patients who travel outside the U.S. for care are treated extremely well, Lundy said. "And sometimes you look at it, hold your breath and think, 'Wow, you paid so much money for this and you got substandard work done.' Sometimes you have to do the work over again."

In a 2009 Gallup poll, the most recent on the matter, 29 percent of Americans said they would consider going abroad for "alternative treatments for a major medical problem." But that number jumped 13 percentage points when those surveyed were asked if they would go abroad if treatment were cheaper and the quality similar to that found in the U.S.

For a number of international hospitals hoping to cash in on this growing market, the latter is increasingly the case. More hospitals than ever are rushing to meet the exacting standards of the Joint Commission International, an organization that has placed its seal of approval on "469 distinct accredited or certified organizations In 50 countries to date," a spokeswoman reported, certifying hospitals on everything from architectural design to superbug prevention.

The JCI-accredited hospital at which Schuler was treated -- Fortis Hospitals in Bangalore, India, formerly known as Wockhardt Hospitals and is associated with Harvard Medical International -- exceeded his expectations.

"They picked me up at the airport at 4 a.m. their time and took me to the hospital" for X-rays, Schuler said. "My room was incredible, the care was phenomenal. I was there in the hospital for seven days and I was in what I consider to be a four- to five-star health facility."

"When they rolled me into surgery, I remember looking at my doctor and saying, 'If it's not successful, just let me go,'" Schuler continued. "He said, 'It'll be ok.' By 8 a.m. I was under the knife and by noon they got me up and I was pain-free. I could not believe it."

"The first thing the doctor said after my surgery was, 'My, you're a lot taller than I thought you were!'" Schuler laughed. "I had nothing negative happen to me, so I would promote it 100 percent."

Whether you decide to stay put and visit your own doctor or go abroad for your next costly treatment, do yourself a favor and research your options. In part two of this series, we'll go over the advantages and disadvantages of medical travel, and we'll have tips on what kind of questions to ask when you consider going abroad for treatment.

Retirement: Get real about budgeting for health care

By Susan Garland Kiplinger's Money Power June 5, 2012

The painful truth is that a 65-year-old couple who live until age 92 can expect to incur \$400,000 in unreimbursed medical costs, assuming an annual health care inflation rate of 6 percent, according to Fidelity Investments. What's worse, that figure does not include long-term-care expenses.

But there are strategies to reduce, and pay for, your medical expenses. One of the first steps is to get a handle on your total costs as early as possible. If you are not participating in an all-in-one **Medicare Advantage** plan, the places to start are Medicare.gov, where you can review the costs of Part D **prescription drug** plans, and PlanPrescriber.com, to review the costs of medigap supplemental policies. Retirees who don't anticipate a fixed-income stream, such as a pension, should consider an immediate fixed-payout annuity to pay for essential costs. Medicare Part B, a Part D drug plan and a medigap policy can easily run a couple \$550 a month. To buy an immediate-payout annuity that covers those premiums, the couple would need to shell out close to \$115,000. And they would still need to account for the costs of dental and vision care, hearing aids and drug co-pays.

A stand-alone long-term-care policy can protect you against the huge costs of a nursing home stay or home health care. But if you balk at the idea of paying premiums for a policy you may never need, a new law allows current holders of life insurance and annuities to exchange their policies for either long-term-care or hybrid coverage. Most permanent life insurance policies allow you to use the cash value or dividends to pay for any expenses, including health care. A health savings account is a great way to build up a tax-free nest egg for health care expenses. Contributions are tax-deductible. To qualify, you must have a high-deductible health insurance policy that meets certain federal standards. For example, an "HSA compatible" policy limits annual out-of-pocket expenses for family coverage to \$12,100 in 2012.

You can also take a scalpel to your health care spending by making the most of 20 preventive services, such as screenings for colorectal, prostate and **breast cancer**, that Medicare covers without patient co-pays. If you're still employed, your health plan may offer free screenings or financial incentives to seek help from a "health coach" to manage chronic disease.

