Health & Retirement Services Of Illinois

September 2012 Newsletter

OUR NEWS LETTER HRSI

HHS: Health law has saved seniors nearly $4B on medications

By Elise Viebeck - 07/25/12

The Obama administration touted the healthcare law Wednesday for saving seniors billions of dollars on prescription drugs.

The Medicare agency released figures showing that millions of seniors and people with disabilities have saved $3.9 billion on medications since the law was enacted.

The data also showed that since the beginning of the year, more than 1 million Medicare beneficiaries have saved an average of $629 on prescriptions in the "doughnut hole" coverage gap.

"Millions of people with Medicare have been paying less for prescription drugs thanks to the healthcare law," said Marilyn Tavenner, the head of the Centers for Medicare and Medicaid Services.

"Seniors and people with disabilities have already saved close to $4 billion. In 2020, the doughnut hole will be closed thanks to the Affordable Care Act."

To close the doughnut hole, the government will cover more and more of the value of brand-name and generic drugs until 2020, when seniors will be responsible for 25 percent of the cost for each.

The Supreme Court upheld the vast majority of the law on June 28, and on Tuesday, the Congressional Budget Office found that the ruling cut the law's cost by $84 billion.

In Our Newsletter

Join the remodeling trend with affordable projects

ConsumerReports.org

By Mary H.J. Farrell | ConsumerReports.org

Remodeling is expected to pick up by the end of this year and into 2013, according to a report released recently by Harvard University's Joint Center for Housing Studies. Annual homeowner improvement spending may reach double-digit growth by the first quarter of 2013, the report said, indicating that the outlook is finally improving after a few bad years.

"Home improvement activity has been bouncing around the bottom of this cycle for almost three years now, waiting for the industry to get some traction," said Kermit Baker, director of the Remodeling Futures Program at the Joint Center. "Now, the combination of low financing costs, stronger consumer confidence, improving home sales, and the perception that home prices have stabilized in most markets across the country are encouraging owners to start working on the list of home improvement projects they have been putting off."

If you've been putting off a remodeling project, Consumer Reports has updated Ratings of flooring, countertops, sinks, paint and a host of appliances as well as new remodeling guides for kitchens and bathrooms.

$1,000 bathroom makeover

You don't need to spend a lot to give a bathroom or kitchen a makeover. You can update a bathroom for as little as $1,000 by doing the following:

- Replace the vanity with a new wood model that has a stone counter.
- Add a new mirror and faucet.
- Replace your toilet and faucet and add a new vinyl floor.
- Improve lighting and ventilation with a new combination light and exhaust fan.
- Add a set of sconces on either side of the mirror or medicine cabinet.
- Update towel bars, hooks, toothbrush and toilet paper holders, and cabinet hardware.
- Switch your standard showerhead to one with multiple settings.
- Keep your towels toasty with a heated towel bar, some of which cost $100 or less.

$5,000 kitchen update

Spending $5,000 in the kitchen might not get you new cabinets but you can spruce up what you have now and also get new appliances or countertops. Here are some options:

- If the cabinets are structurally sound, you can give them a fresh coat of paint and improve capacity with inexpensive cabinet organizers.
- An island adds work and storage space whether it's a permanent unit with furniture-style looks or a small portable one on casters.

- The backsplash is a great place to add color or contrast. Paint is the simplest and cheapest option but tile only costs $10 to $40 per square foot installed.
- Salvage shops are stocked with new or gently used stone countertops, hardwood flooring, decorative lumber, kitchen cabinets, and stained glass.
- Improved efficiency, new features and styling, and make replacing your appliances tempting.
- Hard-wearing laminate countertops cost as little as $550 for an average-size kitchen, and trendy but tough quartz starts at $2,800. Add an engineered wood floor for less than $10 per square foot.
- Our tests have found that thinner stainless-steel sinks resisted dents, stains, scratches, and heat as well as thicker, more expensive ones. Get a faucet with a lifetime warranty that covers leaks and stains.
- Proper lighting makes a kitchen more inviting and safer. Undercabinet fixtures are the best source of task lighting. Update ceiling-mounted fixtures, especially dated fluorescent boxes.

2013 Medicare drug premiums expected to remain unchanged

Posted by: Colleen Stoxen Updated: August 6, 2012

The average basic premium for Medicare prescription drug plans in 2013 is projected to stay about the same as this year, about $30 a month, Health and Human Services Secretary Kathleen Sebelius said Monday. The average premium for this year, also projected at $30, ultimately averaged $29.67. The drug benefit took effect in 2006, and most of Minnesota's 700,000 beneficiaries receive the supplemental coverage, which is nearly free to very low income people.

Since Congress acted in 2010 to begin closing the "doughnut hole" gap in the benefit, beneficiaries have received an additional $3.9 billion savings on prescription drugs, an average of about $600 per person, Sebelius said.

The projection for 2013 premiums was based on bids submitted by drug companies and health plans for basic coverage. Open enrollment for next year begins Oct. 15 and ends Dec. 7, when beneficiaries who wish may change plans.

Medicare Beats Private Plans for Patient Satisfaction: Survey

People with individual or employer health plans paid more out of pocket, had worse access to care

THURSDAY, July 19 (HealthDay News) -- Older Americans enrolled in Medicare health plans have better access to care and are less likely to have problems paying their medical bills than people who insure themselves or receive coverage through their employers, according to a new study.

As the U.S. government considers proposals to cut Medicare spending, researchers from the Commonwealth Fund, a private health-policy advocacy foundation, cautioned that the health and financial security of people on traditional Medicare plans could suffer if policy makers move them to private Medicare Advantage plans. They noted that those enrolled in these private plans are less satisfied with their insurance and have more problems receiving the care they need.

