Health & Retirement Services Of Illinois

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OUR NEWS LETTER

HRSI

Medicare report: Improve tracking of serious hospital errors

By Kelly Kennedy, USA TODAY

WASHINGTON – Medicare inspectors must do a better job of tracking reports of serious mistakes in care at the nation's hospitals, as well as of informing rating agencies of the errors, according to a report released Tuesday by the agency's inspector general.

Hundreds of serious errors go unrecorded, the report found, because the inspectors who find problems at hospitals don't tell the national agencies that accredit hospitals. That means that those hospitals continue to participate in Medicare and that they don't learn from their mistakes, Inspector General Daniel Levinson writes.

Also, Levinson writes, no one tracks the effectiveness of policy changes or how the hospitals actually correct mistakes.

Last year, the inspector general found that 15,000 Medicare patients die each month in part because of the treatment they receive in a hospital. Tuesday's report focuses on the worst errors — or "immediate jeopardy complaints." They include surgical fires, patient suicides, sexual assault, surgeries performed on the wrong patients and medical instruments left inside a patient after a surgery.

State survey and certification agencies check complaints and are supposed to report them to the Centers for Medicare and Medicaid Services (CMS). That should lead to a review to determine whether the hospital has fixed the problem and will still be allowed to work with Medicare.

However, the report shows, CMS regional offices notified hospital accreditors of only 28 of the 88 sampled immediate jeopardy complaints.

State agencies also only required the hospitals to provide performance data for one of the 19 cases that required corrective plans.

In some cases, state agencies did not inform the hospitals of the nature of the mistake, because they wanted to protect the complainant's identity. That meant the hospitals did not know what they needed to fix.

In Our Newsletter

Researchers did not look at why the problems were occurring, according to IG officials, which raised the possibility that it could have been an oversight or the result of unclear instructions from CMS.

Levinson recommends the following steps:

•CMS should evaluate compliance with quality-assurance measurements.

•State agencies should monitor hospitals' improvements.

•CMS should make it clear that state agencies tell hospitals what mistakes they've made.

•CMS should notify accreditors when hospitals make mistakes.

In a response to Levinson, Medicare Administrator Don Berwick said that he agrees with the recommendations and that several improvement have already been made.

Both Levinson and Berwick said a new program, the Partnership for Patients, focuses on patient safety and should help with the reporting issues.

Lawmakers should keep funding for Medicare Part B

By Bill Bro, CEO, Kidney Cancer Association

Last year, more than 1.3 million new cases of cancer were diagnosed in the United States. According to the American Cancer Society, more than 50,000 of these individuals were diagnosed with kidney cancer.

These patients are fighting for their lives. And their fight may get harder.

The Congressional super committee that was formed last summer to get the federal budget under control is preparing to submit a plan next month that may include cuts to Medicare Part B - the program that enables tens of thousands of kidney cancer patients to access the vital cancer treatments they require. The lawmakers on this committee must take these dangerous cuts off the table now.

We know that with the right treatment kidney cancer can be defeated. In fact, more than 200,000 kidney cancer survivors are living in the United States right now. Recent advances in diagnosis, surgical procedures and treatment options will help even more patients to defeat the disease, allowing them to maintain their normal schedules and lifestyles.

Medicare Part B is the federal a program responsible for covering treatment for a staggering 50 percent of kidney cancer patients in the United States. Cutting Medicare Part B would limit access to treatments for thousands of kidney cancer sufferers and could even result in the closing of the cancer clinics that provide their life-saving treatment.

If lawmakers were looking to prioritize federal expenditures, they would be hard pressed to find a more far-reaching program than Part B. Reducing its funding would make it harder for the physicians who provide treatments covered under this program – treatments that can only be administered under the supervision of healthcare providers.

The last time this program was cut was in 2003 in the Medicare Modernization Act, and the predictions then of clinics being forced to close have unfortunately come true. In the last three and a half years alone, 199 community oncology clinics have been forced to shut their doors - and 369 more are struggling to stay afloat financially. Over the next 10 years, some predict there will be a shortage of Oncologists that could leave one in four cancer patients without expert and safe care they need.

We understand that the growing national debt will require lawmakers to make difficult decisions regarding the federal budget. However, Congress must not lose sight of what's actually important: the health, well being and life of the people it was elected to represent.

Medicare Part B is a promise to all Americans that access to treatment during their most challenging times will never be questioned. The program is responsible for keeping millions of cancer patients in their day-to-day fight to defeat the disease. Congress should know by now that Americans want it to be left alone.

7 Dangers to Watch Out for When Using Your Debit Card

by Business Insider Editors
Monday, November 7, 2011

provided by
BUSINESS INSIDER

Standalone ATMS That Skim Cash

The FBI estimates that a criminal activity called "ATM skimming" is costing U.S. banks hundreds of millions of dollars per year. Skimming often involves using hidden cameras or placing electronic devices over the ATM's standard card reader in order to steal information from a card's magnetic strip. For these reasons, you should avoid shady-looking ATMs, especially if they're secluded or aren't officially tied to a bank.

