Health & Retirement Services Of Illinois

November 2012 Newsletter

OUR NEWS LETTER HRSI

13 Ways Americans Throw Away Money

By Jill Krasny, Gus Lubin and Shlomo Sprung | Business Insider – 21 hours ago

Blame the government or blame the economy, but Americans should also blame themselves for their declining net worth. We waste a whole lot of money. Seriously, over half a trillion dollars.

This list is based on estimates due to limited available data, and the true total is surely higher. We included things like cigarettes and gambling, even though some would claim they are are worth their cost. This is a personal finance site after all, and these are costs you can cut.

$6 billion in unused gift cards each year

smcgee/Flickr$41 billion in gift cards went unused from 2005 to 2011, worth $6 billion a year, according to TowerGroup. Most of these are considered lost or discarded.

But don't ditch those unused gift cards just yet—you might be able to turn them into cold, hard cash. Last year, deals site CouponSherpa launched a movement called Gift Card Exchange Day, during which consumers could sell their unwanted or slightly used gift cards for cash. On the marketplace, people post an ad for their card in the hopes that a gift card reseller will buy it. "On average you could pocket between 75 and 92 percent of the value of your original gift," reports BI's Mandi Woodruff.

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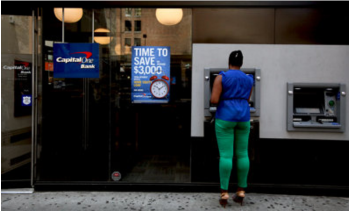
$7 billion in ATM fees each year



Woman using an ATM at a Capital One Bank in Midtown, New York City.Americans pay through the nose at the ATM machine, according to Bankrate.

What's more, these penalties are higher than ever right now. The only way to ditch them may be dumping your big bank for a credit union. Not only do some credit unions reimburse you for ATM fees, some will even pay you for using their card.

$12 billion in traffic tickets each year

Grahamtastic/FlickrDrive too fast? Park in the wrong spot? You are spoon feeding money to the government and the insurance companies.

The National Motorists Association estimates that Americans spend 7.5 to 15 billion dollars on traffic tickets, assuming 25 to 50 million traffic tickets, costing an average of $150 with an insurance surcharges for half of them costing around $300. (We averaged the range in this estimate.)

$29 billion on candy each year

Victoria Castañeda/FlickrMost candy has *negative* nutritional value. We're going to go ahead and call it a waste of money.

How much? US confectionery sales totaled $29 billion in 2010, with 60 percent spent on chocolate.

$31 billion on lottery tickets each year

birdvoyeur/FlickrAmericans spent $59 billion on lottery tickets in 2010. Most of them did not get rich. The average lottery ticket pays 47 cents on the dollar, meaning that Americans wasted around $41 billion.

$44 billion on tobacco each year

WikiMediaCommonsAmericans burned $44 billion on tobacco, according to the BLS. It's become such a problem that low-income New Yorkers are spending a *quarter* of their annual salary on cigarettes. And we're not counting the indirect health costs, which are covered below.

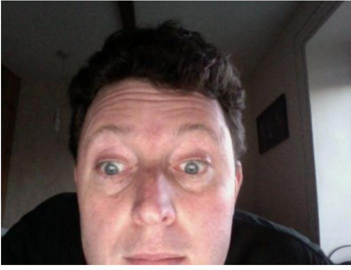
But help may be on the way. Researchers like Dr. Ronald Crystal of Weill Cornell Medical Center are developing vaccines that could provide immunity to nicotine and even cocaine. It's a one-time shot that could help stop addiction.

$50 billion on alcohol each year

John Niedermeyer/FlickrAmericans spent $50 billion getting drunk, according to the BLS.

One might argue that booze isn't a waste of money, but, well, we're not convinced. Again we're not counting indirect costs related to drinking.

$49 billion on credit card interest each year



NickCotter/FlickrWe calculated this figure based on a Gallup survey showing that the average cardholder had an unpaid balance of $2,210 at the end of the month. Throw in an average APR of 12.75% for 174 million cardholders, and you get total annual interest payments of $49 billion.

You seriously need to stop wasting money on credit card interest and end the debt cycle for good.

$69 billion at the casinos each year

Wikimedia CommonsCasinos earned gross revenue of $125 billion in 2010. We're going to be generous and estimate that 45 percent of this money was returned to gambler's in winnings. That leaves $69 billion money that people willingly gave away.

Warren Buffett says it was while watching people throw away money at a casino that he first realized how easy it would be to get rich.

$76 billion on soda each year

abdallah/FlickrThe US soda market is worth $76 billion, according to Beverage Digest. As your mom told you, these drinks provide no nutritional value, and you're better off drinking water.

$146 billion in wasted energy each year

tolomea/FlickrThat's our calculation based on $443 billion in annual home energy costs, and the claim that consumers could cut energy costs by a third if they followed recommendations from the government-backed Energy Star program.

Energy Star's website has a whole host of suggestions to save you money:

-- Changing your air filter every three months at the minimum and using a programmable thermostat could save you over $180 a year.

-- Lowering your water heat thermostat from 140 to 120 degrees can save you more than $400 a year.

-- Replacing five light bulbs with Energy Star bulbs or fixtures can save you $70 per year, and Americans waste $9 billion on energy inefficient lighting.

-- You could save $40 a year by only using cold water to wash your clothes and as many as $36 per year by using the right sized pot on your stoves.

-- In the average home "75% of the electricity used to power home electronics and appliances is consumed while the products are turned off."

$165 billion in wasted food each year

dpstyles™/FlickrWhen you trash food, you throw out money. The habit costs $165 billion nationally, according to the National Resources Defense Council, which means it costs $529 per person.

If you're tempted to toss out old food, then pick up new habits. Hit up Google to find creative uses for certain foods, offer leftovers to Fido, or plan meals around weekly sales so you don't overbuy.

Another option is to pile up your plate with veggies. They'll help you lose weight, and are often cheaper than the packaged and processed goods at the front of the store.

Who knows how much wasted on bad health?