"Policies designed to move the elderly out of Medicare and into private plans need to be carefully designed, so as not to expose beneficiaries to the poorer access to care currently experienced by many working-age adults with private insurance," said KristofStremikis, senior researcher at the Commonwealth Fund, in an organization news release.

The study was based on a 2010 health insurance survey conducted by the Commonwealth Fund that involved more than 4,000 U.S. adults.

Although only 8 percent of people with Medicare rated their insurance as fair or poor, 20 percent of adults covered by an employer-sponsored plan and 33 percent of those who purchase their own insurance reported dissatisfaction with their coverage.

In 2010, the study found, 23 percent of Medicare beneficiaries were unable to afford the care they needed. The same was true for 37 percent of those who received insurance through their jobs.

Meanwhile, those with employer-sponsored health plans and those who bought their own insurance were nearly twice as likely to report problems with their medical bills than people with Medicare, the study found.

The researchers said coverage of Medicare beneficiaries improved over the past decade, while access to care and problems with medical costs got worse for adults with other types of health plans.

People with individual or employer-sponsored health plans were much more likely to have high out-of-pocket expenses, the researchers said. Although 29 percent of older adults on Medicare reported spending 10 percent or more of their income on medical costs, 37 percent of those with employer-based insurance and 58 percent with individual insurance did the same.

Paying rent and buying food and other essentials was a problem for 27 percent of adults with employer-sponsored plans and 33 percent of those with individual insurance. On the other hand, 13 percent of Medicare beneficiaries were unable to pay for their basic necessities.

For Medicare patients, however, satisfaction with their coverage depends on whether they were enrolled in traditional Medicare plans or in Medicare Advantage plans that are offered by private insurance companies.

Although 15 percent of people with Medicare Advantage rated their insurance as fair or poor, just 6 percent with traditional Medicare felt the same way about their coverage.

People with Medicare Advantage plans also were more likely to have trouble affording their medical care than those with traditional Medicare. Thirty-two percent of those enrolled in Medicare Advantage had at least one problem with accessing care due to cost, compared with 23 percent of those with traditional Medicare.

"In the policy debates over the federal budget deficit, the affordability of Medicare and the expansion of health insurance through the Affordable Care Act, listening to the experiences of individuals -- whether covered by Medicare or private employer insurance -- is important," the study's authors wrote.

The researchers concluded that state insurance exchanges to be established in 2014 may be a way for states to offer traditional Medicare coverage to working-age adults.

"As we expand insurance and move toward near-universal coverage, it is imperative that we ensure health plans provide financial protection and good access to care," Karen Davis, president of the Commonwealth Fund, said in the release. "The achievements of Medicare in fulfilling the goals of health insurance coverage for beneficiaries can provide important lessons for the entire U.S. health system."

The study was published July 18 in the journal *Health Affairs*.

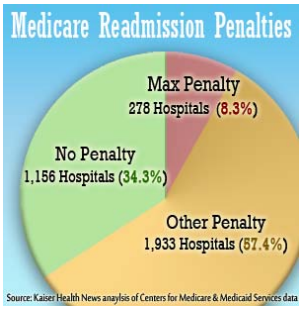
Medicare To Penalize 2,211 Hospitals For Excess Readmissions

By JORDAN RAU KHN Staff Writer AUG 13, 2012

More than 2,000 hospitals — including some nationally recognized ones — will be penalized by the government starting in October because many of their patients are readmitted soon after discharge, new records show.

Together, these hospitals will forfeit about $280 million in Medicare funds over the next year as the government begins a wide-ranging push to start paying health care providers based on the quality of care they provide.

With nearly one in five Medicare patients returning to the hospital within a month of discharge, the government considers readmissions a prime symptom of an overly expensive and uncoordinated health system. Hospitals have had little financial incentive to ensure patients get the care they need once they leave, and in fact they benefit financially when patients don't recover and return for more treatment.



Nearly 2 million Medicare beneficiaries are readmitted within 30 days of release each year, costing Medicare $17.5 billion in additional hospital bills. The national average readmission rate has remained steady at slightly above 19 percent for several years, even as many hospitals have worked harder to lower theirs.

The penalties, authorized by the 2010 health care law, are part of a multipronged effort by Medicare to use its financial muscle to force improvements in hospital quality. In a few months, hospitals also will be penalized or rewarded based on how well they adhere to basic standards of care and how patients rated their experiences. Overall, Medicare has decided to penalize around two-thirds of the hospitals whose readmission rates it evaluated, the records show.

More On Readmission Penalties

- Hospitals Treating The Poor Hardest Hit By Readmissions Penalties
- Readmissions Penalties By Hospital (PDF file)
- Readmissions Penalties By State
- Readmissions Penalties By Hospital By Region
- Sources And Methodology
- Download Data For All Hospitals (CSV file)

The penalties will fall heaviest on hospitals in New Jersey, New York, the District of Columbia, Arkansas, Kentucky, Mississippi, Illinois and Massachusetts, a Kaiser Health Newsanalysis of the records shows. Hospitals that treat the most low-income patients will be hit particularly hard.

A total of 278 hospitals nationally will lose the maximum amount allowed under the health care law: 1 percent of their base Medicare reimbursements. Several of those are top-ranked institutions, including Hackensack University Medical Center in New Jersey, North Shore University Hospital in Manhasset, N.Y. and Beth Israel Deaconess Medical Center in Boston, a teaching hospital of Harvard Medical School.

"A lot of places have put in a lot of work and not seen improvement," said Dr. Kenneth Sands, senior vice president for quality at Beth Israel. "It is not completely understood what goes into an institution having a high readmission rate and what goes into improving" it.

Sands noted that Beth Israel, like several other hospitals with high readmission rates, also has unusually low mortality rates for its patients, which he says may reflect that the hospital does a good job at swiftly getting ailing patients back and preventing deaths.

