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OUR NEWS LETTER HRSI

Health Law Enrollment in U.S. to See Slow Start Next Week

By Alex Wayne & Alex Nussbaum - Sep 24, 2013

Enrollment in the Affordable Care Act's public health exchanges, a key effort to reach people without health insurance, will start slowly, a senior Obama administration official said.

While the U.S. exchanges begin selling insurance plans on Oct. 1, the medical coverage doesn't take effect until Jan. 1, a gap that may lead some Americans to hold off on purchases until the last minute, said the official, who asked not to be identified because the person wasn't authorized to speak on the record. The biggest portion of sign-ups will occur closer to January, the officials told Bloomberg News today.

Michael Nagle/Bloomberg

A volunteer with the Get Covered America campaign, talks with a person who is uninsured, about the health insurance possibilities through the Affordable Care Act in Englewood, New Jersey, on July 27, 2013.

A volunteer with the Get Covered America campaign, talks with a person who is uninsured, about the health insurance possibilities through the Affordable Care Act in Englewood, New Jersey, on July 27, 2013. Photographer: Michael Nagle/Bloomberg

In Our Newsletter

Such a scenario would mimic patterns surrounding the initial enrollment periods for Medicare Part D prescription drug plans in late 2005 and Massachusetts's health-care law in 2006. The Obama administration has said it's seeking at least 7 million people to enroll through the Affordable Care Act by April.

"A majority of individuals would say, 'If I'm not going to get my insurance until Jan. 1, then I'm certainly not going to pay my premium on Oct. 1,'" Dan Schuyler, a director at the consulting firm Leavitt Partners in Salt Lake City, said in a telephone interview. "Realistically, a lot of people will not actually buy the product until the end of November at the earliest."

The $1.4 trillion Affordable Care Act seeks to extend coverage to most of the nation's 50 million uninsured by expanding state Medicaid programs and creating government-run insurance exchanges, with many people eligible to have their premiums subsidized by taxpayers. About 25 million Americans by 2016 are expected to have gained coverage under the health law, commonly known as Obamacare.

Judging Success

The success of the exchanges probably can't be judged until December or beyond, said Schuyler, who wasn't part of the briefing. The initial open-enrollment period runs from Oct. 1 through March 31, 2014.

The Obama administration does expect some glitches with the program, one official said, describing it as still in a testing period. The officials said they are confident people will be able to sign up for plans on Oct. 1 if they want to, despite some technical problems with the websites and coordination between federal and state agencies.

"We should not look at enrollment in October or November as the final measure of what enrollment in the marketplaces will be when the open-enrollment period closes," said Juliette Cubanski, an associate director of Medicare policy analysis at the Kaiser Family Foundation. "We need to give the outreach campaigns time to take effect, just as they did in 'Part D.'People got the message over a period of several months."

Medicare Roll-Out

Enrollment in government health programs has traditionally been slow to start. The Children's Health Insurance Program, which began in 1998, saw 897,000 people enrolled in its first year, Larry Levitt, a senior vice president at the Kaiser Family Foundation, said in a February report published on the website of the Journal of the American Medical Association. Four million children were enrolled within five years.

Medicare's prescription drug program, known as Part D, also"ran into early problems" that slowed initial enrollment, Levitt wrote. It rebounded and "has operated reasonably smoothly since then," he said. More than 30 million Medicare beneficiaries are in the drug plans now.

The Obama administration will be able to track the progress of Americans who start to sign up at healthcare.gov, beginning next week, and nudge them with e-mail reminders if they don't finish the process in October, the officials said. They offered no specific estimate for how many sign-ups they expect.

1. 5 things to think about when picking your health insurance plan

By **Jen Christensen**, CNN Thu October 3, 2013

Some people find open enrollment season for health insurance more daunting than tax time.

STORY HIGHLIGHTS

- Study: Many Americans are confused by health care insurance open enrollment
- Be realistic about your potential costs and how much coverage you need
- Don't stick with a plan just because you had it last year -- understand your options
- Staying healthy is the best way to avoid paying more for health insurance

(CNN) -- Frankie Huff is working on her doctoral degree in Florida and can tackle most complicated education theories with ease. That's not the case when it comes to picking a health insurance plan through her school.

"It is daunting -- at times, more difficult to interpret than the scholarly research I pore through for my own dissertation," Huff said. "I feel like handing it over to my partner after the first page."

Welcome to open enrollment season -- a season some people dread more than tax time.

While you've been hearing a lot about Obamacare this week, the majority of Americans don't need to buy their policies through the new health insurance marketplaces, also called exchanges. Instead, most will get next year's health insurance through work. In fact, you probably have an e-mail sitting in your inbox right now reminding you to pick a plan.

And Huff is not alone in her lack of confidence over how to pick the right policy.

A good number of people look at that open enrollment e-mail and essentially take a wild guess at what plan works best for them, according to a recent study published in the Journal of Health Care Economics.

Just 11% of the people surveyed could figure out what a four-day hospital visit would cost given a hypothetical insurance plan. These were people who thought they had a pretty good grasp on how health insurance works.

"Americans do seem a little terrified when it comes to making decisions about insurance," said Thomas M. Harte, the owner of Landmark Benefits Inc. in Hampstead, New Hampshire, and president of the National Association of Health Underwriters. "When they come in I tell them they can relax and we have a casual conversation about what it is they are looking for in insurance and what's most important to them, and I try to take that fear away."

Studies show the more you know about your insurance plan the more you can save. Here are five things to think about when you pick your health plan for next year:

Be realistic

You want to look at three costs: your deductible, your maximum out-of-pocket costs, and the premium cost contribution compared to the year before.

Glossary: Understanding health insurance terms

Just because it is the most expensive plan doesn't mean it is the right one for you. Not everyone needs a "Cadillac plan," Harte says. Less than 10% of the population is admitted to the hospital every year.