Follow these steps from the Better Business Bureau to avoid being "skimmed" yourself:

• Cover the key pad when punching in your PIN.
• Inspect the ATM: Avoid shady ATMS and jiggle the card swiper to see if it's been tampered with.
• Monitor your account consistently so you can spot unusual activity.
• Report fraud immediately to your bank.

Gas Stations That Can Freeze Your Funds

In 2008, SF Gate reported that scammers drained $45,000 from customers who used their debit cards to pay for gas at an Arco station in San Jose, Calif.

For this reason, it's safer to use a credit card during gas station trips because you'll be charged for the exact amount you spent, making it easier to detect any fraud. Conversely when you use a debit card, your account will show a hold, which can range anywhere between $50 and $75, depending on the station, and can last for days after your visit, according to CBS Moneywatch.

Restaurants and Bars Where the Card Leaves Your Sight

The danger in using your debit card at restaurants and bars is that the card has to leave your sight, which compromises your data, reports Banktime.

You may *think* that plunking down that debit card is the easiest way to settle a check, but in a crowded dining environment, unsuspecting prying eyes (namely the waiter who's taking your card) can pose a real threat to your bank account.

Foreign Hotels That Prolong Settled Payments

Traveling can automatically mark you as an easy target for theft and using your debit card along the way might be a big mistake.

Not only is your information recorded at some foreign hotel you're not accustomed to, you won't be able catch fraud as quickly as you normally would back home because the charges will take longer to appear on your statement.

Most hotels require that a card be placed on file during check-ins, but the length of the hold is determined by the hotel and can range from 20% of the total stay to $100 per day. It can also take up to two weeks upon departure for your hotel account to be settled, which could wreak havoc on your finances.

According to BNET, a consumer reported that the hotel room he paid for in cash cost $140 in overdraft fees because he placed his debit card on file during the visit. The customer was unaware his bank would make the hold amount temporarily "unavailable," but it did and this caused his scheduled bill payments to bounce.

Recurring Payments That Make It Harder to Resolve Fraud

If a company asks for your bank card number, instead of bank details, to set up something known as recurring payments, *run!*

Recurring payments are different than direct debits because if there is a dispute, you have to go through the actual company, not your bank.

Basically, you are giving the company permission to "take a payment whenever you think I owe you," explains Martin Lewis on MoneySavingExpert.com.

It's also much more difficult to cancel your recurring payments because again, you'll have to go through the company.

Public Wi-Fi Locations That Can Hack Your Data

According to Private I blog, it's much easier for hackers to steal your information through an unsecured wireless connection so don't even think about using an ATM card at your favorite Starbucks or Barnes & Noble.

If you must use a card, fork over the credit because that will make it less of a challenge for these crooks to steal your data.

If you must do your shopping online, follow these steps on Private I blog to secure your activity.

Internet Shopping Sites and Phone Orders That Hijack Personal Info

If you like shopping online, protect yourself by *not* using your debit card. You have no idea how the information is transferred. For example, what if the computer you're using gets a virus or the website you're on gets hijacked by hackers?

"You don't use a debit card online," says Susan Tiffany, director of consumer periodicals for the Credit Union National Association, told CreditCards.com.

If any disputes were to occur, it's a much bigger hassle trying to get it resolved if you've used a debit card and the amount is already deducted from your bank account.

Same goes for phone orders--you never know who's on the other end of the line.

SHIP Programs Can Help Seniors Save Money On A Medicare Drug Plan

By Susan Jaffe

Nov 07, 2011

Three weeks after suffering a heart attack, Bernie Hollander came to a recent meeting at Leisure World in Silver Spring with his wife, Rose, to learn about the Medicare drug plans being offered next year.

"I'm a heart patient, I'm a diabetic – I have a lot of problems," said Hollander, 81, who lives in the retirement community. But getting the expensive medications he needs isn't one of them.

He was at the meeting to get updated advice from Leta Blank, head of the Montgomery County Senior Health Insurance Assistance Program. SHIP, as it is commonly known, helped him sort through dozens of insurance policies last year to find one that would cover the eight drugs he takes. His medications cost $14,000 through the end of September, and his share of the bill was $5,000.

"The SHIP program tells you basically what is your best value for your dollar," he said.

Medicare Drug Plans in 2012

See more on Medicare's 2012 Part D plans:

- Shopping Tips For Medicare Drug Plans

- **Video**: The ABCs of Medicare Part D

Funded by the federal Older Americans Act and local jurisdictions, SHIPs help people navigate Medicare, the federal health-care program that serves 46.5 million older or disabled Americans. There is a SHIP in nearly every county, providing advice over the phone, in person and at public meetings. Some SHIP counselors even make house calls.

