Health & Retirement Services of Illinois

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OUR NEWS LETTER

10 Huge Mistakes to Avoid When Trying to Save Money

By Jennifer Calonia October 5, 2014

Addressing the issue of saving money is the most fundamental, yet neglected, aspect of personal finance in the U.S. today. According to a 2012 survey by Credit Donkey, almost 50 percent of Americans don't have more than $500 in their emergency savings accounts, which not only puts a kink in savers' finances in the event of an unforeseen expense, but also creates undue stress for failing to prepare a safety net adequately.

So, in our latest Money Mistakes series, we highlight the top 10 money mistakes Americans make when it comes to saving money.

1. Not budgeting

There are a number of philosophies on the best approach to take when budgeting your money; but at times, the thought of sitting down with statements, bills, and an expense sheet is just too stressful. This mind-set is an easy trap to fall victim to, but is one of the worst money mistakes to make if you want to grow your savings fund.

Hope A. Rising of Clearwater, Fla., learned this lesson the hard way. "Rather than make savings a part of my life I 'lived for the moment' and now have virtually no savings for emergencies," Rising said. "For example, my car recently broke down and I had to borrow money to have it fixed, rather than just being able to take the money out of the bank."

2. Saving too little

It's commendable that about half of Credit Donkey's survey participants had saved up some cash; but often, individuals don't save enough money to carry themselves through a challenging and sudden financial crisis. A common recommendation when it comes to the appropriate amount to save in a nest egg is about three months' salary, or six months worth of expenses (i.e. mortgage, auto loan, utility bills, gas, etc.).

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For instance, the average American in 2013 made $42,693 before taxes. Take away about 25 percent of that income for taxes, and the average person walks away with $32,020 annually. Three months of net income (the ideal emergency fund amount) is about $8,000 to help keep you comfortably afloat in an emergency.

3. Not setting specific goals

Determining what exactly you're saving for, and when you need to save by, is a helpful motivational guide to follow. It acts as a constant reminder of what you're working toward, and lets you know when your efforts have been successful.

Examples of this include saving money for a down payment on a car in the next six months, or getting more specific like committing to saving $200 per month for the next six months, to achieve this goal.

4. Failing to track spending

Creating a budget is the start of the savings process and setting a goal is the end of it, but there has to be a quantitative way to follow your progression in the time between. Tools such as Mint.com or even a simple spreadsheet are great ways to avoid this money mistake.

5. Living paycheck to paycheck

When budgeting your spending allowance, don't stretch your money to the last dollar. Not allowing yourself about a $100 per month buffer sets you up for disaster, as small, seemingly harmless purchases quickly add up.

6. Overdrawing an account

Overdrawing a checking account is usually the result of making one of these other money mistakes, but expensive overdraft fees are a cost you have complete control over. A $35 overdraft fee might not sting now, but as more pile up on your account statement, the damage can become apparent in a short period of time.

Simply put, overdrawing is a money waster and an entirely avoidable circumstance if you stay diligent with your savings plan.

7. Claiming the wrong tax withholding

Claiming the lowest withholding allowance when it comes to your federal taxes is a mistake that Americans commonly make. When you do so, the government takes away more income taxes throughout the year, and you're left with a fat tax return check.

Don't let this windfall fool you -- what you're doing is essentially giving Uncle Sam an interest-free loan and getting nothing back in return. Instead, you can claim the withholding allowance you rightfully qualify for, and use the extra cash in each paycheck to grow your savings fund in a high-interest savings account.

8. Signing up for low deductibles

One way to increase the amount of cash you can save each month is to lower your premium and raise your deductible for auto and health insurance. This means you assume more risk up front by paying a lower monthly premium, with the expectation to pay more out of pocket in the event you have to file a claim (which should be no problem if you've saved that emergency fund).

According to the Insurance Information Institute, increasing your deductible from $200 to $1,000 can lower collision and comprehensive coverage premiums by at least 40 percent.

9. Buying name brands

More customers are employing frugal tactics like passing on branded products in lieu of a generic version. Similarly, retailers have caught onto the fact that shoppers are looking for a frugal alternative in today's challenging economic times.

That's not to say you should never splurge on a brand that's worth it, but most generics are the same product as their pricier counterparts. Look for generic products on the lower shelves of grocers aisles.

10. Waiting

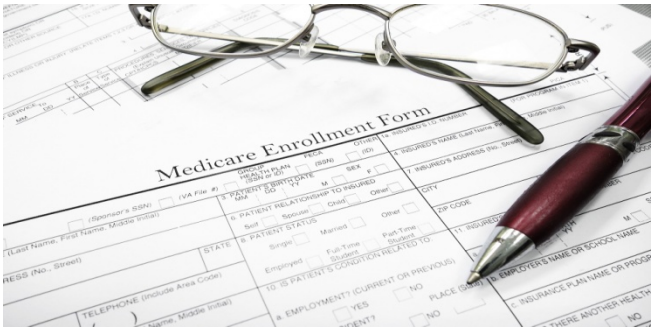
One of the worst money mistakes you can make is procrastinating on getting started with your savings plan, since achieving a savings goal can take longer than you might expect. Paying $500 per month toward an emergency fund at the income outlined in mistake No. 2, for example, would take the average American 16 months to save up three months' income.

Save more money with the help of these top dividend stocks

The smartest investors know that dividend stocks simply crush their non-dividend paying counterparts over the long term. That's beyond dispute. They also know that a well-constructed dividend portfolio creates wealth steadily, while still allowing you to sleep like a baby. Knowing how valuable such a portfolio might be, our top analysts put together a report on a group of high-yielding stocks that should be in any income investor's portfolio.

