Health & Retirement Services Of Illinois

May 2013 Newsletter

OUR NEWS LETTER HRSI

Insurers set to submit plans for Illinois exchange

March 30, 2013|By Peter Frost, Chicago Tribune reporter

Health insurance companies hoping to compete for a share of an estimated half-million new customers in Illinois can begin submitting health plans Monday to the state for inclusion on the Illinois health insurance exchange.

Operated in a partnership between the state and federal governments, the Illinois exchange is an online marketplace where individuals and small businesses can begin buying health insurance starting Oct. 1 for coverage that begins in 2014.

State officials expect about 486,000 people to purchase health coverage via the exchange, a key component of President Barack Obama's health care overhaul that requires individuals to carry health insurance or pay a penalty.

Insurers have a monthlong window to submit plans for state and federal approval.

Yvonne Clearwater, Illinois' acting deputy director of health products, said a staff of about 20 workers in the state Department of Insurance will have until the end of July to review up to 400 separate health plans that the state expects will be submitted by dozens of insurers. From there, the plans will be sent to federal regulators, who have final say in approval.

Many insurers, including two of the three largest in Illinois, have been cautious about committing to participate in the exchanges, largely because of a tangle of new requirements set forth by the federal government that are still trickling in.

"While the application process starts (Monday), we continue to get guidelines. In fact we just got some more (Thursday)," said Bill Berenson, president of Aetna Inc.'s Illinois division, the state's third-largest health insurer. "As we look at making final decisions, we want to make sure we're taking a very balanced approach."

Aetna, which offers individual health insurance in 24 states, has said it plans to participate in exchanges in up to 15 states this fall. While Berenson declined to say whether Illinois is one of those

In Our Newsletter

states, he said the market "is a very important one to the Aetna enterprise and one that we're really committed to."

UnitedHealthcare, the No. 2 insurer in Illinois, offered less insight on its plans.

In a statement, the company said that "there is a great deal to evaluate before pursuing the exchange in any market, and we're holding back … until greater clarity can be established."

United executives have said the company could submit plans in 10 to 25 states, though analysts expect the final number to be on the low end of the range.

The state's largest insurer, by far, is Blue Cross & Blue Shield of Illinois. It plans on offering multiple insurance products on the exchange, said Kurt Kossen, vice president of retail markets for Health Care Service Corp., Blue Cross' Chicago-based parent.

Blue Cross, which controls more than half of the health insurance market in Chicagoland, also operates the state's largest small group plan that served as Illinois' benchmark for essential health coverage.

All plans in the exchange must provide a baseline level of coverage, dubbed essential health benefits. Mandated items and services fall under 10 categories, including ambulatory care, prescription drugs and laboratory services.
Plans on the exchange also must adhere to stringent financial boundaries set for the actuarial value of each product, or the percentage of the cost of benefits they will pay.

Those requirements limit the creativity of insurers to offer differentiated products, which the government hopes will spur more competition on cost.

The plans insurers can begin submitting Monday also must include financial details, like monthly premiums, deductibles and copayment amounts.

But consumers won't be able to see which companies are offering plans and at what prices until the exchange website goes live, likely in September after federal regulators finish their review.

Five Really Dumb Money Moves You've Got to Avoid

THE WALL STREET JOURNAL *By Brett Arends | The Wall Street Journal* The Wall Street Journal/Tim Foley/The Wall Street Journal -

You know the smartest things to do with your money. But what are the worst moves? What should you avoid?

Weirdly enough, they are things that a surprising number of people are still doing—even though they probably know, in their heart of hearts, how foolish they really are.

Any list is going to be incomplete. But here are five to avoid.

1. Reaching for yield

What this country needs is a good 5% certificate of deposit. Instead the collapse in interest rates, and the Federal Reserve's policy of keeping them down for as long as possible, is driving people crazy—especially people who need to generate income from their investments.

In these circumstances, people start to do really foolish things in the desperate hunt for higher interest rates. That includes taking on crazy amounts of risk, or investing in complex products they don't understand, in the hope of higher yields. The Fed is producing a bull market in scams, Ponzi schemes and associated rackets.

The Securities and Exchange Commission recently warned about an epidemic of bogus high-yield "corporate promissory notes" being marketed to investors by scam artists.

The Wall Street Journal's Jason Zweig highlighted the woes of those sold complex "reverse convertibles," a legal but complicated product with embedded risks. Eric Lewis, chief investment officer of Bedrock Capital Management in Los Altos, Calif., suggests that if you can't explain an investment to a friend, including what might go wrong, you should think twice.