This is their busy season: The annual open enrollment period for Medicare drug plans – also known as Part D plans – began last month and runs until Dec. 7. Although drug coverage is optional, millions of Medicare beneficiaries enroll in a plan, and choosing the right one can be tricky.

They can also get advice about Medicare Advantage managed care policies, which are also open for enrollment now, and offer medical coverage within a network of health care providers along with, in many cases, drug coverage.

Drug coverage is optional for Medicare beneficiaries. But seniors who want it must search dozens of policies covering different drugs from different pharmacies at different prices. For 2012, there are 30 drug plans offered in Virginia and 31 in Maryland and the District. Insurers can modify benefits and pricing from one year to the next. And drug prices can change as often as every four weeks. SHIP counselors can help untangle the details.

Surveys have shown that once seniors choose a drug plan, most stay in it even if there are cheaper alternatives as years go by. But they would be smart to take a fresh look every autumn: In a study presented in October, researchers examined the plans used by about 270 California seniors and found that three-quarters of them would save an average of $450 if they changed plans in 2011.

"Never, ever assume that if your drugs are covered this year they will be covered next year," said John Glowacky of the Arlington office of the Virginia Insurance Counseling and Assistance Program, which is part of SHIP. "And just because you have a no-deductible plan now, there's no guarantee that it will remain a no-deductible plan."

In the District and Maryland, premiums for six of the top 10 drug plans will rise in 2012 by as much as 16 percent, according to an analysis for Kaiser Health News by Avalere Health, an independent research firm. In Virginia, premiums for half of the 10 plans with the highest enrollment are going up by as much as 17 percent next year.

To help find the best buy, SHIP counselors use the online "plan finder" at the top of Medicare's website. Users enter their Zip code and the names of the drugs they are taking, plus other information. The website then produces a list of plans covering those drugs at nearby pharmacies and their estimated annual cost. (Before choosing a plan, SHIP counselors recommend calling the insurer to verify the information.)

At the District's SHIP – the Health Insurance Counseling Project at the George Washington University Law School – seven law students, backed by their professor Suzanne Jackson, handle some of the tougher cases. Seniors can also get help from another lawyer, a program director and community volunteers. Counselors make regular visits to senior centers across the city. Last year they held more than 70 Medicare meetings and helped nearly 3,000 people individually.

In Fairfax County, SHIP manager Howard Houghton trains volunteers to help beneficiaries shop for coverage, speaks at senior centers and records podcasts for the county's Web site.

"Like Johnny Appleseed," he says, he crisscrosses his territory to reach as many of the county's 113,000 Medicare beneficiaries as possible.

Even though the Medicare drug benefit took effect five years ago, some area seniors still don't use it. Robert Townes, 77, of Arlington, couldn't afford the medicine to treat his high blood pressure and other health problems and would often skip doses or cut pills in half because they cost $700 a month.

In September, Glowacky – from the Virginia SHIP program – helped Townes enroll in a Medicare prescription drug policy and get a federal government subsidy to pay for coverage. Now he pays $50 a year for drugs that come in the mail every three months.

"I feel like a different person," he said. "I'm doing pretty good for an old man.

Why Your Tax Bill Might Surge Next Year

by Bob Jennings
Tuesday, November 8, 2011

provided by
FOX BUSINESS

In a recent tax planning meeting with one of our clients, we shocked them with what their income tax future looked like for 2013 if Congress continues to do nothing to provide a long-term permanent set of tax laws (and it looks as if lawmakers are headed down this track).

They had no idea what tax breaks were expiring this year and next year, and how much it would cost them personally in extra income tax. But they aren't alone, many Americans and even tax professionals aren't aware that their tax bill could rise dramatically next year.

These clients are your average American family and their situation is a good example of the law changes that will affect all of us. Here's their tax situation with a table summarizing the expiring tax laws that are scheduled to occur in 2011 and 2012.

Meet the Smiths: 26-year-olds Bill and Joan have been married for five years and have two young children. Bill earns about $65,000 a year in sales and Joan has gone back to work and earns about $35,000 annually. Bill owes quite a bit on his college student loans and will pay about $3,000 in interest on them in 2013. With Joan working again, they are paying $3,000 for year-round child care. Joan inherited some AT&T stock from her grandmother, which pays her $1,000 in dividends every year. Finally, counting home mortgage interest, they have about $20,000 in itemized deductions.

The first big change affecting the Smiths will be a combined increase in income tax rates, and a tightening of tax brackets as a result of the expiration of the Bush tax cuts. We estimate this will cost them $960 in 2013.

Bill will lose the complete deduction of his student loan interest in 2013, costing about $840. The pair's allowable deduction for child care will drop to $2,400 from $3,000, and they will also see their credit for children drop in half, costing another $1,000.

The marriage tax penalty will come roaring back to hit the Smiths in 2013, costing an estimated $500. The tax on their dividend income will go increase to $280 from $150, adding another $130. Finally, although we did not calculate the effect, without Congressional action to once again "fix" the alternative minimum tax, the Smiths could owe this ugly tax as well!