Penalties Will Increase Next Year

The maximum penalty will increase after this year, to 2 percent of regular payments starting in October 2013 and then to 3 percent the following year. This year, the $280 million in penalties comprise about 0.3 percent of the total amount hospitals are paid by Medicare.

According to Medicare records, 1,933 hospitals will receive penalties less than 1 percent; the total number of hospitals receiving penalties is 2,211. Massachusetts General Hospital in Boston, which U.S. News last month ranked as the best hospital in the country, will lose 0.5 percent of its Medicare payments because of its readmission rates, the records show. The smallest penalties are one hundredth of a percent, which 50 hospitals will receive.

Dr. Eric Coleman, a national expert on readmissions at the University of Colorado School of Medicine, said the looming penalties have captured the attention of many hospital executives. "I'm not sure penalties alone are going to move the needle, but they have raised awareness and moved many hospitals to action," Coleman said.

The penalties have been intensely debated. Studies have found that African-Americans are more likely to be readmitted than other patients, leading some experts to be concerned that hospitals that treat many blacks will end up being unfairly punished.

Hospitals have been complaining that Medicare is applying the rule more stringently than Congress intended by holding them accountable for returning patients no matter the reason they come back.

Hospitals That Serve Poor Are Hit Harder Than Others

Some safety-net hospitals that treat large numbers of low-income patients tend to have higher readmission rates, which the hospitals attribute to the lack of access to doctors and medication these patients often experience after discharge. The analysis of the penalties shows that 76 percent of the hospitals that have a lot of low-income patients will lose Medicare funds in the fiscal year starting in October. Only 55 percent of the hospitals treating few poor patients are going to be penalized, the analysis shows.

"It's our mission, it's good, it's what we want to do, but to be penalized because we care for those folks doesn't seem right," said Dr. John Lynch, chief medical officer at Barnes-Jewish Hospital in St. Louis, which is receiving the maximum penalty.

"We have worked on this for over four years," Lynch said, but those efforts have not substantially reduced the hospital's readmissions. He said Barnes-Jewish has tried sending nurses to patients' homes within a week of discharge to check up on them, and also scheduled appointments with a doctor at a clinic, but half the patients never showed. This spring, the hospital established a team of nurses, social workers and a pharmacist to monitor patients for 60 days after discharge.

"Some of the hospitals that are going to pay penalties are not going to be able to afford these types of interventions," said Lynch, who estimated the penalty would cost Barnes-Jewish $1 million.

Atul Grover, chief public policy officer for the Association of American Medical Colleges, called Medicare's new penalties "a total disregard for underserved patients and the hospitals that care for them." Blair Childs, an executive at the Premier healthcare alliance of hospitals, said: "It's really ironic that you penalize the hospitals that need the funds to manage a particularly difficult population."

Medicare disagreed, writing that "many safety-net providers and teaching hospitals do as well or better on the measures than hospitals without substantial numbers of patients of low socioeconomic status." Safety-net hospitals that are not being penalized include the University of Mississippi Medical Center in Jackson and Denver Health Medical Center in Colorado, the records show.

Bill Kramer, an executive with the Pacific Business Group on Health, a California-based coalition of employers, said the penalties provide "an appropriate financial incentive for hospitals to do the right thing in terms of preventing avoidable readmissions."

The government's penalties are based on the frequency that Medicare heart failure, heart attack and pneumonia patients were readmitted within 30 days between July 2008 and June 2011. Medicare took into account the sickness of the patients when calculating whether the rates were higher than those of the average hospital, but not their racial or socio-economic background.

The penalty will be deducted from reimbursements each time a hospital submits a claim starting Oct. 1. As an example, if a hospital received the maximum penalty of 1 percent and it submitted a claim for $20,000 for a stay, Medicare would reimburse it $19,800.

The Centers for Medicare & Medicaid Services has been trying to help hospitals and community organizations by giving grants to help them coordinate patients' care after they're discharged. Leaders at many hospitals say they are devoting increased attention to readmissions in concert with other changes created by the health law.

Sally Boemer, senior vice president of finance at Mass General, said she expected readmissions will drop as the hospital develops new methods of arranging and paying for care that emphasize prevention. Readmissions "is a big focus of ours right now," she said.

Gundersen Lutheran Health System in La Crosse, Wis., and Intermountain Medical Center in Murray, Utah, were among 1,156 hospitals where Medicare determined the readmission rates were acceptable. Those hospitals will not lose any money. On average, the readmissions penalties were lightest on hospitals in Utah, South Dakota, Vermont, Wyoming and New Mexico, the analysis shows. Idaho was the only state where Medicare did not penalize any hospital.

Even some hospitals that won't be penalized are struggling to get a handle on readmissions. Michael Baumann, chief quality officer at the University of Mississippi Medical Center, said in-house doctors had made headway against heart failure readmissions by calling patients at home shortly after discharge. "It's a fairly simple approach, but it's very labor intensive," he said.

The problems afflicting many of the center's patients—including obesity and poverty that makes it hard to afford medications—make it more challenging. "It's a tough group to prevent readmissions with," he said.

BOOMERS FACE BURDEN OF PARENTS' LONG-TERM HEALTHCARE COSTS

New

CFP(R) Practitioner Forbes *August 13, 2012*

Boomers are confronting a new and unpleasant possibility: being forced–legally –to pay long-term-care expenses racked up by their parents.

How is this possible, you may ask? Filial-support laws on the books in 29 states are being dusted off and can be enforced – laws that entitle e.g. a nursing home to recover expenses from adult children if e.g. Medicaid does not pay them.

Recently in Pennsylvania, an adult son was required to pay an outstanding $92,943 bill that his mother's nursing home presented to him. On May 7, 2012, the Pennsylvania Superior Court upheld a lower court decision (Health Care & retirement Corp. of America v. Pittas) that allowed a nursing home to seek payment from a family member (adult son) for costs his mother incurred from 9/2007-4/2008....because he was considered to be of sufficient means to pay the $92,943 tab. (The son's 2009 income was $85,000). His mother had applied to Medicaid to cover this bill but the nursing home successfully sued the adult son for payment before the Medicaid claim was resolved.