Look at what you spent last year. If you notice you didn't go to the doctor very much, or didn't get a lot of prescriptions, and you have some savings, pick the plan with the less expensive premiums. The deductibles will likely be higher, but even if you have to visit your primary care physician once or twice, it'll probably still be cheaper. Plus,

with Obamacare, all plans that are not grandfathered in will cover preventive health services, whether you meet your deductible or not.
Preventive health services include immunizations, blood pressure tests, mammograms, mental health services, smoking cessation programs, depression screening, diet counseling, and other services.

Don't get sentimental

A lot of people stick with the kind of plan they've always had out of habit, but your life circumstances change over time. If you've had a new baby you may want one kind of plan that covers those costs. If your children have left home, you may not need as much coverage.
Pick the policy that fits your current needs best.
Harte says he often has to remind clients that with life changes, certain policies may be better than others.

Understand your options

Employers often offer three types of plans: Point of Service, Preferred Provider Organizations and Health Maintenance Organizations.
If you aren't attached to a particular doctor, you may want to pick the HMO option, which could save you some money. An HMO is typically the cheapest, but you've got to use doctors who are in that program's network. Even if you love your doctor, it doesn't hurt to check to see if he or she is in the HMO network as well.
With a PPO you will likely pay a higher premium, but you'll have a wider variety of doctors to choose from. It will save you money to stick with those doctors, but you can also go out of network for a higher fee.
A POS plan, which is a mix of an HMO and PPO, typically provides a wider variety of doctors as well. But with that plan you'll have to pick a primary care physician who will need to give you a referral to see any kind of specialist. POS plans are typically more expensive, but they give you the most flexibility.
Each kind of plan comes with a standardized form that includes a summary of benefits and coverage. That's mandatory under Obamacare. Read through it. It will walk you through all the benefits of each plan so you can compare them easily. It should tell you how much you will pay for it. If something isn't covered by the plan, it should say so.

Stay healthy

It may sound simple, but many people can pick a less expensive plan if they practice good health habits. Preventable illnesses make up 70% of health care costs, according to a study in the New England Journal of Medicine.
Participate in your company's wellness program. Watch what you eat, exercise, don't smoke, drink less and maintain a proper weight.
11 simple weight loss tips
The less you need to go the doctor, the less you spend. The fewer unhealthy behaviors you have, the less your -- and others' -- insurance costs. For instance, it costs 18% more for an insurance company to provide coverage for a smoker, according to the Centers for Disease Control and Prevention.

Talk to the experts

Don't guess -- find a trusted adviser who can help walk you through the details.
"People are afraid to ask questions. You should never be afraid to ask," Harte says.
Talk to someone who can explain terms to you or even help you just crunch the numbers. Your benefits person at work or a broker should be happy to help you figure out the plans and what's available.

How I became mortgage-free within 8 years

YAHOO! CONTRIBUTOR NETWORK

By Kevin Stone | Yahoo Contributor Network – Fri, Sep 20, 2013

I remember the moment I decided to pay off my mortgage early. I was walking into my gym in August 2007 and saw a sign that read: "Clear your mind of can't." The sign was intended to inspire my workout, but my mortgage was on my mind. Earlier that day I had opened my most recent statement and was shocked by two things:

1. I had purchased my house exactly three years earlier in August 2004 after applying a 20-percent down payment and of $49,045) my loan balance stood at $216,650, only $11,900 lower than the original. Ouch.

2. Adding fuel to the fire, my 4.625 percent interest rate was adjusting by the maximum allowable 2 percent in its first eligible year, increasing my payment from $1,362 each month to $1,613. Double ouch.

How I paid off my mortgage

For those first three years I had gone about my life, making my minimum monthly payment through automatic bill pay and not paying much attention to my statements. Although I was discouraged when I read the mortgage statement that day taking out an adjustable-rate 30-year mortgage in the amount of $228,550. After three years of payments (a total in August 2007, I didn't want to feel like a victim. I decided to take action and, as the gym's sign had encouraged, rid my mind of "can't."

I made changes in what I would now classify as three different categories: financial changes; conventional savings and spending habits; unconventional savings and extra income. (These categories have become clear to me in retrospect, but I didn't actually define them at the time because quite frankly I didn't know exactly what I was doing!)

Financial changes

I calculated all of my monthly expenditures on a spreadsheet and came up with $4,000 a month. I decided that any income I made above and beyond $4,000 would go directly toward my mortgage.

Then, the very next month in October 2007, I refinanced my loan to a 15-year mortgage at 5.625 percent, 1 point below my soon-to-be newly adjusted 30-year rate. Since I was determined to pay the loan off early, I figured I might as well shorten the duration. This change increased my monthly payment by $350, but actually increased the amount paid toward my principal by over $400 each month!

I opened up a new bank account in November 2007 and started to transfer extra funds to it each month. This account and these funds were dedicated exclusively to my next mortgage payment.

About a year later, in December 2008, I took my mortgage payment off automatic bill pay and started to pay manually each month, forcing me to pay attention to my payment and its amount, so I did not repeat my first three years of minimum payments (and minimum attention).

All of these actions helped me hold myself accountable for managing my expenses and ensure I was making as high of a monthly payment as I could afford. I was very fortunate at the time that my consulting work was

bringing in enough money to cover my monthly expenses with extra left over, but I did not count on this situation always being the case so I decided to act further. And seeing that extra line on my monthly statement that said "Extra Principal Added" helped fuel me along.

Conventional cost savings and spending habits

I didn't take on any additional forms of debt in the next several years. I ended up keeping my truck for 12 years and figured I saved $500 a month by *not* signing up for a car payment. That "extra" money went directly into the mortgage.

I took advantage of a deal at my gym: If I paid $700 for a three-year membership, I could then pay only $20 a year for life. After three years I had an extra $50 each month to put toward the mortgage (and I am still using the $20-a-year option and plan to until I can't walk anymore).

Every year I sent my entire tax refund directly to my separate mortgage account. It would have been nice to buy something, but I got just as much satisfaction watching it reduce my mortgage principal.

Since I traveled for work I racked up a pretty hefty credit card tab for business expenses each month. (I don't consider this personal debt, since it was for my job and it was paid off monthly.) I redeemed the points I earned for cash multiple times a year and was able to put several thousand dollars directly toward my payments.