Luckily for the Smiths — but not for many Americans — other major changes for 2013, which do not personally affect them, include a phase out of itemized deductions and personal exemptions if their income starts to climb.

In summary, because of tax laws expiring this year and next, we estimate that the Smiths will owe $3,598 more in income tax in 2013 than in 2011 with no change in their income.

Major Individual Income Tax Benefits Expiring 12/31/2011:

• Personal tax credits applied against income tax no longer apply

• Higher alternative minimum tax exemptions revert back to extraordinarily-low thresholds

• $250 school teacher expense deduction ends

• Mortgage insurance premium deduction expires

• State and local sales tax deductions expire

• Tuition and related fees deduction end

• IRA to charity tax-free transfers stop

• 2% Social Security tax reduction ends

Major Individual Income Tax Benefits Expiring 12/31/2012:

• Marriage penalty equalization ends

• Dividends taxed at capital gains rates removed, taxed at regular rates now

• Capital gains low tax rates expires

• Removal of itemized deduction phase out for higher income Americans

• Removal of personal exemption phase out for higher income Americans

• Child care deduction limit of $3,000 reverts to $2,400

• Child credit reduces from $1,000 per child to $500 per child

• Low 10% tax bracket for low income Americans is eliminated

• Lower income tax rates and smaller brackets expires

• Refundable adoption credit and reduced deduction

• American Opportunity college education credit expires

• Major reduction in earned income credits and refunds

• Income tax exemption for debt forgiven on home foreclosures and repossessions

• Deduction for student loan interest ends

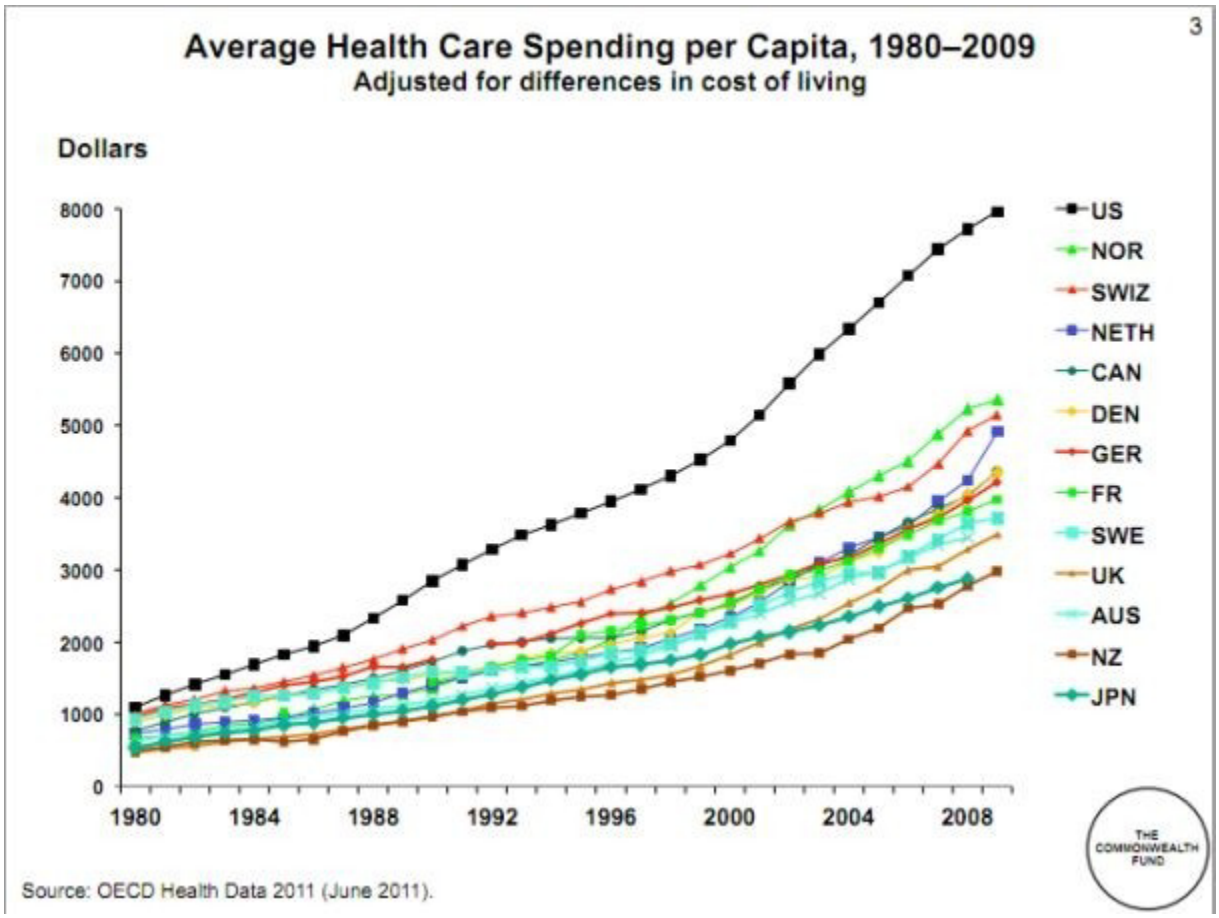
• Education IRA limit drops from $2,000 to $500

Bob Jennings is a CPA, EA and CFP and author of "Understanding Social Security & Medicare."