Health & Science

If you find Medicare sign-up rules confusing, read this



By Caroline Mayer October 6

“Welcome to America’s hottest talk line. Ladies, to talk to interesting and exciting guys free, press 1 now. Guys, hot ladies are waiting to talk to you . . . .”

Wait! I thought I was calling Social Security to ask a question about enrolling in Medicare.

It’s the first hour of my mission to sign up for Medicare and already I’m making mistakes. In this case, it’s minor (and amusing), misdialing the toll-free number by one digit. But it serves as a warning: There are many missteps I can make, some of them serious, if I’m not careful.

Even for me, a consumer reporter who has written about health-insurance issues, enrolling in Medicare is a daunting task. The terminology is confusing and the options are seemingly infinite, based on the amount of promotional material that’s begun arriving in my mailbox. The letters from various insurance carriers began appearing exactly six months before my 65th birthday, and after three months, they weighed 1.5 pounds. More packets arrive daily. Medicare experts tell me I can thank the data brokers for the onslaught: Names and birth dates are for sale to anyone.

Enrolling is a task I’d like to put off, but I can’t. I no longer have job-based insurance, and my current health insurer has notified me that my policy will soon expire, on the first of the month in which I turn 65.

I know that the decisions I make may differ from those made by friends, relatives and even my husband. Yet we share many of the same frustrations in the sign-up process. For anyone

in a similar situation, here are some of the lessons I've learned since I embarked on my Medicare sign-up mission.

Just do it!

Yes, Medicare is complicated, but turning 65 is the time to deal with this. The government will not automatically enroll you, unless you are already drawing Social Security benefits.

You may be like many people who have chosen to delay receiving Social Security payments until at least age 66 to ensure the full monthly payout. But you'll be sorry if you do that with Medicare, because there's a very strict enrollment period that runs from three months before your 65th birthday to three months after it. If you miss that, you will be penalized, unless you have health insurance through your job or your spouse's.

First stop: Medicare, with its helpful Medicare.gov Web site and its "Medicare and You" booklet, available through the mail or online. Medicare is also easy to reach by phone (as long as you dial correctly) at 800-MEDICARE. If there's a long wait to talk to a representative, you can leave your number and someone will call you back. Really. It worked for me.

More information — and even one-on-one guidance — is available from your State Health Insurance Assistance Program (SHIP), a federally funded, free counseling service.

● Get to know the lingo.

Unless you understand how Medicare is structured, you may not be able to make good decisions about what you're buying. Here are some of the terms you might see:

Part A of traditional Medicare covers inpatient hospital services, skilled nursing home care and hospice, among other things.

Part B of traditional Medicare helps cover preventive care and physician and outpatient services, among other things.

Part D plans are private insurance plans covering prescription drug costs.

Medicare Advantage is an alternative to traditional Medicare. In this program, private insurance plans are paid by the federal government to provide coverage that is equivalent to original Medicare.

Private Medigap plans supplement traditional Medicare and help pay some out-of-pocket costs, such as co-payments and deductibles and sometimes emergency medical expenses overseas. These policies are optional, but if you want one, you're best buying it when you sign up for traditional Medicare. Otherwise, you won't be guaranteed coverage and may be subject to medical underwriting, through which you could be denied coverage or charged a higher rate for preexisting conditions.

Failing to sign up can be costly.

You may be in for a surprise if you're among the many baby boomers I've encountered who believe Medicare is free. It's not. Not only is there an annual deductible ($147 for Part B in 2014), but there are also monthly premiums, ranging from $104.90 to $335.70 for individuals. (The exact premium is pegged to your income, generally based on the tax return you filed two years earlier.)

If you don't sign up in your initial enrollment period or when your job-based coverage ends, you will pay a penalty that will raise your premiums for Medicare Part B and Part D for the rest of your life. Every year you delay signing up for Part B, your monthly premium rises by 10 percent — and missing the deadline by just one month is considered a one-year delay. There is also a waiting period for the coverage to kick in, so you could be without any insurance for several months, perhaps even a year, if you miss the deadline. For Part D, the penalty is 1 percent for every month's delay. So a year's delay would add 12 percent to the monthly drug premium base, currently set at $32.42.

Don't make assumptions.

Perhaps the biggest mistake you can make is assuming that your health insurance will stay the same when you turn 65. Retiree plans can end, and even coverage from some workplace plans ends, especially if you or your spouse is employed by a firm with fewer than 20 employees. You also need to apply for Medicare at 65 if you are on COBRA, the program that allows you to purchase health coverage offered by your employer if you've been laid off. You also need to apply even if you are entitled to the military's Tricare coverage for life.

Don't rely solely on advice from your spouse or close friends. "You need to look at your own medical needs: doctors, hospitals, drugs," advises Jennifer Whittaker, operations supervisor for Allsup Medicare Advisor of Belleville, Ill., a company that provides enrollment advice for a fee.

‘Open enrollment’ may be a misnomer.

Once you’ve signed up for Medicare, you should be notified each fall about an open season that allows you to switch plans. This year, that season runs from Oct. 15 until Dec. 7. But the open enrollment period allows easy switching only for certain plans, not all of them — and that may affect what you do when you turn 65.

Open enrollment does not give you a free pass to move from one Medigap plan to another, for instance. Although some plans (and some states, like New York) do guarantee the ability to make a change, Medicare allows plans to evaluate your health if you try to switch. So if you’ve developed an illness, you may be rejected or face a sharp rate increase. (If you stay with your existing plan, your rates can always rise — but only if they are rising for the plan or group as a whole.)

“If you didn’t pick a benefit you wanted initially, you may not be able to get it in the future,” says Diane Omdahl, co-founder of 65 Incorporated, another for-fee consulting firm based outside Milwaukee.

