Health & Retirement Services of Illinois

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OUR NEWS LETTER

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Why ACA's auto-enroll tool may not be best for your clients

by Caitlin Bronson | Jul 28, 2014

Naperville, Ill.-based producer Mark Brown was pleased when he heard about the new auto-enrollment tool proposed by the Department of Health and Human Services. Brown believes the tool, which will automatically re-enroll policyholders in their existing insurance plan, will eliminate some of the hassle he has come to associate with the Affordable Care Act.

"No one liked signing up the first time," Brown said. "They will like it less the second, especially if there is an increase in their premium."

The auto-enrollment tool is set to go forward through the federal Healthcare.gov, with a choice to adopt the tool in states running their own health insurance marketplaces.

Major healthcare research firm Avalere believes higher premiums are exactly what clients will end up facing, however—especially if the auto-enroll tool goes forward. Jenna Stento, a senior manager at Avalere, told Kaiser the new feature "could conceivably mean people will pay more in premiums unless they proactively take steps to comparison shop."

As it turns out, the 87% of Americans who used federal subsidies to help pay premiums for their newly minted exchange plans face some complicated issues in automatic re-enrollment. Namely, much higher premiums and out-of-pocket costs.

That's because federal subsidies are attached to so-called Silver plans, which operate as the "benchmark plan" in the US. However, according to an Avalere estimate, these plans will cost 8% more in 2015, meaning a new, lower-priced plan will become the new benchmark for federal subsidies.

If clients are automatically re-enrolled in what was previously a benchmark plan, they could see federal subsidies remain the same while overall out-of-pocket costs increase.

To illustrate the point, Avalere offered the hypothetical case of a Maryland resident named "Sue." Last year, Sue enrolled in a benchmark Silver plan in her region with a monthly premium of $214. Based on her income, her contribution was set at $58, qualifying her for a federal subsidy of $156 to make up the difference.

Even if Sue had chosen a plan with a higher premium, her federal subsidy would have remained the same. However, she would have had to pay more out of her own pocket.

In 2015, however, the fluctuation in premium price means Sue's plan is no longer the "benchmark" plan in her area. In fact, it is the ninth-lowest of 18 Silver plans, with a new monthly premium of $267. The new benchmark plan costs $231 for a monthly premium. Sue's contribution will remain the same, qualifying her for a higher federal subsidy of $173 to make up the difference between her $58 and the $231 monthly premium for the "standard" plan.

Automatically re-enrolling with that carrier means she will have to pay another $36 a month to maintain her previous plan—something that could be surprising to Sue as she assumes all things will remain the same.

And that's not just characteristic of Maryland. In its research, Avalere investigated premiums and plans in nine states, with eight heading for new benchmark plans.

The bottom line?

Producers working with clients in states with new benchmark plans shouldn't be so quick to default to the auto-enroll.

"There could be significant financial value to take a look at the site and see if there might be more affordable options for you, given the changes since last year," Steno concluded.

10 low-tax places to retire

By Emily Brandon

Taxes will likely be a big part of your retirement budget, unless you live in a state that offers tax

breaks to retirees. These states don't tax Social Security or many other types of retirement income, according to an analysis of state taxation of retirement benefits by Wolters Kluwer.

Alaska

If you can get past the cold weather, Alaska is a tax haven for retirees. Alaska has no income tax or sales tax, and the state doesn't tax pension or Social Security income.

Florida

Joelk75/Flickr

Florida offers generally pleasant weather and access to the beach, in addition to tax breaks for retirees. Seniors in Florida don't need to pay taxes on their Social Security or pension payments, and there's no state income tax. But the state sales tax rate is 6 percent.

Illinois

REUTERS/Jim Young

Income from federally qualified retirement plans, individual retirement accounts, certain capital gains on employer securities and Social Security are excluded from taxation in Illinois. However, the state sales tax is 6.25 percent, and property taxes can be higher than in other states.

Mississippi

Ken Lund/Flickr

Although Mississippi does have an income tax, income from Social Security, retirement accounts, pensions and annuities is exempt from taxation. But watch out for Mississippi's 7 percent sales tax.

Nevada

David McNew/Getty Images

Nevada has no individual income tax, which includes the Social Security and pension income retirees get. But the sales tax is 6.85 percent.

Pennsylvania

Thinkstock

Social Security and pension benefits aren't taxed in Pennsylvania, but most sales are taxed at 6 percent. The cost of living and housing costs are also typically significantly less than in neighboring states like New York and New Jersey.