Unconventional cost savings and extra income

I started participating in some local focus groups in summer 2008 that paid around $100-$200 for about an hour or two of time; I did a couple of these. I also started taking online surveys in my free time. Just an hour or two a week made me about $10-$15 monthly on average, but I got selected for a special survey that paid me $700 to visit one of my favorite restaurants once a week for four weeks, and they even paid for my food and drink.

I got rid of all my dress pants for work and bought the wrinkle-free pants that I could wash at home instead of having to go to the dry cleaner. I admit it was a strange step to take, but it saved me $100 a month in dry cleaning fees.

Another habit I started: I would think about what percent of my home I owned by looking at my principal balance. Here's how the conversation would go in my head: "50 percent? That means I own half of my bedroom, half of my kitchen, half of my yard... The bank owns the other half. I want to own the other half." That would move to 60 percent, 70 percent, 80 percent, etc. over time. If nothing else, this made me pay attention to the dollars involved even more and inspired me to continue the process.

Looking back

I was in the middle of a career change when I took out my original mortgage in 2004; I had just left my position as a software consultant in order to become a real estate broker. In 2004 and 2005, working wholly on commission, I made under $30,000 annually. I even tried to supplement my income by fixing and flipping a few houses, but I was ultimately unsuccessful at making any money. So in 2006 I decided to throw in the towel on that professional experiment and decided to go back to software consulting as an independent consultant. Since 2006 my income has varied from as low as $50,000 in 2007 to around $100,000 other years.

After identifying my goal of a paid-off home, I started small those first few months in 2007 by refinancing and then paying just an extra $100. Soon, I was able to squeeze out an extra $500 monthly. Eventually, I was averaging over $2,000 extra and some months (like tax refund time and during good consulting months) I put as much as $8,000 extra toward my mortgage.

On June 12, 2012, eight years after I bought my house, I paid my loan off in full and am now a proud homeowner free of debt. Looking back at the whole process I couldn't be happier, and every month throughout when I made that extra payment and watched my principal amount decrease, it encouraged me to keep at it until I reached my goal. I am still amazed at what I was able to accomplish in those five years, from 2007 to 2012, when I decided to pay closer attention and work to become mortgage-free.

What You Might Not Know About the $100 Bill

By Lisa Scherzer | The Exchange –

> Associated Press - FILE - This Sept. 24, 2013 file photo shows a sheet of uncut $100 bills as they make their way through the printing process at the Bureau of Engraving and Printing Western Currency Facility …morein Fort Worth, Texas. The new $100 bill, with a number of an array of high-tech features designed to thwart counterfeiters, will finally get its coming out party on Tuesday, partial government shutdown or not. The Federal Reserve, which has not been affected by the shutdown, will have armored trucks rolling from its regional banks around the country headed to banks, savings and loans and other financial institutions with the new C-notes. (AP Photo/LM Otero, File) less

Correction: A previous version of this article said it costs 7.8 cents to produce each $100 note. The correct amount is 12.5 cents.

The Federal Reserve today began circulating a new $100 bill with a fresh design and smarter security features. And it'll be more than two years after it was originally scheduled for release.

The new design for the $100 note was unveiled in 2010, but its actual release was pushed back because of production delays. In December 2010, a printing problem that caused the bills to crease and therefore become unusable meant the new bills couldn't be released in 2011 as originally scheduled. The last redesign of the $100 note began circulating in March 1996.

A new, high-tech hundred

The well-known image of Benjamin Franklin will still be on the new design, but he won't be surrounded by an oval. The new design is also supposed to make it harder for counterfeiters to copy and easier for the public – and store cashiers – to authenticate.

Two key security features of the new bill include a 3-D security ribbon with images of bells and 100s and a color-shifting bell inside a copper inkwell on the front of the note. If you tilt the bill back and forth, you'll see the bells change to 100s as they move, shifting in color from copper to green in an effect that makes the bell seem to appear and disappear in the inkwell. The new note also features raised printing – if you move your finger along Franklin's shoulder on the left side of the note, it feels rough, a "result of the enhanced intaglio printing process used to create the image," NewMoney.gov's site says.

The older $100 notes will eventually get returned to the Federal Reserve, where they will be destroyed. Check out the neat interactive NewMoney.gov has about the makeover.

Getting to know the $100

Here are some facts you might not have known about our beloved C-note.

1. The $100 bill is the second-most common bill in circulation, behind the $1 bill. There was $863.1 billion in $100 bills (or 863.1 million notes) in circulation as of the end of 2012, compared with $10.3 billion in $1 bills (10.3 billion notes).

2: The typical life span of U.S. currency notes varies by denomination. The average life span of a $100 bill is 15 years, compared with 5.9 years for a $1 bill and 7.7 years for a $20 bill, according to the Federal Reserve. $100 notes are often used as a store of value, which means that they pass between users less frequently than lower denominations that are more often used for transactions, like $5 notes.

3. Less than 1/100th of 1% of U.S. currency per year are reported as counterfeit, according to the Secret Service. Internationally, the $100 note is the most counterfeited. In most cases, because the amount of cost, time and effort it takes to counterfeit currency, replicating a $1 bill isn't a profitable endeavor.

4: The share of $100 bills as a portion of all denominations has been consistently rising for decades. As of June 2013, 77% of the value of all U.S. currency is in the form of $100 bills. The big question is where are those $100 bills held – how much of U.S. currency is here in the U.S. and how much is abroad? An oft-cited figure used in several reports is that about 50% to two-thirds of all $100 bills were held outside the U.S. as of 2011. But Edgar Feige, professor emeritus of economics at the University of Wisconsin-Madison, has said that that figure is an overestimate, and that the Fed's own figures suggest that around 25% of $100 bills are located outside the U.S.