A high-yield bond fund such as the iShares High Yield Corporate Bond exchange-traded fund, which lends money to risky companies, sports a yield of about 5%. That's the maximum yield you can earn without taking on much more risk.

2. Going into the poor house to send Junior to a country-club college

Over the past 40 years, the cost of tuition and fees at a private university has tripled—after accounting for inflation. The cost of a public university has quadrupled.

The cost of getting a bachelor's degree has become a scandal in this country. Students spend $160,000 on a four-year degree and the results are too often questionable.

Financial planners strongly advise parents against plundering their own retirement savings, which they are likely to need, to pay for this.

Admittedly, a degree has become a protection racket—you can't get a job without one, but there are fewer jobs for those with them. But the smart move for the budget-constrained is to get a bachelor's degree at a public university. The tuition and fees average less than $9,000 a year instead of $30,000 at a private college.

3. Owning stock in your employer

This is one of the silliest and riskiest moves any investor can make. If the company hits trouble, you get whacked twice. You can lose your job and your savings—all in one fell swoop. Ask anyone who worked for Enron…or Lehman Brothers.

The law, amazingly, actually encourages this crazy move. While employers' 401(k) plans are subject to punitive regulations, lest they allow you to take on too much "risk," employers are allowed to offer their own stock among the investment options. Many do.

The Employee Benefit Research Institute says that the percentage of 401(k) assets held in employers' stock has been halved since 2000, but the numbers are still alarming. Furthermore, it's the youngest workers—those best able to take a gamble—who are shunning their employers' company stock.

At companies where the 401(k) plan offers the option, workers aged 40 or over typically hold about 20% of their entire 401(k) account in the company's stock, according to EBRI data. Crazy.

4. Taking Social Security too early

If you can afford to delay taking your Social Security retirement benefit, do.

Someone earning $50,000 a year who starts claiming Social Security as soon as he or she is able, age 62, will typically collect a monthly check of about $1,000, according to the Social Security Administration. If they wait until they are 70, that amount would double.

Taking Social Security too early, or without thinking through the consequences, is one of the biggest financial blunders people can make—roughly on a par with buying tech stocks in 2000 or a Las Vegas condo in 2006. The lure of getting money early can blind people to the big cost down the road.

(Many retirees may not have much of a choice. Hard labor at low pay over a lifetime takes its toll on a person. Also, many companies all but force older workers into early retirements.)

In any case, it doesn't take more than just a few years before the total money accrued with the higher, later benefits surpasses the total earned starting at the earlier retirement age.

But that understates the bigger issue. Social Security is insurance. For many retirees, the big risk isn't that they will run out of money before they turn 70, but after 85. According to the Centers for Disease Control, more than half of women currently age 65 will live to 85 or longer, and three out of eight men.

David Blanchett, head of retirement research for financial research firm Morningstar, says it makes sense for women, married couples and those with good health to wait longer for a bigger paycheck.

5. Buying long-term bonds

A surprising number of people still subscribe to the flawed and circular argument that bonds, including long-term government bonds, are "safe." In reality, bonds—especially long-term government bonds—are the rare example of a bubble that has been explicitly declared.

The Fed is openly printing money and using it to buy up such bonds, driving up the price and driving down the interest rates, in order to help the economy. There is no dispute about this. It's public policy.

A 30-year Treasury bond currently sports an interest rate of just 3.1%. That's barely half a percentage point above long-term inflation forecasts. Based on history, the yield should be at least 4.5%, or two percentage points above inflation.

Thirty-year Treasury inflation-protected securities, known as TIPS, sport a "real" or inflation-adjusted yield of 0.6% a year. Again, it should be 2%.

The only reason to buy such bonds in any quantity is to gamble on a 1930s-style depression and world-wide deflation. Such bonds are a gamble, not a safe haven.

Obama administration recruiting 'navigators' for health law plans

By Tom Howell Jr. - The Washington Times April 3, 2013

The Obama administration proposed guidelines on Wednesday for “navigators” who will assist people who buy health insurance on virtual marketplaces under President’s Obama’s health care law.

The marketplaces, or “exchanges,” established by the Affordable Care Act are state-based portals where persons without employer-based insurance can shop among competing private health plans. Participation in the exchanges is set to begin on Oct. 1. Insurance coverage from the exchanges will take effect on Jan. 1.

More than half of the states asked the federal government to set up an exchanges for them. Other states are running them on their own or in a partnership with Washington.

The exchanges will award grants to so-called navigators, which are organizations that are supposed to provide “fair and impartial” information to consumers as they wade through the exchanges’ requirements.