If you're paying out of pocket, haggle on price before any big medical procedure. Insurance companies and Medicare get deals on procedures, and you can, too. At Healthcare Blue Book.com, you can find a "fair price" for surgical procedures, **lab tests** and doctor services. And scour your hospital bill for procedures you didn't receive.

Moving to Bali

THE WALL STREET JOURNAL *By Judith Schneider*

'How did you find Bali?' and 'What do you do all day?' are the two most common questions asked of us. I am a retired lawyer from California; my husband is a vintner (plus many other things). We're both 68 years old, and most people can't wrap their minds around the change we made moving to Bali, Indonesia, seven years ago.

As we approached retirement age, we kept a watchful eye for those places that were exotic, less expensive (we lived in California for 35 years) and comfortable for Americans. A top priority was warmth. We both grew up in Connecticut, and I spent four winters in Buffalo, N.Y., so we were done with cold and snow. We visited all the warm climates we could find on the globe.

It was by chance that a client/friend asked me to visit her in Ubud, Bali. When I returned, I said to my husband, "This may be it."

What was "it"? A constant 85-degree temperature, stunning landscapes, and a warm and gracious people with smiles so perfect that seeing them every day is added sunshine. We moved to Bali in May 2005. Unless changes in our health necessitate a return to the U.S., we plan to spend the rest of our lives here.

Laid-Back Lifestyle

Bali, with a population of about four million, is one of about 17,500 islands that make up Indonesia. We settled in a suburb of Ubud, which is considered the cultural and religious center of Bali. In our village, women and men wear sarongs as daily clothing, children take off their shoes and walk barefoot when the school day ends, and the entire community goes to a sacred spring to retrieve holy water.

We leased a half acre of land for 20 years for \$50,000. The property overlooks a river valley with a small waterfall on the far side. We built a "villa," as a single-family home in Bali is called. Our house has a swimming pool, furniture handmade to our specifications, and flowers everywhere. But in Balinese fashion, there is no front door. An opening, yes, but no door to shut.

The cost to build our house today (approximately 2,000 square feet) would be about \$350,000. That said, a perfectly nice home could be built for half that amount. A reasonable monthly budget for home maintenance, transportation, food and entertainment is about \$1,000.

◆ Amed villages

A string of cottage colonies along the island's eastern coast. Beautiful beaches. Swimming, snorkeling and diving without the crowds.

wikitravel.org/en/Amed

◆ ARMA Museum

Based in the town of Ubud. Features works from Balinese artists and Indonesian painters, as well as foreign artists who drew their inspiration from Bali.

armabali.com

◆ Gunung Kawi

Set amid rice fields and palm trees, this Hindu temple from the 11th century features a series of royal tombs carved in rock.

bali-travel-life.com/gunung-kawi.html

◆ Tanah Lot

A prominent rock formation off the island's southwest coast and site of a centuries-old temple.

wikitravel.org/en/Tanah_Lot

◆ Tirta Empul

Dating to the 10th century, this temple has spring waters believed to heal illnesses and sanctify visitors.

sacred-destinations.com/indonesia/bali-pura-tirta-empul.htm

◆ Ubud

This town and the surrounding villages are the artistic and religious center of the island. A wonderful market, and no end of authentic eating places.

wikitravel.org/en/Ubud

Source: WSJ reporting
The Wall Street Journal

When it comes to cooking—and cleaning and all of those other daily time-consumers—we hire Balinese help. Our cook, who is paid \$75 a month, shops in the market at 6:30 a.m. and prepares all of our meals from scratch. It's very healthy. Sundays we are on our own, and that is our brunch and pizza day. (We wouldn't want to forget our roots.) A meal costs about \$15 with no alcohol. Alcohol comes with a 300% customs duty. The local beer is good and keeps us looking younger.

What do we do? We are very involved with a children's home, ensuring there is always enough food and medical care. My husband assists in teaching spoken English to schoolchildren. Many people in the U.S. want to help the Balinese (Indonesia is a poor country), so we check out projects to start and then follow the progress and oversee funds.

As for relaxation, we let Bali happen. Schedules and appointments here are extremely fluid; thus, we wait to hear what's taking place and join in if we're so inclined. Poetry readings, yoga, spa visits, massages, a classic film being shown at a coffeehouse, even an invitation to a wedding: All tend to be spur-of-the-moment. It's very liberating to do whatever strikes your fancy.