A New Jersey man paid a nursing home 5 months of expenses because his uncle accidentally breached the Medicaid assets limit when his Social Security payments accumulated in a bank account. This uncle was childless so his NJ nephew was deemed the closest living relative. The nursing home was supposed to monitor the account collecting Social Security payments to insure they didn't breach limits and trigger Medicaid disqualification. Even though the nursing home dropped the ball for some months (during which time Medicaid refused to pay nursing care costs), they went after the NJ nephew. The NJ man could have sued but decided instead to pay the nursing home the $30,000+ tab to avoid further "aggravation."

At a time when filial responsibilities in the US seem weak, recent events are a wake-up call to both Boomers *and* financial planners:

1. Boomers already juggling college expenses and retirement for themselves have not necessarily paid much attention to their parents' potential long-term care needs – because it was assumed Medicaid would step in if parents spend down virtually all their assets. Boomers may feel they don't have the means to cover this potential liability, but a court may disagree!
2. More Boomers and parents need to have "the talk" - since many Boomers don't know if they parents have long-term care insurance or not. If they don't, perhaps they still can be insured. If so, perhaps this is an expense an adult child/children need to pick up for their parents if they can't afford it themselves.
3. If parents DO have long-term care insurance, it should be reviewed by a qualified professional (someone who does NOT benefit from selling a new policy) to see if coverage is adequate or not. I

have a number of clients who came to me with insufficient long-term care insurance which I have augmented with an additional policy that adult children pay for.

4. Many aging parents of Boomers may resent and resist having adult children discuss their financial situation but the new, uncomfortable reality that adult children DO have the responsibility and right to clarify their parents' financial matters. In the case of John Pittas (the adult son required to pay the $92,943 nursing home bill), he said "At the time [his mother received care], I didn't even they that they [my parents] were very poor and basically living off of my father's Social Security check."
5. Some cultures (e.g. South Asians resident in the US) think they have the issue of care for parents covered if "Mom and Dad live with us" – but doing so may not cover all of their parents' long-term care needs. What happens once Mom or Dad can no longer perform 2 or more of the daily living skills alone (e.g. feeding, bathing, dressing)? Long-term care insurance can cover care at home, too – not just nursing home care.

In addition to Boomers and their parents, here are some of the other professionals who should be involved in the new reality of long-term care needs:

1. Fee-Only financial advisors (that is, financial advisors who don't sell products). A Fee-Only planner can be the first person you consult – he/she should be a neutral professional who listens to all parties and can help determine next steps. Potentially acrimonious family discussions sometimes are diffused by the presence of a paid professional.
2. Long-term
   care insurance specialists
3. Elder care and/or estate planning attorneys

CDC to baby boomers: Get tested for hepatitis C

By MIKE STOBBE, AP Medical Writer

ATLANTA (AP) — All baby boomers should get a one-time blood test to learn if they have the liver-destroying hepatitis C virus, U.S. health officials said Thursday.

It can take decades for the blood-borne virus to cause liver damage and symptoms to emerge, so many people don't know they're harboring it. Baby boomers account for about two-thirds of the estimated 3.2 million infected Americans.

More than 15,000 Americans die each year from hepatitis C-related illnesses and the number has been growing, according to the Centers for Disease Control and Prevention.

"Unless we take action, we project deaths will increase substantially," said CDC Director Dr. Thomas Frieden, in a call with reporters.

Hepatitis C virus is most commonly spread today through sharing needles to inject drugs. Before widespread screening of blood donations began in 1992, it was also spread through blood transfusions.

The virus can gradually scar the liver and lead to cirrhosis or liver cancer, and is the leading cause of liver transplant. It can trigger damage in other parts of the body, as well.

It's possible some people were infected in ways other than dirty needles or long-ago blood transfusions. Some experts say tattoos, piercings, shared razor blades and toothbrushes, manicures and sniffed cocaine may have caused the virus to spread in some cases.

However it happened, health officials say baby boomers are five times more likely to be infected than other adults.

Officials said they decided to issue the recommendations after seeing the number of Americans dying from hepatitis C-related diseases nearly double from 1999 to 2007.

Another reason: Two drugs hit the market last year that promise to cure many more people than was previously possible.

Previously, testing was recommended only for people considered at highest risk, like current and former injection drug users.

About 3 percent of baby boomers test positive for the virus, the CDC estimates. Of those, some manage to clear the infection from their bodies without treatment, but still have lingering antibodies that give a positive initial test result. That's why confirmatory tests are needed.

Still, only a quarter of infected people are that lucky. Most have active and dangerous infections, health officials said.

"I have met too many patients who were diagnosed with hepatitis C at the time they developed liver cancer or when they needed a liver transplant," said Dr. Andrew Muir, a Duke University physician who is a leader in an advocacy organization called the National Viral Hepatitis Roundtable.

The CDC call for testing is "a bold and important move," Muir said in a statement.

The recommendation applies to people born from 1945 to 1965 who have not already been tested. They should get a blood test at their next visit to the doctor, Frieden said.

The CDC proposed the new guidelines earlier this year and made them final on Thursday.

More Older Adults With Multiple Problems

By PAULA SPAN August 16, 2012

I do look for good news, for promising trends for our elders and ourselves, honest. Whenever I can, I report on things like the potential health benefits of caregiving.