That’s also the situation you could face if you want to change from a Medicare Advantage plan to traditional Medicare with a Medigap plan.

One of Omdahl’s clients who was on a Medicare Advantage plan recently developed diabetes, and he concluded that switching to traditional Medicare with Medigap would work better financially. But his diabetes kept him from finding an affordable Medigap plan. If he had signed up for traditional Medicare with a Medigap plan, he would not have been charged extra when he subsequently developed diabetes.

So what does open enrollment really mean? If you’re on a Medicare Advantage plan, you can switch to another plan. You can also switch Part D drug plans annually. And since both Medicare Advantage and the drug plans change premiums, benefits and providers regularly, it’s important to review your plans yearly.

● Consider your health over the long term, not just how you feel now.

Since it may not be easy to switch Medigap plans in the future, many Medicare advisers suggest that if you are choosing a Medigap policy, buy the best coverage you can afford when you sign up.

The cheapest price is not necessarily the best.

Consider more than the cost of the premium when you sign up for a Medicare Advantage or Medigap plan. Look at co-payments and deductibles, too. The cheapest premium might not provide you with the cheapest overall plan. Also, review a company's complaint records as well as its financial stability to hopefully ensure that it will be around as long as you plan to be.

For Medicare Advantage plans and drug plans, the Centers for Medicare & Medicare Services (the agency that runs Medicare)provides a helpful five-star rating system based, in part, on member satisfaction surveys.

Customer satisfaction ratings for Medigap plans are harder to find, but one valuable site for me was Missouri's Complaint Index for Medigap issuers. (Many of the companies on this list operate nationwide.)

Several companies rate the financial strength of insurance carriers, although you may have to pay to get information. Two of the most frequently cited rating firms are Weiss Ratings and A.M. Best, neither of which charges for basic information.

Make calls and ask questions; you'd be surprised by what you learn.

"Once you pick a plan, call and confirm its different points, such as the premium and out-of-pocket limits," Omdahl advises. "It's rare, but sometimes the information online isn't accurate."

You may also discover added discounts. After I narrowed my search to two Medigap companies, I learned that if I went with the plan that my husband used, we'd both get a 5 percent discount on premiums. None of my research mentioned a "household discount."

Don't be afraid to seek help.

In addition to advice from Medicare and your state's health-insurance assistance program, tools that helped me included the National Council on Aging's MyMedicareMatters, AARP's Medicare Question and Answer Tool and the Medicare Rights Center fact sheets. Consumer Reports' "Managing Medicare" article also is a valuable primer.

You might also consider seeking advice from an independent insurance agent. But remember, these agents typically talk only about the plans they offer — and they usually receive a commission on the policies they sell.

There's also a growing list of firms that will help you for a fee. These include:

•65Incorporated.com, with a fee of $299 for an initial enrollment consultation, $499 for a couple.

•Allsup Medicare Advisor, charging $500 to $850 for a complete initial assessment.

•Goodcare.com, with a $585 initial consultation, $195 more for each additional hour.

•Healthcare Navigation, with consultation fees ranging from $750 to $1,250.

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HealthCare.gov gets makeover for fall enrollment drive

By Sarah Ferris - 09/23/14

The Obama administration is giving a makeover to its much-maligned health insurance website this fall, promising smoother and simpler sign-ups for thousands of people.

About 70 percent of new customers will be able to use a new, shorter form when they log onto the federal website, HealthCare.gov, on Nov. 15.

The user-friendly version will require people to answer fewer questions, scroll through fewer screens and will save their answers if they want to jump back to other parts of the application, officials told *The New York Times*, which first reported the overhaul on Tuesday.

“The streamlined application will allow people to get through the process a lot faster,” Andrew M. Slavitt, who steers the website for the Centers for Medicare and Medicaid Services (CMS), told the *Times*.

The administration said it would roll out the changes gradually over the next two months to ensure that the website is fully functional by Nov. 15, when exchanges open for the second year.

Applicants with “more complicated household scenarios” will be asked to use the traditional form. That includes families who do not have the same permanent address, parents who are responsible for a child who is not on their tax return, or individuals with dependents who are not on their tax return.

The poorly functioning website was one of the biggest complaints about the new healthcare law when HealthCare.gov launched last fall.

The Obama administration has since brought in new leadership to help give the website a fresh start in its second year. In addition to hiring Slavitt away from the private sector to improve the website, the Obama administration also tapped Sylvia Mathews Burwell to replace former Health and Human Services Secretary Kathleen Sebelius.

Despite last year’s shaky launch, 7.3 million people are now paying health insurance customers, purchased through the federal health insurance exchanges — about 1 million people more than officials expected.

While most people have said they are satisfied with their plans, two-thirds said they were turned off by their experiences using the federal exchange, according to a poll released last week by the nonpartisan think tank, Commonwealth Fund.

No increase in Medicare Part B premiums

By Elise Viebeck - 10/09/14

Premiums and deductibles in Medicare Part B will remain the same next year, saving seniors more than $125 compared with projections, federal health officials said Thursday.

The Centers for Medicare and Medicaid Services (CMS) touted the news as a boon to seniors and evidence that ObamaCare is successfully slowing the growth of healthcare costs.

"The stabilization of Part B premiums is another example of how we are containing healthcare costs to provide a more sustainable and affordable health delivery system," CMS Administrator Marilyn Tavenner said in a statement.

"This means even greater financial and health security for our seniors next year as their premiums will remain unchanged."

Medicare Part B covers care from doctors, durable medical equipment, outpatient hospital stays and some home health services.

Seniors enrolled in the benefit will pay $104.90 and $147 for premiums and deductibles, respectively — the same amount as this year.