Our skyrocketing health care costs, in one chart

Posted by **Sarah Kliff** at 05:58 PM ET, 11/09/2011

In case you needed a reminder, our health care costs are still way out of control. Here's what that looks like in graph form:



This chart comes from the Commonwealth Fund's annual report, out today, comparing health spending and outcomes in 11 industrialized countries. The United States by far has the highest spending per capita, at $7,960 per person. None of the other ten, industrialized countries in the survey even come close: Norway, which has the next highest spending, hovers around $5,352.

And even after all that spending, Americans are not getting the care they think they need. The Commonwealth Fund also found that more than 40 percent of Americans went without care last year because of the cost.

Dr. Wal-Mart: May offer more primary healthcare, seeks partners

November 9, 2011

It's not enough to be a clothing store, grocer, pharmacy, auto servicer and more. It looks as if Wal-Mart Stores Inc. now plans to play doctor too.

The largest retailer in the country recently sent out a request for information to potential partners to help it offer a range of medical services without the traditionally steep prices.

In the 14-page document, Wal-Mart said that it "intends to build a national, integrated, low-cost primary care healthcare platform that will provide preventative and chronic care services … in an affordable and accessible way."

Among the areas Wal-Mart is exploring: HIV management, obesity and arthritis monitoring, depression care, pregnancy and STD testing, drug screening, physical exams and even stress and sleep help.

Wal-Mart said it would select partner vendors for clinical care, diagnostic and preventative services, health and wellness products and more by mid-January.

[Update 2:30 p.m.: After the document went public, Wal-Mart released a statement distancing itself from the proposal.

"The RFI statement of intent is overwritten and incorrect," said Dr. John Agwunobi, president of Walmart U.S. Health & Wellness. "We are not building a national, integrated, low-cost primary care health care platform."**]**

All this not long after Wal-Mart said that it would no longer give new part-time employees health insurance benefits.

Items You Should Stop Buying

Farnoosh Torabi
Monday, November 14, 2011

Some things in life are just best left un-purchased because they simply don't provide their money's worth — or have much cheaper alternatives. Here's a list of six everyday items we don't really need. Ditching them all together could save an average of $1,500 a year.

Lottery Tickets

Last year Americans spent $58 billion on lottery tickets or about $200 per person. But, according to Powerball stats, the odds of hitting the jackpot are just one in 195 million. Instead, create your own luck by investing

that $5 a week into a retirement account. Over 30 years, earning say 6% a year, your lotto habit could turn into $9,000 investment.

Retailer Extended Warranties

Extended warranties from retailers rarely prove beneficial. First, they can end up costing more than just repairing the product on your own. Also, beware of the fine print on these types of warranties, which may include language that could later disqualify your claim. Bottom line, researchers say: skip it. Some products, like cars, with an average warranty cost of $1,000, have become more reliable over time, which means they aren't likely to break down within the time frame of the warranty, according to Tod Marks of Consumer Reports. For a large appliance like a gas range, a 3-year warranty period is typical, she says. However, researchers find that only one in five actually need repair in the first three years.

Keep in mind that if your purchase ever breaks or fails within the first few months or year of use, you can always try negotiating with the manufacturer directly for compensation or a free replacement.

Unlimited Cellular Plans

It may seem like a wise purchase, but based on data from BillShrink.com, we may be overdoing by buying unlimited cell phone plans. In fact, we waste an average of $336 a year because we overestimate the number of voice minutes and texts we're using. If you lower your plan by one payment bracket, you can save at least $10 to $20 a month, or up to $240 a year. Before you make the switch though, track your usage for a few months, and find the plan to match.

Cleaning Supplies

The markup on cleaning supplies has much to do with packaging and advertising. Otherwise, it costs very little to make a cleaning detergent. We can save by creating our own natural alternatives with simple, inexpensive household ingredients like vinegar, ammonia, baking soda and water.

For example, to make a window and glass cleaner, simply mix a half-cup of white vinegar, a quarter-cup of rubbing alcohol, and 3.5-cups of water. The total cost comes to just 50 cents. Compared to the $3 to $4 you'd spend on a similar product at the grocery store, this one home-made formula could save you more than $40 per year.

Plastic Bags

Another household basic that makes little sense to spend money on is plastic bags. Simply re-use this free commodity provided by your grocery store, and you'll rarely have to pay for plastic bags again. Uses include kitchen and bathroom trash can liners, packing material for mailers, compost or kitchen scraps, lunch bags, pet cleanup, and more.

