Health & Retirement Services Of Illinois

May 2012 Newsletter

OUR NEWS LETTER HRSI

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HEALTH INSURERS' CUSTOMER REBATES MAY REACH $1.3 BILLION

More U.S. employers tie health insurance to medical tests

By Julie Appleby, Kaiser Health News

Once a year, employees of the Swiss Village Retirement Community in Berne, Ind., have a checkup that will help determine how much they pay for health coverage. Those who don't smoke, aren't obese and whose blood pressure and cholesterol fall below specific levels get to shave as much as $2,000 off their annual health insurance deductibles.

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By William Rozier, for USA TODAY

Elliptical: Daryl Martin, 60, executive director of Swiss Village, which ties deductibles to health goals, uses the elliptical machine in the early morning hours at the Swiss Village Wellness Pavilion

At Chicago-based Jones Lang LaSalle, a real estate firm, workers can earn up to $300 in cash for having a physical and hitting certain medical goals, or completing health coaching programs.

Gone are the days of just signing up for health insurance and hoping you don't have to use it. Now, more employees are being asked to roll up their sleeves for medical tests — and to exercise, participate in disease-management programs and quit smoking to qualify for hundreds, even thousands of dollars' worth of premium or deductible discounts.

Proponents say such plans offer people a financial incentive to make healthier choices and manage chronic conditions such as obesity, high blood pressure and diabetes, which are driving up health care costs in the USA. Even so, studies of the effect of such policies on lifestyle changes are inconclusive. And advocates for people with chronic health conditions, such as heart disease and diabetes, fear that tying premium costs directly to test results could lead to discrimination.

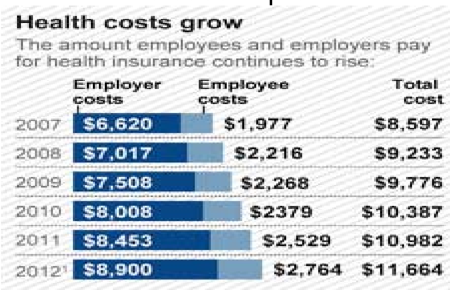
Employee reaction has also been mixed. "It's an invasion of privacy," says Bradley Seff, 54, a court reporter who in August 2010 filed a lawsuit against his employer, Broward County, Fla., for introducing such a plan.

Nonetheless, such plans appear to be the wave of the future. Faced with crippling health care costs, the number of employers embracing such programs inched up from 49% in 2010 to 54% last year — and more say they expect to do so soon, according to a survey by consultants Aon Hewitt. Big-name participants include insurer UnitedHealthcare, car rental firm Hertz, postage meter maker Pitney Bowes and media owner Gannett, owner of USA TODAY. More employers are expected to adopt them starting in 2014, when the health law — if the Supreme Court upholds it — would allow them to offer larger incentives or penalties.

"We're seeing a big move in this direction driven by employers' concern about rising health costs and their sense that employee behavior has a lot to do with high costs," says Kevin Volpp, a professor at the University of Pennsylvania School of Medicine, who has studied the use of such incentives.

Cost savings seen

Leaders at Swiss Village credit their 8-year-old wellness program, along with a high-deductible insurance plan and an on-site fitness center, with slowing health care cost increases. Indeed, workers saw no increase in premiums from 2005 to 2011.



Health costs grow

The amount employees and employers pay for health insurance continues to rise:

	Employer costs	Employee costs	Total cost
2007	$6,620	$1,977	$8,597
2008	$7,017	$2,216	$9,233
2009	$7,508	$2,268	$9,776
2010	$8,008	$2379	$10,387
2011	$8,453	$2,529	$10,982
2012[1]	$8,900	$2,764	$11,664

Source: TW/NBGH Value Purchasing Survey
1 - As of March 11
By Janet Loehrke, USA TODAY

"We continue to embrace what we're doing," says Daryl Martin, executive director of the non-profit organization. Even so, a few high-cost medical issues among its 230 covered employees and their dependents last year caused Swiss Village to raise employee costs 14% this year. What's important, Martin says, is that the company's approach keeps health "at the forefront of what people are thinking about."

Of the employers who offer such programs, about one-third offer financial incentives to those who undergo specific medical tests, according to the Aon Hewitt survey. And 5% of those tie the financial rewards or penalties to meeting specific medical-based standards. The survey also found an expansion of such tests is on the horizon: 57% of employers said they planned to add incentives for spouses and dependents in the next three to five years.

"A lot of costs come from spouses, but only 29% had incentives for spouses," says Cathy Tripp, a senior vice president at Aon.

Employers will still have to craft plans to comply with federal and, in some cases, state requirements, Volpp says. The programs must be voluntary — meaning an employer can't require a worker to participate as a condition of coverage — and the employer must offer a "reasonable alternative" to qualify for the reward, or to avoid the penalty for those who can't achieve the goals.

But Dick Woodruff, vice president of federal relations for the American Cancer Society Cancer Action Network, worries that there's no definition of what a reasonable alternative must include.

Some workers also complain that the programs are an intrusion into their private lives.

"They portrayed it as voluntary, which it isn't, because if you don't participate, they fine you every paycheck," says Seff, the former Broward employee who is suing over the program. He has since retired on disability with back and neck problems. "I don't think any employer should do it."

In an effort to slow rising costs, Broward County in 2009 began asking workers to fill out a health information form and have a finger-stick blood test each year to check blood sugar and cholesterol levels, according to court filings. Workers who declined were docked $40 a month. Those who participated were offered disease-management programs if they had asthma, high blood pressure, diabetes, congestive heart failure or kidney disease. The county stopped docking those who declined to participate Jan. 1, 2011, after Seff's lawsuit was filed, court documents show.

The lawsuit, which argues that the county's program violates the Americans with Disabilities Act, is likely the first of its kind in the nation, says Seff's attorney, Daniel Levine in Boca Raton, Fla. Without ruling on whether the wellness effort was voluntary, a federal district court judge backed the county in April of last year, saying the plan fell under provisions of the law meant to protect bona fide benefit programs. The case is now on appeal. Broward County attorneys did not return requests for comment.

Some state lawmakers are also concerned about the potential for discrimination. Colorado passed legislation in 2010 that requires wellness programs to be accredited, bars penalizing workers for not participating or failing to meet a health standard — and allows appeals if an employee is denied an alternative. A similar bill was brought unsuccessfully in California last year, according to a February report by Georgetown University's Health Policy Institute.

Concern for consumers

While supporting wellness programs in general, several patient advocacy groups warned the Obama administration last March that additional consumer protections are needed. Tying medical test results to financial incentives or penalties in premiums or deductibles could discriminate against some workers, especially those who already have health problems, the groups said.