There is an English-language library here, as well as an English-language Christian church service and a Rotary Club. If you choose to shop, there are two large U.S.-style supermarkets called Delta and Bintang. Wi-Fi, Starbucks, FedEx and satellite television are all here for the expat. Or you can choose to ignore them.

Many expats have a car or motorbike. We do, as well, but we never get behind the wheel. Why? From our perspective, most Balinese don't appear to follow the rules of the road, so we prefer to hire people who are used to driving here. It's much safer. Speaking of which, strolling the streets of Ubud at night is the same as the daytime—safe.

Hitches and Quirks

If you're thinking about spending any extended time in Bali, paperwork comes into play. Most people start out trying to get a "retiree visa," which under current rules would allow you to stay indefinitely—but that can be costly and time-consuming. One alternative: a "social visa." This allows you to remain in country for as long as six months, at which point you reapply. For our part, we typically use that opportunity to head to the States to visit children and grandchildren.

No, Bali isn't perfect. Medical care, for the most part, is substandard when compared with the U.S.; thus, expats typically have evacuation insurance to a country chosen by their insurer, typically Singapore or Australia. (Fortunately, some excellent clinics are starting to appear.)

Other hitches and quirks: the long rainy season (November into early April); heavy traffic in the island's main city of Denpasar; the plane trip back and forth to the U.S. (a 17-hour flight); our heights and weights (we feel like Gulliver in a society where most people are about five feet tall and weigh about 100 pounds); and haircuts. Balinese are almost all long- and straight-haired. I have curly short hair, which baffles most hairdressers, so I go to a hotel for tourists for my needs. My husband has straight black hair. No problem. The cost for his haircut: 50 cents.

Most of these issues are minor, to say the least. Most days border on the breathtaking. Each evening, as we lie in our bed watching the stars, we experience the hush of Bali. A lilting melody drifts down the valley as an upriver village has a ceremony. The magic of this island lulls us to sleep.

Many Illinoisans losing Medicaid on July 1 do not know it yet



Alex T. Paschal

Jennifer Bowman, a 24-year-old single mother, works at her station on Monday, June 11, 2012, at the Whiteside County Health Department in Rock Falls, Ill., where she is a secretary. Bowman makes less than \$2,000 a month and said she can't afford to see a doctor after she loses Medicaid coverage on July 1. More than 25,000 working parents in Illinois stand to lose their state-provided health care coverage on July 1 — and most of them don't know it yet. (AP Photo/The Telegraph, Alex T. Paschal)

• By CARLA K. JOHNSON | AP Medical Writer June 12, 2012

CHICAGO — More than 25,000 working parents in Illinois stand to lose their state-provided health coverage on July 1 — and most of them don't know it yet.

State officials will eliminate their coverage in just three weeks as part of the \$2.7 billion package of cuts and taxes the Legislature passed in May in an effort to save Illinois' Medicaid program from possible collapse. But with the clock ticking, the state has just sent out notices to the Medicaid families who will be affected once Gov. Pat Quinn signs the bill, as he has promised to do.

Among the few who do know is Jennifer Bowman, a 24-year-old single mother from Sterling. She makes less than \$2,000 a month working as a secretary and says she can't afford to see a doctor if she loses her state Family Care coverage. She found out only because she is employed by the Whiteside County Health Department.

"I support my son all by myself. I have health issues," Bowman said. "Once I lose my medical card at the beginning of July, going to the doctor isn't an option for me anymore."

The state agency responsible for Medicaid sent roughly 26,000 notices to parents losing coverage on Friday, an agency spokesman told The Associated Press. Other letters to seniors losing help with prescription drug costs are being mailed in batches this week, Illinois Department of Healthcare and Family Services spokesman Mike Claffey told the AP on Monday.

"We are acting to save the Medicaid program from the brink of collapse," said Quinn spokeswoman Brooke Anderson. "We have been facing an unprecedented crisis in Illinois and must move quickly to implement the changes that will rescue the program and preserve services for those who need it most."