Ultra-High SPF Sunscreen

Think SPF 80 is worth paying up for? Think again. Experts say don't bother splurging on any sunscreen with more than SPF 45. In fact, FDA regulations are now limiting the maximum SPF to 50, since there's little proof a higher SPF works any better. Topping Consumer Reports' "most-recommended" list is the SPF 45 "No-Ad" sunblock with aloe and vitamin E. It was also the least expensive sunscreen in the test at just 59-cents per ounce.

3 Wichita doctors offer 'concierge medicine' as national concept expands to Kansas

- THE ASSOCIATED PRESS
- November 13, 2011

WICHITA, Kan. — Three Kansas doctors are practicing some form of "concierge medicine" at their Wichita medical offices, a concept that has been growing nationally since the idea was launched in Seattle in 1996.

Concierge medical practices typically don't accept insurance and charge patients a membership fee. In return patients get 24-hour access to the doctor or his partner, same-day appointments, basic lab work and other service. The fee doesn't cover specialists or hospitalizations.

The Wichita Eagle reports that Drs. Aly Gadalla, Doug Nunamaker and Josh Umbehr are in the minority among their physician peers in practicing concierge medicine.

Experts say doctors and patients alike have been drawn to the idea nationwide by a shortage of physicians, especially in primary care, as well as a desire by more physicians to take care of fewer patients.

"I knew this was what I was going to do," said Nunamaker, a former hospitalist at Wesley Medical Center and Umbehr's partner in Atlas MD. "I'm seeing fewer patients a day and for more time. The Family medicine that I went in to do, we do that every day."

Umbehr, a Family medicine practitioner, started Atlas MD in September 2010 after graduating from family practice residency. Some physicians advised him to join a traditional family practice before easing his way into a concierge practice.

"I was too impatient," Umbehr said. "I had this vision and wanted to do this as soon as possible."

Atlas MD charges patients a membership fee of between $10 and $100 a month, depending on the patient's age. Most patients also have traditional or catastrophic Health insurance to cover specialists or hospital visits.

"I knew this was what I was going to do," said Nunamaker, a former hospitalist at Wesley Medical Center and Umbehr's partner in Atlas MD. "I'm seeing fewer patients a day and for more time.

Because the practice does not accept insurance, its overhead is low. Besides Umbehr and Nunamaker, Atlas MD's only other employee is a registered nurse. Between them, the two doctors have about 500 patients.

Both doctors work emergency room shifts to supplement their incomes.

Gadalla operates a hybrid concierge practice. Membership to his concierge practice is $100 a month, but he also accepts insurance.

He said what his concierge patents get from him is unlimited access to his cell phone number and e-mail, and no wait times for appointments. Those patients can also schedule appointments with him on Saturdays and Sundays at no extra charge.

Gadalla, an internal medicine specialist, launched his concierge practice last year. He declined to specify how many patients he has.

Tom Blue, executive director of the American Academy of Private Physicians in Glen Allen, Va., said an exact figure on the number of concierge practices in the U.S. is difficult because they don't have to register as a concierge practice. But he said his organization, which was founded in 2003 to support the growth of concierge medicine, estimates there are about 3,500 in the nation.

The first concierge practice was launched in Seattle in 1996. That practice, MD2, is still in business today.

The Roth IRA Answer To Retirement Medical Costs

Robert Laura, Contributor

11/21/2011 @ 12:07PM

Earlier this year Fidelity Investments estimated that a couple retiring today at age 65 can expect to pay $230,000 in Medicare premiums and uncovered expenses over the course of their golden years… a poisonous reality that must be met in addition to regular retirement savings. The fact that rising health care costs also tops the biggest concerns among many retirees means finding a antidote for both saving and investing appropriately to offset the burden of future medical expenses.

To address healthcare concerns and future living costs, I often suggest that soon-to-be retirees maximize their funding of a Roth IRA and consider taking a more aggressive, long-term stance with the investments inside of it. You are likely familiar with the popular features of the Roth IRA, including tax-deferred growth and tax-free-withdrawals, but many haven't considered how additional features can be used to offset future medical expenses, such as the fact that there are no required distributions at age 70½ and that owners can invest in anything they want within their Roth.

To start, since there are no required distributions at age 70½, investors may take a longer-term approach on the types of investments earmarked for future medical expenses. For instance someone aged 60 and planning to retire in five years, can be aggressive if they're healthy and don't anticipate needing access to the Roth funds until they are, say, 75 … an age commonly associated with at least one major medical or long-term care service need.

Thus, a 60 year-old has 15 years until the funds are likely to be required. If it were just five years instead, there would be different considerations in the investments selected since there is less time for average returns to work in an investor's favor. That being said, Roth investments reserved for medical expenses that are 10 or 15 years away may be a great place to increase your overall risk tolerance, with considerations given toward growth-oriented mutual funds, ETFs, or even popular individual growth stocks like Apple, Google, or Amazon.