Tobyotter/FlickrThis is where the indirect costs of smoking, drinking, and eating junk food come in. Bad health leads to lower productivity, high insurance and health care costs—even if universal health care spreads the cost to other tax payers.

The real problem is that bad health makes people less happy and takes years off one's life.

Your Credit Score: Not the Same Score Lenders See

By Blake Ellis | CNNMoney.com

The credit score you receive may be much higher or lower than the one a lender uses when deciding whether to give you a mortgage, credit card or auto loan, a new government report finds.

One out of five consumers is likely to receive a score that is "meaningfully" different from the score used by a lender to make a credit decision, according to study from the Consumer Financial Protection Bureau that analyzed 200,000 credit files from the three major credit bureaus, TransUnion, Equifax and Experian.

As a result, many of these consumers receive either better or worse terms on mortgages, credit cards, auto loans and other credit products.

"This study highlights the complexities consumers face in the credit scoring market," said CFPB Director Richard Cordray in a statement. "When consumers buy a credit score, they should be aware that a lender may be using a very different score in making a credit decision."

The credit score a lender sees often depends on the type of loan or credit product they are considering. Lenders that use FICO scores, the most commonly used score, could be looking at one of 49 different scores to determine how risky you are -- including a FICO auto score, a FICO bankcard score and a FICO mortgage score.

As a consumer, it's impossible to know which score a lender will use to make a decision and how it will compare to the score available to you. That means the scores available for purchase from the major credit bureaus are often unreliable when it comes to determining whether you will qualify for certain credit products, the CFPB found.

While the group of consumers whose scores vary dramatically from the ones lenders use represent a minority, these discrepancies can have a big impact. Some consumers who see a higher score than a lender may apply for loans and credit cards they aren't qualified for, while consumers who see a lower score than a lender may accept offers with higher interest rates or worse terms than they could find elsewhere.

The CFPB therefore advises consumers to shop around. Even if your score doesn't seem high enough to qualify you for a credit card with a decent rate, you may want to apply anyway in case the score the lender sees is a bit higher, for example.

For the most part, however, scores are relatively consistent, meaning that if the score you see is excellent, it's likely going to be excellent when lenders view it as well -- no matter what scoring model they use. Nevertheless, the agency recommended that companies selling credit scores make sure consumers realize that there can be discrepancies between the scores they receive and those that creditors use.

Beginning Sept. 30, the CFPB will begin supervising credit reporting agencies, meaning it will be able to write new rules and conduct on-site audits. Its scope will cover about 30 companies, including the major credit bureaus.

When Doctors Stop Taking Insurance

The Agenda: Health October 1, 2012 *By RONI CARYN RABIN*

Tim Bower

Private health insurance used to be the ticket to a doctor's appointment. But that's no longer the case in some affluent metropolitan enclaves, where many physicians no longer accept insurance and require upfront payment from patients — cash, checks and credit cards accepted.

On Manhattan's Upper East Side, it's not unusual for a pregnant woman to pay $13,000 out of pocket in advance for childbirth and prenatal care to a physician who does not participate in any health plan. Some gynecologists are charging $650 for an annual checkup. And for pediatricians who shun insurance, parents on the Upper East Side are shelling out $150 to $250 whenever a child falls or runs a high fever.

Efforts by insurers to rein in health care costs by holding down physician fees — especially for primary care doctors, who play a critical role in health care though they are among the lowest paid doctors — appear to be accelerating the trend, and some patients say it's getting harder to find an in-network physician.

OrlenePaxson, 33, a stay-at-home mom on Manhattan's Upper East Side, was unable to find an obstetrician she liked who would accept her insurance. Many were not accepting new patients, and one highly recommended doctor did not return her call for five days and did not want to see her until 12 weeks into the pregnancy. It was Mrs. Paxson's first pregnancy and she did not want to wait, so even though her policy does not cover any out-of-network services, she and her husband chose a doctor who doesn't take insurance and paid the entire $13,000 fee themselves.

Once their daughter was born 20 months ago, Mrs. Paxson needed a pediatrician but could not find one who was in her plan, accepting new patients and within walking distance. So she again chose an out-of-network doctor.

"We stayed with her for a year and a half because we loved her," Mrs. Paxson said. At her first scheduled visit after the baby was born, the doctor "talked to me for almost three hours. She knew it was our first baby."

But three months ago, Mrs. Paxson switched to an in-network pediatrician, largely because of the cost of the vaccines. "They didn't cover a dime of it," Mrs. Paxson said of her insurance, adding that she was not complaining. "I made informed decisions."

Though data on private practices is scanty, a new survey of 13,575 doctors from around the country by The Physicians Foundation found that over the next one to three years, more than 50 percent plan to take steps that reduce patient access to their services, and nearly 7 percent plan to switch to cash-only or concierge practices, in which patients pay an annual fee or retainer in addition to other fees.

When doctors stop taking regular insurance or drop a health plan, patients are free to take their business elsewhere. If they have health plans that cover out-of-network expenses, these patients may be reimbursed for fees they pay in cash, but probably not for the entire sum.

The cash-upfront trend raises an uncomfortable question. Can the Affordable Care Act, intended to widen access to health care, succeed by expanding insurance coverage if primary-care doctors are walking away from insurance?

“If all it means is that doctors who serve the wealthy are figuring out ways to avoid the hassles of insurance, I’m not sure it’s a public policy problem,” said Marsha Gold, a senior fellow at Mathematica Policy Research in Washington and an expert on health care financing. “The real problem comes in if it really restricts the choices people have and makes it worse than it is now. We don’t really have the data to know.”

The country is already facing a shortage of physicians, according to the Association of American Medical Colleges. By 2025, the nation will have 100,000 fewer doctors than needed, according to the association. With fewer medical students choosing to go into primary care, shortages in this area are expected to become especially acute.

Physicians are increasingly feeling shortchanged by insurance companies, said Dr. Bob Hughes, an otolaryngologist in Saratoga Springs who is president of the Medical Society of the State of New York. “Insurance companies do not negotiate with physicians. It’s all take-it-or-leave-it contracts,” he said.