"When you start increasing premiums or pumping up the deductibles, you're making it more expensive and harder for people to access insurance," says the Cancer Society's Woodruff, who adds that offering gift cards or bonuses are a better way to reward people for participation.

Employers argue, however, that since they're on the hook for the bills, they can ask workers to take more responsibility.

"House money, house rules," says Ken Sperling, global health care practice leader at Aon Hewitt.

The first worker wellness programs, which began about a decade ago, rewarded simple participation: attending a health fair or filling out "health risk assessments," with the worker perhaps receiving a $25 gift card in return.

Today, many offer discounted premiums to workers who meet standards related to blood pressure, cholesterol and weight, with the value of those discounts running between $30 and $60 a month, says Jim Pshock, founder and CEO of Bravo Wellness in Avon, Ohio. Bravo administers such programs for about 220 employers nationwide, including Colorado construction firm Oakwood Homes and Nashville's Ardent Health Services.

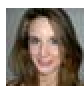
Although employers may set specific goals — such as a body mass index (BMI) below 30, the level considered obese — many also reward achievement of less daunting targets. One employer rewarded workers if their test results didn't worsen, Pshock says.

At Swiss Village, workers get $500 off their deductible for each of these measures: not smoking, having a BMI of 27.5 or less, a low-density lipoprotein cholesterol level (LDL) of 130 milligrams per deciliter or less, and blood pressure of 130/85 or less. LDL levels above 129 are associated with higher risk of heart disease, while blood pressure greater than 120/80 is considered a risk factor for heart attack and stroke.
A second tier of awards allows employees who approach those ranges to earn $250 per category. The testing takes place at an on-site health fair or at a doctor's office, with the results gathered by an independent insurance firm that runs the company's program.
The information is generally gathered by firms that run wellness programs or insurance plans.
UnitedHealthcare, which offers its "Personal Rewards" program to large, self-insured clients, says it does not use the information to set premiums.

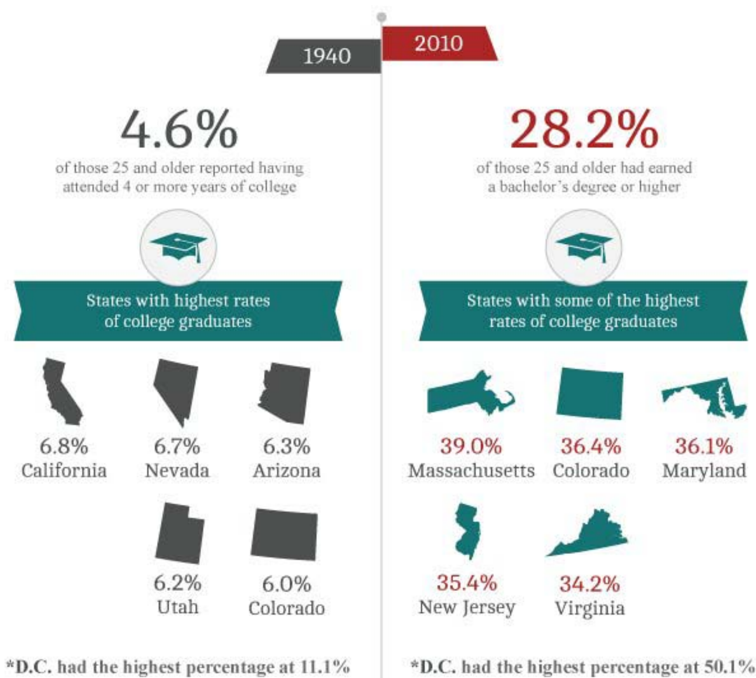
But do they work?

Given the available data, it's hard to parse how much of the reported savings from such programs come from improved health, and how much from the frequent pairing of such programs with high-deductible policies.
"We just don't know how effective (incentives) are," Volpp says. There is pretty good evidence they help smokers quit, he says, but less that they prompt workers to lose weight and keep it off.
Volpp says the medical literature shows they work best when participants have choices: get below a certain BMI, or lose 5% of current body weight, for example. And, he says, rewards should be immediate.
"If you want the employee to do a health assessment or (medical) screening, you should give them the reward right after they do it," Volpp says.
At Jones Lang LaSalle, workers who make a pledge — on the honor system — that they don't smoke, or will take a stop-smoking class, and achieve a healthy weight, get 10% off their contribution toward insurance premiums.
In 2010, the firm added a cash bonus program, offering $50 to workers who get a physical and another $50 for every one of four medical tests they take: weight, blood pressure, glucose and cholesterol, plus an extra $50 if they do all the tests. If they meet specified goals — or complete a coaching program — they receive the money as a cash bonus. Spouses and domestic partners are also eligible, says Howard Futterman, senior vice president of benefits.
Last year, 65% of employees participated. While it's early, he says, indications are the program is having an impact on costs: Health spending rose 6% in 2010, but only 3% in 2011.
"Our long-term goal is to make health and well-being part of our culture and everyday values," Futterman says. "When people start doing it naturally and you don't have to pay them for it, that's when you know you've succeeded."
Kaiser Health News is an editorially independent program of the Henry J. Kaiser Family Foundation, a non-profit, non-partisan health policy research and communications organization not affiliated with Kaiser Permanente.

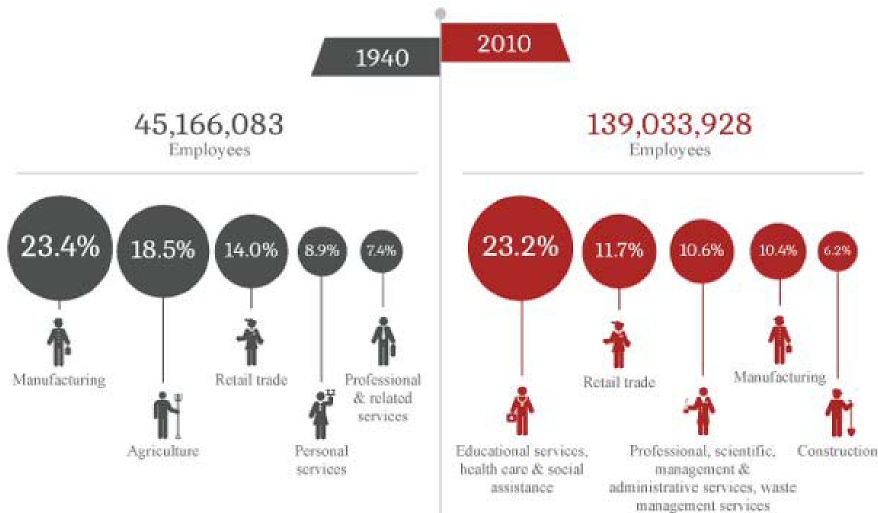
1940 Census graphics show dramatic change in education, economy