South Dakota

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Thinkstock

South Dakota's state sales tax is a relatively low 4 percent. There's also no income tax for individuals, and Social Security and pension benefits aren't taxed.

Texas

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Nils Geylen/Flickr

There's no income tax in Texas, including retirement income such as Social Security and pensions. However, property tax rates can be high, and the sales tax rate is 6.25 percent.

Washington

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REUTERS/Jason Redmond

Plentiful outdoor activities as well as access to both the ocean and mountains are big draws of Washington. Another perk: Social Security, pension and other forms of income aren't taxed. The sales tax is 6.5 percent.

Wyoming

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Thinkstock

Wyoming doesn't tax any form of income, including retirement benefits and Social Security. And the state sales tax is a relatively low 4 percent.

HEALTH CARE

Millions of uninsured Americans exempt from ObamaCare penalties in 2016, report finds

Published August 07, 2014

A new congressional report has estimated that more than 25 million Americans without health insurance will not be made to pay a penalty in 2016 due to an exploding number of ObamaCare exemptions.

The Wall Street Journal, citing an analysis by the Congressional Budget Office and the Joint Committee on Taxation, reported that the number of people expected to pay the fine in 2016 has dwindled to four million people from the report's previous projection of six million. Approximately 30 million Americans are believed to be without health insurance.

The latest report is likely to spark fresh concerns among insurers, who have maintained that the number of exemptions to the law's individual mandate are resulting in fewer young, healthy people signing up for health insurance. An insurance pool skewed toward older, comparatively unhealthy people is likely to result in premiums rising.

Under the Affordable Care Act, the fine for not purchasing health insurance is either $95 per adult or 1 percent of family income, whichever is greater. That amount is set to increase to $695 per adult or 2.5 percent of family income in 2016, with a total family penalty capped at $2,085.

The Act provided exemptions to the penalty for certain groups, such as illegal immigrants and members of certain Native American tribes or religious sects. The Obama administration has since added exemptions for hardships like domestic violence, property damage suffered in a fire or flood, or having a health plan canceled when ObamaCare came into effect this past October 1. One exemption, written as being for people who "experienced another hardship acquiring health insurance" does not require documentation.

Residents of 21 states who have opted not to expand their Medicaid program under the health law may also be exempt from the penalty. The Journal reports that more than 4 million Americans who receive subsidies through the federal ObamaCare exchange could qualify for hardship waivers if the subsidies are struck down in court.

The Affordable Care Act was narrowly upheld by the Supreme Court in June 2012 in a ruling based in part on acceptance of the administration's argument that the law's individual mandate was not a tax. Republicans have argued that the Obama administration has undermined its own argument by issuing so many exemptions and should scrap the mandate completely.

The Centers for Medicare and Medicaid Services told the Journal that approximately 77,000 individuals and families have requested an exemption as of this past April. However, that number is expected to rise because many exemption requests can only be claimed on tax returns filed in 2015.

The Obama administration has given people whose insurance plans were canceled because they did not meet ObamaCare's minimum coverage requirements an exemption that runs until October 2016. They are also allowed to buy a minimum amount of coverage originally available to people under 30.

Smokers Paying Less For Some Health Plans Than Expected

By Shefali Luthra

AUGUST 4TH, 2014

The health law allows insurance plans to charge tobacco users as much as 50 percent more for their premiums, but plans on average increased costs for these consumers by significantly less, according to a new study published in Health Affairs.

Researchers found the median surcharge amount to be about 10 percent. Close to 90 percent of plans stayed well below the maximum surcharge, according to the study's authors. But even still, because tobacco users were still charged more than others, they more frequently could not access affordable health insurance, a situation that the authors said could deter tobacco users from purchasing insurance at all.

Affordable coverage is defined as "access to at least one plan with premiums of less than 8 percent of income after subsidies," according to the study. The authors used that standard because the health law exempts from the requirement to buy insurance individuals who do not have at least one insurance option that costs less than 8 percent of income.

Insurers' pricing may be based on the use of health care services by tobacco users. "It seems as if smokers don't actually – at least in the age range that the health insurance exchanges are targeting – use 50 percent more in terms of costs for health care," said Cameron Kaplan, an assistant professor of preventive medicine at the University of Tennessee Health Science Center and the study's lead author.

On average, smokers appear to use about 10 percent more health care, Kaplan said, so plans for the most part have reflected that in their pricing, a strategy he said makes sense if insurers "want to attract people into their plan." Though smokers have more health problems than do non-smokers, Kaplan added, tobacco users in the exchange appear, for whatever reason, "to be the people who avoid using health services."