It is hard to say how much the healthcare law is contributing to slow Medicare spending growth. Some economists have debated the point with the administration, arguing that the recovering economy is the key factor.

A maze to opt out of Obamacare individual mandate

Many fear it will take a long time to process ACA exemption applications near tax day. | Getty

By RACHAEL BADE | 10/9/14

There are dozens of ways to escape Obamacare's individual mandate tax — but good luck figuring that out come tax season.

Tens of millions of Americans can avoid the fee if they qualify for exemptions like hardship or living in poverty, but the convoluted process has some experts worried individuals will be tripped up by lost paperwork, the need to verify information with multiple sources and long delays that extend beyond tax season.

"It's not going to be pretty," said George Brandes, vice president of health care programs at Jackson Hewitt, a tax prep firm. "Just because you theoretically qualify for hardship, or another exemption, doesn't mean you're going to get it."

The worries may foreshadow a messy tax season next year as the one in 10 Americans who remain uninsured calculate their tax bill for the first time under Obamacare's individual mandate.

Those without health insurance will have to cough up $95 per person or 1 percent of their income, whichever is greater. That penalty eventually jumps to $695 or 2.5 percent.

The White House expanded the list of exemptions allowing the uninsured to bypass the penalty for legitimate reasons, including religious restrictions, falling on rocky times or a death in the family. Another big out created after the controversy over canceled health plans was the so-called affordability exemption that allows people to opt out if premiums are still not affordable.

The Congressional Budget Office expects 23 million of the 30 million Americans who remain uninsured in 2016 to qualify for exemptions. It's part of the reason the CBO in June downgraded from 6 million to 4 million the number of people it estimates will pay the penalty.

The uninsured have two ways to opt out: The easiest way is fill out a new tax form for those exemptions that don't require Obamacare marketplace approval. Some will be simple, including the exemption for being uninsured for under three months or those living below a certain income — about $10,150 for singles and $20,300 for married couples.

But many must be approved by the marketplace, including for people citing religious beliefs, like being Amish, or those who qualify for the dozen or so “hardships,” such as being evicted, experiencing domestic violence or having a health plan canceled because it doesn’t meet the law’s requirements.

There’s even one for being in jail, another for having medical debt and one for taking care of sick family members. An open-ended “hardship” exemption lets people try to explain situations not listed that stood in their way of coverage.

That’s where things get complicated. For marketplace approval, applicants must fill out an exemption application, gather proof of their situation, mail it off and wait a few weeks for approval.

Once they get the exemption certification number in the mail, they then fill out a newly drafted tax form to skirt the penalty.

Some math may be required: If the exemption covers only a few months of the year, the individual is responsible for calculating how much of the penalty he or she will owe.

The process brings up a number of problems, the first being a time crunch. The marketplace is now taking about two weeks to process exemption applications, according to H&R Block. Many fear it will take much longer during tax season, particularly because the entire process is manual.

Given how most people wait until the last minute to do their taxes, there is concern delays could push beyond tax day, April 15.

“What happens on April 14 when you go to the marketplace and file for an exemption?” asked Kathy Pickering, the executive director of The Tax Institute at H&R Block.

Nina Olson, the IRS taxpayer advocate, said her team is “very worried that taxpayers will have returns coming in where they believe they’re covered by exemptions but they haven’t gone through the steps … particularly those needing” approval.

“What are we doing with that return in the meantime while the taxpayer goes … [for approval]? … Are we holding the entire refund?” she asked.

TurboTax estimates that less than 5 percent of exemption-eligible people have applied so far, suggesting a lack of education on how the process works.

The Centers for Medicare and Medicaid Services says it does not expect many people to apply for exemptions after Jan. 1, but many tax preparers predict the opposite. They say most uninsured individuals will come to their offices in early 2015 not knowing how to apply for exemptions — or even that they can opt out.

They then could have to return home to begin the paper scramble. While exemptions for homelessness and domestic violence require no proof, most hardship applicants will need to search for utility notices of power being turned off, for example, bankruptcy papers or insurance claims for disaster victims of floods or fires.

Some uninsured may have to pay tax prep fees twice. That’s because many also live in poverty and each year depend on tax refunds to pay rent, car bills and other essentials. They may simply pay the tax penalty to get their refunds right away — then return to the tax preparers later to file an amended return once they get their exemption certifications weeks later.

Others, who can afford to wait, may ask the IRS for an extension to file their taxes.

Not everyone is worried about the exemption process.

TurboTax's Obamacare tax product leader Sacha Adam predicts it will all work out: "It seems like a lot of people say this is too complex. … But that's not our perspective."

But the company is also hoping the IRS will allow people waiting for exemptions from the marketplace to simply file their returns and skirt the penalty without the exemption numbers.

That's far from a certainty, however.

Many experts do not think average Joe Taxpayer will be able to figure out the exemption tax forms.

"They are likely to be confused, frustrated, even angry, and certainly bewildered, completing these forms," said Tim Jost, an Affordable Care Act expert.

The Washington and Lee University School of Law professor is concerned about how individuals will claim the so-called affordability exemption, which would require people to confirm that they could not find insurance with premiums costing less than 8 percent of their income.

Individuals will not be required to submit paperwork proving to the IRS that coverage costs more than 8 percent of their salaries, but experts say tax preparers will want to confirm this for themselves in case of audits.

The new exemption-tax-form instructions come with a chart for claiming this exemption, requiring entry of how much was earned each month and comparing that with the monthly cost of the cheapest plans offered by an employer or the marketplace.

Jost is not sure that information will be readily available because employers have no legal obligation this year to respond to employees' inquiries, since the ACA's "employer mandate" has been delayed until next year.