A June report by the Medicare Payment Advisory Commission, which advises Congress and focuses primarily on the government plan for seniors, suggests adults ages 50 to 64 are having more trouble getting an appointment with a new physician. Some 30 percent of privately insured individuals who were looking for a new primary care doctor in 2011 reported problems finding one, compared with 26 percent in 2008. (Only 14 percent had a problem finding a specialist in 2011.)

Cash-only practices may exacerbate the access problem. Since her doctor stopped accepting her insurance, Kathryn Vanasek, 43, a mother of two in Manhattan, hasn’t been back for a checkup or preventive screenings, relying on a new walk-in clinic for urgent problems like an ear infection.

Her annual physical would cost at least $250 out of pocket, Ms. Vanasek said, but she would not get any money back from her insurer until she met the deductible.

“You are making a decision between preventive medicine and reactive medicine,” she said.

If you choose to see a physician who will not accept insurance, experts advise a few precautions:

Read the fine print on your health insurance policy. Though many plans provide out-of-network coverage, the reimbursement may cover only a fraction of your costs.

Try to estimate your out-of-pocket costs in advance so you can pay the physician with money saved in a flexible spending account, which is sheltered from taxes.

Ask yourself whether you really must see a doctor who does not take insurance. Is the care really better? Ask acquaintances outside your regular circle for references. If you are willing to travel, you may find a highly recommended physician who takes your insurance.

Keep track of your expenses and receipts, file out-of-network claims promptly and keep copies for yourself. Call your insurer to follow up; it is not unusual for an insurance company to lose paperwork.

Watch for expenses that will not be reimbursed. Children's vaccines, for instance, may not be reimbursed even if you have out-of-network coverage. The global fee quoted by an obstetrician for childbirth should encompass all care required unless you have complications, need to see another specialist or require a last-minute Caesarean section.

Doctors who don't take insurance are likely to refer to others who don't. Make every effort to ensure that expensive services, such as hospitalizations and surgery, are with network providers and that you have the required approvals from your insurer.

Poll: Medicare prescription drug program popular

David JacksonShare

The Medicare prescription drug program is popular, a poll finds.(Photo: Sue Ogrocki, AP)

10:07AM EST October 3. 2012 - Here's one program candidates aren't likely to mess with: The Medicare prescription drug plan.

A new poll sponsored by a health care group shows that 90% of seniors are satisfied with the program known as Medicare Part D, and approval has constantly risen since the plan came on line in 2006.

"Nearly seven years later, 9 in 10 Medicare beneficiaries have prescription drug coverage," says the poll. "Satisfaction among those with Medicare Part D has grown 12 points from 78% to 90%. Most are very satisfied with their coverage and say their plan offers excellent value, reasonable costs, and convenience."

The survey was sponsored by Medicare Today, an initiative of the Healthcare Leadership Council.

The pollster say that seniors "feel peace of mind" with the prescription drug program, and regard it as "a safety net."

Neither President Obama nor Mitt Romney have criticized Medicare Part D, though Obama has noted that the Bush administration pushed the plan without new revenues to help finance it.

Among other poll findings show that without Part D:

-- 84% report that out-of-pocket drug costs would be higher.

-- 61% would be unable to fill all of their prescriptions.

-- 53% would be more likely to cut back or stop taking medicine altogether.

The survey did note that seniors could be better informed about the open enrollment plan for Medicare Part D that starts Oct. 15.

Said the poll:

"Each year during open enrollment, seniors have the opportunity to assess their situation, compare plans, and choose one that best meets their needs. This year, most say they will not shop around during open enrollment because they are satisfied. Some, however, find comparing plans difficult. There are opportunities to raise awareness of Medicare's Plan Finder tool and other sources of help."

Medicare knee replacements surge 162% since 1991

By CHARLES FIEGL, amednews staff. ***Posted Oct. 8, 2012.***

Washington The popularity of total knee arthroplasty surgeries among Medicare patients has grown considerably as beneficiaries are living longer and seeking to increase their mobility, but the shift has led to fiscal concerns for the entitlement program.

The Sept. 26 issue of *The Journal of the American Medical Association* featured a study on the rapid growth of total knee replacements and revision surgeries. Its authors also noted a slight increase in readmissions among artificial knee recipients since 1991, as the average length of hospital stays after surgeries has been cut in half, to 3.5 days in the 2007-10 period.

Overall volume growth has been driven both by the increased number of Medicare enrollees and by increased per capita utilization, said Peter Cram, MD, a lead author of the study and director of the division of general internal medicine at the University of Iowa Carver College of Medicine in Iowa City. The number of total knee replacements increased 161.5% between 1991 and 2010, when 243,802 such surgeries were performed. Per capita utilization nearly doubled during that period, to 62.1 procedures per 10,000 Medicare beneficiaries from 31.2 surgeries per 10,000 enrollees.

"We are an aging society, and the number of beneficiaries is going up every year," Dr. Cram said. "What we sought to do in our study is look at the long-term trends. We had different lessons sandwiched together in the same paper."

Average hospital stays after knee replacement surgery were cut in half from 1991 to 2010.

For patients, knee replacements are relatively safe and have low rates for complications, mortalities and length of hospital stays. However, 30-day readmissions rates have risen to 5% in 2010 from 4.1% in 1991. Shorter hospital stays are causing the increase, a change that should have been expected by health policymakers, Dr. Cram said.

The volume of revision knee replacement surgeries has increased to 19,871 in 2010 from 9,650 in 1991. The per capita rate also has increased, to 5.1 revision procedures per 10,000 beneficiaries from 3.2 surgeries per 10,000 patients.

For Medicare officials, the doubling of per capita utilization of primary knee replacement surgeries is a cause for concern, Dr. Cram said. However, he said there is no conclusive evidence that points to overutilization of the procedure. Some patients elect not to have the surgery, which could point to underutilization, he added.

"It's an effective therapy for an aging population who wants to be physically active. It allows you to ski mountains, hike the Appalachian Trail and run with your grandkids as you get older," he said.