But there's a whole lot of the other kind of news, and — sorry! — here's a bit more: The Centers for Disease Control and Prevention has reported stiff increases in the proportion of older adults with "multiple chronic conditions" — more than one of the diseases that commonly affect this population. During the decade that ended in 2010, according to the agency's large national survey, the percentage of adults over age 65 who reported both hypertension (high blood pressure) and diabetes jumped to 15 percent from 9 percent; those with hypertension and heart disease bumped up to 21 percent from 18 percent; and the prevalence of hypertension and cancer climbed to 11 percent from 8 percent.

These are statistically significant increases, found across all racial and ethnic groups examined — blacks, whites, Hispanics — and most income groups. By 2009-10, 45 percent of the respondents older than 65 had two or more chronic diseases, including stroke, emphysema, asthma and kidney disease. A decade earlier, only 37 percent did.

That's alarming, because people with more than one chronic disease have a harder time managing their health. They're more likely to be hospitalized. They fill more prescriptions and make more doctors' visits. They cost themselves and the nation more.

Yet this is hardly a problem restricted to the elderly, as the C.D.C. reports. Among adults ages 45 to 64, rates of multiple chronic conditions climbed significantly as well, also crossing racial and income categories. In the middle-aged group, the proportion with multiple diseases rose to 21 percent from 16 percent a decade earlier.

C.D.C. researchers speculated that widespread obesity could contribute to the change. So may the improved medical care that keeps people alive with multiple diseases that, in previous generations, might have killed them.

But money appears to play a role, too. Look at this vast difference in the proportion of people who reported delaying or forgoing medical care in the past year because of costs: Only about 7 percent of those over age 65 did so, not a significant increase from a decade before. But nearly a quarter of those ages 45 to 64 said they had, a significant jump. They've also grown more likely to forgo prescription drugs.

Score one for the nearly universal health insurance that older people have through Medicare. Without it, the numbers might be even scarier.

Yet a separate study recently published in The Journals of Gerontology suggests another factor: We largely fail to take certain obvious steps to improve our health, even after a diagnosis of a serious chronic disease. Some of the most common and dangerous diseases in the United States are modifiable or preventable by changes in the way we live.

This picture also emerges from a broad national database — the United States Health and Retirement Study — which tracks those ages 50 to 85. Led by Jason Newsom, a health psychologist at Portland State University in Oregon, the researchers looked at three key health behaviors over 10 to 14 years after a diagnosis of heart disease, diabetes, cancer, stroke or lung disease.

The biggest change came in smoking after a heart disease diagnosis; 40 percent of smokers quit at that point. Of course, that means that most smokers with heart disease didn't. Fewer than 20 percent of smokers with lung disease gave up cigarettes. The decrease in excessive alcohol consumption was small. Rates of regular vigorous exercise (at least three times a week), though it's recommended for those conditions, didn't improve at all.

Over all, the study concluded, "the vast majority of individuals do not make major lifestyle changes following diagnosis of a serious chronic disease, either in the short term or in the long term."

Let's not pile all the blame on sick people for failing to do what might make them less sick. "Changing your daily behavior is one of the hardest things you can do," Dr. Newsom acknowledged in an interview. "We're creatures of habit."

Yet smoking cessation (which Medicare covers) and other behavioral programs do enable people to change. In this study, most of those who stopped smoking, curbed excessive drinking or exercised regularly were able to maintain those behaviors; relapse rates were low.

Even after a frightening diagnosis, especially after one, these are changes worth making. "If you've had a heart attack and you stop smoking, you cut your risk of another heart attack in half," said Dr. Newsom.

The C.D.C. data suggests that people are more apt to get treatment when they can pay for drugs and doctors. Maybe, 10 years hence, we'll see that broader health insurance coverage has made a difference. Meanwhile, we can help ourselves — although the Oregon study shows how seldom we do.

Looking to save on prescriptions? It's complicated

BY LINDA A. JOHNSON Posted on Wednesday, 08.15.12 AP BUSINESS WRITER

HealthWarehouse holds costs down by getting volume discounts directly from manufacturers. It sells about 3,500 drugs for people as well as pets, including refrigerated medicines. On the third Friday of each month - this Friday - it offers a free prescription worth up to $500 to new customers or patients submitting a new prescription.

If you're shopping online, avoid sites that don't require a prescription. That's illegal and they likely to be selling potentially dangerous counterfeit drugs.

Stick with sites with a blue-and-red Verified Internet Pharmacy Practice Sites seal. They have been checked out by an association of state boards that license U.S. and Canadian pharmacies. The group lists approved Internet pharmacies at www.nabp.net/programs/accreditation/vipps/find-a-vipps-online-pharmacy.

DISCOUNT CARDS

Scores of discount cards are available online, generally for free. Most are good for a variety of medicines, including generic drugs, at tens of thousands of U.S. pharmacies. But each card could offer a huge discount on one drug and only a couple dollars or nothing at all off another.

The pharmacies provide discounts so they'll remain competitive, particularly with cards offered by huge groups such as AARP and AAA. The prices generally are negotiated by third parties such as prescription benefit managers that already work with a huge network of pharmacies, according to consumer advocate Edgar Dworsky.

"Different stores, different cards, different drugs all yield different prices," sometimes varying by 100 percent or more, noted Dworsky, who runs the site www.ConsumerWorld.org.

He just completed a survey, at www.consumerworld.org/pubs/prescriptiondrugcardsprs.pdf, showing how difficult it can be to compare prices using different discount cards for specific drugs. Most pharmacists won't do multiple price lookups because their automated systems usually require them to first enter all the doctor, patient and medication information and sometimes charges them for each lookup. So first promise you will fill the prescription, Dworsky said.

He generally found that paying cash at Costco was cheaper than using a discount card. That's partly because the operation sponsoring each discount card, the company organizing the pharmacy network and the individual pharmacy each take a small transaction fee.

-One of the cards with the best prices, according to Dworsky, is at www.needymeds.org.

Its president, Dr. Richard Sagall, said the site's discount card has average savings of 45 percent to 50 percent and also covers some pet and nonprescription medicines.