Elizabeth Colvin of Austin Foundation Communities has seen plenty of instances where businesses haven't provided needed information to employees to help them navigate ACA, and worries the same may happen here.

"They may not be responsive, but they also may try to give the information and not understand what needs to be provided," she said. "There's a pretty steep learning curve."

If their employers did not offer coverage, people claiming the affordability exemption will have to check the Obamacare exchanges to ensure the cheapest plan available to them in 2014 — minus the Obamacare tax credit they would have received had they signed up for the plan — exceeded 8 percent of their income.

But it's unclear that the exchanges during tax season in early 2015 will have the ability to retroactively determine how much people would have had to pay for insurance, Jost said.

Observers are also concerned about the Medicaid exemption for individuals who would have qualified had they not lived in a state that refused to expand it. In Florida and Texas alone, that's around 1.8 million people.

Currently, these individuals who applied and were rejected on the federal website HealthCare.gov will be mailed an exemption certification to use on their tax returns, according to CMS. But those who applied directly through their state will have to find their rejection notices and send them to the exchanges to get exempted.

What happens if people can't find their rejection notice? Or if they knew they wouldn't qualify in 2014 so didn't bother applying at all?

The good news is that the uninsured have many exemptions they can try to claim should one fall through the cracks.

While some expect the uninsured to throw their hands up and just pay the penalty, one thing is certain: Many who try to get around it will have to muddle through a confusing process.

"If taxpayers are in a situation where they want to apply for an exemption, they're going to have a lot of work to do to figure it out," Pickering said.

Avalere Analysis Reveals Significant Consolidation Among PDPs

Christine Harhai Senior Manager

According to a new Avalere Health analysis of the Centers for Medicare & Medicaid Services' (CMS) Landscape Files for 2015, the number of Part D standalone prescription drug plans (PDPs) will shrink by about 14 percent, from 1,169 in 2014 to 1,001 in 2015.

This reduction in plans is largely driven by a consolidation of offerings by a number of top plan sponsors, including Aetna, Cigna, CVS, and UnitedHealth.

Average monthly premiums for standalone PDP market will decrease.

Based on Avalere's calculations, these consolidations are expected to shift a large number of beneficiaries into lower-cost plans, driving down average premiums in the market by 2 percent from $39.88 in 2014 to $38.95 in 2015. However, significant premium variation exists among the top PDPs by enrollment. While Aetna's Medicare Rx Saver plan (a new offering for 2015 that combines the sponsor's Aetna/CVS pharmacy PDP and its Aetna Medicare Rx Essentials PDP) will reduce premiums by more than 30 percent, WellCare's Classic plan will increase its premiums by more than 50 percent. Despite sizeable premium increases from some sponsors, there continue to be many low-cost options available for consumers – in 2015, five of the top ten PDPs will have average premiums below $30.

Monthly Premiums for Top 10 PDPs in 2015

2015 PDP Offering	2015 Plan Enrollment	2014 Average Premium[1]	2015 Average Premium[2]	% Change (2014-2015)
AARP MedicareRx Preferred*	3,787,148	$43.41	$50.15	16%
SilverScript Choice**	2,494,772	$29.43	$23.16	-21%
Humana Preferred Rx Plan	1,718,529	$22.72	$26.40	16%
Humana Enhanced	1,251,903	$47.53	$52.81	11%
AARP MedicareRx Saver Plus	1,157,050	$23.22	$28.00	21%
Cigna-HealthSpring Secure***	1,116,931	$30.85	$31.78	3%
WellCare Classic	1,115,683	$20.72	$31.46	52%
Humana Walmart Rx Plan	833,139	$12.60	$15.67	24%
Aetna Medicare Rx Saver****	548,771	$35.56	$24.46	-31%
First Health Part D Value Plus*****	452,209	$44.58	$38.81	-13%
TOP 3 PLANS	8,000,449	$34.28	$36.39	6%
TOP 10 PLANS	14,476,135	$34.77	$34.90	0%
ALL PDPs	22,476,584	$39.88	$38.95	-2%

Source: Avalere Health analysis using DataFrame®, a proprietary database of Medicare Part D plan features and 2015 PDP data released by CMS on September 19, 2014.
[1] 2014 premiums are enrollment-weighted using September 2013 enrollment data.
[2] Avalere projects 2015 enrollment with September 2014 enrollment. New plans will not have any enrollment reported.
*UnitedHealth consolidated the AARP MedicareRx Preferred PDP and the AARP MedicareRx Enhanced PDP into the new AARP MedicareRx Preferred PDP for 2015.
**SilverScript Basic was renamed as SilverScript Choice for 2015. Additionally, CVS Health consolidated the former SilverScript Choice PDP and the SilverScript Plus PDP into the new SilverScript Plus plan for 2015.
***Cigna Medicare Rx Secure and Cigna-HealthSpring Rx PDP were consolidated into the new Cigna-HealthSpring plan for 2015.
****Aetna/CVS pharmacy Prescription Drug Plan and Aetna MedicareRx Essentials consolidate to become the new Aetna Medicare Rx Saver plan in 2015.
*****First Health Part D Value Plus and First Health Part D Essentials consolidate to become the new First Health Part D Value Plus plan in 2015.

As premiums decline, Avalere's analysis finds that Part D sponsors may be shifting more cost-sharing responsibilities to beneficiaries. In 2015, the proportion of PDPs with $0 deductibles will drop to 42 percent from 47 percent in 2014. In addition, Part D sponsors continue to move away from offering coverage in the gap due to the continued closing of the donut hole mandated by the Affordable Care Act (ACA). As in previous years, about three-quarters (74%) of PDPs will not offer coverage of drugs in the Part D coverage gap next year.