The data from the article show a success story, said John R. Tongue, MD, president of the American Academy of Orthopaedic Surgeons. Patients were apprehensive about the surgeries decades ago. Recovery required weeks in the hospital, as some patients would be afraid to get out of bed. But attitudes have reversed during the past 20 years, because knee replacements can relieve pain and increase mobility dramatically.

"It's very positive," Dr. Tongue said. "The only criticism I hear now is 'I should have done it sooner.' "

There were 243,802 knee replacement surgeries in 2010, a jump of 161.5% from 1991.

More and more patients taking advantage of the surgeries will lead to higher Medicare program costs. The procedure itself costs about $15,000 to $30,000, Dr. Tongue said. The bundled Medicare payment for the procedure is spent on the device implants, facility fees, therapy providers and the surgeons. The surgeon probably will receive about $1,500 of the total, he said.

New Medicare payment models, such as the bundled payments used for knee replacements, aim to achieve lower costs while maintaining high quality to prevent patients from being readmitted.

The AAOS supports new Medicare payment models to support care coordination and empower patients to engage in programs prescribed by physicians, Dr. Tongue said. But he said the Medicare program needs to consider that seniors are living longer and doctors increasingly are performing surgeries on patients with one or more comorbidities.

“Some of my patients are obese, diabetics or have a history of coronary disease,” he said. “These patients in the past would have shunned this type of procedure, but now they seek it out.”

Will a “silent exodus” from medicine worsen doctor shortage?

Many physicians, nervous about the impact of health system reform and dispirited by trends in medicine, are exploring career options that involve treating fewer patients.

By KEVIN B. O'REILLY, amednews staff.*Posted Oct. 8, 2012.*

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Frustrated by mounting regulation, declining pay, loss of autonomy and uncertainty about the effect of health system reform, doctors are cutting back the number of hours they work and how many patients they see.

Between 2008 and 2012, the average number of hours physicians worked fell by 5.9%, from 57 hours a week to 53, and doctors saw 16.6% fewer patients, according to a survey of nearly 14,000 doctors released in September. If the trend continues through 2016, it would equate to the loss of 44,250 full-time physicians, said the report, conducted by the doctor-recruiting firm Merritt Hawkins & Associates for the Physicians Foundation. The foundation was started in 2003 with more than $30 million from class-action settlements that 22 state and county medical societies made with health plans.

“This is a silent exodus,” said Mark Smith, president of Merritt Hawkins. “Physicians are feeling extremely overtaxed, overrun and overburdened.”

Only half of doctors will continue their current practice during the next three years, the survey said. Many plan to cut back on hours, retire, see fewer patients, seek hospital employment, work part time, transition to a concierge model or seek a nonclinical job in health care. Sixty percent would retire today if they could, compared with 45% in 2008.

A quarter of doctors cited long hours and lack of personal time as among the least satisfying elements of their careers. Nine in 10 physicians agreed that most doctors “are unsure where the health system will be or how they will fit into it” during the next five years.

“There’s a great degree of uncertainty and angst related to problematic reimbursement, the high-regulation environment and many other things,” said Walker Ray, MD, a retired pediatrician and vice president and research committee chair for the Physicians Foundation. “Now, what this all is about is more than professional grumbling. All professions at times have unhappiness surfacing. What we’re looking at are trends where physicians are in their own individual minds and their own individual practices, making decisions that may affect the supply of physicians going forward.”

Impact on access to care

The less-intensive doctor work schedule could hamper access to care for the 30 million Americans the Congressional Budget Office estimates will obtain health insurance coverage under the Affordable Care Act during the next decade. The U.S. Census Bureau also projects a 36% rise in Americans eligible for Medicare during that period.

In 2010, the Assn. of American Medical Colleges projected a shortage of 130,600 physicians by 2025, with half of the shortfall occurring in primary care specialties. That estimate accounts for the work patterns of older physicians and female doctors, who are more likely to work part-time schedules, said Clese Erikson, director of the AAMC’s Center for Workforce Studies. But the projection does not factor in growing hospital employment of physicians, a trend noted in the foundation’s report.

Hospitals directly employ about 20% of practicing physicians, according to the American Hospital Assn. Many other physicians are employed in group practices owned by health systems. The proportion of doctors in independent practice is now a minority, says the MGMA-ACMPE, the entity formed by the merger of the Medical Group Management Assn. and the American College of Medical Practice Executives. That matters because hospital-employed physicians work fewer hours and see fewer patients than do independent doctors, the foundation’s survey showed.

20% of practicing physicians were directly employed by hospitals in 2011.

Employed physicians averaged 53.1 hours a week, compared with 54.1 for doctors in private practice. Employed physicians saw 17% fewer patients — 18.1 a day — compared with 21.9 a day seen by practice-owning doctors. Slightly more than 20% of employed doctors worked fewer than 40 hours a week, compared with 18.4% of physicians with an ownership stake in their practice. More than 60% of physicians younger than 40 are employed by a hospital, physician group or other entity.

"We know that an employed physician is less productive than a practice owner," said Smith of Merritt Hawkins. "Physicians are looking for a safe harbor [in hospital employment], for someone to say, 'I think I see what's coming, and I can mitigate this risk for you.' "

The foundation survey was sent to more than 630,000 U.S. physicians. Despite the low response rate, an academic consultant cited in the report said the survey's margin of error is less than 1%. Smith said a sample of nonresponding physicians was later contacted to answer a few of the survey's dozens of questions, and their responses were highly consistent with those of doctors who completed the full survey. Respondents were likelier than the general population of physicians to be white, male, older and in solo or independent practice. Yet the lighter workload seen was not limited to the older physicians surveyed. Doctors younger than 40 averaged 19 patients a day, compared with 19.8 for physicians 40 and older.

Leaders at physician organizations said the low morale reflected in the survey is unsurprising.

"Many doctors have been beaten down pretty significantly by the current system and have developed an unfortunate cynicism about the potential for change," said David Bronson, MD, president of the American College of Physicians.

More than 60% of doctors younger than 40 are employed by a hospital, physician group or other entity.

Long-term trends have hit smaller, independent practices especially hard, said Glen Stream, MD, president of the American Academy of Family Physicians.