The surcharges have drawn criticism from groups such as the American Lung Association. It argues that higher costs will discriminate against smokers and preclude them from obtaining coverage.

"No one wants tobacco users to be uninsured – we know they have health consequences," said Jennifer Singleterry, the lung association's director of national health policy. "We certainly want someone who has lung cancer to have insurance."

The study's findings suggest the picture is complicated, Kaplan said.

The health law includes federal subsidies to help people at the lower end of the income scale purchase health coverage, but that assistance is calculated based on premium price tags before any tobacco surcharge is factored in. That means, the researchers noted, federal subsides often aren't enough to make plans affordable – even with the lower-than-expected add-on premium costs.

States vary in the level of surcharge they allow. Of those assessed in the study, six states plus the District of Columbia prohibit any kind of tobacco surcharge; three states allow surcharges smaller than the 50 percent maximum; and 26 allow surcharges of 50 percent.

But of those states, only in Montana did plans have a median difference in costs for tobacco users that hit the 50 percent maximum, the researchers found. Seven other states – Missouri, Ohio, Maine, Nevada, New Hampshire, New Mexico and Nebraska – had median surcharges of 25 percent or higher.

Kaplan added that it is possible rates could converge in coming years, with more insurers bringing their surcharge to around 10 percent of premiums but "there's a lot of uncertainty" regarding how these extra charges might change.

Though some supporters of the tobacco-user surcharge argue a larger premium could encourage people to quit smoking, so far there's "really not enough data" to support an argument either way, Kaplan said.

Singleterry agreed. "There needs to be a lot more research before anyone can determine whether having that surcharge in place" results in smokers quitting, she said.

Because of the variation in surcharges – both across plans and state lines – the researchers also suggested a potential for self-segregation between tobacco users and non-users. Smokers, they argued, could favor plans with lower surcharges, in turn resulting in higher costs for some insurers than others. But because smokers don't necessarily cost much more to insure than non-smokers, Kaplan said, that kind of sorting wouldn't necessarily drive plan costs too high.

"In the end it could just sort of be all right," he said, "because the plans can price this out perfectly."

Drug Coverage Premiums and Spending Forecast Remain Low

By Paul Jenks Posted Aug. 1

The Department of Health and Human Services has announced a slight increase in the Medicare Part D program's premiums for next year. The prescription drug benefit, first implemented in 2006, now offers drug coverage to 39 million people.

Also, the Congressional Budget Office this week offered another illustration of changing long-term health care cost estimates and has adjusted its outlook on spending on the Part D program.

The congressional budget scorekeeper noted that several trends in the drug market has contributed to lower spending, which are substantially less than initial estimates provided to Congress in 2003 when the program was established. The CBO noted two major drug market developments contributing to the slowing of price increases:

- Many existing brand-name drugs lost their patent protection and faced new competition from generic substitutes, which have the same active ingredients as their brand-name counterparts but are much less expensive.
- New brand-name drugs (which tend to be more expensive than older brand-name therapies) were introduced at a slower rate than in the late 1990s.

ObamaCare premiums slated to rise by an average of 7.5 percent

By Elise Viebeck - 08/11/14

Premiums on ObamaCare's health insurance exchanges will rise by an average of 7.5 percent next year, according to a new analysis.

Data compiled by the Health Research Institute (HRI) at PricewaterhouseCoopers found modest changes in premiums for 27 states and the District of Columbia, with the increases mostly falling short of dire predictions for ObamaCare's second year.

The average national increase of 7.5 percent is "well below the double-digit increases many feared," HRI Managing Director Ceci Connolly wrote in an email.

The highest proposed rate increase so far came in Nevada, where consumers with Time Insurance Co. might see their insurance premiums rise by 36 percent. Some consumers in Arizona, on the other hand, could see rates drop by 23 percent.

Overall, the highest average price increases under ObamaCare so far have come in Indiana, where some consumers will see prices rise by 15.4 percent. The biggest average savings were found in Oregon, where premiums will drop an average of 2.5 percent in 2015.

"The average individual monthly premium for next year, before any subsidies are applied, is $384," Connolly wrote. "And insurance commissioners get a chance to weigh in on rates before fall enrollment."

Forecasts of massive "sticker shock" became a theme of last fall's debate over the healthcare law as the administration struggled to launch HealthCare.gov, which serves as the enrollment portal for people in 36 states.