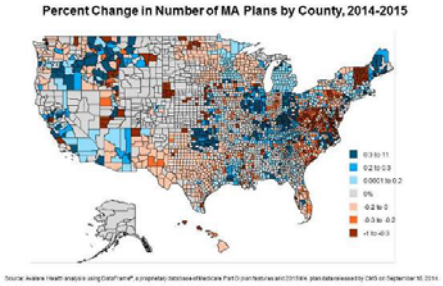
"When seniors choose a prescription drug plan for 2015, they should carefully look at their options to select the plan that best meets their health and financial needs," said Christine Harhaj, senior manager at Avalere Health. "While beneficiaries will welcome lower premiums, they will need to look at other facets of benefit design including how their medications are covered, cost sharing responsibilities, and total out-of-pocket spending."

Plan consolidations come as some sponsors combine enhanced plan offerings in order to reduce the number of PDPs in their books of businesses that offer coverage of drugs in the Part D donut hole,. Still others may be responding to CMS' indications that it may soon impose stricter limits on the number and type of PDPs sponsors can offer in the future under the so-called meaningful differences policy.

Changes to Medicare Advantage plan participation vary largely by geography

Avalere also found that participation by Medicare Advantage (MA) plans will dip modestly in 2015 amid continued payment reductions enacted under the ACA, including lower benchmark growth rates and the end of the Quality Bonus Payment (QBP) demonstration. The total number of MA plans will decline from 2,527 in 2014 to 2,450 in 2015—a 3 percent decrease.

While plan participation is largely stable across the country, there are more sizeable plan withdrawals in high-population density areas of the Southeast and Mid-Atlantic. Despite large numbers of plan exits in some higher population areas, the magnitude of plan reductions was often greater in rural areas, where a small number of plan exits represented a significant share of the market.



“To succeed in the market today, Medicare health plans need to be efficient, reasonably priced, and focused on quality metrics,” said Dan Mendelson, CEO, Avalere Health. “There will inevitably be some plans that can’t survive in this demanding environment, and others that enter precisely because their operations are prepared to meet the challenge of public programs.”

For 2015, plan sponsors are responding by relying on more highly managed plan products, like Health Maintenance Organization (HMO) plans. Overall, the number of HMO plans will increase by 1.5 percent from 1,721 to 1,747, while the number of preferred provider organizations (PPOs) will decrease by nearly 9 percent from 593 to 541. Meanwhile, drug benefits are shaping up to be more limited in 2015. While the majority of Medicare Advantage prescription drug (MA-PD) plans continue to offer enhanced drug benefits, fewer plans will offer $0 drug deductibles and gap coverage next year.

Report: Taxpayer data on ObamaCare state exchanges at risk

By Bernie Becker - 10/23/14

Taxpayer information given to the state-based insurance exchanges created by ObamaCare could be at risk, **according** to a new federal audit.

The Treasury Department's inspector general for tax administration said in a report released Thursday that the IRS needs to boost its efforts to ensure that taxpayer data are protected.

Currently, the report said, the tax agency doesn't get enough assurances that tax information is safe before releasing it to the state exchanges.

"The IRS must do more to ensure that federal tax information submitted to the ACA [Affordable Care Act] exchanges is protected and prevent its unauthorized disclosure," said Russell George, the inspector general for tax administration.

Under the health law, people can receive a tax credit to help with the costs of insurance on the state exchanges. The IRS is charged with calculating the maximum amount of the tax credits, and in reconciling the credit a taxpayer received with their income.

To help with that process, the healthcare law allows the IRS to share certain taxpayer information with the state exchanges.

In a statement, the IRS said it had taken "aggressive steps" to make sure that tax information given to state health exchanges was protected, and that the inspector general's report would help strengthen their efforts.

"The IRS emphasizes there have been no data breaches involving federal tax information shared with the exchanges, and TIGTA did not find any specific or elevated risk to federal tax information maintained by the exchanges during the audit," the agency said in a statement.

"The IRS has a long and proven track record of safely and securely transmitting federal tax information through data sharing agreements to nearly 300 federal and state agencies on a regular basis. Historical results show extremely low incidence of data issues," the agency added.

George's report did say that the IRS has taken many positive steps to protect taxpayer information, and noted that there's no perfect system for keeping that data safe.

The IRS, for instance, began working with other agencies to develop safeguards two years before people started enrolling for insurance in October 2013.

Agency officials also required state exchanges to describe how they planned to protect taxpayer information from disclosure, and made on-site visits to check in on the exchanges.

But the inspector general added that the IRS does not require state exchanges to conduct an initial security check before getting the tax information.

The agency also didn't require that top officials at state exchanges promise in writing that they understood the risks and importance of protecting the tax information. Plus, exchanges might not get on-site reviews of new systems to protect tax data for up to three years.

The inspector general said that meant the IRS didn't have enough assurances that the state exchanges had internalized all the risks involved in protecting taxpayer data.

You may want to thank George W. Bush — not Obamacare — for the remarkable Medicare cost slowdown

By Lori Montgomery October 22

The cost of Medicare has been slowing dramatically in recent years, leading to much head-scratching by health economists and much credit-mongering by politicians. President Obama, for instance, claimed earlier this month that his Affordable Care Act is driving down both Medicare costs and the overall cost of healthcare.

Now comes evidence that an entirely different program may deserve more of the credit, at least as far as Medicare is concerned -- the Medicare prescription drug program, enacted under president George W. Bush.

Loren Adler and Adam Rosenberg of the bipartisan Committee for a Responsible Federal Budget make this argument in a post on the web site of the prominent health policy journal, Health Affairs.