The navigators will be especially helpful to consumers who are disabled, do not speak English or are not familiar with how health insurance works, according to the Centers for Medicare and Medicaid Services.

“Navigators will be an important resource for consumers who want to learn about and apply for coverage in the new Marketplace,” CMS Acting Administrator Marilyn Tavenner said Wednesday.

The navigators are supposed to help people with their eligibility applications and enrollment through the exchange, but not determine whether participants qualify for tax credits or select a qualified health plan for them.

Rather, the state-run or federally facilitated exchanges will determine eligibility and offer services such as a call center for customer assistance.

Navigators must develop expertise in the exchanges and avoid conflicts of interest, the rule said. For example, navigators cannot issue health insurance or be paid “directly or indirectly” by a health insurance issuer in connection with their enrollment of individuals or employees into health plans.

Medicare readmissions drop for 3 high-profile conditions

■ CMS cites success in a program that fines hospitals $280 million for failing to prevent heart attack, heart failure and pneumonia patients from returning.

By Charles Fieglamed news staff— Posted March 15, 2013

Washington Fewer Medicare patients have been returning to the hospital in the months after the Centers for Medicare & Medicaid Services began penalizing facilities for excessive readmissions, a top CMS official said.

The positive signs from the hospital readmissions reduction program drew praise from lawmakers during a recent Senate Finance Committee hearing. The penalties have gone forward despite warnings from hospitals and researchers about the potential harmful effects of the readmissions policy.

The program began cutting pay to more than 2,200 hospitals beginning Oct. 1, 2012 — reductions that were projected to hit $280 million in the first year. CMS is basing those cuts on hospitals' rates of repeat hospitalizations of Medicare beneficiaries within 30 days of the patients' initial admissions for heart attack, heart failure and pneumonia. The policy probably will be expanded in the future.

During the final quarter of 2012, CMS saw the all-cause readmission rate fall to 17.8%, said CMS Center for Medicare Director Jonathan Blum, who also is the agency's acting principal deputy administrator. The rate had been between 18.5% and 19.5% over the past five years.

"This decrease is an early sign that our payment and delivery reforms are having an impact," Blum stated in Feb. 28 testimony to the committee. Although the program is in its infancy, hospitals had prepared for the penalties for years, he added.

At the same time, new evidence regarding readmissions should cause health policymakers to change the program further, stated Karen Joynt, MD, MPH, and AshishJha, MD, MPH, from Harvard University School of Public Health in a perspective published online March 6 in *The New England Journal of Medicine*.

The Medicare Payment Advisory Commission had suggested that a slight decrease in national readmission rates from 2009-11 was tied to increased utilization by hospitals of observation services, which do not require patients to be admitted to the hospital.

In addition, hospitals that are being penalized are more likely to be considered teaching hospitals or safety net facilities, the Harvard article stated.

"Given these two new insights, we believe that there are several steps that could be taken to sustain the gains that have been achieved while avoiding substantial harm to hospitals that care for the most socially and clinically vulnerable patients," Drs. Joynt and Jha wrote (link).

Other readmission factors

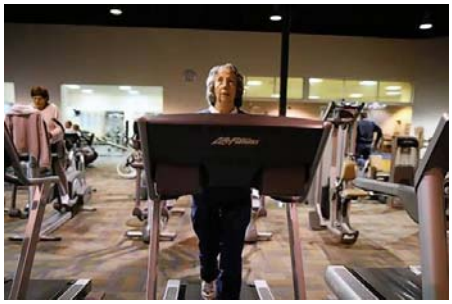
The researchers recommended that readmission rates account for socioeconomic factors, so hospitals caring for a disproportionate share of poorer and often sicker patients are not penalized unfairly. This is a change the American Hospital Assn. and other organizations have recommended.

Timing of a readmission also should be considered so those occurring hours or days after discharge, for instance, are weighted more heavily than those occurring toward the end of the 30-day period. Finally, mortality rates should be considered, so high-performing hospitals get credit for keeping sicker patients alive, the researchers stated.

“Factoring a hospital’s mortality rate into its readmission-penalty calculation could ensure that the best institutions (those with the lowest mortality rates — often large teaching hospitals) were not inappropriately penalized,” the authors wrote. “As things stand, hospitals with high mortality rates but low readmission rates do better under the CMS payment scheme than hospitals with low mortality rates but high readmission rates.”

The American Medical Association has outlined five responsibilities physicians should consider when caring for patients recently discharged from the hospital (link). The recommendations in the AMA Center for Patient Safety report are: assessment of patient health, goal setting to establish desired outcomes, support for self-management, medication management and care coordination.