*By [Liz Goodwin](#)*

National Affairs Reporter

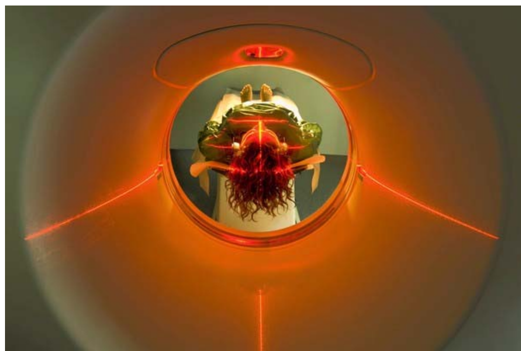


The National Archive released the full results of the 1940 Census online today, and put together some intriguing full-page graphics to illustrate how the country has changed over the past 70 years. Two visuals jumped out at us as intriguing: Above, the image shows the huge increase in the percentage of the population that has a college degree, and below, the graphic shows the way the workforce has transformed since 1940. The manufacturing and agriculture sectors shrank as education and health services grew. Check out more of the graphics here.



Unnecessary medicine: Physician groups list 45 overused tests, procedures

Nine organizations release lists of medical exams and treatment that are often unneeded, costly — even possibly harmful



CT scans for cases of acute rhinosinusitis are unnecessary because most cases can be diagnosed clinically and resolve without treatment in two weeks, says the American Academy of Allergy, Asthma & Immunology. (Francesco Ruggeri, Getty Images / April 3, 2012)

By Deborah L. Shelton and **Julie Deardorff**, Chicago Tribune reporters *April 4, 2012*

Should you get a cardiac **stress** test as part of your annual checkup? A **chestX-ray** before outpatient surgery?A CT scan or antibiotics for chronic sinusitis?

In most cases, no.

But patients get these commonly used tests and procedures — and many more — all the time, even though medical experts say they often are unnecessary, can be harmful and contribute to the nation's skyrocketing health care costs.

On Wednesday, nine physician specialty societies collectively representing about 375,000 physicians nationwide are each unveiling a top five list of tests or procedures commonly used without good cause.

The American College of Cardiology, for example, says stress tests are unnecessary for otherwise healthy adults without cardiac symptoms because they rarely result in any meaningful change in patient care.

The American College of **Radiology** recommends against chest X-rays before outpatient surgery for patients who have normal physical exams and no previous problems because the images do not usually change patient care and have not been shown to improve patient outcomes.

And the American Academy of **Allergy**, **Asthma**& Immunology says that because most cases of acute rhinosinusitis can be diagnosed clinically and resolved without treatment in two weeks, there is no need for antibiotics or a sinus CT scan or other imaging.

The lists, which include information about when a particular test or treatment may be appropriate based on clinical evidence and guidelines, are part of the Choosing Wisely campaign, a multiyear effort aimed at reducing the use of unnecessary medicine and promoting greater dialogue between patients and

physicians.

The Congressional Budget Office estimates that up to 30 percent of health care expenditures in the U.S. go toward tests, procedures, doctor visits, hospital stays and other services that many medical experts say do not improve patients' health.

"Unfortunately, in some of the political rhetoric about health care costs and all of the accusations about rationing, consumers get understandably worried," said Dr. Christine Cassel, president of the American Board of **Internal Medicine** and ABIM Foundation, which organized the Choosing Wisely campaign.

Patients "think more is better, and 'Maybe I'm not getting something I need,' when, in fact, more is not necessarily better," she said. "There are a number of things that not only aren't necessary and are potentially costly, but also have a risk of harm to the patient."

The lists cover a wide range of tests, procedures and treatments, some of which are routinely used for thousands, even millions, of patients. Others are only for specific kinds of patients such as those with certain **cancers** or undergoing **kidney dialysis**.

For example, the American Society of Nephrology said dialysis patients with limited life expectancies — six months or less — and no signs or symptoms of cancer shouldn't get routine cancer screening, including mammograms, **colonoscopies**, Pap smears and PSA tests.

The American Society of Clinical Oncology, which is meeting in Chicago this week, recommended against using advanced imaging technologies such as PET, CT and radionuclide scans to determine cancer spread in patients with early-stage **breast cancer** and **prostate cancer** that is at low risk of metastasizing.

In both cases, the tests can lead to unneeded invasive procedures, overtreatment, unnecessary radiation exposure and misdiagnosis.

Some outside experts applauded the effort to reduce unnecessary care.

"The greatest advance in medicine in the past 50 years is not the latest wave of good ideas. It's the ability and mandate to ask whether any idea advantages any patient, and if so, how much?" said Dr. NortinHadler, author of "Worried Sick: A Prescription for Health in an Overtreated America."

"These lists scratch the surface of good ideas that have proved disappointing at best," Hadler said. "Every patient has the right to ask a physician 'How certain are you that any particular test or intervention will advantage me?' and expect an informative answer."

Others said the campaign has shortcomings.

Dr. Adam Cifu, an associate professor of medicine at the **University of Chicago** and co-author of a clinical reasoning textbook called "Symptom to Diagnosis: An Evidence-based Guide," said the list is a good start but two things seem problematic.

One is that the recommendations come from sub-specialty groups, which means they're a little biased in terms of the patients they see, Cifu said.

For example, the American Academy of Allergy, Asthma & Immunology recommends against diagnosing asthma without spirometry, a test using a device that measures air flow. But general internists,

pediatricians and family practitioners see simpler asthma cases and may not need the tool, which can be costly, he said.

Cifu also said groups often choose the least debatable problems, which might not have the greatest impact.

Dr. Steve Devries, a preventive cardiologist at **Northwestern Memorial Hospital**, said the procedures on the list are still common practice.

"There's a natural inclination to screen for **heart disease** in people before they have symptoms. The idea is if **heart problems** are identified early, a **heart attack** can be prevented," he said.

But the stress test as a 50th birthday present hasn't panned out, said Devries. "An abnormal stress test often leads to an **angiogram** which, if confirming a narrowed artery, often leads to a stent procedure," he said. "Unfortunately, placing stents in people who do not have symptoms has not been shown to prevent heart attacks or save lives."

What does prevent heart attacks, Devries added, is eating a Mediterranean diet, as well as exercise and, for selected high-risk individuals, **aspirin** and cholesterol medication.