After examining Medicare cost projections through the years from the Congressional Budget Office, the pair determined that the prescription drug program, known as Medicare Part D, "has accounted for over 60 percent of the slowdown in Medicare benefits since 2011," though the program accounts for barely 10 percent of overall Medicare spending.

"Through April of this year, the last time the Congressional Budget Office (CBO) released detailed estimates of Medicare spending, CBO has lowered its projections of total spending on Medicare benefits from 2012 through 2021 by $370 billion," the pair write. "The $225 billion of that decline accounted for by Part D represents an astounding 24 percent of Part D spending."

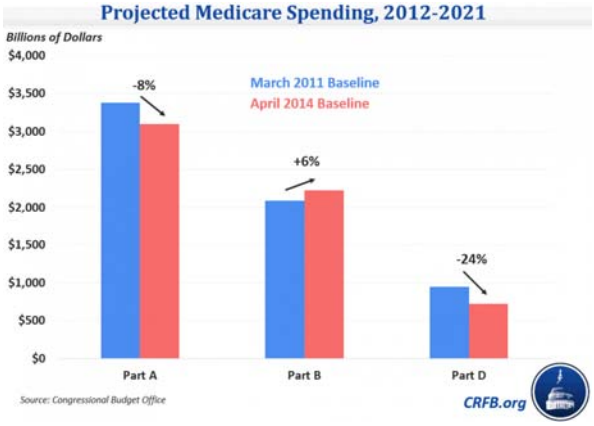
Meanwhile, spending on Parts A and B -- the hospital and general medical insurance -- is projected to decline by only $145 billion. Other major sources of savings include sharp automatic budget cuts known as the sequester ($75 billion) and increased recoveries of improper payments to providers ($85 billion).

The pair note that by starting in 2011 -- the year after the Affordable Care Act was enacted -- their analysis "excludes the direct impact of various spending reductions" in the ACA. However, they write, the analysis would reflect ACA savings "to the extent that the Medicare reforms have controlled costs better than originally anticipated."

As card-carrying budget wonks, Adler and Rosenberg are less concerned about who gets credit for the cost slowdown than what the findings suggest for future government spending. And the news, alas, is not necessarily good.

If projections for Parts A and B were declining, that might suggest that the slowdown in Medicare spending was part of some permanent, fundamental changes in the way hospitals and doctors provide health care. But Part A is down only 8 percent while Part B is actually rising, largely due to lawmakers' insistence on reversing scheduled cuts to provider reimbursements.

The fact that Part D is responsible for the lion's share of the savings, the pair write, "is reason to be cautious about its permanence."



"Lower Part D spending primarily stems from the 'patent cliff' – a number of blockbuster brand-name drugs that have lost patent protection, paving the way for cheaper generic competitors — and a decrease in the rate of introduction of new brand-name drugs. It is unclear whether these trends in the prescription drug market will continue or are temporary phenomenon," the pair write, adding: "With the recent rise of specialty drugs, highlighted by the $1,000/pill Hepatitis C treatment Sovaldi, the tide may already be shifting."

In a recent analysis of the Part D slowdown, the CBO concluded that it can be almost entirely explained "by broader national trends in per-capita drug spending that occurred as a result of the pharmaceutical technological slowdown" -- as well as lower-than-expected enrollment in the prescription drug program.

"The decrease in Medicare spending growth has already been a remarkable shift, and prolonging the slowdown in Parts A and B would be a tremendously important contribution," the pair write. "Unfortunately, though, the outsized role that Part D has played in the Medicare slowdown is bad budget news because it may prove fleeting."