Illinois has little experience informing Medicaid patients they're losing coverage. The program has had few eligibility limits imposed, and mostly the program has grown to cover more residents over the years. Last year, a new income limit was placed on state coverage for children covered by a program called All Kids. But, in that case, the Legislature gave a year before the 4,000 children already enrolled lost their coverage. Their families got many months' advance notice.

Now, advocates are bracing for phone calls from Medicaid recipients who may have only a week or two to make backup plans. Clinics are rescheduling appointments for patients in the middle of treatment.

With Quinn's signature, some Medicaid programs will die at the beginning of the state's fiscal year, which is July 1. While the poorest Illinois residents will continue to receive benefits, parents making more than 133 percent of the federal poverty guidelines — about \$20,000 a year for a two-person household — will see their coverage under Family Care suddenly halt.

"We're worried that when people receive the notices we'll get a flood of phone calls from people in a panic," said Kathy Chan, director of policy for the Illinois Maternal and Child Health Coalition. "This is going to be a shock to a lot of recipients. ... We're also concerned with what the notices will say. Will they get them in time? Will they understand what the notices are telling them?"

Some patients will be able to see doctors at federally funded community health clinics, which charge fees based on ability to pay. But some pockets of Illinois, including McLean and Adams, don't have these health centers. Capacity is limited at other health centers, advocates say. Another part of the legislation requires many hospitals to provide free surgeries and other care to needy patients, but not everyone losing coverage would qualify.

Seniors enrolled in Illinois Cares Rx also will get notices about the July 1 termination of that program, which provides financial help with prescription drug costs to about 180,000 low-income older adults and people with disabilities.

"It's ridiculous," David Vinkler of AARP said of the late notice, adding that some senior centers are still signing people up for Illinois Cares Rx because, officially, the program still exists. AARP is urging the governor to save the program using a veto.

The Chicago-based Health and Disability Advocates has scheduled a web-based seminar this week to explain how seniors can qualify for a similar federal program that assists with prescription drug costs.

Dental care is another problem. Medicaid covers 2.7 million Illinois residents and most won't lose coverage entirely. But all adults on Medicaid will lose some benefits like regular dental care.

"We are contacting all adults with Medicaid coverage to move up dental appointments since we know dental coverage is being totally eliminated for adults," said Melinda Whiteman, executive director at Eagle View Community Health System in the western Illinois village of Oquawka.

Lucy Ramirez of Chicago Family Health Center said the clinic also is rescheduling dental appointments for June and will send post cards to Family Care patients urging them to come in before July 1.

It's unclear how many losing coverage already have other insurance or the ability to enroll in a health plan at work. Besides state insurance, Bowman also has a high-deductible health plan, meaning she pays the first \$10,000 out of her pocket. That will protect her from catastrophic medical bills, but she has used Family Care for regular doctor visits.

She said she's annoyed Family Care coverage will continue for the very poor.

They take it away from the person who goes to work every day 40 hours a week, but give it to the person who sits at home all day. ... Because I go to work, in their eyes, I don't deserve to be helped."

Uninsured “near-seniors” struggling with health access and costs

Trouble paying medical bills also is a growing problem for some older Americans who are privately insured or on Medicare, the Kaiser Family Foundation finds.

By JENNIFER LUBELL, *Posted June 18, 2012.*

Washington Uninsured patients ages 55-64, who typically are not yet eligible for Medicare, are experiencing significant difficulties accessing and affording health care, according to a report from the Kaiser Family Foundation. Even for people of that age who have insurance, paying medical bills and obtaining needed care can pose a challenge.

More than 40% of uninsured adults in the “near-senior” age bracket reported having unmet medical needs or delaying care, and they cited cost barriers as the biggest factor, according to the study. The foundation based its conclusions on data from the 2010 Health Tracking Household Survey and earlier surveys by the Center for Studying Health System Change.

Almost a third of these aging patients without insurance said they had problems affording prescription drugs they needed. Three in 10 uninsured near-seniors lived in families reporting problems paying medical bills.