Regardless of the exact percentages of $100 bills abroad, the demand for those denominations has certainly jumped in the past few years. In late 2011 and early 2012, international demand for $100 notes exceeded the Federal Reserve's estimates, increasing approximately 40% between October 2011 and February 2012. Some have posited that following the 2008 financial crisis, fears about the safety of the banking system spread, and many more people put their trust in cash as a protective measure – and obviously the large denomination is easier to store than smaller bills.

5: The $100 note has been the largest denomination of currency in circulation since 1969. Following the passage of the Federal Reserve Act in 1913, Federal Reserve banks began issuing Federal Reserve notes in 1914 in denominations ranging from $1 to $10,000. In 1969, notes greater than $100 were retired due to declining demand.

6: It costs 12.5 cents to produce one $100 bill because of the new security features (the older version cost 7.8 cents to make). It costs 9.8 cents to make $5, $20 and $50 notes. Each year, the Federal Reserve Board projects the likely demand for new currency and places an order with the Department of the Treasury's Bureau of Engraving and Printing, which produces U.S. currency and charges the Board for the cost of production. The budget for new currency for 2013 is $797.6 million – about 6.8% higher than the 2012 budget. The increase comes largely from the increased cost to print 2.5 billion new $100 notes.

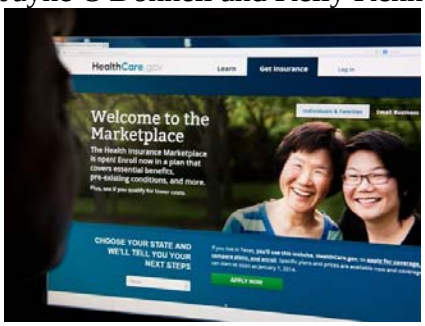
7: Along with the $100 bill now, the government has revamped the $5, $10, $20 and $50 bills over the last decade to add security features. The $1 is the only bill to go without a touch-up. There was a brief proposal by a UK design firm to put President Obama on the $1 note as part of a broader redesign of all U.S. currencies.

8: The Federal Reserve ships $100 bills abroad by pallet (a small bed); each typically contains 640,000 bills, or $64 million.

9. Stationery firm Crane & Co., based in Dalton, Mass., makes the paper the C-note is printed on. Crane has been the only supplier of currency paper to the U.S. treasury since 1879.

Health care exchanges working out kinks a week later

Jayne O'Donnell and Kelly Kennedy, USA TODAY October 8, 2013



The HealthCare.gov insurance exchange Internet site.(Photo: KAREN BLEIER, AFP/Getty Images)

Story Highlights

- Kentucky remains a health insurance sales standout with 6,000 enrollees
- There's still three to six months to sign up, depending on whether you want coverage Jan. 1
- Feds say wait times for HealthCare.gov have been cut in half

Katie Busch was ready to shop for insurance last Sunday on the online exchange the federal government set up for her home state of Pennsylvania. It took a week for her to even set up a user name.

All last week, she kept getting error messages. This Sunday, Busch was finally able to log in and start the application. The Pottstown, Pa., mother of two is looking for insurance only for herself, but when she got to the family section, hit save and continue, the system kept asking her if she wanted to add another person.

A week after the launch of the health insurance exchanges that are the centerpiece of the health care law, the federal and state-run sites are working out the bugs. Technical difficulties are keeping many people from enrolling or even from setting up accounts. Though consumers, including Busch, are frustrated, administration officials and state spokespeople say the sites were overwhelmed by demand, problems are being addressed, and there will be plenty of time for people to sign up once the bugs are worked out.

"The tremendous interest in access to affordable health coverage is very encouraging," says Joshua Sharfstein, Maryland's secretary of Health. "We're hearing through the call center and elsewhere that people are planning to stick with it until they are successful."

The first week the exchanges were up "saw both successes and glitches, which is consistent with what we expected," says Heather Howard, director of the State Health Reform Assistance Network, which provides technical assistance to 11 state exchanges. "This was a massive undertaking."

Comparisons with the error-ridden launch of the Medicare Part D website in January 2006 can go only so far, says Howard, who was New Jersey's commissioner of Health at the time. Back then, consumers had already enrolled in the plan, and website issues sometimes kept them from getting their medications. That's a far bigger deal than causing people to delay signing up for something they have three to six months to complete, depending on when they want coverage to start.

After all, she says, it's not like shoe shopping: "They're not going to go somewhere else. This period is really for people to explore."

At HealthCare.gov, which is handling insurance sales for 31 states, browsing has gotten a bit easier since last week. Wait times have been cut in half, says Department of Health and Human Services spokeswoman Joanne Peters. Still, logging in remains a challenge because of error messages such as those Busch got and "unknown user" responses.

"The work done to increase access to HealthCare.gov in light of the overwhelming demand is beginning to show results," Peters said. "But we won't stop until the doors to HealthCare.gov are wide open, and at the end of the six-month open enrollment, millions of Americans gain affordable coverage."

Traffic continues to be high, and the federal site will shut down again at 1 a.m. ET Tuesday to add more server capacity, move an "over-stressed" component from virtual machine technology to "powerful dedicated hardware" and to make more software changes. People have been able to enroll over the phone.

Around the state sites:

• **Kentucky.** The website for the state, which had more than 600,000 uninsured people in 2011, got 3.1 million page views the first week it was up. By Monday, more than 14,000 had completed applications, and almost 7,000 had enrolled in plans. An additional 155,000 people had checked to see if they were eligible for subsidies or for Medicaid. And 209 small businesses had started applications.

"All of these numbers are, obviously, more than we expected," said Jill MidKiff, spokeswoman for Kentucky's Health Cabinet. "We've heard a lot of good news stories about people who were really excited — many in their 40s and 50s who said they had never had insurance before."

• **Maryland.** This state-run site saw tremendous interest: 170,000 unique visitors to Maryland Health Connection by noon Monday. The call center received more than 10,000 calls, and 13,500 people created accounts. The site experienced problems early on, and officials added server capacity, made technical adjustments and planned to update the system software. "We are still in the ramp-up stage of this launch," the state reminded in a statement.

• **Rhode Island.** In the first three days, HealthSource RI was open, 26,039 Rhode Islanders visited the site, for a total of 30,416 website hits. And 580 people made it all the way through the process.