Cassel said both physicians and patients need to talk about frequently ordered tests or treatments, many of which are requested by patients. She said she hopes the lists also encourage more discussion about appropriate individualized testing and treatment plans.

"It's (a responsibility of) both patients and doctors," she said. "Physicians sometimes are reluctant to say 'You don't need this.' Or they are afraid of malpractice. If patients have the same information as the doctor, they can ask if they really need it. They start on a level playing field, which leads to shared decision-making, which is a model of medical care that leads to the best outcomes."

Dr. Ronald Falk, president of the American Society of Nephrology, said his organization first came up with a list of about 100 overused tests and treatments before it whittled it down to five.

Many of the group's concerns had to do with the use of medications, such as non-steroidal anti-inflammatory drugs, in patients with **hypertension**, **heart failure** or **chronic kidney disease** from all causes, including **diabetes**.

"The use of that category of drugs in patients with **kidney disease** can make all sorts of problems worse," Falk said. "It can raise blood pressure, make anti-hypertensive drugs less effective, cause fluid retention and worsen **kidney** function. We would like other treatments, such as **acetaminophen**, considered first in patients with chronic kidney disease."

Other organizations releasing lists Wednesday are the American Academy of Family Physicians, American College of Physicians, American Gastroenterological Association, and American Society of Nuclear Cardiology. Eight additional specialty societies will release lists in the fall.

What Older Workers Don't Know About Social Security

By Emily Brandon | U.S.News& World Report LP – Mon, Apr 2, 2012

Many people on the verge of retirement lack knowledge about how Social Security works. Most older workers can't identify basic information about the Social Security calculation, including how many years of earnings are factored into their payout and how much their payments will increase due to delayed claiming, according to a recent AARP and Knowledge Networks online survey of 2,053 people ages 52 to 70 who plan to claim Social Security within the next 15 years. Here is what most people in their 50s and 60s don't know about Social Security:

How many years of work are factored into the payout. Social Security benefits are calculated based on your 35 highest-paid years in the workforce, but only 7 percent of survey respondents knew this. Most older workers guessed that the five (30 percent) or 10 (21 percent) years in which they earned the highest salary would be used to calculate their benefit amount.

You can get more than 30 percent bigger payments by waiting to claim. Most people (89 percent) know that their monthly Social Security payments will be bigger if they wait until their full retirement age to sign up for benefits instead of claiming at age 62. But very few people can identify exactly how much more they'll receive. "One thing that they generally know is that if you delay your claiming decision even a year, you will get a boost in your benefit, but when you actually ask them how much, they have no sense of what that actual amount is," says Jean Setzfand, AARP vice president for financial security. Only about a quarter (or 29 percent) of the survey respondents were able to estimate the percentage increase within 10 percentage points of the actual increase. For the survey respondents who are between ages 52 and 70, the increase in payments for delaying claiming from 62 until full retirement age ranges from 30.5 percent to 41.2 percent. Most of the survey respondents underestimated the value of waiting to claim their Social Security benefits.

Your payments could increase by 8 percent annually after your full retirement age. The majority of older workers (62 percent) know that their monthly payments will increase even more if they delay claiming past their full retirement age. But only 34 percent of those surveyed were able to identify a percentage increase that was within 2 percentage points of the actual increase. For most people in the age group surveyed, Social Security checks will grow by 8 percent for each year of delayed claiming beyond their full retirement age, up until age 70. Most of the survey respondents overestimated the benefit of delaying claiming after their full retirement age. "If you expect to live well beyond 80, you will maximize your benefit by claiming at 70. If you expect to die at three or more years before 80, then you will maximize your benefit by claiming at age 62," says William Reichenstein, a Baylor University professor and principal of Social Security Solutions. "You get two-thirds of 1 percent more for each month of delay. You could get 32 percent more by waiting until 70."

The age you can receive the highest possible monthly benefit. Social Security payouts grow for each year of delayed claiming up until age 70. After age 70, there is no additional benefit to waiting to sign up. But only 29 percent of those surveyed were able to identify age 70 as the year they would max out their benefit. Many people (41 percent) incorrectly guessed that it was between ages 65 and 67.

How the earnings test works. People who work and claim Social Security benefits at the same time before their full retirement age may see a temporary reduction in their Social Security payments if they earn too much. The earnings limit is $14,640 in 2012 for people below their full retirement age, above which 50 cents of each dollar earned is deducted from Social Security payments. For beneficiaries who will turn 66 in 2012, the earnings limit is $38,880, after which 33 cents of each dollar is withheld. While most older workers (76 percent) are aware of the earnings test, 71 percent incorrectly believe the reduction in benefits is permanent. Once you reach full retirement age, your checks will be recalculated to factor in any withheld benefit and your continued work

record. "Most people who work before full retirement age are going to lose much, if not all, of the benefit, but there is an adjustment later," says Reichenstein. "When they hit full retirement age, they raise the benefit amount." And once you turn your retirement age, there is no penalty for working and collecting retirement benefits at the same time.

Spouses can claim benefits. Only about half (48 percent) of those who are married or who have ever been married are aware that they're eligible for Social Security spousal benefits. Spousal payments can be worth as much as 50 percent of the higher earner's Social Security payment. Dual-earner couples who have reached their full retirement age can even claim Social Security twice by signing up for spousal payments, then later switching to payments based on their own work record. "If both members of the couple wait until the full retirement age of 66, then either one of the spouses could begin receiving a spousal benefit based on the other spouse's record, and then continue to delay their benefit up until age 70, which would then maximize both of their benefits," says Jim Blankenship, a certified financial planner for Blankenship Financial Planning in New Berlin, Ill., and author of *A Social Security Owner's Manual*.

How to maximize widow and widower's benefits. Almost all older workers (95 percent) know that widows and widowers can collect Social Security benefits based on the earning record of the deceased spouse. Most people (78 percent) also correctly report that the age the deceased spouse signed up for benefits affects how much the surviving spouse will get. But only 52 percent of respondents correctly reported that the age the surviving spouse claims benefits can also affect how much he or she will be paid. To receive the maximum widow or widower's benefit, the surviving spouse must claim no earlier than his or her full retirement age. "Typically, the higher-earning spouse is the husband. The later that he waits to [receive] benefits, the higher the survivor's benefit will be at his demise," says Blankenship. "If he began receiving benefits early, at age 62, that would permanently reduce the amount that his wife could receive as a spousal benefit and the survivor's benefit she could receive upon his passing."

SENIORS ADJUST TO NEW STATE RULES FOR LONG-TERM CARE PAYMENTS

- April 2, 2012,

Long-Term Care and Couples: Who Pays?