On average, uninsured 55- to 64-year-olds have lower incomes and are in poorer health than those with commercial insurance, and a disproportionate share of the uninsured are Hispanic adults. They also have lower average incomes than seniors on Medicare, “with a substantially higher portion living on incomes below 300% of poverty,” the study stated.

More than 40% of adults ages 55-64 say cost is the biggest barrier to getting health care.

Wanda Filer, MD, a family physician who works in a large, federally qualified health center in York, Pa., said she sees these types of patients all the time. “These are people who have forgone care because they don’t know how they could pay for it, and they’ve come to a point where they come into trouble and need some help, or they’re people who have been discharged from other practices. In our area, it tends to be large medical group practices that are owned by health systems.”

The patients receive letters saying they’re being discharged because of inability to pay, “and they’re looking for a new primary care source, and they come to us because we’re a federally qualified health center,” said Dr. Filer, who serves on the board of directors of the American Academy of Family Physicians.

Dr. Filer said people in this age bracket may be uninsured for several reasons, including losing a job because of illness. “I don’t think it’s necessarily told to them that’s why they lost their jobs. ... I’ve heard the story so many times, that because of their medical issues and deteriorating attendance and performance and need to be out to get care, they’re often let go.”

Other uninsured near-seniors are self-employed and put off seeking health care when they were younger and healthier, Dr. Filer said. That becomes more difficult once an individual gets older and costly medical needs begin to mount.

Richard Madden, MD, an AAFP board member in Belen, N.M., said he tries to work with uninsured patients in this age group by keeping in touch, handling issues by phone and setting up sliding-scale or nominal payments based on income, a process that is done through the health system to which he belongs.

“Some of these people are looking for jobs, so the hope is they’ll get something with insurance” that’s affordable, Dr. Madden said.

15% of privately insured adults ages 55-64 had trouble paying medical bills in 2010.

Aging seniors without insurance face particular difficulties getting comprehensive health insurance in the individual market because their age and health status can mean high, unaffordable premiums, the study said. The report's authors suggested that these populations could benefit from insurance market changes in the Affordable Care Act, or through proposals such as raising the Medicare eligibility age to make the pre-Medicare pool bigger.

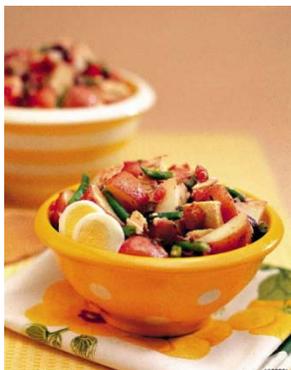
"This is exactly the target group" for the health insurance exchanges under the ACA, said J.B. Silvers, PhD, a professor of health care finance and professor of banking and finance at Case Western Reserve University in Cleveland. "After risk adjustment, the insurance companies can offer community rates and stay solvent. After subsidies, the pre-65 [age group] can afford it. Both win, and providers avoid bad debt."

Medicare seniors appear to be faring somewhat better than the pre-65 populations. Access to care overall "has remained relatively unchanged over time for seniors on Medicare but has eroded for insured and uninsured adults," the study stated. Medicare seniors reported problems accessing care at a significantly lower rate than uninsured near-seniors and at a similar rate to near-seniors with private insurance, after controlling for differences in demographics and health status.

The addition of a Medicare drug benefit in 2006 has "muted the effects of rising costs for prescription drugs for seniors between 2003 and 2010 relative to adults aged 55 to 64 with private insurance," the study said. Nevertheless, problems paying medical bills have increased for Medicare seniors and insured adults in their late 50s and early 60s.

The portion of privately insured, aging adults who had trouble paying medical bills increased from 10% in 2003 to 15% in 2010, the study said. In addition, the share of Medicare seniors struggling to pay bills has grown from 7% to 10% during the same period. Medicare seniors who lacked supplemental coverage, had lower incomes or were African-American had more problems accessing and affording care than other Medicare seniors.

Vitamin D plus calcium tied to longer life



French salad (Bob Fila, Chicago Tribune / June 17, 2012)

By Amy Norton Reuters *June 15, 2012*

NEW YORK (Reuters Health) - Older adults who take **vitamin D** and **calcium** supplements may live a bit longer than their peers, a new research review suggests.