"People in small and solo practices are struggling, with all the administrative and regulatory burden of insurance and payment challenges," said Dr. Stream, an employee at a hospital-owned clinic in Spokane, Wash. "In a small group, you don't have any negotiating power with insurance companies. If you're in small or solo practice, life is hard."

Physician leaders said the survey results highlight the need to expand federal funding for residency slots, which have been capped since the Balanced Budget Act of 1997. The AAMC, American Assn. of Colleges of Osteopathic Medicine, the American Medical Association and many other physician organizations support expanding residency slots.

On Sept. 25, Rep. Joseph Crowley (D, N.Y.) introduced a bill to boost Medicare-funded residencies by 15%, or about 15,000, during the next five years. Rep. Aaron Schock (R., Ill.) introduced a similar bill in August, and Sen. Bill Nelson (D, Fla.) proposed comparable legislation in September 2011. The AMA has publicly supported Nelson's bill, which has not received a hearing or been put to a vote.

Shortage sparks debate over NPs' role

The looming physician shortage is drawing more attention to the use of nurse practitioners, physician assistants and other midlevel health professionals to help maintain access to care. But the shift toward more team-based care in patient-centered medical homes should occur in a physician-led environment, the AAFP said in a Sept. 18 report. The American Academy of Nurse Practitioners objected to the report, arguing that NPs could help fill the physician gap by independently treating patients.

Dr. Stream, of the AAFP, said a two-tier system of primary care — physicians for some, nurse practitioners for others — is untenable.

"To the people who propose that to fill this gap that we should somehow alter our expectations of the kind of care people should get — that is not what we want in this country," he said. "It's not a viable, ethical or reasonable solution."

Primary care doctors complete 21,700 hours of education and training over 11 years, said the AAFP report. That compares with 5,350 hours of training and education NPs get during five to seven years. The AMA backed the academy's report, noting a recent survey showing that 86% of patients believe they benefit from a physician-led primary care team.

"Physicians and other health professionals have long worked together to meet patient needs for a reason — the physician-led team approach to care works," said AMA President Jeremy A. Lazarus, MD. "Patients win when each member of their health care team plays the role they are educated and trained to play."

ADDITIONAL INFORMATION:

The practice changes physicians are planning

In 2012, only half of surveyed physicians said they will continue their current medical practice over the next one to three years. The other half are pondering other options — respondents could choose any that applied to them. Many plans involve treating fewer patients, and that shift could impede access to care amid projected doctor shortages and expanded health insurance coverage.

Practice plan	Physicians agree
Continue as I am	49.8%
Cut back on hours	22.0%
Retire	13.4%
Relocate to another practice or community	10.9%
Seek nonclinical job in health care	9.9%
Cut back on patients seen	9.6%
Switch to cash/concierge practice	6.8%
Work part time	6.5%
Work locum tenens	6.4%
Seek job outside health care	6.4%
Seek hospital employment	5.6%
Close practice to new patients	4.0%
Other	5.5%

Source: "A Survey of America's Physicians: Practice Patterns and Perspectives," Physicians Foundation, Sept. 21 (**physiciansfoundation.org/uploads/default/Physicians_Foundation_2012_Biennial_Survey.pdf**)

What feeds physician frustration

Three-quarters of physicians have a pessimistic outlook about the future of the medical profession, says a recent survey. More than 80% say the profession is in decline. Doctors said the following factors —

respondents could choose any they felt applied — played a “very important” role in the profession’s decline.

79.2%: Too much regulation/paperwork

64.5%: Loss of clinical autonomy

58.6%: Physicians not compensated for quality

54.4%: Erosion of physician-patient relationship

45.9%: Money trumps patient care

43.7%: Scope of practice encroachment

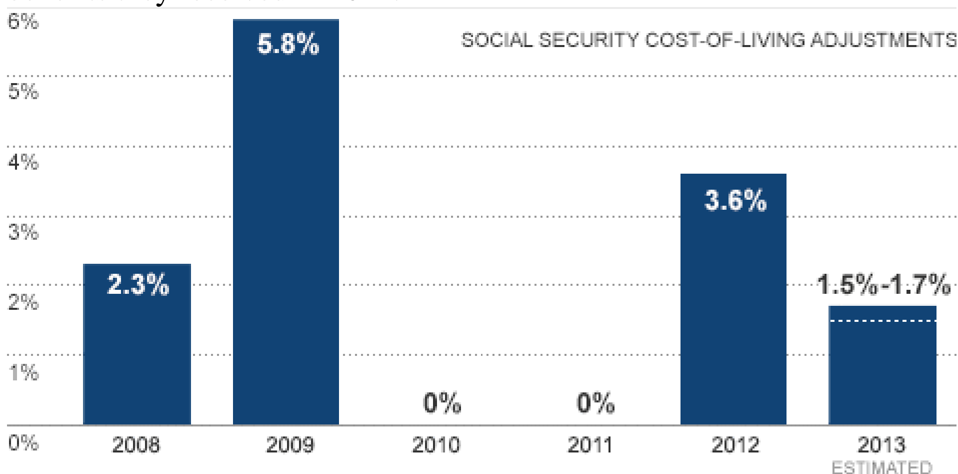
6.9%: Too many part-time doctors

“A Survey of America’s Physicians: Practice Patterns and Perspectives,” Physicians Foundation, Sept. 21

Social Security Benefits Will Get Small Cost of Living Bump

CNNMoney *By Chris Isidore | CNNMoney.com – 22 hours ago*

NEW YORK -- Social Security recipients will get less than a 2% increase in their benefits next year to account for a rise in cost of living, according to an estimate published Tuesday. That's less than half the increase in benefits they received in 2012.



(Courtesy of CNNMoney)

The American Institute for Economic Research, a private think tank, estimates Social Security checks will increase between 1.5% and 1.7% in 2013.

The Labor Department will release its September inflation reading on Oct. 16, which is the final of 12 readings used to calculate the cost of living adjustment made annually to benefits. The Social Security Administration will announce the 2013 benefit increase at that time. Benefits increased by 3.6% in 2012, when inflation was higher.