By Kelly Greene

Associated Press

Medicaid is tightening up its restrictions for families hoping to use it to help pay long-term-care costs. Some states no longer let older adults buy annuities and then exclude those assets when they apply for financial assistance. Others are more aggressively recovering from the estates of people whose care costs were paid by Medicaid.

But there's another layer of rules for families in which the person hoping to get government help paying for long-term care has a spouse who is still living independently. States are treating such "well" spouses in dramatically different ways.

The limit in Texas, for example, is based on monthly income that could be generated using current interest rates. At the moment, the well spouse could hold on to a generous $1.2 million, says John Ross IV, a lawyer in Texarkana, Texas, who specializes in elder-law issues. By contrast, Arkansas has stuck with the federal maximum of about $113,000.

As a result, some families have their loved one admitted to a nursing home on the Texas side of the border, when possible, so that Medicaid qualification is governed by Texas rules, he says.

New York is one of just a few states that have allowed what's called "spousal refusal"—a technique that lets the well spouse hold on to more assets so the spouse needing long-term care can qualify for Medicaid. This year's state budget originally would have eliminated that concession for families seeking assistance paying for "community-based" long-term care, mainly home health care.

Lawmakers restored spousal refusal to the budget last week. That means family caregivers can hold on to more savings and still get Medicaid help paying for home-health care for at least another year.

So-called Medicaid planning, which is essentially giving assets to loved ones so you can qualify for government assistance, is highly controversial. What do you think? Should it be allowed? Are there situations when it is, or isn't, appropriate? Or should families that don't buy long-term-care insurance simply be out of luck?

How to get the most from Social Security

By Mark Miller | Reuters – Tue, Apr 10

CHICAGO (Reuters) - The trustees of Social Security will release their annual report on the program's health sometime in the next few weeks, and the news will not be good.

The 2012 briefing is expected to show further deterioration in Social Security's financial outlook, due to the higher-than-expected 2.9 percent cost-of-living adjustment awarded this year and a decline in the taxable wage base available to the program. The report is the official gauge of the program's health - signed by three Cabinet members, the Social Security commissioner and two independent Congressional appointees.

Social Security is not in imminent danger of running out of money, but it faces a financial crunch a bit further out - around 2035. That is when Social Security's Trust Fund is projected to be exhausted due to the drawdown of benefits by the baby boom generation. At that point, the program would have sufficient tax revenue to pay only about 76 percent of promised benefits.

Steve Goss, chief actuary of the Social Security Administration (SSA), is one of the nation's top experts on retirement data. Since he is like a walking encyclopedia on Social Security's workings and features, Reuters talked with him ahead of the trustee report's release to find out how beneficiaries can get the most out of the current Social Security program:

Q: You've been at the Social Security Administration nearly 39 years. We hear a lot of talk now in Washington that the aging baby boomer population is the big problem facing Social Security. Is that a surprise, or is it impossible to surprise an actuary?

A: It's not a surprise at all. People say it's about the growing number of older people living longer, but it's all just about birth rates. Our birth rates dropped after 1965 when the baby boom ended, to the lowest-ever single year of births experienced in this country's history - 1.74 births per woman, on average, in 1976. It dropped very quickly over a short period of time and stabilized at 2.

Q: So Social Security's main long-term challenge is the change in ratio of workers to retirees?

A: Imagine that in an earlier generation each of us had three children. So when we get old and retire, we each have three kids in the work force contributing toward taking care of us - chipping in to buy us a house or pay our rent, or paying in to Social Security. But back in that 1965-to-1976 period, we shifted to having only two children. If only two kids are sharing that burden, that's got to be either half again more they will put on the table, or one-third less that we're going to get - it's just straight-up arithmetic. Or we have to find a way to extend the time period over which we can work.

Q: With traditional pensions declining, Social Security is the only game in town for many people in terms of a guaranteed income source for retirement. Is there a way for people to "buy" more Social Security than they could otherwise get?

A: There's one way to do this that is discussed extensively. Social Security uses a formula called the primary insurance amount, or PIA. If you wait to start receiving Social Security until your Full Retirement Age (FRA), you get 100 of your PIA. If you take it at 62, when you first become eligible, you get only 75 percent. But if you wait until age 70, you get 132 percent of the PIA.

From 75 percent to 132 percent at 70 - that is close to a doubling of the monthly retirement income that you can have for the rest of your life. What's key on this is that Social Security is one of the few providers of a true inflation-indexed life annuity. So if people who do have some savings would use those assets to push back the date that they file for Social Security benefits, they can, in effect - easily and at a very good rate of return - "buy" a CPI-indexed life annuity.

Q: And you get the benefit of all the COLAs along the way.

A: Exactly. If you do wait until age 70 - or whenever you start receiving benefits, you don't miss out on any of those COLAs that started at age 62. They add up and they are right there when you start getting your benefits.

Q: You're 63 now, but you won't be receiving Social Security yourself, correct?

A: Right. Federal workers first came into Social Security after the 1983 reforms. Workers who were hired after that point all are in Social Security; people like me had the option to join, but I stayed in the civil service retirement system. If I get Social Security at all, it would be from the work I did before joining Social Security. I'll be enrolling in Medicare, but Social Security won't be significant for me. And even though we are in an office where we make projections 75 years into the future, I don't have any plans for retirement at all. As long as I'm healthy and having fun doing my job, I want to stay here.

(The author is a Reuters columnist. The opinions expressed are his own.)

8 Insider Secrets to Booking Cheap Airfare

By Daniel Bortz | U.S. News – 19 hours ago

(Photo: Getty Images)Travel plans are calling for more belt-tightening than usual these days, making budget vacations extremely desirable. But such trips aren't possible if you pay too much for airfare. And unless you know where to look, finding affordable flights can be a huge hassle. "For the airlines, it's about getting you to pay the most you're willing to pay, which is the opposite of what the consumer wants," says Joe Brancatelli, publisher of the travel website JoeSentMe.com. On a single flight, he adds, there can be more than a dozen pricing categories. "On a 150-seat plane, there could be 50 different prices," he says.

With summer right around the corner, U.S. News spoke to Brancatelli and other travel industry experts about the best ways to stretch your travel budget. Here are eight insider secrets to booking cheap airfare:

Book six weeks in advance. Passengers pay the lowest price, nearly 6 percent below the average fare, if they buy six weeks before their flight, according to a study by the Airlines Reporting Corporation (ARC). After compiling data from every U.S. travel agency over the last four years, it determined that most people booked the cheapest airline tickets 42 days in advance. But the six-week rule isn't necessarily a surefire strategy for snagging the cheapest fare. "This is just a trend," explains Chuck Thackston, ARC's managing director of data and analytics. "Airlines will make valuable deals available all the time. But, on average, we see this 42-day approach works."