FITNESS AFTER 65 IS NO ONE-SIZE FITS ALL ENDEAVOR



Carol Johnson, 80, works out on a treadmill at a recreation center in Sun City (Lucy Nicholson Reuters, REUTERS / January 16, 2013)

Dorene Internicola Reuters *April 8, 2013*

NEW YORK (Reuters) - America's ageing population is posing special challenges, fitness experts say, because it is difficult to design effective workout routines for people with such a wide range of abilities.

For one 70-year-old, the goal may be to run a marathon, for another it's getting out of a chair.

"If you are teaching 10-year-olds, it's perfectly reasonable to do an activity that everybody would participate in," said Dr. WojtekChodzko-Zajko, an expert on aging with the American College of Sports Medicine.

But 20 80-year-olds could be as different as chalk and cheese."

Some baby boomer could be athletic, he explained, while others would be unable to get out of bed.

There are now more Americans age 65 and older than at any other time in U.S. history, according to Census Bureau figures. Some 40 million people age 65 and over lived in the United States in 2010, accounting for 13 percent of the total population. The older population grew from 3 million in 1900 to 40 million in 2010.

Older adults should be doing aerobic activity to help maintain body weight, strengthening exercises to develop and maintain muscle mass and some type of flexibility training, according to Dr. James Graves, Dean of the College of Health at the University of Utah.

Physical activity can reduce the risk of diseases such as diabetes, hypertension and osteoporosis, he said, as well as improve the quality of life by maintaining functional capacity, such as the ability to climb stairs, open doors, and carry groceries.

"A very healthy 70-year-old can safely participate in high-intensity activity while a frail 60-year-old needs to lower the intensity," said Graves. "My recommendation is to work with a personal trainer or group leader who

has knowledge and qualifications to work with the elderly."

Mary Ann Wilson is the creator and host of the "Sit and Be Fit," a senior fitness program that has aired on U.S. public television since 1987.

The majority of her viewers are women over 65. For that population, she said, the goal of exercise is health and well-being, not physical prowess.

"Gravity has been working on them for 70 years," said Wilson, a registered nurse who specialized in geriatrics. "Gravity is not our friend after many years of pulling our heads, shoulders and upper torsos forward and down."

The 30-minute class includes warm-up, circulation and strength segments, a finger segment (for stiffness), standing for balance, and final relaxation.

Posture, breathing, balance, cognitive functioning and reaction time are among the most importantâ ”and neglectedâ ”components of elder fitness, she said.

"Focusing on gait is really important because as we age our gait changes," said Wilson.

Karen Peterson, author of "Move with Balance: Healthy Aging Activities for Brain and Body," stresses a mind-body approach in workouts with seniors.

"In our society it seems people don't really like to do things unless they're good at it already," said Peterson, a kinesiologist based in Maui. "But what the brain likes is to be challenged."

Her exercises include tossing a bean bag to improve reaction time, walking a figure-eight pattern for balance, as well as eye stretches, jaw relaxers, childhood games and cognitive challenges to keep body and mind alert.

"We take balance exercises and add conversation or math problems," she said. "The concept is to always progress, always get more challenging."

To tackle the isolation and diversity of the older population, Peterson initiated a mentoring program in which the fitter seniors work with the frailer.

"Some partners will become friends," she said. "They'll get really turned on."

Experts agree that it's never too late to do something. "Exercise is effective even in the most frail individual," Wilson said. "If they can wiggle their toes, they can exercise."

PUT THE BRAKES ON DISTRACTED DRIVING

April 10, 2013

Using a cell phone while driving may quadruple your odds of having a crash that sends you to the hospital. Plus, hands-free models aren't as safe as you might think. The main risks with either kind of phone are answering, dialing and other tasks that lead you to take your eyes off the road. The best place to have the call is before or after you are on the road.

Teens, frequent mobile phone users, are four times more likely than adults to have a crash or near crash related to their use.

And phone calls aren't the only problem. Distracted driving is any activity that could divert a person's attention away from the primary task of driving. *All* distractions endanger driver, passenger and bystander safety.

Other safe-driving tips:

- Give yourself plenty of time to get from point A to point B, especially if the weather is bad.
- Keep your car well maintained. Replace wiper blades and brake pads when needed, for example.
- Always use your seatbelt while driving.

For more information, videos and resources for helping keep teen drivers safe, visit the Be Smart. Be Well.website.

Sources: U.S. Department of Transportation; Virginia Tech Transportation Institute

Insurers: Hospital prices rising steeply

By Sam Baker - 03/18/13

Hospital prices are rising quickly, according to a study by the insurance industry.