The healthcare law's first enrollment period was a major test for the insurance industry, which set premium prices with little information about exactly who might sign up for coverage.

The 2015 rates shed light on how well their guesses panned out.

Companies are generally raising prices if their new customers are older, sicker or will use more medical care than projected.

Firms with a healthier pool, on the other hand, have an incentive to lower premiums.

The PWC analysis noted that "bellwether" firms such as Blue Cross Blue Shield have submitted increases that are typically above 9 percent.

"Health plans are just beginning to understand this new market and will keep experimenting with different

products, different networks and running a retail-style business," Connolly wrote.

ObamaCare's second enrollment period begins Nov. 15.

Consumer advocates are urging people on the exchanges to prepare to comparison shop if they want to avoid price increases of any magnitude.

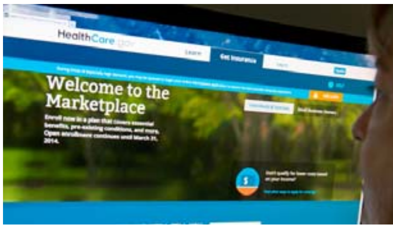
Experts are also waiting on state insurance regulators to deliver the final verdict on some of the higher proposed rate increases.

Those officials play a serious role in determining how much plans will actually cost consumers, according to a recent blog post for the journal *Health Affairs*.

"The business tendency will be to … err on the side of caution and to pad estimates to protect reserves," wrote Christopher Koller and Sabrina Corlette.

"Comprehensive, independent, public scrutiny of the requested rate increases and the insurers' justification for them is absolutely necessary to find a healthy balance between product affordability and insurer stability."

Consumers' next Obamacare challenge: Tax forms



Next year, the IRS will have to make sure those who don't have coverage are penalized. | Getty

By PAIGE WINFIELD CUNNINGHAM and MACKENZIE WEINGER | 8/11/14

If consumers thought logging on to HealthCare.gov was a headache, sorting through complex forms ahead of tax deadline day 2015 is their next big Obamacare challenge.

The health care law's benefits are rolling out, but its major math problems start next year as the IRS tries to ensure that millions of Americans are correctly calculating their benefits and that those who don't have coverage are penalized unless they qualify for an exemption.

That means much new paper-shuffling between now and April 15, which could be especially confusing for low- and middle-income Americans unaccustomed to lots of reporting to the IRS. The insurance exchanges and employers must send consumers details about their health plan and benefits or exemptions in time for them to file a tax return. If any of that information is delayed or wrong, tax refunds could be delayed.

"We're having some trepidation," said Judy Solomon, vice president for health policy at the liberal Center for Budget and Policy Priorities. "This is going to be another new thing just like the roll out of HealthCare.gov."

Last month, the Obama administration released drafts of the forms employers and individuals will have to fill out. But those leave unanswered many questions about how it'll all work. The details are expected to be included in "practical" instructions the agency plans to release later this month that will detail how to complete the new forms, the IRS said.

At this point, the new forms look "very daunting" for taxpayers, said Mark Ciaramitaro, vice president of health care services at H&R Block. "Overall, we expect the complexity level is just going to go up for a significant group of moderate- to low-income people, whether they got insurance through the marketplace or they didn't."

Before they can file a tax return, individuals will have to get documents from their state- or federal-run exchange about the plan they bought and any subsidies they received. Or, if they're covered through an employer, they'll have to provide proof of that. If they qualify for an exemption from having coverage, they'll have to send that to the IRS, too.

But if they completely ignore the question of having health coverage, now a new line on the standard 1040, it's unclear how the IRS will respond, says George Brandes, vice president of health care programs at Jackson Hewitt. The result, he worries, could be that filers trying to comply with the law are penalized with delays while those ducking it aren't.

"You're at much greater risk for having things gummed up if you've done what you're supposed to do," Brandes said. "We're not name calling here — it's just sort of a recognition of the reality of how this is going to work."

Tax Foundation economist Alan Cole agrees and, like many experts, doesn't expect the IRS to vigorously enforce the law's individual mandate in its first year, using this upcoming filing season more as a trial run.

"Especially given that this is low stakes, that this is the first year of the mandate, and that it's small, I would not expect a serious crackdown of any sorts this coming year," he said.

Applying for an exemption is another point of potential confusion, advocates and experts say. The Congressional Budget Office expects millions of Americans who remain uninsured to qualify. As for the penalty, CBO in June downgraded the number of people it estimates will pay the fine from 6 million to 4 million.