Researchers found that older adults who were given vitamin D and calcium supplements were 9 percent less likely to die over three years than those given **placebo** pills.

Vitamin D on its own, however, showed no effect on death rates.

The findings are based on data from eight past clinical trials — where people were randomly assigned to take vitamin D (with or without calcium) or get inactive placebos for comparison.

Those types of studies offer the strongest kind of evidence on whether the supplements have health effects or not, said Dr. Lars Rejnmark, the lead researcher on the review.

A 9 percent dip in death risk over a three-year period might sound small. To put it in context, Rejnmark's team — some of whom have connections to supplement makers that market vitamin D and calcium products — estimates that to prevent one death, 151 older adults would have to take vitamin D and calcium for three years.

But that effect is "at least as pronounced" as the benefits linked to cholesterol-lowering statins and **blood pressure** drugs, said Rejnmark, an associate professor at Aarhus University in Denmark.

"In my view, a 9 percent reduced mortality in the general population of elderly is of major importance," Rejnmark told Reuters Health by email.

"Except for stopping smoking," he added, "there are not many other known interventions that are capable (of) such a reduction in the risk of death."

EIGHT TRIALS, 70,000 PEOPLE

Rejnmark and his colleagues report the findings in the *Journal of Clinical Endocrinology & Metabolism*.

For their study, the researchers combined the results from eight clinical trials that involved more than 70,000 older adults altogether — mostly women.

In each trial, people were randomly assigned to take vitamin D or a placebo; some studies used a combination of vitamin D and calcium.

The doses varied, but most trials used a daily vitamin D dose of 10 to 20 micrograms. That's in the recommended range: in the U.S., health officials suggest that most adults get 15 micrograms (or 600 IU) of vitamin D per day, while people older than 70 should strive for 20 micrograms (or 800 IU).

In trials that used calcium, the dose was 1,000 milligrams per day. In general, women older than 50, and all adults older than 70, are told to get 1,200 milligrams of calcium each day.

Vitamin D and calcium are probably best known as bone-builders. Older women often take the supplements to ward off the bone-thinning disease **osteoporosis**.

And some trials have found that the supplement combination can prevent falls and bone fractures in the elderly.

But that probably does not explain the lower death risk in this study. When the researchers factored in hip and spine fractures, they did not account for the dip in death risk.

Another possibility is that supplements curbed people's risk of dying from **cancer**. There's some evidence that calcium and vitamin D may lower the odds of **colon cancer**, Rejnmark said. But he added that the evidence is not yet "firm."

SUPPLEMENTS MAY CARRY RISKS

For now, Rejnmark said the findings support getting the recommended amounts of vitamin D and calcium.

But that doesn't mean supplements don't carry any risks.

In particular, Rejnmark noted, some research has linked calcium supplements (not calcium-rich food) to an increased risk of **heart attack** in older adults — though it's not clear if the supplement is to blame.

As for known side effects, calcium supplements may boost a person's risk of kidney stones. And very high levels of vitamin D can cause symptoms like nausea, vomiting, constipation and poor appetite.

In the U.S., the Institute of Medicine says people should get no more than 100 micrograms, or 4,000 IU, of vitamin D each day. The upper limit for calcium in older adults is 2,000 milligrams.

People can, of course, get calcium and vitamin D through food too. Dairy foods are rich in calcium; other sources include greens like broccoli and kale, and fortified juices and breakfast cereals. Food sources of vitamin D are relatively few, but include fatty fish like salmon and tuna, plus fortified milk, juice and cereals.

America's best ice cream



By Liz Weiss | U.S. News – Thu, Jun 7, 2012

On a warm summer day, nothing's more enticing than a creamy scoop of America's most delectable frozen treat. Whether they are artisan creations or from a homemade batch, these tantalizing swirls delight sweet-toothed enthusiasts of all ages. And as the warm air wafts through our windows, we can almost taste the melted deliciousness dripping from a sugary waffle cone...

That brings us to another subject. Few topics are as controversial among dessert-lovers as ice cream. Taking parlor reputation, flavor diversity, and online reviews into consideration, U.S. News Travel has compiled a list of America's best ice cream spots to indulge in this summertime delight.