The site also has links to more than 1,000 discount coupons, scholarships and camps for children and adults with a particular disease, more than 10,000 clinics providing medical care for free or low cost, and other help.

Sagall notes that unlike other discount cards, his site's card doesn't require people to provide personal information that can be used for marketing purposes. The site even has a link to download a free book on how to save on prescription medicines.

COMPARISON SHOP

Given the huge variation in prices with different programs, do as much comparison shopping as possible.

Some state health departments run websites that enable residents to comparison shop at pharmacies in their area, but they may not include information on manufacturer coupons or available discount cards.

Another option is www.goodrx.com, which also has an iPhone application. After you enter your drug name and zip code, it lists prices at numerous area pharmacies, along with printable coupons needed to get those prices.

Once you've found the best deals for your medicines, don't assume you're set for good. If prices for your drugs rise down the road, do your homework again.

The Deadly Disease Most Women Ignore

By Lisa Collier Cool Aug 22, 2012

Rosie O'Donnell says it's a "miracle" that she survived, after ignoring heart-attack warning signs because she didn't recognize her danger. When the former talk-show host, 50, developed soreness and aching in her chest and arms after helping "an enormous woman" out of a car, she chalked it up to muscle strain.

When the ache persisted—and she became nauseated with clammy skin—O'Donnell was worried enough to Google women's heart attack symptoms. "I had many of them, but really? –I thought – naaa," she wrote in her blog. **Like 50 percent of women who have heart attacks,** she didn't call 911. Instead, she took an aspirin, then waited until the next day to get help for what turned out to be a 99 percent blockage in her LAD coronary artery, a type of heart attack called the "widow-maker."

The Myth that Puts Women's Lives at Risk

Often thought of as a man's problem, heart attacks kill 267,000 American women annually: more than all forms of cancer combined. **Every year since 1994, heart attacks have killed more US women than men.** Yet many women still think that breast cancer (which kills 40,800 women a year) is their biggest health threat.

Most women—and even doctors—don't know the gender-specific symptoms of a heart attack, says cardiologist Noel BaireyMerz, MD, director of the Barbra Streisand Women's Heart Center at the Cedar Sinai Heart Institute. "Fewer than half of women have the classic Hollywood heart attack with crushing chest pain—often described as feeling like an elephant is sitting on you—that's typical in men."

Women's Heart Attack Symptoms Often Misdiagnosed

Instead, women typically have less dramatic heart attack symptoms that may not include *any* chest pain. As a result, women are misdiagnosed at a far higher rate than men—and are more likely to die after a heart attack than men are, according to a new studyof 1.4 million heart attack patients.

"Relatively young women like Rosie O'Donnell have the highest rate of heart-attack fatalities, because their symptoms are frequently misdiagnosed," both by women themselves and by emergency physicians, says Dr. Merz.

One shocking study reported that up to 50 percent of the time, women's heart attack symptoms go unrecognized by emergency and medical professionals. And nearly two-thirds of heart attack deaths in women occur in women with

Young Women Also At Risk

If you think you're too young to have a heart attack, here's what you need to know: Of the 435,000 American women who have heart attacks annually, 83.000 are under age 65 and 35,000 are under age 55. Under age 50, women's heart attacks are twice as likely to be fatal as in men.

To protect yourself, get checked for such common risk factors as high blood pressure, high cholesterol, and high blood sugar. Alert your doctor if you have a family history of heart disease, particularly if relatives were affected at an early age. A healthy diet, regular exercise, and keeping your weight down are the best ways to trim heart attack risk.

And if you smoke, here's yet another reason to kick the habit: **Women who smoke risk having a heart attack 19 years earlier than non-smoking women.**A study that tracked nearly 120,000 women ages 30 to 55 for 12 years found that those who smoked were *four times*more likely to suffer a heart attack or die from heart disease than the nonsmokers.

Seven Warning Signs Women Should Never Ignore

Because most heart attack research has focused on men, adds Dr. Merz, "symptoms that are extremely common in women are called 'atypical,' when they're only atypical in men. Lack of awareness of women's warning signs—and not getting health care soon enough—are major contributors to why heart attacks kill more women than men every year."

When a heart attack strikes, getting medical help within the first hour reduces the risk of dying by 50 percent. If you have any of these warning signs, call 911**.**

- **Shortness of breath**. During a heart attack, or in some cases, days or even weeks preceding the attack, many women report gasping as if they'd just run a marathon or having trouble talking, one study reported.
- **Non-chest pain**. Instead of an explosive pain in the chest, women may develop less severe pain in the upper back, shoulders, neck, jaw, or arm. "Get immediate medical help if you have any unusual symptom above the waist, even if it's not in your chest," advises Dr. Merz.
- **Unusual fatigue**. In one study of female heart attack survivors, 71 percent experienced unusual fatigue in the days and weeks before the attack—often so extreme that the women were too fatigued to make their bed, lift a laptop, or walk to the mailbox.
- **Heavy sweating.** Women may be suddenly drenched with sweat for no apparent reason. Frequently, women feel both hot and chilled, with clammy skin, during a heart attack, as happened to O'Donnell.
- **Nausea or dizziness.** During an attack, women frequently vomit or feel like they're going to faint. The nausea can also feel like heartburn, says Dr. Merz.
- **Anxiety.** Many women experience a feeling of impending doom or intense fear before or during a heart attack. Heeding that inner warning can be lifesaving.

Doctor Shortage May Swell to 130,000 With U.S. Cap

By Alex Wayne - Aug 28, 2012

With a shortage of doctors in the U.S. already and millions of new patients set to gain coverage under President Barack Obama's health-care overhaul, Americanmedical schools are struggling to close the gap.