The administration has provided a long list of reasons why someone could be excused from the mandate. Some exemptions — like belonging to a religious organization that opposes insurance or joining a health care sharing ministry — must be applied for through the person's exchange. Tax filers would then receive a certificate of exemption to provide to the IRS.

The application requirements for some of those exemptions are "hopelessly complex," Brandes said, pointing to one that addresses people in states that didn't expand Medicaid. "They created a blanket exemption for those folks, but they also created an impossible application process. It's craziness," he said.

Other exemptions, like one granted to people unable to find a premium costing less than 8 percent of their income, must be applied for directly on a tax return.

And some low-income earners who qualify for an exemption during open enrollment may find themselves ineligible if their earnings increase later in the year — making coverage suddenly affordable.

"That is so complicated," CBPP's Solomon said. "How does anyone understand that? The folks who are helping consumers are reeling. A consumer can't be expected to understand this."

To top it off, applying for an exemption via the federal exchange can be done only via regular mail.

"It's just a paper process, and that's a problem," said Cheryl Fish-Parcham, private insurance program director for Families USA, an advocacy group that supports the Affordable Care Act. She also said she's heard anecdotally that some people haven't heard back about whether they're exempt from the individual mandate.

Centers for Medicare & Medicaid Services spokesman Aaron Albright said that each application for an exemption is reviewed on a "case-by-case basis" and that every person will be notified whether the exemption is granted or denied.

Then there's the challenge of making sure people collect the subsidies for which their income qualifies them. Because the monthly subsidies are based on an estimate of what people will earn during the year, some Americans are expected to owe the IRS if they ultimately earned more than expected.

To prevent the possibility of owing Uncle Sam at the end of the year, people are supposed to quickly report to HealthCare.gov or their state-run exchange if their income changes over the course of the year. But not everyone may know that, said Anthony Wright, executive director for Health Access California, a consumer advocacy group.

"I think there's a lot of burden to just educate people so it doesn't become an issue," Wright said.

Experts aren't just worried about the problems taxpayers could have as they try to navigate such complicated requirements. Exchange enrollees won't be able to file their taxes until it sends them a 1095-A form, and there are some concerns that the forms will be late, especially in states with struggling exchanges.

Albright said that won't happen. "People will get their information in time for tax season," he said.

Yet the skeptics fear that some taxpayers could be faced with delayed returns.

"There's just not a good track record out there for us to suggest the 1095-As are going to be delivered on time," said Chris Condeluci, who served as tax counsel for Senate Finance Committee Republicans during drafting of the ACA.

For many of the people Obamacare was targeting, this could be a potential "nightmare," said Ed Haislmaier, senior research fellow at the conservative Heritage Foundation, which staunchly opposes the law. "For people who have fairly simple returns and tend to file early, the simple lack of a necessary piece of paper if it's not generated in time will delay their ability to do that," he said.

And even if the forms aren't late, Brandes is concerned that the information on them could be riddled with inaccuracies. "They're still processing inconsistencies from last time around," he noted. "This is taxmaggedon here."

Social Security strategies that can boost your income

By Jeanie Ahn : Yahoo Finance

When David Beermann retired earlier this year from a career as a nurse at age 66, he expected to receive his full Social Security benefits. His wife Sandra, a retired teacher, also planned to file for full benefits when she turned 66 in September

But after a chance encounter with a local financial planner, the Beermanns have adopted a new Social Security strategy that will result in potentially $70,000 of additional income over the course of their expected lifetimes. Tony Drake, a certified financial planner in Waukesha, Wisc., said people like the Beermanns, who are or have been married, stand to gain thousands of dollars y utilizing their spousal benefits.

Often retirees are unaware of all their Social Security benefits and how to best maximize their income. They assume there's only one way to receive benefits, and Social Security Administration employees themselves aren't all trained to dispense financial advice on the often-complex rules. But a little planning can provide a significant boost in retirement income for benefit recipients, says Drake.

Below is a breakdown of the spousal strategies that Drake says could work for you:

#1 File and suspend: Half from your better half
This particular strategy works well if you have one spouse who's the primary breadwinner and wants to work a bit longer, and the other lower-earning spouse is ready to retire. The higher-earning spouse would apply for benefits, but then suspend collecting them. This allows the other spouse to begin collecting one-half of the filer's benefit immediately. The spouse who is still working won't receive any Social Security checks at that time, but would continue to accrue delayed retirement credits – about an 8% increase a year until age 70 – the age when they would start collecting. The great thing about this strategy is that the primary earner collects a full benefit while the spouse collects half of his/her benefit.