Scan for morning deals. Airlines only post a limited number of seats at a reduced fare at night, so Thackston advises snagging seats early. "Those tickets may sell out later in the day," he says. The early morning is the time you'll see most of these deals available, although a few airlines release discounted tickets throughout the day.

Best time to buy: Tuesdays at 3 p.m. Eastern. If you don't find the discounts you're looking for in the early morning, a study by Farecompare.com says the best time to buy airline tickets and shop for travel (domestically) is on Tuesday at 3 p.m. Eastern. However, George Hobia, founder of AirfareWatchdog.com, argues that the best deals vary frequently, so there's not one specific day or time of the week to buy.

Cheapest day to fly: Wednesday. According to a recent Farecompare.com study, the cheapest day to fly is Wednesday for domestic travel. "The day with the most seats is likely to have better supply, and thus ... more

empty seats that require discounting to fill the plane—meaning they have to release more seats at their cheapest price point," according to the website. Other low-cost days to fly are Tuesday and Saturday, says Farecompare (Friday and Sunday are the most expensive days to travel).

Fly out early. The cheapest flight is typically the first flight of the morning. "Yes, that means you have to get up at 4 a.m.," says Rick Seaney, chief executive of Farecompare.com. The next-cheapest flight times are during or after lunch or at the dinner hour. "Of course, the absolute cheapest time to fly is on those limited routes with red-eyes," he says.

Check low-cost airlines individually. Comparison sites like kayak.com don't necessarily do all the work for you. Some low-cost airlines, like Southwest in the United States and Ryanair in Europe, don't allow their tickets to be quoted on popular comparison websites, says Seaney. So be sure to check them separately. And do your homework to make sure the so-called "low cost" airline doesn't tack on extra fees that drive up the cost, like a bloated baggage-check charge, which Seaney says is a tactic employed by some of the budget airlines.

Sign up for free alerts on AirfareWatchdog.com. Almost every major online booking site offers airfare alerts that ping you when fare prices fall. AirfareWatchdog.com stands out from the pack by using people to vet deals rather than computer systems. "We only send updates when we think we've found a good deal, whereas other sites might update you when a flight drops $2," says founder George Hobia.

Build a relationship. "The question isn't how much is it to fly from here to there, the question is, 'Who's asking?'" Brancatelli says. If you're an elite member of the airline's frequent-flyer program or if you have a credit card that's tied to the airline, you automatically have a leg-up on other travelers. "The more the airline knows you, the more it tailors its pricing to you," Brancatelli explains. Credit cards tied to the airlines now offer perks that were once standard, such as free checked bags, priority boarding, and seat selection, so they may be worth signing up for if you fly frequently on one airline.

$10 premium hike can prompt patients to shop for other insurers

Price increases above a certain point are linked to measurable losses in market share for health plans.

By EMILY BERRY, amednews staff.*Posted April 11, 2012.*

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In a study that could predict how people will shop for coverage through state-based health insurance exchanges, University of Michigan researchers found that a modest $10-per-month increase in the price of insurance coverage pushed consumers to shop for a new health plan.

The study, published online Jan. 25 in *Health Economics*, examined responses to an increase in the out-of-pocket cost for health benefits for 3,182 of the university's retirees during a four-year period (**ncbi.nlm.nih.gov/pubmed/22278904/**).

"What we found overall was that with that $10 increase, you get a 2% to 3% decline in enrollment," said study co-author Richard Hirth, PhD, a professor at the University of Michigan School of Public Health.

Perhaps more significant than what the study says about university retirees is what it might say about the people who will choose health insurance through health insurance exchanges beginning in 2014, Hirth said.

Younger people tend to be more price-sensitive than retirees, so they are more likely to switch plans when prices go up. For that reason, Hirth said he expects that people buying coverage in the exchanges will change plans based on an even smaller price increase than $10.

But he said there are important differences between the people in his study and those who will buy coverage in the exchanges. For example, exchange shoppers will have more options, and their choices could be presented in myriad ways because of the leeway states have in designing the exchanges.

It's difficult to predict how consumers will shop in the exchanges, said Judy Hibbard, DrPH, professor of health policy in the Dept. of Planning, Public Policy and Management at the University of Oregon.

"In the exchanges, it's going to be difficult to compare," she said. "When you're trying to process lots of different variables and compare, it's going to be cognitively difficult. People will take shortcuts. I don't know what the shortcut will be, but they probably won't be able to do the comparison that is necessary."

Making the most of that shiny new HSA

Discovery Communications Wellness Center Medical Director Liz Sequeira arrives to examine patient BonnaryLek (L) during a medical appointment at the clinic in the Discovery headquarters in Silver Spring, Maryland December 3, 2009.
Credit: Reuters/Jim Bourg

By Matt Stroud
NEW YORK | Thu Apr 19, 2012

(Reuters) - Health savings accounts have been around for almost a decade, but lately people have been snapping them up like they are milk and rock salt, and a big snow storm is brewing.

Enrollment in these specialized tax-deductible, tax-free accounts has exploded: In March 2005 there were slightly more than 1 million accounts; a year ago there were 11.4 million, according to America's Health Insurance Plans, a trade group. Since then, the growth has been exponential, with Fidelity Investments saying its HSA business grew 61 percent in a year.

The idea behind these accounts is this: Consumers set aside pre-tax dollars in a special account that they can use for the out-of-pocket medical expenses that arise when they are in high-deductible plans.

Some of that new popularity stems from the growth of lower cost high deductible health insurance plans that are showing up in employer's benefit packages.

But the big tax advantages that these accounts confer on their owners is also significant.

"I don't know of anything else that has a triple tax advantage like an HSA," says Paul Ashley, a financial adviser with First Person Benefit Advisors in Indianapolis. "You pay into the account pre-tax; then it sits in the account, tax free, whether you acquire gains through interest or investments. And then when you spend money for a qualified purpose, you're not taxed there either. That's a powerful incentive."

Furthermore, account holders keep their accounts even when they change jobs, points out Jennifer L. Zegel, an associate with the Philadelphia-based law firm Reger Rizzo &Darnall. "I think HSAs have grown rapidly in recent years because they are portable."

Whatever the reasons, there's a decent chance that an HSA may be in your future. You may already have one.