"There are still some issues with identification verification," said Dara Chadwick, spokeswoman for HealthSource RI. "That's a problem on the federal side, I'm being told."

About 3,000 people created accounts — or a user name and password — but not everyone was able to get further because of the verification issue. On Day 1, the state site crashed for a couple of hours because of the "enormous volume," but it came back up the same day.

• **New Mexico**. State officials are deferring to the federal exchange until implementing their own in 2015. They did set up a Small Business Health Options Program, or SHOP. By Monday, 486 employers had begun the application process to cover 890 people.

"This is much more than I was expecting to get," said Mike Nuñez, interim CEO for New Mexico Health Insurance Exchange. "We were hoping for 1,500 to 2,000 for the whole year."

New Mexico's system went live on Day 1 and remained in good shape for the rest of the week, Nuñez said. Next year, the same team will create the individual exchange.

• **Washington.** Officials expected 130,000 people to sign up in time to receive coverage by Jan. 1. Monday the state announced 9,452 people had enrolled in insurance or its Medicaid program. The state exchange received

160,000 unique visitors the first week and 800,000 hits, said Michael Marchand, director of communication for the Washington Health Benefit Exchange.

"I've heard, 'It sounded too good to be true.' But when I went online, I found out it was true,'" Marchand said. "It's going to change their lives."

Marchand, who handled public affairs for his region during the Medicare Part D roll out, said the "bumps in the road" for Part D were the same as for the exchange. The site, he said, is now running smoothly.

As for Busch, her husband has insurance through his company that is paid in part by the state Medicaid program because their two children are on the autism spectrum. They feared they could lose the state contribution if she was added to the plan. She's been without insurance since the birth of her second child two years ago and just learned she has a genetic syndrome that requires medical treatment. HealthCare.gov won't let her find what insurance coverage would cost her. She tried contacting the call center over the weekend but gave up because the hold time was too long.

"The whole thing is nothing but a headache," Busch says. "I swear the computer techs must be on shutdown, too. That's how frustrated I am with the whole thing."

Report: A mere 51,000 people signed up on Obamacare site in first week

Vince Coglianese Managing Editor 10/10/2013

The Daily Mail reports that only 51,000 people signed up for Obamacare via Healthcare.gov during its first week, falling far short of the Obama administration's expectations.

MailOnline credits "two sources inside the Department of Health and Human Services" with providing "an exclusive look at the earliest enrollment numbers:"

The career civil servants, who process data inside the agency, confirmed independently that just 6,200 Americans applied for health insurance through the problem-plagued website on October 1, the day it first opened to the public.

Neither HHS nor the Centers for Medicare & Medicaid Services would comment on the record about the numbers. Enroll America, the president's organization of health care 'navigators' who are charged with helping Americans sign up, didn't reply to a request for information about its level of success so far.

The White House also did not respond to emails seeking comment.

The Congressional Budget Office is hoping for at least 7 million enrollees by the end of the 6-month open enrollment period to keep Obamacare financially afloat. At this rate, total national enrollment would be approximately 2 million, including state-run exchanges.

The report comes after a Comedy Central interview with HHS Secretary Kathleen Sebelius earlier this week where she claimed she had no idea how many Americans had signed up for Obamacare.

"I can't tell you," Sebelius told "Daily Show" host Jon Stewart, "because I don't know."

Study: Obamacare to cut Illinois' uninsured by almost half

By Andrew L. Wang October 10, 2013

More Health Care News

Amid a political battle that has shut down the federal government, a new study shows that Obamacare will substantially reduce the number of people without health care coverage but will hardly eliminate the problem.

In Illinois, more than 800,000 residents are expected to gain some form of health care coverage through the Affordable Care Act, although even more people won't be insured, according to an analysis by the **Robert Wood Johnson Foundation,** which specializes in health care research. The study estimates there are about 1.8 million uninsured people in Illinois.

Underscoring the importance of marketing the new law, many of those who won't be insured will be eligible for some form of government assistance, the study found.

Of roughly 980,000 Illinois residents expected to remain without coverage after the law is fully in place, an estimated 549,000, or 56 percent, won't take advantage of tax credits available to buy policies on the new health insurance exchange or enroll in Medicaid, which is being expanded, the study projects.

The study offers a nationwide analysis of what effect the Affordable Care Act will have on the lack of health care coverage, including a state-by-state breakdown.

The massive health law's centerpiece is the individual mandate, a requirement that most individuals have coverage from Jan. 1 on or pay a tax penalty.

Supporters say the law's coverage expansions will put a sizable dent in the country's estimated 48 million-person uninsured population. People with insurance are more likely to use primary care services that will prevent minor ailments from developing into major afflictions, which often are costly to treat, they say. Insured people are also less likely to fall into financial ruin if they're hit with big health bills, proponents argue.

But the law has prompted staunch opposition among Republicans, particularly in the U.S. House of Representatives, which has refused to pass a resolution to fund the government unless money for the Affordable Care Act is stripped out. Opponents call the mandate an improper interference into individual liberties.

The law will put harsh burdens on businesses, make some people pay more for insurance than they otherwise would and stifle economic growth. Some budget hawks also argue the law will cause federal spending to balloon.

IN ILLINOIS, 45 PERCENT DROP

The study estimates that the state's 1.8 million uninsured will fall by 45 percent, or roughly 814,000 people, after President Barack Obama's health care overhaul is fully implemented. Some of those people will gain coverage as a result of the expansion of Medicaid, which makes more of the working poor eligible for coverage. Others will buy policies through **GetCoveredIllinois.gov,** the state's online health insurance marketplace, which went live last week. The cost of the insurance will be offset by tax credits, based on income.

Health benefits exchanges run by states and by the federal government **went online Oct. 1** and saw greater than expected interest from users, though the federal exchange, which is operating in 36 states, continues to experience significant technical glitches.

The Robert Wood Johnson study estimates that 18.2 million people across the country will gain coverage through health reform, leaving 30.7 million without.