Steven Cunningham, director of research and education for AIER, said that the increase will not be enough to cover the actual rise in costs faced by many seniors, who receive the overwhelming majority of Social Security benefits.

Seniors don't typically have the same spending patterns as younger workers, whose purchases are more closely tracked by the government's inflation reading.

Cunningham pointed to larger increases in items more important to senior's spending, including food and beverages, which increased 2%; motor fuel, which rose 1.9%; and medical care, which jumped 4.1%. The AIER's estimate of the cost of every day items purchased by seniors showed a 2% increase over the last year.

"They're falling behind by about a half percentage point a year or so. It's not a huge amount, but over time that adds up," said Cunningham.

In 2009, benefits increased by 5.8% following a sharp rise in gas prices in 2008. But social security recipients saw no increase in 2010 and 2011, when spending dropped due to the recession and prices remained low.

This calculation doesn't only affect those receiving Social Security benefits. It is also used to raise the ceiling on wages subject to payroll taxes. This year's maximum is $110,100, but a 1.7% increase would subject an additional $1,872 to the 6.2% tax.

Investigators: CMS needs better identity theft database

By Allison Bell
OCTOBER 10, 2012

Officials said CMS needs to do more to protect victims' access to benefits.
The Centers for Medicare & Medicaid Services (CMS) should try to get away from basing Medicare numbers on Social Security numbers, according to officials at the Office of the Inspector General for the U.S. Department of Health and Human Services (HHS OIG).

HHS OIG officials have included that recommendation in a report on how CMS Medicare program managers have handled breaches of Medicare enrollee information and actual cases of Medicare-related identity theft.
A provision in the American Recovery and Reinvestment Act (ARRA) requires CMS to notify the affected Medicare enrollees and provide other help when breaches occur, HHS OIG officials said in the report.

The investigators used CMS breach data to conduct the analysis.

The investigators found 14 reported breaches of protected health information that took place between Sept. 23, 2009, when ARRA took effect, and the end of 2011.

The breaches affected about 14,000 Medicare enrollees.

Although CMS identified the affected enrollees, it had trouble with meeting other ARRA requirements, such as sending information in a timely fashion, giving a description of how CMS is investigating the breach, a description of what happened, and steps enrollees can take to protect themselves, officials said.

One challenge is that CMS updates the identity theft database just once a month. and another challenge is that the database is difficult for contractors to use, officials said.

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Another problem is that CMS usually creates Medicare numbers by adding the letter A to the end of an enrollee's Social Security number, or by adding B to the end of the Social Security number of an enrollee's breadwinner spouse.

Today, there is no easy way to issue enrollees new Medicare numbers because of the Social Security number link, officials said.

CMS officials "have cited high costs, the volume of changes, and operational and systems issues as barriers to altering beneficiary numbers," HHS OIG officials said.

In spite of those obstacles, "CMS should explore different options and then develop a method for reissuing Medicare numbers to beneficiaries affected by medical identity theft," OIG HHS officials said.

CMS also should make sure enrollees can get access to care when others are misusing their Medicare numbers, officials said.
"Misuse of a beneficiary's number could delay or prevent that beneficiary from receiving needed services, particularly when the services are subject to a cap," officials said. "CMS could insert an indicator in the beneficiary claim record that would exclude certain claims from frequency and utilization edits, allowing for payment of legitimate claims for victims of medical identity theft. CMS could also develop other methods for providing assurances and documentation to these beneficiaries that their access to services will not be restricted as a consequence of the theft."

The Best Workout For Your Heart

Thursday, October 18, 2012 7:10 pm
Written by: Cassie Shortsleeve

Faster footsteps equal a healthier heart.

Working out harder instead of longer could be the secret to warding off metabolic syndrome (MS), a combination of risk factors -- which include obesity and high blood pressure -- that increase your risk for cardiovascular disease, according to new research in the BMJ Open.

Ten years after gathering people's baseline fitness habits -- including workout length and intensity --researchers found that those who reported jogging or brisk walking 2 to 4 hours a week cut their risk of developing MS by 35 to 50 percent. (About 19 percent of inactive people developed MS, compared to just 12 percent of very active people.)

The cardiovascular impact of high-intensity exercise versus light exercise has been a longstanding debate, says cardiologist Eric Topol, M.D., director of the Scripps Translational Science Institute and a Men's Health expert advisor. While the jury remains out, the new study lends credence to the high-intensity camp.

"**Higher-intensity exercise** does have a whole different impact on the body's physiology," says Dr. Topol. Everything is more pronounced: Your heart rate is higher, your blood vessels are more dilated, and you're revving up your cardiovascular system as you would a car, Dr. Topol adds.

The results of this study fall in line with past studies on the topic: There's some kind of a threshold that you need to surpass in order to see changes. And it's possible that intense exercise triggers those changes in lipid and glucose metabolism and blood pressure, lowering the risk factors that trigger MS, says David Maron, M.D., a cardiologist at Vanderbilt University's medical center. (Discover tons of ways to keep your heart pumping strong with **The Lean Belly Prescription**, your no-diet, no-workout plan that's better than running five miles a day!)

But don't give up your leisurely evening walks just yet. A recent study in Circulation found that just 2.5 hours of light exercise a week can reduce inflammation in your body thought to be a major contributing factor for developing heart disease. The key: Make sure your heart rate hovers around 120 beats per minute (think: Not quite heavy breathing, but breathing more heavily than normal), and that you put in the recommended 2.5 hours for the week.

So what's the happy medium? Be your own judge. While the BMJ Open study found that light physical activity didn't decrease the participants' MS risk -- even if they walked for 2 hours a week -- brisk walking was categorized as high intensity. If going hard for you means brisk walking, do that until it becomes easy, then take

it up a notch. "Rigorous aerobic activity is really the best," Topol says. So, if you enjoy your nightly stroll, just make sure you're sweating it out in the morning, too. (Looking for a great routine? Try one of these **3 New Killer Cardio Workouts**.)