For example, with the Beermanns, rather than collecting on her own earning record of $1,299 a month – at age 66 – she would file and suspend and utilize the spousal benefit, which would be $1,150 per month, or half of David's benefit. This gives her a little bit of a hit in the short term because her Social Security benefits would have been $149 more per month had she started collecting benefits based on her own record instead of her husbands. But it allows her to get a substantial raise in the future by growing her benefit to $1,700 a month by age 70.

David's benefit doesn't change at all because he still collects his full retirement benefit. Over the course of her expected lifetime, she'll collect $69,840 more than she would have if she simply collected her own. (Life expectancy was calculated using tables from the Social Security Administration.)

Here's a breakdown of how the two different scenarios work:

Scenario #1: She takes her own benefit now, at age 66, at $1,299 per month
$1,299 x 12 months x 20 years =$311,760 collected over 20 years

Scenario #2 with file and suspend spousal benefit strategy:
Collects spousal benefit (half of David's benefit) for 4 years at $1,150 per month
$1,150 x 12 months x 4 years = $55,200

Then at age 70, she collects her own increased benefit at $1,700 for the next 16 years.
$1,700 x 12 months x 16 years = $326,400

$55,200 + $326,400 = $381,600 collected over 20 years

The difference between the two scenarios: $381,600 - $311,760 = **$69,840**

#2 Restricted application: Taking turns to retirement
The Restricted Application strategy is similar to file and suspend and lets a person apply for benefits based on his or her spouse's record while delaying benefits based on his or her own record. It is ideal for couples that have comparable incomes, but one spouse wants to retire and the other wants to continue working.

The retiring spouse claims his/her Social Security benefit, and by doing so allows the working spouse to file a restricted application and collect only the spousal benefit. This allows the working spouse to continue to earn delayed retirement credits and watch his/her benefits grow by about 8% until age 70.

#3 Widower benefit: Claim the hidden legacy
If your husband or wife passed away, the surviving spouse can start to receive benefits at age 60. This can be helpful, especially if the surviving spouse didn't work. A lot of people don't realize that if you become widowed, and your spouse had a higher benefit, you're going to be entitled to that higher benefit. You'll always get the higher of the two benefits: yours or your deceased spouse's.

#4 Divorcee benefit: Uncle Sam pays alimony
Many retirees are unaware that if you're divorced, you can collect benefits on your ex-spouse's record. If you were married for 10 years, your ex is at least 62, and you haven't remarried, you can start collecting Social Security benefits as an ex-spouse at full retirement age (66 for those born between 1943 and 1954) – even if your ex-spouse has remarried. Obviously, this can be a boon if your ex-wife or husband was the higher earner. Note that getting remarried after a divorce generally means that you lose whatever benefit you may have been eligible for from your former spouse.

Some States Bristle At Lack Of Authority Over Medicare Advantage Plans

By FRED SCHULTE, THE CENTER FOR PUBLIC INTEGRITY

AUG 19, 2014

When Minnesota retiree Doug Morphew needed surgery last year, he expected his Humana Medicare Advantage plan to step up and pay the lion's share of the bill.

Morphew said the health plan had told him over the phone he would owe just $450 for the two days he spent in a St. Paul hospital recovering from the operation to repair an aortic aneurysm.

Less than a month later, however, Humana hit him with a bill for $6,461.66, claiming the surgery was not covered because the hospital was "out of network," according to an affidavit he filed with the Minnesota Attorney General's Office last year.

"Considering that I was expecting a bill of $450, I was incredibly upset," said Morphew, 68, who lives in Lonsdale, Minn., and works part time as a transportation industry consultant.

Morphew said that Humana paid the bill, but only after "several months of fighting" with him, and after he complained to state regulators.

In October 2013, Minnesota Attorney General Lori Swanson sent Morphew's formal complaint, and about two dozen others, to Centers for Medicare and Medicaid Services (CMS) administrator Marilyn B. Tavenner. Swanson asked the federal official to "undertake an investigation of Humana's practices and take appropriate remedial and punitive action."

The letter sparked media coverage in the state. But nearly a year later, Swanson is not satisfied with the response.

"As far as I'm aware, there has been no formal enforcement action taken," said Minnesota attorney general's office spokesman Benjamin Wogsland. "We have very serious concerns that continue."