Insurers consistently argue that they get too much blame for rising premiums, a trend they say is driven not by their profits, but by skyrocketing growth in the underlying cost of healthcare services.

Karen Ignagni, the president and chief of executive of America's Health Insurance Plans, said Monday's data on hospital costs reinforce that position.

“The price of health care services is the major driver of overall health care cost growth,” Ignagni said in a statement. “To make health care coverage more affordable for consumers and employers, there needs to be a much greater focus on the underlying cost of medical care.”

According to AHIP's data, the price of inpatient hospital care rose by 8.2 percent per year between 2008 and 2010.

Four states — New York, Texas, Tennessee and Pennsylvania — saw their costs rise even higher than average, according to the study, **published** in the American Journal of Managed Care.

AHIP said price increases are driven in part by consolidation in the hospital industry. As hospitals merge and gain bargaining power, it's harder for insurers to negotiate lower payment rates.

Medicare Plans to Boost Pay to U.S. Hospitals by 0.8%

By Alex Wayne - Apr 26, 2013

Hospitals will get a pay raise from the U.S. government for treating patients in the nation's Medicare program.

The U.S. Centers for Medicare and Medicaid Services plans to raise payments 0.8 percent beginning Oct. 1 for services that elderly and disabled patients receive after being admitted to hospitals, according to a regulatory proposal today. Long-term care hospitals that treat patients after they're discharged from acute-care centers would see a 1.1 percent increase.

The proposed payment changes would raise government spending for hospital care by about $53 million next year, including programs that aim to discourage hospitals from readmitting patients soon after they are discharged and to punish hospitals that too frequently spread infections to patients. A final rule on the fiscal 2014 payments is scheduled to be issued by Aug. 1.

"Dedicated professionals are working day and night in hospitals to provide the care that Medicare beneficiaries need," Marilyn Tavenner, the acting administrator of the agency that runs Medicare, said in a statement. "The new policies in this proposed rule support hospitals' important work and the people with Medicare who depend on them by promoting safety and care improvement."

Acute-care facilities are the most-numerous type of hospital in the country and include facilities owned by HCA Holdings Inc. (HCA), the largest publicly traded chain, as well as nonprofits such as Cleveland Clinic. Medicare, the U.S. government's health-care program for the elderly and disabled, pays more than $100 billion a year to hospitals.

9 Tips for a Longer Life that You Shouldn’t Be Following

By Woman s Day | Healthy Living – Fri, Apr 26, 2013

Learn which tips to dismiss so you can really live longer **By Anne Roderique-Jones**

Extend Your Life
"Stop drinking coffee and alcohol." "Take an aspirin daily." How many times have you heard *that* advice for adding years to your life? Turns out, **lots of long-held wisdom just isn't true**. Read on to see which suggestions you should ignore and what actually ups longevity. *Photo by Getty Images.*

1. Lay off the java.
You've probably read that multiple cups of coffee a day can be bad for you (jitter city), but research published in the *New England Journal of Medicine* may prove the opposite. Male and female participants who had two or three cups a day and didn't smoke were 10% and 13% less likely, respectively, to have died during the 14-year-long study than those who never or rarely drank coffee. Men and women who drank a single daily cup were 6% and 5% less likely, respectively, to pass away. According to the researchers, more cups mean a lower risk of stroke, diabetes and heart and respiratory disease. But watch the cream and sugar-extra fat and calories could negate any longevity benefits.

2. Get eight hours of sleep every night.
While research suggests snoozing fewer than six or more than nine hours a night raises your mortality risk, "everyone has different sleep needs," says Shelby Harris, PsyD, director of the behavioral sleep medicine program at Montefiore Medical Center in Bronx, NY. So if you wake naturally after only, say, six-and-a-half hours a night, forcing yourself to reach eight hours won't lengthen your life. To learn how much sleep you need, try awakening without an alarm for a week, if you can swing it. If you feel good and have enough energy most of the day, you've found your ideal amount of rest.

3. Lower your body mass index (BMI).
According to a study published in the *Journal of the American Medical Association*, weighing a little more can lengthen your life span. Adults with a BMI that qualified them as overweight but not obese (that's between 25 and 29.9) were 6% less likely than all others in their age groups to die. While BMI isn't always an accurate measurement of a person's health risks, registered dietitian Jen Brewer, author of *Stop Dieting and Start Losing Weight*, says if the extra weight comes from muscle mass, you're more likely to have lower cholesterol levels and a better ratio of HDL (good cholesterol) to LDL (bad cholesterol). It may also lower your risk for **life-threatening heart disease**, stroke and diabetes. And that's good for staying alive.