USE IT OR KEEP IT

At first blush, HSAs sound like Flexible Spending Accounts - the tax-sheltered accounts that allow employees to set aside some of their pay to fund medical or dependent care expenses. But there's one major difference: While FSAs expire at the end of each year, HSA funds roll over year to year. HSAs also are sometimes confused with employer-funded health reimbursement accounts (HRAs). These accounts are set up by employers to reimburse employee medical expenses. HRAs offer similar tax benefits to HSAs and funds can be kept year to year, but HRAs are not transferable when an employee leaves his/her employer.

"The ‘use it or lose it' rule with FSAs scares the bejesus out of people," says John Hauserman, CFP and president of Retirement Quest Wealth Management in Baltimore. "But HSAs are different. I think of these plans as a health retirement account, something you can hold onto for a long time and use as you need it." Some account holders take advantage of this, saving and investing their HSAs from one year to the next so they can use them in retirement, when medical expenses may be high.

But before racing to sign up, consumers should consider some of the downsides and complexities of HSAs.

First, not all employers offer them. The 2011 Kaiser Employer Health Benefits annual survey found that only 23 percent of firms offering health benefits offer a high deductible health plan or an HSA-qualified plan.

And users should be able to shell out some money for their own health care. The high-deductible healthcare plans that allow individuals to use an HSA are required to have deductibles of at least $1,200 for individuals and $2,400 for families. Maximum deductibles are $6,050 for individuals and $12,100 for families.

Aside from preventative services such as an annual checkup with a doctor, there is no reimbursement for medical services until the deductible is reached. And after reaching the deductible, "people typically have to pay additional copayments and coinsurance on the care they receive, making out-of-pocket spending potentially quite a bit higher than the deductible," says Adam C. Powell, a healthcare economist and president of health insurance consulting firm Payer+Provider.

A PLAN FOR THE YOUNG

Ideal HSA candidates are young and likely not to see their doctor regularly, says D. Wes Rommerskirchen, a business development supervisor with Benefit Plans Plus in St. Louis. "If they're young and healthy - or, if they have a family, their family is healthy - they can use it to really build their funds," Rommerskirchen says. "And, when those health expenses hit, they'll have the funds available."

That's another reason why young and healthy people are best suited for HSAs; the accounts have an annual contribution limit of $3,100 for individuals and $6,250 for families.(Someone over the age of 55 can contribute an additional $1,000 each year under catch up provisions.) So it's possible that, in the event of a major medial incident during the first or second year of an HSA plan, individuals might not have enough cash set aside to cover the entire cost.

"It is important to try to keep at least the deductible saved in an HSA so that those expenditures can be made with pre-tax money, says Powell.

But there are limits on what those expenditures can entail. Health club dues, hair transplants and cosmetic surgery - as well as the other expenditures deemed "not includible" by the Internal Revenue Service (see IRS's Publication 502 for a list here) - are off limits. So are over-the-counter drugs such as Advil or Tylenol, unless they're prescribed by a doctor.

And individuals who pull money out of their HSAs for non-medical purposes will pay dearly for that: the withdrawal will be taxed as ordinary income and subject to an additional 20 percent penalty.

BACK DOOR RETIREMENT SAVINGS

Though non-medical withdrawals are always taxed as ordinary income, that 20 percent penalty is dropped at age 65, and that allows for some creative strategies.

Retirees, who presumably will face higher healthcare costs as they age, can use HSA balances built up over the years to supplant their retirement income. Even if they end up drawing down the money for non medical purposes in retirement, the end result is no worse than a traditional tax-deferred account.

Some advisers, like Zegel, suggest stashing the maximum contribution in an HSA, not using it until you retire, and then pulling money out to repay yourself for medical expenses you had when you were building the HSA. Of course that requires keeping all of your medical receipts for years and years.

HSAs can be a great option for many. But it's not right for everyone.

"If someone has chronic medical condition, it would not be a viable option," she says. "They would be paying too much out of pocket. But it's great for people who want to save for future medical expenses."

Preparing For A Future That Includes Aging Parents

By Marilyn Geewax April 24, 2012

Mapping out a vacation is fun.

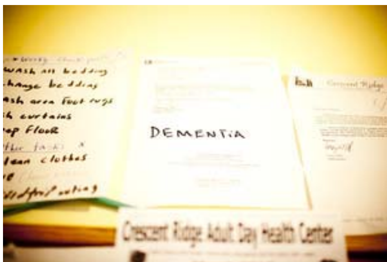
Figuring how to afford care for your confused, elderly father? That one may never cross your mind — at least, not until you need more money to care for him.

"Never thought about it," Natasha Shamone-Gilmore, 58, says about her younger self. "Never ever."

She thinks about it a lot these days. Shamone-Gilmore, a computer trainer in Maryland, now shares a modest home with her husband, 24-year-old son and 81-year-old father.

Like millions of other middle-aged Americans, she had long regarded her parents as robust adults, more than capable of managing their own affairs. "My mom was a very active woman; my dad ... was a Safeway employee for 40-something years," she said.

But time does what it does, and today, her father needs a caretaker. So she has had to step into that role and figure out how to make it all work financially.



EnlargeKainazAmaria/NPR

Natasha Shamone-Gilmore keeps a letter from her father's doctor diagnosing him with dementia on a wall in her kitchen. She uses it at times to remind Franklin Brunson of his condition.

Shamone-Gilmore's family is one of three multigenerational households being profiled by NPR this spring. Their stories will help highlight the importance of family financial planning. The series, Family Matters, began last week and will continue in installments each Tuesday into June.

While aging is inevitable, planning for the costs associated with dependency in the latter phase of life doesn't come easily to most Americans.

"People dread talking about it because we don't like to face our mortality," says Jack Hetherington, a certified elder-law attorney in suburban Philadelphia. He estimates that fewer than 1 person in 5 takes even the first steps needed to prepare legally and financially for taking care of an incapacitated parent.

Consider this contrast between expectations and reality:

Only 13 percent of some 4,000 U.S. workers surveyed for the 2011 Aflac WorkForces Report believe that the need for long-term care would affect their families.

The Cost Of Elder Care

Adults have been providing an increasing percentage of financial assistance to their parents in recent years. Below are the national average annual costs and daily rates paid for various types of adult care.

Type	Average	Annual
Nursing home: semi-private room	$214/day	$78,110
Nursing home: private room	$239/day	$87,235
Assisted living	$3,477/month	$41,724
Home care: home health aide	$21/hour	$21,840
Home care: homemaker	$19/hour	$19,760
Adult day services	$70/day	$18,200

Source: MetLife 2011 Market Survey of Long-Term Care Costs

And yet providing long-term care is, in fact, common. Nearly 10 million adult children are caring for aging parents, according to the MetLife Mature Market Institute. Other adult children are contributing to the cost of a parent's assisted-living care, which MetLife says averages about $3,500 a month.