Citing patient confidentiality laws, Humana spokesman Tom Noland declined to comment on specific cases. But he said that Humana "has worked actively with CMS to resolve the matters outlined in the letter." CMS said it is satisfied that Humana has largely fixed any problems.

Medicare pays the privately run health plans -- an alternative to traditional Medicare -- a set monthly rate for each patient. About 16 million Americans have signed up, about one third of the elderly and disabled people eligible for Medicare, at an annual cost to taxpayers of more than $160 billion. A Center for Public Integrity investigation published in June found as much as $70 billion of improper payments to Medicare Advantage plans from 2008 through last year.

Many health plans also collect monthly fees directly from patients and may charge co-payments for medical services, such as $10 for a doctor's office visit. The plans also can limit care to doctors and hospitals in their networks, so long as patients are advised of these restrictions.

Humana has pitched its plans in Minnesota through radio and television ads, telemarketing and the mail, typically telling seniors it offers more benefits than standard Medicare and will cost them less out of pocket.

But Humana "sometimes denies claims for services that are covered under original Medicare," overcharges for copayments, "misrepresents" which doctors and hospitals patients can go to and hides behind "red tape and delay" to avoid paying claims, according to Swanson's letter.

Swanson turned to CMS because state regulators lack the legal authority to impose sanctions on Medicare Advantage carriers. When Congress created the Medicare Advantage option in 2003, it gave CMS that power, thus preempting state laws and oversight.

Minnesota officials don't believe CMS should have a "monopoly" on oversight. "We think states should have authority over improper determinations by Medicare Advantage plans," Wogsland said. "If they (CMS officials) don't take action, there's no other remedy."

Other state officials also have been frustrated by the limits on their authority. In October, Connecticut Attorney General George Jepsen called for federal officials to "aggressively scrutinize" UnitedHealthcare's decision to drop a large number of doctors from its Medicare Advantage plans, a move that had caused an uproar from patients and medical groups.

Medicare has also reported its own difficulties keeping tabs on the fast-growing program.

In a little noticed proposal in March, CMS officials said they were "constrained in the number of program audits we can conduct each year, due to limited resources." The agency is only able to audit about 30 Medicare Advantage companies a year -- about one in ten -- of the 300 operating.

CMS proposed that health plans conduct and pay for self-audits with the goal that each organization would be looked over at least every three years. But in May CMS backed off in the face of industry protests.

"Ensuring that Medicare beneficiaries receive high quality care and timely services while enrolled in a Medicare Advantage plan is a top priority for CMS, an agency spokesman wrote in an email. He said the agency "may finalize this proposal at a future date."

"We were disappointed to see it rolled back," said David Lipschutz, a senior policy attorney with the Center for Medicare Advocacy. He said the proposal "begged the question" of how often plans are audited.

"We have concerns across the board," Lipschutz said. "It's unfortunate that we have public dollars going toward a privatized program with relatively little oversight."

CMS officials point out that they have taken enforcement action against health plans that fail to pay bills or provide necessary care for their patients.

The agency posts these actions on its website, though patients aren't likely to spot them without considerable hunting around. Even if they do, the sanctions often are written in language that gives little clue to the actual infractions other than they pose a "serious threat to the health and safety" of patients.

From November of 2009 to this August, the agency levied 68 fines against Medicare Advantage plans for a total of about $9.8 million, a review of the CMS website shows.

In that time, CMS terminated four health plans, two of them because they had become insolvent. On 21 occasions, CMS suspended enrollment in health plans, usually after discovering that sales agents misrepresented the benefits to potential customers.

In the case of Humana's performance in Minnesota, CMS officials said they had "not seen increases in complaints or other concerns" since receiving Swanson's letter.

They said Humana "appears to have made significant progress addressing these issues, and we have been satisfied with Humana's responses to date."

But Minnesota official Wogsland called it "disappointing" that CMS had taken no formal action. His office continues to get complaints from patients, hospitals and other health care providers about unpaid bills. "That's a problem," he said.

Darlene Tucker, 75, of Bloomington, who said she got by on monthly Social security income of $1,271, is one.

In an affidavit, she said the Humana agent sold her a plan that was supposed pay the full cost of radiation therapy for breast cancer. But she said she was stuck with co-payments of $994.22, which she couldn't afford.

The health plan never did pay, according to her affidavit. The center that performed the radiation treatments eventually wrote off the bill.

"My fight with cancer was enough for me to deal with at the time. I do not think I should have had to fight Humana for insurance coverage it promised to provide," she said.