One major reason: The residency programs to train new doctors are largely paid for by the federal government, and the number of students accepted into such programs has been capped at the same level for 15 years. Medical schools are holding back on further expansion because the number of applicants for residencies already exceeds the available positions, according to the National Resident Matching Program, a 60-year-old Washington-based nonprofit that oversees the program.

Enlarge image 

Christian Burke/UCSF via Bloomberg

Students participate in a team session at The Kanbar Center for Simulation, Clinical Skills and Telemedicine Education at the University of California at San Francisco (UCSF).

Students participate in a team session at The Kanbar Center for Simulation, Clinical Skills and Telemedicine Education at the University of California at San Francisco (UCSF). The bottleneck will likely affect efforts at health-care reform, spreading doctor shortages that now largely affect rural communities to all parts of the country in the next decade. Patients will probably have to wait to see doctors if they can find room at all, undermining the prospect of cutting health costs through more preventative care.

"The training programs know that they are not now able to train the numbers of physicians that are going be needed," saidTom Price, a Republican congressman from Georgia. "We need to be proactive on this as opposed to reactive. We're actually already later than we should be in addressing the issue."

The 2010 Affordable Care Act's insurance expansion takes effect at a time when the U.S. has 15,230 fewer primary-care doctors than it needs, according to an Aug. 28 assessment by theDepartment of Health and Human Services. The Association of American Medical Colleges predicts the shortage, including specialists, will climb to 130,000 by 2025.

Training Costs

The cost of training one new resident, meanwhile, has grown to about $145,000 a year, said Atul Grover, chief public policy officer for the Washington-based medical colleges group.

There's no easy solution. Boosting the number of taxpayer-financed training slots beyond 85,000 would require Congress to allocate money at a time of contentious budget debates. Adding private financing means tapping new sources of cash, such as from health insurers. Importing doctors from overseas is controversial. And training doctors is long-term work, taking as many as 10 years.

Teaching hospitals quadrupled their lobbying budget last year to $2.8 million, according to the nonprofit Center for Responsive Politics in Washington. They support bipartisan legislation introduced this month that would add 3,000 residencies a year through 2017 at a cost to taxpayers of about $9 billion. Deficit-watching Republicans, including Price, say private funding needs to be identified instead.

'**Fundamental Reform'**

"The problem is the structure of the program is no longer adequate," said Price, who is also an orthopedic surgeon, in a telephone interview. "What we need I believe is fundamental reform of the funding stream."

The influx of as many as 30 million new patients into medical offices starting in 16 months with the health-care law is igniting the debate over training doctors. Medicare now funds more than 75 percent of doctor residencies, a level capped by Congress in 1997.

In the U.S., medical students must undergo a residency at a teaching hospital of three to seven years, depending on their specialty, according to the American Medical Association. During this time, they train under the supervision of other doctors as a prerequisite to board testing that certifies them to practice on their own.

Teaching hospitals pick up the funding for about 10,000 positions annually, Grover said in a telephone interview.

Pressured Fees

Those residencies are paid for using fees from clinical services that are increasingly under pressure, he said. Federal Medicare payments have been cut by the health-care law while hard-pressed states, facing deficits of their own, have been trimming reimbursements for Medicaid, he said.

With private insurers following suit in a tough economy,"our belief is we're not going to have the clinical revenue needed to invest in additional slots," Grover said.

The bottom line, he said, is that "we're going to have to find ways to see more patients with fewer physicians" once the health-law's insurance expansion kicks in.

Representatives Allyson Schwartz of Pennsylvania, a Democrat, and Aaron Schock of Illinois, a Republican, are co-sponsoring the legislation to increase the residency cap.

"It is an expense that is necessary," Schwartz said in an interview. "We've seen an increase in the number of doctors that medical schools are training in this country. There's not an adequate number of residencies" to handle that increase.

Radical Change

The existing shortage is based on an ideal of roughly one primary-care physician for every 2,000 people, according to the health department's Health Resources and Services Administration, which seeks to boost access to medical services.

Estimates of future shortages calculated before passage of the Affordable Care Act "obviously couldn't be aware of all the changes that were put in play," Ed Salsberg, who directs the health department's National Center for Health Workforce Analysis, said in a phone interview. "There is a real need for new estimates that take more recent developments into account."

When Congress capped Medicare-funded residencies, policy makers thought the U.S. had an excess of slots and wouldn't need more doctors in the future because "everyone believed the health care system was going to change radically" with the advent of managed care, Grover said. That never happened.

Medicare Payments

Medicare, the government-run health program for the elderly and disabled, spent about $9.8 billion to support residents at teaching hospitals in 2009, the most recent figure available from Grover's organization. While spending for residents has increased 54 percent since 1998, total Medicare spending has grown faster, making support for doctor training a smaller fraction of the program.

Exacerbating matters is the budget-conscious climate in Washington. The leaders of Obama's fiscal commission, who issued a debt-reduction plan in December 2010, said Medicare should cut support for teaching hospitals by $6 billion in 2015, "bringing these payments in line with the costs of medical education."

The Medicare Payment Advisory Commission, which monitors the program's spending, said in March that extra Medicare payments to the hospitals are "substantially larger" than the cost of training doctors and treating low-income patients.

Mike Rossi, director of government reimbursement for the University of Pennsylvania Health System, said that assessment is an oversimplification.

Medicare paid about $120 million in 2011 to support 855 of the school's resident doctors, Rossi said. The health system spent about $96 million last year on residents' direct expenses, such as salaries, benefits and malpractice insurance. Indirect costs, mainly "clinical inefficiencies," such as performing multiple tests on patients to instruct residents, added to the tally, Rossi said.

'Dramatically Underfunded'

Medicare is "barely covering the cost at this point of what it takes to train somebody," said Lisa Bellini, director of the University of Pennsylvania's Office of Graduate Medical Education, in a phone interview. Teaching hospitals that don't have as many Medicare patients as the University of Pennsylvania are "being dramatically underfunded," she said.