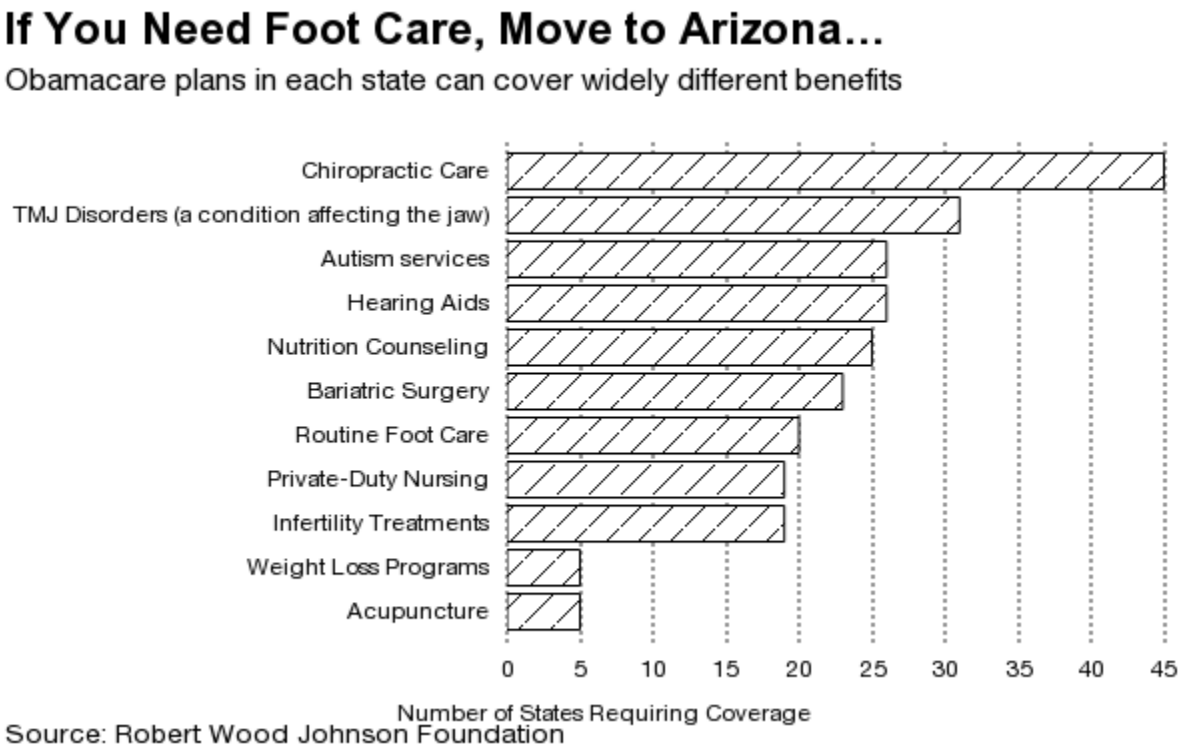
Health Care

Will Obamacare Cover That? Depends on Where You Live

By John Tozzi October 22, 2014

If you want your Obamacare plan to cover acupuncture, California is the place to be. If you need foot care, better try Arizona. Plans in Washington, D.C., will pay for weight-loss programs that New York won't allow, but Obamacare plans in the Empire State will cover surgery to shed those same pounds.

The benefits offered by health plans created under the Affordable Care Act are all over the map. The law requires all health insurers to cover a group of 10 essential benefits in broad categories of medical care, such as hospitalization, prescription drugs, and maternity. Beyond those staples, however, the requirements vary widely from state to state, according to a new report from the Robert Wood Johnson Foundation.



The law instructs each state to select a "benchmark plan" to serve as a model for what other plans in the state must cover. Researchers from the Leonard Davis Institute of Health Economics at University of Pennsylvania examined the benchmark plans to see what's covered where and found a patchwork that defies logic. Only five states cover weight-loss programs, for instance, while 23 cover a far more expensive obesity treatment: bariatric surgery. Chiropractic care is covered in most states and acupuncture in hardly any, even though both are considered alternative medicine. The inconsistencies affect services for people on the autism spectrum, those seeking infertility treatments, and those in need of hearing aids.

The arbitrary coverage decisions reflect battles fought in each state before the Affordable Care Act was passed, says Janet Weiner, associate director for health policy at the Leonard Davis Institute and co-author of the report.

Patients and providers lobby to get certain services considered “mandatory,” while employers and insurers often oppose those expansions of coverage that increase costs.

In theory, the federal government could make Obamacare benefit packages more uniform. But that would require playing the same tug-of-war at the federal level, with a lot more money at stake. “They would have to set up a process in which a lot of these political battles would be fought,” Weiner says, “but they’ve been pretty bloody state to state.”

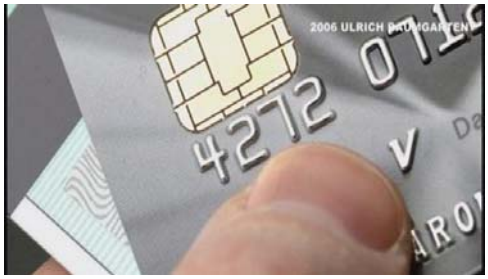
Insurers have no incentive to offer benefits that aren’t mandated in the individual market because it encourages what economists call adverse selection. If only one plan covers infertility treatments, all the families that need it will choose that plan and paying for their care will drive premiums up.

As a result, we’re left with a system where autism services, including applied behavioral analysis, are covered in half the states, according to data from Autism Speaks (PDF) that was included in the report. The cost of therapies for people with autism can pile unaffordable expenses onto families already dealing with a challenging condition.

The researchers point out that three years ago the Institute of Medicine suggested a process for selecting a national package of benefits that would balance inclusive coverage with affordability. While the Department of Health and Human Services is sticking with the state-by-state approach for 2015, federal health officials may reevaluate for the following year. But trying to make coverage more uniform would be a messy battle, as Weiner points out. “For now, some benefits will remain essential in some states,” the report concludes, “and not essential in others.”

Credit-card hacking is Americans' top crime worry: poll

Why the US was slow to adopt secure credit cards



Why the US was slow to adopt secure credit cards

Washington (AFP) - Credit-card hacking is the number one crime on Americans' worry list, far above getting mugged or murdered, according to a Gallup survey released Monday.

As the number of major retailers reporting cyber breaches grows, with thieves stealing credit card data belonging to tens of millions of their customers, awareness of the hacking threat has taken off.

"Americans today are more worried about their credit card information being hacked from stores than about any other crimes they are asked about, and a relatively high percentage say they have been victims of this hacking," Gallup said.

Sixty-nine percent of Americans said they frequently or occasionally worry about computer hackers stealing the credit-card information they have used at stores.

The only other crime that worries the majority of Americans -- 62 percent -- is hacking and data theft of a computer or smartphone.

The next most-worrying crime, at 45 percent, was a home burglarized when no one was home, while 42 percent fretted about having their car stolen or broken into.

Credit-card hacking is the number one crime on Americans' worry list, far above getting mugged or mu …

Tied at 31 percent were the number of people worrying about having a school-aged child physically harmed while attending school and about getting mugged.

Lesser concerns were worry about being the victim of terrorism (28 percent), getting murdered (18 percent) and, at the bottom of the list, being assaulted or killed by a coworker on the job (7.0 percent).

Gallup said that 27 percent of Americans said they or another household member had information from a credit card used at a store stolen by computer hackers during the past year, the most frequently experienced crime on a list of nine crimes.

Similarly, 11 percent of respondents said they or someone else in their household have had their computer or smartphone hacked in the last year, putting that in the top half of crimes on the list.

High-profile hacking at big retail chains, such as discounter Target and home improvement giant Home Depot, is clearly shaking consumer confidence, Gallup said.