"The percentage of adult children providing personal care and/or financial assistance to a parent has more than tripled over the past 15 years," the research group found.

Of course, in today's tough economy, it also is common for elderly adults to be supporting their adult children. But in some ways, that's easier to accept: Parents often plan to leave whatever wealth they have to their children anyway. The flow of wealth from older to younger generation feels natural to many.

But with Americans living so much longer now, the younger generation has to do more thinking about how they might care for parents who have exhausted their savings.

"That's a tough one," says Paul Taylor, director of the Pew Research Center's Social and Demographic Trends project. "You have lots of uncertainties in your own life, let alone worrying about paying for your parents' care."

So like many other baby boomers, Shamone-Gilmore is struggling with bills, and hoping to reform her family for the future.

"Now that it's happened to us, and I am the household coordinator, I am now trying to educate the entire family that: You guys need to get in line," she says. "We're not thinking. No one is thinking."

Experts say any serious plan for caring for aging parents must begin — not with discussions about money — but with a legal document designating someone as having "power of attorney." That paperwork grants authority to another individual to handle decisions if a loved one can't make them as a result of illness or memory loss.

"The purpose is to provide a safety net in case of incapacity," Hetherington says. "If you wait too long and you don't have the capacity to make decisions, you end up in guardianship court, and that could involve lawyers, doctors, judges, time and money."

EnlargeKainazAmaria/NPR

Franklin Brunson (left) and Curtis Gilmore help Natasha's mother, Luella Brunson, sit upright in her hospital bed. Along with caring for her aging father, Natasha keeps a close eye on her 80-year-old mother, who is often hospitalized with complications from chronic obstructive pulmonary disease.

Once the legal paperwork is done, families can turn to an array of sources for legitimate advice on boosting savings, buying appropriate insurance and maximizing home equity.

For example, many employers offer workplace benefits that include free financial planning services. Credit unions can help, too. Public library shelves are loaded with books on how to get started making a financial plan, and websites, such as HelloWallet and Mint.com, offer help.

Individuals can ask for professional referrals from the National Association of Personal Financial Advisors.

Hetherington says taking those first steps can be difficult. "But it's the only way of avoiding problems down the road," he says.

Health Insurers' Customer Rebates May Reach $1.3 Billion

By Alex Wayne - Apr 26, 2012

UnitedHealth Group Inc. (UNH), WellPoint Inc. (WLP) and other health insurers may have to forfeit to consumers $1.2 billion to $1.3 billion in profits from last year because of changes to U.S. law that limit revenue from premiums.

Rebates for exceeding the limits, called medical loss ratio, will amount to about 6 percent of the industry's $21 billion in profits from 2011, said Matthew Borsch, a Goldman Sachs Group Inc. (GS) analyst. For consumers, that translates into rebates of as much as $517 a person, according to the Kaiser Family Foundation.

The rebates are being promoted as one of the successes of the 2010 health-care law, as the Obama administration awaits word from the Supreme Court on whether portions of the overhaul violate the Constitution. Changes to the health system included limiting to no more than 20 percent the premium revenue insurers can keep for administrative costs and profit.

"Today's news is yet another sign of how the Affordable Care Act is already strengthening the health-care system,"Health and Human Services Secretary Kathleen Sebelius said in an e-mail. "The 80-20 rule ensures that consumers get a good value from the money they spend on their insurance plan by requiring 80 cents on every premium dollar to go towards better health care instead of overhead and executive bonuses."

The largest checks based on the national average, $127 each, will go to people who don't have insurance through their employer and instead buy coverage on their own, Kaiser, a nonprofit research group in Menlo Park, California, said in areport today. People employed by large companies will receive rebates averaging about $14 each, the foundation said. Insurers will pay those rebates to the companies, not to individuals.

Excess Costs

"Greater regulatory scrutiny of private insurance is improving value and helping to get excess costs out of the system," Kaiser President and Chief Executive Officer Drew Altman, said in a statement.

Kaiser estimated that the rebates will total $1.3 billion, while Borsch at Goldman said the figure will be $1.2 billion, or 5.7 percent of $21 billion in 2011 profits. Both relied on data insurers submitted to state regulators last week.

The cost to the industry is "more positive than negative," as the government had forecast refunds of about $1.4 billion, Borsch said in a note to clients yesterday.

Eight publicly traded insurers, also including Bloomfield, Connecticut-based Cigna Corp. (CI) and Aetna Inc., would pay a combined $850 million of those rebates this year because they exceeded the limits,

Borsch said. UnitedHealth will pay the most, $307 million, Borsch estimated. A spokesman for the company, Daryl Richard, said Borsch's estimate is accurate.

'Unpredictable' Costs

Aetna, based in Hartford, Connecticut, will pay about $177 million, and Indianapolis-based WellPoint $94 million, Borsch estimates. Coventry Health Care Inc. (CVH), based in Bethesda,Maryland, will pay about $50 million, he projected. Nonprofit Blue Cross Blue Shield plans will owe $250 million, Borsch said.

The industry expected to pay rebates, Robert Zirkelbach, a spokesman for America's Health Insurance Plans, a Washington-based trade group, said in a phone interview last week.

"Given the inherent unpredictable nature of health-care costs, it won't be surprising if some plans are paying rebates to customers in certain markets," he said.

Aetna (AET), the third-biggest U.S. insurer, was able to better price some plans for 2012 after seeing which ones generated rebates last year, Chief Financial Officer Joseph Zubretsky said in a telephone interview.

State Waivers

"If there was a particular geography in the country that was in significant rebate status for 2011, we may have chosen to take those funds and include them in the pricing of the product for 2012," he said.

Rebates may be lower than forecast because insurers"proactively" reduced their premiums to avoid paying back customers, Borsch said. His estimate doesn't reflect waivers the government granted to insurers in seven states, allowing them higher profit limits, he said.

Those waivers won't affect rebates that plans pay by more than about 1 percent, he said. Minnetonka, Minnesota-based UnitedHealth is the biggest U.S. health insurer by sales.

People in Texas and Florida -- states that had their requests for waivers denied by the Obama administration -- will receive the largest rebates, Kaiser said. Texas consumers and businesses will receive $186 million; Florida rebates will total $149 million.

Hawaii is the only state where no one will receive a rebate, Kaiser said.

Rebates could take the form of either checks sent to insurers' customers or discounts on future premiums, Kaiser said.

Consumers probably won’t see any notable reduction in their premiums because other provisions of the health law are increasing costs, Zirkelbach said.

“If the goal is to bring down the rising cost of health care, having this arbitrary cap on administrative costs isn’t the way to do it,” he said.

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