Feds ask 10,000 Obamacare enrollees in Illinois to prove citizenship

A man looks over the Affordable Care Act signup page on the HealthCare.gov website. (Mike Segar / Reuters)

By Peter Frost *contact the reporter*

Healthcare Policies and LawsAffordable Care Act (Obamacare)

Thousands could lose health care coverage Sept. 30 if they don't provide more information

More than 10,000 Illinoisans must provide documentation to prove they are U.S. citizens or legal residents by the first week of September or risk losing the health insurance they bought through the Affordable Care Act.

The federal government this week began sending out notices to policyholders nationwide with discrepancies in their citizenship records notifying them they have until Sept. 5 to submit additional information that could confirm they are in the country legally.

Large employers expect their healthcare costs to rise moderately next year as they shift a growing share of the burden to workers, according to a new national survey. (Peter Frost)

If these people, who have not responded to multiple requests via mail, e-mail or phone, don’t respond, they will lose coverage Sept. 30.

To qualify to buy insurance on the exchanges set up under the health care law, people must prove they’re in the country legally.

Nationwide, federal officials said they were not able to determine the citizenship or legal status of about 970,000 of the 5.4 million people who selected health insurance plans through mid-April on HelathCare.gov, the federal website that hosts the exchanges for 36 states, including Illinois.

BREAKING BUSINESS

Courts issue conflicting rulings on Obamacare subsidies

Certain information in these people's applications didn't square with data that federal government had on file. Those conflicts include Social Security or green card numbers submitted on applications that don't match existing government data.

Nationwide, the federal Centers for Medicare and Medicaid Services, the agency that runs the exchanges, said it received about 970,000 applications with inconsistencies, resolving about 450,000 of them.

Another 210,000 already have responded to notices requesting more information. The remaining 310,000 were sent letters this week warning them they are in jeopardy of losing coverage.

Federal officials said it's important to note that many of these consumers may remain eligible for insurance once they fill in the missing information.

Nearly half of the people whose applications are in question come from two states: Florida and Texas. Illinois ranked seventh, with 10,300 applications with inconsistencies. Wisconsin had 3,700 and Indiana 5,100, federal data show.

Just more than 217,000 Illinoisans selected private health insurance plans on the marketplace as of mid-April, according to federal data. It remains unclear how many of them paid for their policies, the final step in obtaining coverage.

Neither Illinois nor federal officials have released updated enrollment data since May.

Share the Wellness: Lunch on the Run

August 27, 2014

If your lunch hour is cut short because a morning meeting ran late or you simply have too much to do to leave your workplace for a sit-down meal, you may be tempted to skip lunch and work straight through the day.

Depending on where your workplace is located, you likely have several options for picking up a healthy lunch. Or, if you've planned ahead, you can grab a snack to pull you through the afternoon.

Healthy Meals to Go
These days, you can get a to-go lunch at a fast-food place, family-style chain restaurant, sandwich shop or even a grocery store. These tips can help you keep your order healthy.

- **Look for nutrition information.** Most fast-food and chain restaurants post the calories, fat and sodium content of the food they serve on display in the restaurant, in menus or online. Comparing totals can help you make a healthy choice.
- **Don't supersize any part of your order.** Avoiding the temptation will help cut down on the amount of fat, calories, sugar and sodium in your meal.
- **Check out the salads.** Simple garden salads made with greens and fresh vegetables and topped with a low- or no-calorie dressing can be a nutritious choice. Just be aware that extras, such as fried chicken and cheese, can increase the fat and calorie content.
- **Keep it simple.** Ask the server to hold high-fat sauces and extra cheese.
- **Substitute lower-calorie choices for higher-fat foods.** For example: Ask for a baked potato instead of French fries, chicken fajitas instead of a breaded chicken sandwich, and ice water with a lemon or lime slice instead of soda.

Smart Snacks
The following healthy snacks can satisfy your midday hunger for those times when you simply can't get away. Plan ahead by keeping them in your desk drawer or break-room fridge. Opt for a combination of lean protein and high fiber to keep hunger at bay. Try:

- Fresh fruit and a handful of raw almonds
- Nonfat, plain Greek yogurt in individual size servings, topped with ¼ cup of sliced fresh fruit or berries
- Apple slices topped with a smear of peanut butter
- Hummus and sliced fresh vegetables such as bell peppers, celery, carrots, broccoli and cherry tomatoes
- Edamame. This snack is a good source of low-fat protein and is low in sodium.

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