The analysis estimates pre- and post-reform numbers of insured and uninsured for all 50 states and the District of Columbia, based on whether the states have chosen to participate in the Medicaid expansion, which broadens eligibility for the state-federal program to those who income reaches 138 percent of the federal poverty level. The federal poverty level for an individual is $11,490.

Illinois is one of 24 states and the District of Columbia that have opted into the expansion, which starts on Jan. 1 and is to be entirely funded by the federal government for the first three years, falling to 90 percent by 2020.

Illinois' projected 45 percent reduction in the uninsured is just above the average among states that are expanding Medicaid, which is 44 percent. The study estimates that of the 22.5 million uninsured in those states, about 9.9 million will gain some form of coverage as a result of health reform.

For 26.5 million people in states not expanding Medicaid, just 31 percent, or 8.3 million, will gain some form of insurance, the study estimates.

Medicare change may cost patients: New 'two midnights' admissions rule affects hospitals, too

By Kate Harrison

For many Medicare patients at the hospital, phrases like "inpatient" and "observation status" can easily blend in undetected with all the other medical and insurance lingo echoing around the halls.

After all, either of those labels may translate to a bed in an inpatient unit, physician care, scans, medications and hospital food.

But when unexpected bills start arriving weeks later, that label could make all the difference.

While Medicare patients in observation status may have been in a hospital for several days, they were actually in a kind of limbo: They received care, but they were never technically admitted as inpatients.

This means those patients weren't covered by Medicare Part A -- which covers a complete hospital stay once a one-time deductible is met; but Part B, instead.

As a result, patients must pay part of their doctors' fees, along with co-payments for labs, scans and hospital drugs.

It also means that Medicare will not cover their subsequent rehabilitation at a skilled nursing facility -- something that it does cover for Medicare patients who are admitted to a hospital for at least three days.

The number of observation stays at hospitals has been on the rise for several years.

Hospitals complain it is because Medicare has become more strict in denying claims for short inpatient admissions, insisting those visits should have been labeled as "observation." Hospitals receive significantly less reimbursement from Medicare for observation stays than for admissions.

On Oct. 1, a new Medicare rule dubbed the "two midnights rule" went into effect, intended to define the foggy boundaries of observation and inpatient care.

Hospitals say it signals a dramatic shift in how Medicare patients are admitted to hospitals and how those hospitals are reimbursed.

But it's not necessarily for the better -- for patients, or for the hospitals, critics say.

The Connecticut-based Center for Medicare Advocacy, which has long opposed the Medicare observation policy, has said the new rule does nothing to help patients.

"Prior to this two-midnight rule, if you thought someone was sick enough to spend the night in the hospital, then the hospital got reimbursed," said Dr. Dan Fisher, a surgeon and the chief of staff at Erlanger Health System.

"Now you have to be sick enough to spend two nights in the hospital for it to count toward that. If you're not sick enough to spend two nights, then Medicare is starting to say that you're not very sick at all."

TWO MIDNIGHTS

Take the example of a 68-year-old woman who shows up at the hospital with chest pains.

Before the rule, a physician would assess the woman and then decide whether she needed to be admitted immediately for treatment, or whether she should be kept in observation to run more tests.

Now, a physician will need to make that decision based on whether he believes the patient will need to be admitted to the hospital for longer than two midnights -- regardless of whether that patient showed up at 11 p.m. or 11 a.m.

If her case warrants inpatient status, the doctor will have to fill out and sign a form with medical reasons justifying her admission.

If the patient seems as if she may need one night in the hospital -- but not two -- she will stay on observation status, since that length of stay is "generally not appropriate for inpatient admission and inpatient payment under Medicare Part A," the rule states.

Hospital leaders have called the two-midnight minimum arbitrary, and especially confusing in an era where technology and advanced treatments mean that even patients admitted to the ICU may end up staying in the hospital less than two midnights.

Maryellen Howley, director of care management and clinical documentation at Erlanger Health System, called the expectation for a physician to predict a patient's trajectory at the beginning of a visit "pretty ludicrous."

"It's another interference in the care for the patient," Howley said.

Howley said she expects Erlanger will see many more observational patients under the new rule.

"I really don't see any benefit to it," she said. "If what we are projecting is accurate we're going to have more observation, and the [Medicare] beneficiary will have more co-pay."

Meaning patients need to be more vigilant about asking about their current status in a hospital, and what that means.

Memorial Health Care System has a new 30-bed section of the hospital especially designated for observation patients. But in many cases, patients and their families aren't aware there's any difference between observation and admission -- much less their own status.

Even with the new rules, Medicare can go back through the paperwork and retroactively determine that a patient shouldn't have been admitted.

HOSPITAL IMPACT

Hospitals still are gauging what impact the new rules will have on their finances, but there is plenty of worry.

Erlanger and Memorial officials said they had concerns about the policy's impact on physician-patient interaction and on reimbursements. Parkridge Health System deferred its position on the matter to the Tennessee Hospital Association.

"The concern from hospital consultants is that it will just be a different way for [the Centers for Medicare and Medicaid Services] and their contractors to go after hospitals," said Gwyn Walters, vice president overseeing research and reimbursement with the Tennessee Hospital Association.

Memorial Health Care System -- 60 percent of whose patient population is on Medicare -- is especially wary of the new rule's implications.

"We have some high anxiety that it could impact the hospital negatively," said Michael Sutton, the vice president of finance at Memorial. "But until we do further analysis, we can't really project what it will really look like."

But Sutton, like other hospital leaders, says patients should see no difference in their quality of care.

The rule "is not going to change how we care, just how we're reimbursed," Fisher said.

"Maybe we're splitting hairs and maybe we're playing with words," he said. "If a patient is sick enough to stay in a hospital and really needs to stay overnight, Medicare needs to reimburse the hospital. But they're redefining what a hospital stay means."

To add to their worries, hospitals say, insurance companies will often follow where Medicare leads.

A new policy like the two midnights rule could soon become routine for far more patients than those on Medicare, Walters said.

"I think it will have far-reaching implications," she said.