Representative Price said keeping the residency program funded through Medicare is "no longer a feasible solution." He said legislation to address the issue hasn't advanced yet in Congress because of larger budget concerns and the "general lack of knowledge" about the challenges the program faces.

Here's where Medicare could really save some money

Tue Aug 28, 2012

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

By Mark Miller

(Reuters) - Question: What do you call Obamacare's $716 billion cut in Medicare spending during the next decade?

Answer: A good start - and not because seniors don't deserve their Medicare benefits.

The Affordable Care Act (ACA) achieves those spending cuts over 10 years by decreasing payments to Medicare providers. The Republican Party, which is expected to vote today on its platform at its Tampa convention, is likely to adopt the Romney-Ryan health care plank calling for fundamental changes in Medicare and restoration of the $716 billion by repealing the ACA. Democrats, and some health care experts, charge that their plans would boost seniors' out-of-pocket costs for prescription drugs and premiums, and end Medicare as we know it.

But the smoke from the presidential campaign battle obscures an important fact. Obama's Medicare reimbursement cuts are no more than a down payment on a vital project: Getting our nation's health care spending in line with the rest of the industrialized world.

In 2010, the U.S. spent 18 percent of its gross domestic product on health care, about seven percentage points higher than the average for all other industrialized countries, according to the Organization for Economic Cooperation and Development (OECD). Our rate of spending growth for health care is double that of other OECD nations. We're spending $2.5 trillion a year on health care, and researchers who study the health care system estimate that about one-third of every dollar we spend doesn't do anything to improve health.

Here are some of the top targets for greater efficiency and better care - along with estimated annual savings from an authoritative 2009 research project convened by the Institute of Medicine (IOM), the health arm of the not-for-profit National Academy of Sciences. IOM invited leading health care experts to present and discuss research papers on the nature of excess health costs, and evidence on the effectiveness of strategies for controlling them.

PAY FOR VALUE, NOT VOLUME

The current U.S. health care system's reliance on fee-for-service reimbursement encourages health care providers to provide more - not better - care. That could be fixed by paying providers for performance. "The idea is to get providers away from an incentive to just turn the crank faster and faster," says John Rother, chief executive officer of the National Coalition on Health Care (NCHC), a non-profit reform coalition of medical professionals, businesses, organized labor and other groups.

A better approach is to pay providers for performance - outcomes, quality and efficiency. The ACA funds pilot programs for several promising models for this, including incentives for providers to form so-called "Accountable Care Organizations" and patient-centered medical homes. But the transition won't be easy, notes Paul Ginsburg, who served on the IOM panel and is president of the Center for Studying Health System Change.

"The biggest obstacle is the need for coordination between all the different payers, because you don't want to put providers in a situation where half of their patients are fee-for-service, and the other half are in a pay-for-performance model."

The practical application of this model is far in the future. "It's really a dream that is being pursued," says Ginsburg.

IOM's estimated potential annual savings: $210 billion.

COORDINATE CARE FOR THE VERY ILL

A disproportionate share of Medicare dollars are spent taking care of the sickest patients. The non-profit Kaiser Family Foundation reports that 10 percent of fee-for-service Medicare beneficiaries accounted for 58 percent of total Medicare spending. Average per capita Medicare spending for these beneficiaries was $48,210, compared with average per capita spending of $3,910 among the bottom 90 percent.

The IOM research found that major savings could be achieved by doing a better job of coordinating their care. "Today, very ill patients with multiple chronic conditions often receive care in a very fragmented way from different physicians who aren't talking to one another," Rother says. "The result is not only over-treatment but often unnecessary hospitalization."

IOM's estimated potential annual savings: $80 billion.

PREVENTION & LIFESTYLE

Many chronic conditions stem from individual behavior, including obesity, drinking, and drug abuse. That means we spend health care dollars on medical conditions that could be prevented through adoption of healthier lifestyles. But Ginsburg emphasizes that the opportunity here is to change lifestyles, rather than provide medical services.

"We've had a lot of success over a long period of time with smoking reduction," Ginsburg says. "Obesity is much more challenging to figure out."

IOM's estimated potential annual savings: $55 billion.

PAY HOSPITALS LESS

Half of every health care dollar in the U.S. goes to hospitals, Rother says, and many simply charge too much. The cost of inpatient services in the U.S. is 164 percent of the group average for 12 OECD countries, and 45 percent higher than what Canada pays, OECD data shows.

Medicare already uses a system of set prices for procedures, called diagnosis-related groups. But in the commercial insurance arena, more competitive market forces could bring down prices. Ginsburg argues that insurers and employers need to focus on restructuring their provider networks. "We need insurers to evolve their benefit designs to increase incentives to enrollees for using more efficient, lower-priced providers," he says. "That could include narrower networks of providers, or tiered plan designs, where all the hospitals are in the network but enrollees have incentives to go to hospitals that provide higher value."

That's a tall order, Ginsburg notes, especially in markets where a single hospital has dominant market share or pricing power, based on reputation.

IOM's estimated potential annual savings: $85 billion.

ATTACK FRAUD & ABUSE

No one is quite sure how much money is wasted through fraud and abuse in the health care system, but in Medicare alone, estimates run as high as $98 billion a year. The ACA gave the federal government several new tools for fighting fraud, including reforms in payment processes, and consolidation of fraud-fighting initiatives. Last year, the government recovered $4.1 billion, the most ever recovered in a single year - but only a fraction of the estimated total loss.

An FBI investigation in 2007 estimated that fraud and abuse accounted for anywhere from 3 percent to 10 percent of total health care spending. "We know there is a lot of it out there," Rother says. "For every dollar we put into anti-fraud efforts, we get $10 back in savings."

IOM's estimated potential annual savings: $75 billion.

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