The math is pretty straightforward. Take for example a 55 year-old who wants to retire at age 66. By contributing $6,000* per year for the next 10 years, and investing it aggressively during that period of time (assuming a 10% rate of return) they will accumulate nearly $120,000. If, after 10 years, a retiree doesn't need to access this asset for another 10 years, even if they've earned a rate of return of only 6%, at the end of that period they'll have nearly $215,000 for medical and /or long-term care needs.

As an added bonus, if you stay healthy and don't need to use the funds, or if your number comes up before you need to access the funds, these assets may transfer income tax free to your heirs or a favorite charity.

One caveat, of course, is the fact that there are income limits for the Roth IRA. For tax year-2011, investors begin to phase out of eligibility if they're Adjusted Gross Income is above $169,000 for a married couple (filing jointly) or $107,000 for a single or head of households. At the other end of the spectrum, if you're already retired and living on a pension, dividends, or other passive income sources like rental income, you may not be eligible since you must have earned income to qualify.

If the contribution rules present an issue, two solutions come to mind: 1) Ask your employer to begin offering a Roth 401(k). This option was actually made available as part of the Pension Protection Act of 2006 but has only lately began to show up as an available option, although for the most part only with larger employer group plans. 2) Seek out a low-cost, no surrender charge annuity to help grow assets tax deferred. While an annuity option isn't as ideal as a Roth (because taxes will be due on any gains at withdrawal) an aggressive investment stance plus tax-deferral over time may help reduce the overall tax burden.

Finally, funding a Roth for future medical costs can also help early retirees bridge the gap between employer-provided health insurance and the time when they become eligible for Medicare. One of the biggest reasons people put off early retirement rests with their inability to find or afford individual health coverage. With a healthy Roth IRA account balance, however, you can leave work at age 63½ and exercise your employer's 18-month COBRA option to bridge the coverage gap, while ideally paying for it tax free from your Roth.

As people continue to live longer and demand quality health care, medical costs will continue to plague current and future retirees. Pre-retirees need to deal with their future needs by taking their medicine and not only fund a Roth IRA or Roth 401(k) but to also invest it in such a way to meet those future obligations.

**Annual Roth IRA contributions are limited to $5,000 per year, per individual unless you are over the age of 50 and therefore may be eligible to contribute up to $6,000. Other requirements may apply*

25 "Worst Passwords" of 2011 Revealed

By David Coursey | Forbes

If you see your password below, STOP!

Do not finish reading this post and immediately go change your password -- before you forget. You will probably make changes in several places since passwords tend to be reused for multiple accounts.

Here are two lists, the first compiled by SplashData:

1. password	14. master	Last year, Imperva looked at 32 million passwords stolen from RockYou, a hacked website, and released its own Top 10 "worst" list:
2. 123456	15. sunshine	
3.12345678	16. ashley	
4. qwerty	17. bailey	1. 123456
5. abc123	18. passw0rd	2. 12345
6. monkey	19. shadow	3. 123456789
7. 1234567	20. 123123	4. Password
8. letmein	21. 654321	5. iloveyou
9. trustno1	22. superman	6. princess
10. dragon	23. qazwsx	7. rockyou
11. baseball	24. michael	8. 1234567
12. 111111	25. football	9. 12345678
13. iloveyou		10. abc123

If you've gotten this far and don't see any of your passwords, that's good news. But, note that complex passwords combining letters and numbers, such as passw0rd (with the "o" replaced by a zero) are starting to get onto the 2011 list. abc123 is a mixed password that showed up on both lists.

Last year, Imperva provided a list of password best practices, created by NASA to help its users protect their rocket science, they include:

It should contain at least eight characters

It should contain a mix of four different types of characters - upper case letters, lower case letters, numbers, and special characters such as !@#$%^&*,;" If there is only one letter or special character, it should not be either the first or last character in the password.

It should not be a name, a slang word, or any word in the dictionary. It should not include any part of your name or your e-mail address.

Following that advice, of course, means you'll create a password that will be impossible, unless you try a trick credited to security guru Bruce Schneir: Turn a sentence into a password.

For example, "Now I lay me down to sleep" might become nilmDOWN2s, a 10-character password that won't be found in any dictionary.

Can't remember that password? Schneir says it's OK to write it down and put it in your wallet, or better yet keep a hint in your wallet. Just don't also include a list of the sites and services that password works with. Try to use a different password on every service, but if you can't do that, at least develop a set of passwords that you use at different sites.

Someday, we will use authentication schemes, perhaps biometrics, that don't require so much jumping through hoops to protect our data. But, in the meantime, passwords are all most of us have, so they ought to be strong enough to do the job.

Rising cost of long-term care insurance angers seniors

By Jackie Crosby | Star Tribune (Minneapolis)

MINNEAPOLIS — When Dean Di Tosto bought long-term care insurance in 1998, he believed he was locking in a low rate.