Improving healthcare for seniors through telemedicine

By former Rep. Bill Gradison (R-Ohio) - 10/18/13

Nowadays we can use our mobile devices to go almost anywhere, which has been a great advantage for many senior citizens. From the bank and the shopping mall to the supermarket and the movies, it's not difficult to go about the day from the comforts of home. However, when it comes to seeing the doctor - a fairly common occurrence for many seniors - the idea of virtual visits gets a bit more problematic.

The advantages of telemedicine have been advocated by doctors and healthcare experts for years. By connecting a provider and patient virtually from any location and at any time, care can be obtained almost immediately resulting in improved patient outcomes from a trusted provider at a lower cost.

Despite the tangible benefits of telemedicine, there are still barriers limiting the use of these new technologies. One of the important is medical licensure laws that tie providers to state boundaries rather than empowering them via the Internet. State medical board requirements often severely limit the ability of doctors to practice across state lines.

During my time in Congress and now in the private sector, I have seen technology advance but the policy obstacles still remain. Breaking down the interstate licensure barriers for telemedicine that currently exist in the Medicare program will help America's seniors gain access to quality, affordable healthcare.

Seniors as a group are rapidly increasing, with more than 10,000 Baby Boomers reaching the age of 65 every single day. This rate is expected to continue for the next 20 years and, by the year 2050, the number of senior citizens in the United States is projected to skyrocket to 89 million. At the same time, Medicare is facing a 38 trillion dollar shortfall over the next 75 years.

Telemedicine is a perfect tool to use as our population grows older and thus the need for medical attention increases. For seniors with health conditions like diabetes, heart failure, or chronic obstructive pulmonary disease (COPD) receiving treatment can be inconvenient and complicated. For the aging population, these conditions can make it difficult to independently live in their home and in many cases require them to live in assisted living in order to have vital signs and symptoms routinely checked.

Take for example, a senior living in Ohio who regularly sees their doctor to manage their diabetes, no problem right? Well what happens when that senior travels to Florida in order to avoid the Ohio winter? In the current system, that senior has to find another doctor in Florida who isn't up to speed on the current treatment plan and medical history. Wouldn't it be easier for the senior to stay in contact and receive care via telemedicine with their current doctor they know and are comfortable with?

Luckily there is new legislation being introduced into Congress by Reps. Devin Nunes (R-Calif.) and Frank Pallone (D-N.J.) called the TELEhealth for MEDicare Act (TELE-MED) to address these concerns. The bill allows healthcare professionals who are Medicare providers and are licensed to practice physically in one state to be able to treat Medicare patients electronically in any other jurisdiction.

It would also permit that when a provider who has been granted a license to physically provide care within a state or jurisdiction becomes a Medicare provider, he or she may provide care electronically to those with whom they have an established patient-provider relationship regardless of where the patient is located in the United States.

Interstate licensure has already been proven successful by government programs. The Department of Defense has expanded telemedicine opportunities to service members regardless of whether they are on base or at home, and regardless of what state the provider is licensed in. The Department of Veterans Affairs has moved to mostly

eliminate cost sharing on telemedicine, recognizing that treating veterans at home is less expensive than treating them in a VA facility. Medicare has the ability to do the same.

As a former Member of Congress, I have worked on many pieces of legislation pertaining to Medicare issues, and it is evident to me that this bill provides a simple solution to a growing problem.

What Are the Biggest Retail Markups?

By ZelkadisElvi | Just Explain It – Thu, Oct 24, 2013

Retailers markup the price on everything we buy…in some cases as much as 4,000 percent. That means consumers routinely pay much more for an item than it costs to make.

In this Just Explain It, we'll take a look at what items are marked up the most. First, here's how markups work.

A markup is the percentage difference between the actual cost and the selling price of an item. For example, a pair of shoes that cost $90 wholesale…sell for $495 after a 450 percent markup. Shoes and clothes are usually marked up between 100 and 500 percent. Most of the time it's all about the retailer's bottom line. They need to cover operating expenses and make a profit.

So what items are marked up the most? Here are a few, starting with movie theater popcorn.

The markup on a $6 medium-sized bag of the snack can be as high as 1,300 percent. Here's why. Theaters don't make a lot of money from new movies. Most of the ticket sales for first run films go to the movie studios. In order to cash in, theaters up the price at concession stands. That's where they make 40 percent of their profits.

The markup on brand-name drugs could be as much as 3,000 percent. According to Medtipster.com, the active ingredients in Paxil cost almost $8. Retail price for 100 tablets, however, is about $220.

Markups on brand-name drugs reflect the billions of dollars spent on their development, manufacturing and marketing. In order to cover costs and turn a profit, drug companies charge a premium price for their products.

And even with a 4,000 percent markup, bottled water sales are increasing yearly. In 2011, Americans spent almost $22 billion on bottled water, according to the Beverage Marketing Corp. That's over nine billion gallons total -- or almost thirty gallons per person. Here's the kicker: about half of all bottled water comes from tap water.

New Year's Baby? You May Pay More

By ELISABETH ROSENTHAL Healthy ConsumerOctober 24, 2013

Daniel MacDonald/Getty Images

Traditionally, much hoopla surrounds the birth of the first baby of the New Year. But it turns out that can be an expensive bit of good luck.

While medical conditions and encounters don't care whether it's 2013 or 2014, health insurance and subsidies generally play by the calendar year. Deductibles reset on Jan. 1, no matter if you began your six weeks of radiation in December or have been pregnant for the last eight months. And with more and more policies, including those offered under the Affordable Care Act, carrying high annual deductibles of $2,000 or more, that reset can lead to major expenses for consumers who must fulfill the new deductible.

I have spent this year covering medical pricing and have received comments from a number of patients who fell victim to this deductible double jeopardy. Jennifer from Evanston, Ill., wrote:

"My 2nd pregnancy spanned two calendar years, so despite the fact that it was the same pregnancy, I paid my deductible twice, and 20 percent of the hospital charges."