SECRETS OF LIVING TO 100

Blue Zones: Where People "Forget to Die"

By Lisa Collier Cool
Oct 25, 2012

Day in Health

By Lisa Collier Cool

Extreme longevity has always been a quirky thing, happening in isolated mountain villages few people visit. Until recent years, no one asked this question: Could we create those same conditions in the United States so that most people would celebrate their 100th birthday—healthy, happy, and without the aches and pains we usually associate with aging?

Absolutely, says Dan Buettner, author of *The Blue Zones: 9 Power Lessons for Living Longer from the People Who've Lived the Longest*, the second edition to be released in November. Not only is extreme longevity possible here, it's already being achieved in communities across the U.S.—and, in a few instances, Blue Zones principals have been adopted by individual companies, aiming to become Blue Zones Certified Workplaces.

What Are Blue Zones?

Blue Zones are places where people live longer and healthier than anywhere else on the planet, passing their centennial years at a rate 10 times greater than most Americans. For the first edition of his book, Buettner led a team of National Geographic researchers in studying a collection of "longevity hot spots" across the globe. Their work was prompted by a 1999 Danish study of nearly 4,000 twins older than age 75; scientists found that only 25 percent of their hospitalizations were caused by genetic factors and that most of their health profiles were "most likely due to nonfamilial environment."

So Buettner's team set out to study long-living peoples, including those in Nicoya, Costa Rica, where residents boast the lowest middle-age mortality on earth; Sardinia, Italy, where men generally outlive women; and Loma Linda, California, where a community of Seventh-Day Adventists enjoy a life expectancy nine to 11 years longer than the average American. Much of the book's updating focuses on Ikaria, Greece, the most recently discovered and, Buettner says, the"most extraordinary" Blue Zone.

The Island Where People Forget to Die

"In America, once we hit 85, there's about a 50 percent chance you'll suffer from dementia,"Buettner says. "In Ikaria, the rate is about one-fourth ours. They stay sharp to the end." But it's not only their mental health that remains intact; four times as many Ikarian men and two-and-a-half times as many women, reach the age of 90,

compared to Americans. What's more, they stay healthier along the way, living eight to 10 years longer before contracting cancers and heart disease.

And they do it with a smile, Buettner writes in a recent article in *The New York Times Magazine.* In a survey of Ikarian men aged 65 to 100, some 80 percent had sex regularly—and, they reported, they did the deed with "good duration" and "achievement." The islanders' secret, Buettner believes, is a "gold standard" variant of the Mediterranean diet, including diuretic teas—such as rosemary, sage, and dandelion—that help to lower blood pressure and inflammation, plenty of indigenous honey instead of refined sugar, bread made of stone-ground wheat, and two to four glasses of wine each day.

Blue Zones in the United States?

Since his longevity studies began, one of Buettner's aims has been to adapt the same principals into "Blue Zones Projects" in the U.S. The first city to enact a Blue Zones plan for initiating healthy environmental, social, and policy changes was Albert Lea, Minnesota. They called their effort the "Vitality Project," and the results were remarkable. Life expectancy of participants increased by 3.1 years, and their healthcare costs were slashed by nearly half.

Last May, Governor Terry Branstad announced that Iowawould launch the first Healthiest State Initiative, with the towns of Cedar Falls, Mason City, Spencer and Waterloo selected as the state's first Blue Zones Project Demonstration Sites, with six additional communities to join in early 2013.

9 Secrets of Longevity

As Buettner and his team studied the Blue Zones, they identified nine common traits shared by those communities where people live longer. He was surprised that it wasn't only food and lifestyle, but also creating a most beneficial environment. Here's a look at these longevity-boosting traits, known as the "Power of 9.:

- *Move naturally.* "Do your own house and yard work, go up and down your stairs with your laundry, knead your own dough," Buettner advises. "Incorporate more movement every hour."
- *Know your purpose.* "Take time to recognize your values, strengths, talents, passions and gifts," Buettner says. Reflect, and work on yourself.
- *Down shift.* Relieve chronic stress by finding time each day to nap, meditate or pray.
- *The 80% rule.* Cut 20 percent of your daily calories with proven healthy practices: eat a big breakfast, dine with your family, and begin each meal by expressing appreciation.
- *Plant slant.* Eat mostly plant-based foods, and small portions of meat no more than twice a week.
- *Wine at 5.* Drinkers live longer than non-drinkers. This longevity tip had one exception: those in the Loma Linda Blue Zone were Seventh Day Adventists, who abstain from alcohol.
- *Family first.* Living in a loving, thriving family can add up to six years to your life. Work on a positive, committed relationship and stay close to your aging parents and grandparents.
- *Belong.*"Those with the most social connectedness tend to live longer," Buettner says. Be part of a group of healthy-minded, supportive people.
- *Right tribe.* Good friends have a positive effect on your longevity. Support them and adopt healthy behaviors together.

Best Careers for Your Golden Years

Are you thinking of making your golden years shine a little brighter by going back to work? Learn more about these five careers that could be a good fit for older adults.

By Terence Loose

Have you reached your golden years, but find that retirement isn't all it's cracked up to be? Maybe you enjoy being productive and miss having a career. Or maybe your financial situation isn't as golden as you'd hoped, and a little extra income would be nice.

Whatever the reason, there are plenty of careers that could be a good choice for older adults.

And working during your golden years could also benefit your well-being, according to Susan Heathfield, a management consultant and About.com's Guide to Human Resources.

"I think a big benefit seniors get if they choose to work is they stay active and in contact with people of all ages," says Heathfield.

So if you want to go back to work, check out this list of careers that could make your golden years just a little more golden.

Career #1: Accountant

Have you always been good with numbers, but never got to use that passion in your former career? Your golden years could be the time to let your love of digits shine with a second career as an accountant.

As you'd expect, accountants generally deal with financial matters. According to the U.S. Department of Labor, common duties include examining financial records, putting together financial documentation, and preparing tax returns.

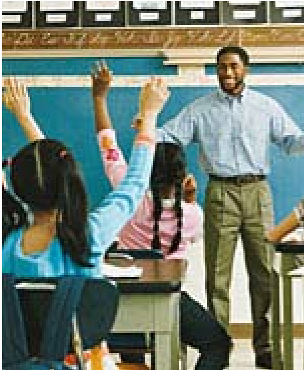
Why It's a Golden Choice: According to Heathfield, this career could be suited for seniors because it's not a physically demanding career.