4. Don't worry, be happy.
Actually, being a glass-half-empty kind of person may keep you kicking longer. In a study published in *Psychology and Aging*, 65- to 96-year-olds who thought life would get worse outlived those who anticipated better days ahead. "Our findings revealed that being overly optimistic was associated with a greater risk of disability and death within the following decade," says lead author Frieder R. Lang, PhD, of the University of Erlangen-Nuremberg in Germany. "Pessimism about the future may encourage people to take health and safety precautions."

5. Take a daily aspirin.
Popping that pill can help you live longer by preventing heart attacks, strokes and even cancer-right? "If you're a healthy, 45-year-old female, it may *not* make a difference," says Nieca Goldberg, MD, medical director of the Joan H. Tisch Center for Women's Health at New York University's Langone Medical Center in New York City. In fact, taking a daily aspirin can lead to bleeding, allergies and upset stomach. Ask your doctor if you can skip the pill, suggests Dr. Goldberg.

6. Drink 8 glasses of water a day.
Once believed to be the amount everyone needs for proper hydration, a longevity essential, a 2002 study from Dartmouth Medical School in Hanover, NH, debunked the 8X8 rule. As Dr. Goldberg explains, "there's no magic number of glasses," emphasizing it's more about getting fluids, not necessarily from straight-up H20. Herbal tea and juices are hydration helpers (though soda isn't), but fruits and vegetables (like celery and leafy greens) are an even healthier way to get your liquids.

7. Milk does the body good.
You're taught that drinking it by the glassful keeps bones healthy and prevents fatal injuries. Yet a 12-year-long Harvard study found that women who drink milk three times a day break more bones than women who drink less than one glass of milk per week. While lowfat dairy may agree with you, calcium is what's key for strong bones. You can get it from leafy greens, beans, vitamin D (sunshine!) and even lifting weights.

8. Cut out booze.
A daily glass of wine not only can help your heart but also add years to your life. University of Texas at Austin researchers found that moderate drinking, such as a small glass of wine (about four ounces) a day, reduces mortality among older and middle-aged adults. Dr. Goldberg says it's because heart disease is the leading killer of women, and wine is chockfull of antioxidants, which prevent serious sickness. So fill 'er up-without overflowing that glass.

9. Take a multivitamin.
Even though half of all adults pop one, the 2011 Iowa Women's Health Study found that women taking multivitamins don't live longer than those who get their nutrients from food alone. Only calcium supplements are linked to a lower death risk, with 37% of users dying compared to 43% of nonusers in the study. Researchers' conclusion: Get the vitamins and minerals from fruit and vegetables, not capsules.

Watch out for refinancing scams

By Ilyce R. Glink Yahoo! Homes Contributor Spaces – Fri, Apr 26, 2013

Struggling homeowners aren't the only victims any more. Own a home? Watch out, you could be the victim of a refinance or housing scam and not even know it.

Since the beginning of the Great Recession, con artists have been targeting struggling homeowners. Posing as government agencies, nonprofits and attorneys, these scammers prey on homeowners ready to do anything to save their homes from foreclosure.

But even as authorities catch on to the latest scams and shut them down, new ones evolve. Today, it's no longer just struggling homeowners who run the risk of falling victim to hustlers.

"Many people who have been scammed were being proactive," says Yolanda McGill, Senior Counsel for the Fair Housing and Fair Lending Project at the Lawyers' Committee for Civil Rights Under Law. In many cases she has seen, homeowners could see life changes ahead – such as retirement or company downsizing – and wanted to refinance and lower their payments in advance of these events.

"These people were doing just fine but thought it made sense to refinance and get a new loan at a lower interest rate – and they ended up [being scammed] because they just went online and found someone or heard an ad and called on it," McGill says.

Today's con artists know there's money to be made off borrowers looking to take advantage of today's low mortgage interest rates – and they've come up with a variety of ways to do it.

Here are some of the most common refinancing scams out there, and how you can protect yourself.

Phony government programs

The Home Affordable Refinance Program (HARP) is a free government program that allows homeowners who are on-time with their payments but underwater on their mortgages to refinance. Con artists know this program exists – and know how to take advantage of it – by creating a phony government program that sounds like it could be real to play off the lack of knowledge borrowers have about the real program.

In this scam, a third party will contact you via phone, e-mail, flyer or direct mail to solicit your business. The scammer will generally say they're affiliated with, or approved by, the government, and often add phony, official-looking logos to their e-mails, direct mail and website.