This year, the beginning of the Affordable Care Act health exchanges may amplify the problem for some patients as they switch to new insurance. Rebecca wrote:

"My State Insurance is switching to ObamaCare, and my deductibles start ALL over again with no option to dispute my prenatal and birthing care as an extension of existing care. So, $4,000 deductible and now another $3,000 for the last month and birth."

Unfortunately, that is how insurance works. "Deductibles accumulate on an annual basis, so claims for 2013 accrue until December 31st and then start again for 2014," said Susan Pisano, vice president of communications for America's Health Insurance Plans, a trade group. She noted also that insurance companies generally do their accounting according to when a claim was submitted, not when the service occurred.

Paying Till It Hurts

This year, Elisabeth Rosenthal has been writing a series of articles on the high cost of medical care in the United States. She has so far covered colonoscopy, pregnancy, joint replacement and prescriptions.

This double jeopardy can prove extremely costly in a country where even routine pregnancies ending in simple vaginal delivery can cost $15,000. It may also be burdensome to patients undergoing prolonged or complicated treatment, like breast surgery followed by reconstruction.

Experts point out there are also time constraints built into Health Care Flexible Spending Accounts, which allow consumers to place pretax dollars for unreimbursed medical expenses. But these special accounts also track to the calendar year. Although most plans allow for a grace period of a few months – allowing you, for example, to get reimbursed next March for care rendered this month — ultimately these plans are "use it or lose it." If the money is not spent by the deadline, you lose it. According to Wage Works, the employer keeps the unused portion and generally uses it to defray administrative costs of the plan or, sometimes, to pay for participants who have gone over their limit.

Unfortunately, disputes over hospital bills can take a long time to settle, leaving patients out of luck and money. Dr. Marguerite Duane, a physician who was featured in my recent article on the high costs of pregnancy, thought she was being sensible when she put thousands of dollars into her Flexible Spending Account during her last pregnancy to pay for the unreimbursed expenses related to the birth of her son, Ellis.

But when the hospital mistakenly charged Dr. Duane for an extra night, she spent many months disputing the bill. By the time an accurate bill was generated, she was no longer eligible to use the money.

Which is all to say that, as far as health insurance is concerned, the devil is in the details. And as millions of Americans are signing up for insurance policies under the Affordable Care Act, it pays to scrutinize very carefully how each policy works. Also, as the end of the year approaches, there are ways to minimize your financial exposure, experts said.

Ms. Pisano pointed out, for example, that it might behoove a patient being treated in 2013 to push a hospital to submit the bill as early as possible or schedule elective treatment early in December so that it did not slip into January. Likewise, an obstetrician can bill at the beginning or the end of a pregnancy – a decision that may have huge implications for patient out-of-pocket costs.

In terms of Flexible Spending Accounts, patients don't need to settle billing disputes to tap into these funds, said Jody Dietel, chief compliance officer of the benefits firm WageWorks. They should submit the bill as soon as they get it. If, after adjudication, the final bill is for less than the payout, they will simply have to repay the difference. Said Ms. Dietel: "This is free money, but like coupon shopping you have to be a little organized to use it."

GEOGRAPHY AFFECTS WHAT DRUGS SENIORS PRESCRIBED

BY LAURAN NEERGAARD AP MEDICAL WRITER Oct 15

WASHINGTON (AP) -- Where seniors live makes a difference not only in how much health care they receive but also the medications they're prescribed - as some miss out on key treatments while others get risky ones, new research shows.

More than 1 in 4 patients on Medicare's prescription drug plan filled at least one prescription for medications long deemed high-risk for seniors, according to the study released Tuesday by the Dartmouth Atlas Project.

Seniors who live in Alexandria, La., were more than three times as likely as those in Rochester, Minn., to receive those potentially harmful drugs, which include muscle relaxants and anxiety relievers that can cause excessive sedation, falls and other problems in older adults.

On the flip side, far more seniors who survived a heart attack were filling prescriptions for cholesterol-lowering statin drugs in Ogden, Utah, than in Abilene, Texas - 91 percent compared to just 44 percent, the study found. That's even though statins are proven to reduce those patients' risk of another heart attack.

Even more surprising, the study found just 14 percent of seniors who've broken a bone because of osteoporosis were receiving proven medications to guard against another fracture - ranging from 7 percent of those patients in Newark, N.J., to 28 percent in Honolulu.

"There's no good reason" for that variation, said lead researcher Dr. Jeffrey Munson, an assistant professor at the Dartmouth Institute for Health Policy and Clinical Practice.

Researchers with the Dartmouth Atlas have long shown that the type and amount of health care that people receive varies widely around the country, and that those who live where Medicare spends more don't get better quality care.

The newest report examined 2010 prescription data from the 37 million patients who get drug coverage under Medicare Part D, and found even more of a mixed picture when it comes to seniors' medications. For example, patients in the South were more likely to fill prescriptions for those riskier medications, but less likely than those in other regions to get the long-recommended treatments for heart and bone conditions.

The average Part D patient filled 49 monthlong prescriptions - either new ones or refills - in 2010.

But the study suggests doctors in some areas prescribe more readily. The highest number of prescriptions filled was in Miami - 63 - and the lowest in Grand Junction, Colo., 39.

Overall, patients in regions where Medicare Part D spent more on medications weren't more likely to receive the most effective medications, the study found.

Yes, seniors who are sicker will use more medications, but the general health of a region's Medicare population explains less than a third of the variation, the researchers concluded.

Patients don't always fill their prescriptions, because of cost or fear of side effects or myriad other reasons - something this study couldn't measure. It also didn't examine differences in benefits between cheaper and more expensive Part D plans.

But if doctors were following guidelines on best medication practices, there would be far less variation around the country, Munson said.

Doctors "really need to ask themselves, `Is there a good reason why my patients are getting less effective care than patients in the other regions,'" he said.

He urged patients to ask more questions, too: Why is this medicine being prescribed? What are the pros and cons? Is there something else I should consider taking?

The Dartmouth Atlas, funded by the Robert Wood Johnson Foundation, studies health trends using Medicare data; similar figures aren't readily available for the general population.

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