10. Brooklyn Pharmacy & Soda Fountain

(Photo: Michael Turkel/Brooklyn Pharmacy & Soda Fountain)

Brooklyn, N.Y.

Favorite Flavor: Mint Chocolate Chip (Cost: \$3.75)

Run by Peter Freeman and Gia Giasullo, Brooklyn Pharmacy & Soda Fountain adds an inventive twist to classic flavors with ingredients like toffee and maple egg cream. Inside the Pharmacy (or "The Farm" for those in the know), you'll find an eclectic mix of creamy malts, floats, shakes, and egg creams. Standouts include the "Rocket Shake" (a milkshake laced with fresh coffee and scoops of coffee ice cream) and the "Flatbush Ave. Float" (a blend of your choice of ice cream layered with chocolate or vanilla egg cream).

Should you prefer a decadent sundae rather than a float, try the "Sundae of Broken Dreams." This frosted dessert (vanilla ice cream drizzled with caramel sauce, whipped cream, and crispy pretzels) keeps customers smiling.



(Photo: Courtesy of Roots Ice Cream) **9. Roots Ice Cream**

Charleston, S.C.

Favorite Flavor: Beet (Cost: \$3)

As its name suggests, Roots Ice Cream is all about showcasing Charleston flavors by sourcing fresh ingredients from local farmers. And with its versatile array of seasonal specialties, including Cucumber-Mint, Bourbon-Peach, Beet, and Sweet Tea, Roots Ice Cream has become a local favorite. Although Roots has no official parlor, you can find its artisan blends at farmers markets throughout the Lowcountry, including in Marion, Kiawah Island, and Mt. Pleasant.



8. Capogiro Gelato Artisans

(Photo: Courtesy of Capogiro Gelato Artisans)

Philadelphia

Favorite Flavor: Cioccolato Scuro "Bitter Chocolate" (Cost: \$4.50)

If you're craving a spoonful of pure bliss, it's hard to match Capogiro's artisan gelato. Owner Stephanie Reitano has mastered the art of flavor, infusing her signature sorbets and gelato with seasonal ingredients. Capogiro's offerings vary from tried-and-true Nocciola Piemontese (hazelnut gelato made with nuts from Italy's Piedmont region) to bold flavors like peppery Basil. For a rich treat, try Cioccolato Scuro (Bitter Chocolate), a favorite among loyal fans. You can order a cup or cone at 13th Street in Philadelphia or at one of the other three locations in Pennsylvania.



(Courtesy of Sweet Action Ice Cream)

7. Sweet Action Ice Cream

Denver

Favorite Flavor: Strawberry Balsamic (Cost: \$2.75)

With 24 delectable flavors enriched with local ingredients, this trendy shop values quality as much as inventiveness. Its eclectic blends were not under the radar for long. Food & Wine labeled Sweet Action "One of the best ice cream spots in the U.S." and USA Today praised the parlor as the best ice cream shop in Colorado. From Salted Butterscotch to Lemon Ricotta, Sweet Action Ice Cream crafts each variety with care. For pure sweetness, give the Strawberry Balsamic or Pistachio flavors a whirl.



6. Graeter's

(Photo: Courtesy of Graeter's)

Cincinnati

Favorite Flavor: Black Raspberry Chocolate Chip (Cost: \$2.75)

This fourth-generation landmark creamery dates back to 1870, when Louis C. Graeter crafted the original confection in Cincinnati. The secret behind Graeter's recipes is the elaborate French Pot swirling process. Fresh cream and egg custard are gradually folded together until they reach a thick texture and one-of-a-kind rich taste.

Then, fresh ingredients are sprinkled in, like liquid gourmet chocolate and Madagascar vanilla beans. Signature flavors include Butter Pecan (endorsed by Oprah Winfrey), Cinnamon, and Black Raspberry Chocolate Chip. Other Graeter's branches can be found in Columbus and Dayton, Ohio, and Lexington and Louisville, Ky.



(Courtesy of Sweet Republic)**5. Sweet Republic**

Scottsdale, Ariz.