It can be hard to tell the difference. "If you get an official-looking letter with your loan number or address on it, don't assume it's real," McGill advises. "You should assume it's fake – no matter what – and contact your lender."

After the initial contact, a scammer may ask you to fill out paperwork that details your financial and loan information. They will likely tell you to pay them a fee, and in exchange they'll help you qualify for the HARP program or something that sounds equally government-like, but is fake. The scammer will probably tell you not to contact your lender, lawyer or housing counselor because he or she will handle all the details of the refinance with your lender. You may even be told to start making your mortgage payments to the scam company instead of your lender, especially if the paperwork you signed contained a hidden quit claim deed, transferring your interests in the property to the scam artist.

How to prevent it: Contact your lender directly to see if you qualify for the HARP program, and don't believe a third party when they tell you they can expedite the process.

"The best help is free," McGill says, "and a housing counselor cannot charge you enormous fees." You don't have to pay to qualify for HARP, and if someone tells you that you do, it should set off an alarm that you may be dealing with a scammer.

Also beware of signing any paperwork with a third-party company that involves your house. Always ask a real estate attorney not affiliated with the company to check the paperwork. Check out the company online by searching the name of the company and the word "complaints." You can also see if the company or individual is licensed to do business in your state by going to your state's department of professional regulation. If the company isn't listed or has paperwork that is missing, you'll know something's amiss.

Real estate attorneys with ulterior motives

Refinancing can be a frustrating process, and loan modifications are exponentially more so. Real estate attorneys know this and they understand the homeowners and borrowers are often looking for ways to make refinancing and the loan modification process easier. An honest attorney will tell a borrower he doesn't need legal help to refinance his property, even through the HARP program. Though the best help you can get for a loan modification is free – in the form of a HUD-approved housing counselor – not everyone is convinced they don't need an attorney.

"Many people are frustrated, and they think they can pay someone to help them because that makes logical sense. Usually, you assume that if you're paying for something you'll get better service," McGill explains.

Scammers understand this logic, and use it to take advantage of homeowners. In this refinance scam, an attorney – real or fake – will tell you they can help you refinance your home. They'll tell you they can call your lender for you and negotiate your refinance, or help you qualify for the HARP – for a fee.

How to prevent it: An attorney simply cannot do a better job with your lender than you can, so don't believe anyone who says he can expedite the refinancing process or get you a better deal. It isn't true.

When might you need an attorney? If you're fighting a foreclosure and need some legal heft, you'll want to find an attorney who had had legitimate experience in this area. If the attorney you hire isn't doing anything or has made false promises or has charged you for work that isn't completed, you can file a complaint with your state's legal disciplinary committee or call the state bar association for information.

Rent-to-own or leaseback scheme

This scam could also cost you your home. To pull this off, a scammer – sometimes posing as a real estate investor or attorney – will urge you to sign over the title or deed to your home. The con artist may tell you that doing so will allow a borrower with better credit to get a new loan at a low rate, which will ultimately benefit you.

But the scammer has no intention of ever selling you back the home. And when the new borrower defaults on the loan, you end up evicted from your own house – and in a worse position than you were before because you still are name on the mortgage to the property. In other words, you've sold the house but still owe every last dollar on the loan.

How to prevent it: Never, under any circumstances, sign over the deed or title of your home. If a low credit score is keeping you from refinancing, contact your lender to find out about your options, or ask a family member or good friend if they'd be willing to co-sign the loan. Worst case scenario, you may have to build up your credit before you can refinance.

In many cases, these scams exist together as a suite of services. A con artist may tell you they can help you refinance under HARP and, if that doesn't work, do a sale-leaseback of your home or go to court for you to fight a foreclosure. Today's scammers are ready for anything, so be on guard when shopping for lenders or housing counselors.

If you feel you've been scammed, file a report on the Prevent Loan Scams, and contact your state's attorney general. You may not get your money back, but you can prevent the scammer from taking advantage of someone else.

Doctor-Owned Hospitals Prosper Under Health Law

By JORDAN RAU KHN Staff Writer **APR 12, 2013**

Doctor-owned hospitals are earning many of the largest bonuses from the federal health law's new quality programs, even as the law halts their growth.

The hospitals, many of which specialize in heart or orthopedic surgeries, have long drawn the ire of federal lawmakers and competitors. They say physicians often direct the best-insured and more lucrative cases to their own facilities, while leaving the most severely ill patients to others.

Some researchers say the doctors' financial interests encourage them to perform more tests and procedures, driving up the cost of care. The health law banned construction or expansion of these hospitals except in unusual circumstances.