Now the 83-year-old Minnetonka, Minn., resident feels duped. His insurance company, John Hancock, raised the premiums twice in the past three years. The payments could go from $140 a month to $202 a month, a 44 percent increase.

"I understand the need for these increases," he said. "I'm not a dummy. But it should affect future new policyholders, not those of us who have already put in thousands of dollars. Many people can't go out and make more money to make up the difference."

Trapped between fast-rising costs for care and weak returns on their investments, insurers have been raising long-term care premiums by double-digit percentages.

In Minnesota, for example, John Hancock, one of many companies to seek increases from the state, secured average rate increases of 13 percent in 2008 and 40 percent in 2010.

Some worry that higher premiums will make people less likely to get long-term care insurance - a potentially serious problem at a time when aging baby boomers' needs for long-term care are about to explode. Ultimately, that could force people to lean on government programs to pay for nursing-home care and other costs.

"We've identified it as a priority for our health reform cabinet," said Minnesota Commerce Commissioner Mike Rothman, whose office regulates the insurance industry. "We're looking at it, monitoring it, and making sure that when those rate increases come in, that they're not exorbitant."

Long-term care insurance pays a fixed amount of daily benefits for a certain period of time. Premiums are based on such factors as age, gender and health.

State and federal lawmakers have spent considerable energy trying to encourage the middle class to plan ahead with long-term care insurance, without much luck.

The Obama administration last month scrapped the CLASS Act, a long-term care insurance program and major piece of federal health care reform.

Even though the Medicaid program was designed as a safety net for people in poverty, middle-class seniors routinely deplete their assets and turn to the state.

More than 180,000 Minnesotans have long-term care insurance policies, designed to help seniors pay living costs later in life without being forced to deplete savings or sell their homes. The average cost of care is about $48,000 a year, but nursing homes can cost $80,000.

In Minnesota, Medicaid pays about 40 percent of elderly long-term care. Costs could rise fivefold by 2035 to an "unsustainable burden" of $5 billion, according to a report last year from the Citizens League. Minnesota launched a program in 2008 that allows median-income households that buy long-term care policies to shelter some assets if they apply for Medicaid. Still, only about 11 percent of people in the state have the insurance.

Minnesota has tightened its long-term care law to add consumer protections and force insurers to build a stronger case to regulators for premium increases. But those rules only affect policies written in 2002 and beyond.

Long-term care coverage is a relatively new product. Though policies have been available since the 1970s, sales didn't start taking off until 1996, when the federal government offered modest income tax advantages.

A combination of factors has driven the recent price increases.

Insurers set their rates on assumptions that some people would let their policies lapse. But people held on to policies longer than expected. And their claims are bigger because they're living longer.

Low interest rates have had perhaps the biggest impact, because insurers planned to cover claims based on reserves they invested. When those investments fell short of expectations, insurers turned to policyholders to make up the difference.

"It's the perfect storm," said Amy Pahl, who advises insurance companies on long-term financial projections and regulatory matters for the actuarial firm Milliman.

"You're looking at collecting premiums and investing them for 30, 40 or 50 years before a payout," she said. "Ten or 15 years ago, interest rates appeared to be sustainable at 6 or 7 percent. Every American knows that's unachievable now."

The difficulty of making the risks and financing work over such a long time horizon has led a number of companies to get out of the business, including Blue Cross and Blue Shield of Minnesota, Allianz Life and Ameriprise, Paul said.

A decade ago, 130 companies sold long-term care insurance. Today there are about 20, she said.

Deb Newman - whose Richfield, Minn.-based company, Newman Long Term Care, is one of the biggest long-term care sellers in the country - has sympathy for policyholders facing increases. She's one of them.

A policy she bought 18 years ago went from $725 annual premiums to about $1,100. Even so, it's a better deal than waiting, she said. Similar coverage would cost someone who bought a policy now about $5,000 annually.

"People are understandably surprised when the insurance companies say, 'Oops, we have to go back and increase everyone's premiums by 40 percent,' " she said. "But it's still a tremendous value relative to what they could purchase today."

The squeeze is especially tough for people who bought policies in the 1980s and 1990s. Some of those policies didn't cover assisted living or adult day care, because they didn't exist at the time.

In an e-mailed response to questions, a John Hancock spokeswoman said, "The company has always tried to provide alternatives to policyholders facing rate increases so they can keep premiums close to their current levels."

The alternatives include reducing the benefit period, adjusting the benefit amount or allowing policyholders to reduce inflation coverage, the company said.

Di Tosto, a former marketing executive who runs a small business with his son, said he can afford higher premiums for himself and his wife, Inga. He remains angry that his choices are to pay up, reduce his benefits, or cancel and lose the $50,000-plus he has paid over the past 13 years.

He's made it a crusade to push elected officials to do more to protect the state's elderly and infirm.

"Many people are old and too feeble to fight," he said. "Somebody has to stand up."