Favorite Flavor: Salted Butter Caramel (Cost: \$2.95)

Since 2008, Sweet Republic owners Jan Wichayanuparp and Helen Yung have attracted ice cream connoisseurs with their homemade batches. The milk and creams used are provided by local dairy farms, while tasty toppings, including marshmallows, brownies, and waffles, are all made by hand.

And that's not all: From its birchwood ice cream sticks to its recycled glass bottles, this shop prides itself on its eco-friendliness. To indulge your taste buds with an extra burst of flavor, try the zesty Honey Blue Cheese or decadent Mayan Chocolate flavors. You'll find Sweet Republic headquartered on Scottsdale's Shea Boulevard. Sweet Republic products are also sold at select grocery stores throughout the state.



4. Molly Moon's Homemade Ice Cream

(Photo: Kathryn Barnard/Molly Moon's Homemade Ice Cream)

Seattle

Favorite Flavor: Salted Caramel (Cost: \$3.45)

Since opening in spring 2008, this beloved Seattle ice creamery draws dessert fanatics far and wide. In fact, Molly Moon's Homemade Ice Cream's handheld delights have become so popular that customers are willing to brave long lines for a single scoop.

Fans go wild for the Salted Caramel and "Theo Chocolate" (fudgy chocolate ice cream drizzled with fair-trade Theo chocolate bars) flavors. Another favorite: Balsamic Strawberry (made with locally grown strawberries and

a honey balsamic reduction). The original Molly Moon's is located on North 45th Street, though the company also operates four other stores in the Seattle area.



(Photo: Paige Green © 2012/Bi-Rite Creamery)

3. Bi-Rite Creamery & Bakeshop

San Francisco

Favorite Flavor: Salted Caramel Ice Cream (Cost: \$3.50)

For a cool, creamy batch crafted from scratch, look no further than Bi-Rite Creamery & Bakeshop, a San Francisco landmark set in the heart of the Mission District. Aside from its signature creamy scoops, Bi-Rite boasts a versatile selection of delicacies, ranging from ice cream sandwiches to popsicles to fully loaded sundaes. To top it off, owners Anne Walker and Kris Hoogerhyde pride themselves on making all the toppings — including marshmallows, peanut brittle, and hot fudge — at their adjoining bakery. For intense flavor, try their "dainty gentleman" signature sundae (honey-lavender ice cream lathered in hot fudge, sea salt, and blood orange olive oil).



2. Toscanini's

(Photo: James Leighton/Toscanini's)

Cambridge, Mass.

Favorite Flavor: Burnt Caramel (Cost: \$4.25)

With brag-worthy accolades from the New York Times, People magazine, Bon Appetit, and Gourmet magazine (to name a few), it would seem misleading not to include this Boston-area gelato shop on our list. With its setting in the heart of intellectual academia, Toscanini's draws a cerebral clientele that sparks fresh ideas for bold flavors.

Kulfi, an intense blend with pistachios and cardamom, was inspired by a Harvard professor from India. Other notable gelato flavors include Grape-Nut, Pear Chardonnay sorbet, and the beloved Burnt Caramel. The secret behind owner Gus Rancatore's much-admired caramel concoction: Heating the sugar until the crème caramel — the golden delicious crust — appears on the surface (much like a crème brûlée) and then off-setting the prominent sugary taste with cold cream and milk.



(Photo: Jeni's Splendid Ice Creams)

1. Jeni's Splendid Ice Creams

Columbus, Ohio

Favorite Flavor: Brambleberry Crisp (Cost: \$4.50)

With its broad selection of creative flavors — ranging from Wildberry Lavender to Riesling Poached Pear Sorbet to Brambleberry Crisp — it's no wonder Jeni's Splendid Ice Creams has foodies swooning across the nation. Jeni Britton Bauer's handmade sorbet, frozen yogurt, and ice cream push the boundaries of dessert artisanship. What makes her batches so delicious? Key ingredients, like grass-grazed cream, whole fruits, and fair-trade vanilla. You'll find Jeni's original shop in the North Market of Columbus. There are currently eight other stores spread across the state and two additional locations in Nashville.

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