And an even more enticing reason: you might be able to work a flexible schedule, says Heathfield.

"It's a job that can be done part time. Or you could work for a number of companies that need supplemental staff at various times of the month," says Heathfield. "That also means you don't have to sign up for the daily grind to and from the office, which I don't think many seniors want."

Education Options: Most accountant positions require a bachelor's degree in accounting or a related field, says the Department of Labor. But note that some employers look for candidates with master's degrees in accounting or business administration (MBA) with an emphasis in accounting.

Career #2: Elementary School Teacher



Are you the energetic type of retiree who wants to help guide the next generation? If so, a career as an elementary school teacher could be a good fit.

Just make sure you're ready to create lesson plans for subjects like math or reading. Or how about assessing student's strengths and abilities? Or preparing students for tests? According to the U.S. Department of Labor, these are common job duties for elementary teachers.

Why It's a Golden Choice: If you're a senior with a lot of energy and patience, this is the type of job that could keep you young and lively, says Heathfield.

"It's a position in which you'd be mentoring the younger folks, and that's such a wonderful thing for an older adult to do: passing on all their life experience to the next generations," says Heathfield.

Education Options: Every state requires public elementary teachers to have a bachelor's degree in elementary education and be certified with a teaching license, according to the Department of Labor. And in certain states, elementary teachers are also required to major in a specific content area like math or science.

Career #3: Dental Assistant

Were you always good at making people feel relaxed? As a dental assistant, you could help patients feel more at ease while they're in the dental chair.

According to the U.S. Department of Labor, dental assistants could do everything from scheduling patient appointments, keeping patients' records, instructing them on proper dental hygiene, and processing X-rays and other exams.

Why It's a Golden Choice: According to Heathfield, interacting with patients could make this a good career option for seniors.

"They do some of the hygienist's duties, and they are still the front desk greeters," says Heathfield. "So they have a lot of positive interaction with people, which I think is great for seniors."

Education Options: According to the Department of Labor, there are several paths to prep for a dental assistant career. For example, some states don't have any educational requirements, while other states require dental assistants to graduate from an accredited program and pass an exam. Accredited programs include certificate or associate's degree programs.

Career #4: Personal Financial Advisor

If you're good with numbers but also desire more personal contact with adults, a career as a personal financial advisor could really add up for your late-in-life career.

Just as the title implies, the duties for a personal financial advisor seem to have a healthy mix of personal interaction and studious financial work. How so? According to the U.S. Department of Labor, these advisors could meet with clients to discuss financial goals, recommend investments or choose them for their clients, and research investment opportunities.

Why It's a Golden Choice: If given a choice, career expert and author Laurence Shatkin says that personal financial advisor would be a good option for a retiree who has a solid business background or a love for finance.

"It's one way a person can leverage business - especially financial - experience, and for those who want to cut back to part-time work," Shatkin says.

Another perk for older adults: it's a job that might offer a flexible schedule, so you could still keep up with your hobbies.

Education Options: For this role, the Department of Labor says a degree in finance, mathematics, economics, law, accounting, or business is good preparation. Although advisors generally need a bachelor's degree, a master's degree in finance or business administration could help with advancement into a management position.

Career #5: Pharmacy Technician

Do you enjoy interaction with people and helping people stay healthy? And how do you feel about standing a majority of the time? If those are both thumbs up, a career as a pharmacy technician could be an easy pill to swallow.

Pharmacy technicians are those nice workers at the counter when you pick up your prescription. Working as a pharmacist's right-hand helper, they generally take information from customers for prescriptions, fill prescriptions, compound or mix medications, and accept payment for prescriptions, says the U.S. Department of Labor.

Why It's a Golden Choice: This is a great option for older adults who don't want to retire anytime in the near future.

"I think [pharmacy technicians] can be employed until they're 90 if they want," says Heathfield. "Full time, part time, whatever; it's a field where there's not enough people to fill the spots because of all of the baby boomers who are becoming elderly and require more medication to stay healthy."

Education Options: According to the Department, most pharmacy technicians learn their skills on the job, but requirements can vary by state. In fact, some states require technicians to pass an exam or earn a certificate through a formal education program.

BONE UP ON PREVENTING OSTEOPOROSIS

Over time, your bones begin to thin and you are at risk for osteoporosis, a disease in which the bones become weak and are more likely to break. Unless you've had a bone density test, you can't tell that your bones have gotten weaker. But fractures of the wrist, spine, ribs or hip are anything but silent. They are painful and disabling. In addition, fractures of the spine can result in compressed vertebrae and loss of height.

You can help keep your bones strong and healthy now and as you get older.

- **Talk with your doctor to see if you need a bone density test.** If your bone density is low, there are several medicines that can improve bone health and decrease the risk of disabling fractures.
- **Be as active as possible.** Weight-bearing exercise, like brisk walking and climbing stairs, strengthens bones. Using free weights or weight machines is also helpful. Stretching, yoga and tai chi improve your balance and reduce the risk of falling.
- **Get enough vitamin D and calcium.** Your body needs these nutrients every day to build new bone. Low-fat dairy products like milk, cheese and yogurt are good choices, as well as leafy green vegetables and other green favorites, including broccoli, celery, brussels sprouts and asparagus. Ask your doctor or dietitian whether you need a supplement.
- **Eat plenty of fruits and vegetables.** They contain minerals and vitamins that are crucial for keeping bones strong.
- **Limit alcohol and sodium.** Drinking too much alcohol can block bone growth. Consuming too much sodium causes your body to get rid of calcium in urine.
- **If you smoke, try to quit.** Quitting isn't easy, but it's one of the best things you can do for your bones.

Your bones support you all day long, so support them with healthy eating and an active lifestyle.

For more information and resources on designing an exercise program to help prevent osteoporosis and more, visit the health and wellness section of the Blue Cross and Blue Shield of Illinois website.

Sources:*National Institutes of Health; Livestrong*

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