But physician-owned hospitals have emerged as among the biggest winners under two programs in the health law. One rewards or penalizes hospitals based on how well they score on quality measures. The other penalizes hospitals where too many patients are readmitted after they leave. There are more than 260 hospitals owned by doctors scattered around 33 states, according to Physician Hospitals of America, a trade group. They are especially prevalent in Texas, Louisiana, Oklahoma, California and Kansas.

Of 161 physician-owned hospitals eligible to participate in the health law's quality programs, 122 are getting extra money and 39 are losing funds, a Kaiser Health News analysis shows. That's a stark contrast with other hospitals -- 74 percent of which are being penalized.

Largest Bonuses

Medicare is paying the average physician-owned hospital bonuses of 0.21 percent more for each patient during the fiscal year that runs through September, the analysis found. Meanwhile, the average hospital not run by doctors is losing 0.30 percent per Medicare patient.

Doctor-owned hospitals comprise nine of the 10 hospitals getting the largest bonuses in the fiscal year that begin last October, the data show. The top one is Treasure Valley Hospital in Boise, Idaho, a 10-bed hospital that boasts a low patient-to-nurse ratio and extra attention, right down to thank-you notes sent to each discharged patient.

Physicians who own their own hospitals say they are not surprised they have done so well under the program. "From our hospital, which did pretty well, the single-minded obsession with quality has been the hallmark of our success, and the value-based purchasing just reflects that," said Dr. John Dietz, an orthopedist and part owner of Indiana Orthopaedic Hospital in Indianapolis, which is getting a 0.72 percent bonus. "It's the difference between renting a home and owning a home: the pride of physicians in owning the hospital."

But Jean Mitchell, an economist at Georgetown University's Public Policy Institute who has examined patterns of patient cherry-picking among these hospitals, said Congress should have excluded them from the program. "This is a disgrace," she said. "Talk about a law that's backfired."

Physician-owned hospitals are less likely to face penalties for high readmission rates, because many do not take the heart failure and heart attack cases that Medicare analyzes when determining whether to levy a penalty. They also tend to have far fewer low-income patients, KHN's analysis shows. It's a population that is generally less able to buy medications, pursue follow-up appointments and find help while recuperating – problems that often send patients back to the hospital.

"These hospitals are on balance not seeing the same population," said Dr. Daniel Podolsky, president of UT Southwestern Medical Center, a teaching hospital in Dallas. "A lot of that is the demographics and the geography."

'Just Seems Unfair'?

Dr. AshishJha, a professor at the Harvard School of Public Health, has documented how the readmission penalties are hitting safety net hospitals particularly hard. "Providing extra rewards for hospitals that treat the healthiest, wealthiest patients just seems unfair," he said.

Past research has shown that physician-owned hospitals score highly in following basic clinical guidelines and pleasing patients -- the factors that Medicare is using to determine bonuses and penalties in its "value-based purchasing" program. Those successes are made easier by the fact that many of their patients come in for elective surgeries rather than emergencies, allowing for more orderly preparations than at a typical acute-care hospital.

"We do surgery and we do surgery well," said Dr. Robb Linafelter, chief executive of Lincoln Surgical Hospital in Nebraska, which is getting a bonus of 0.78 percent on each Medicare patient payment. He said because the doctors own the hospital, they can direct resources to best serve patients. His hospital offers single-bed rooms, interactive TVs and allows patients to order food from outside restaurants. "Those things are going to make the patient experience so much better," he said. "At a community hospital, doctors don't have control over where the dollars are spent."

The narrow focus on these specialty hospitals also helps them excel, said Stacie Vance, chief of nursing operations at Indiana Orthopedic. "You don't get too many athletes who play more than one sport," she said. "It's the same way with hospitals. If you're allowed to specialize in something you can do one thing great. If you want to specialize in four or five things, you can probably do them okay."

It's unclear whether physician-owned hospitals will continue to benefit under the health law's quality programs. Most were eligible to participate in the value-based program this year, but by some estimates, two-thirds or more of the physician-owned hospitals probably will not qualify for inclusion in the next fiscal year, which begins in October. That's because they may not have enough cases to have their mortality rates evaluated, a mandatory part of the program. However, almost all of the doctor-owned hospitals that were eligible this year are on track to regain eligibility in the third year of the program, which begins in October 2014, because the rules change again.

The actual amount of money involved for many of these hospitals this year is not substantial, because many have small caseloads of Medicare patients and the maximum bonuses are not enormous. "It's not a significant amount, but I'll take it," Linafelter said. "It's more of a recognition that we are a facility that is doing things right."

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