Health & Retirement Services Of Illinois
September 2011 Newsletter

OUR NEWS LETTER HRSI

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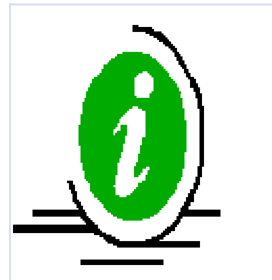
10 Things You Should Not Keep in Your Wallet

by Kathryn Tuggle
Thursday, July 28, 2011

provided by FOX BUSINESS

What you keep in your wallet will determine how at risk you are for identity theft in the chance you lose it. Here are 10 items experts suggest keeping at home.

We all make sure we've got our keys, wallet and phone before we head out the door, but more often than not, we are carrying around things that are better left at home. Some items we carry on a daily basis can be virtually impossible to replace, and others may leave us at risk for identity theft in the event of loss. We checked in with the personal finance experts at LearnVest to find the top 10 things you shouldn't carry in your purse or wallet.



Social Security Card

"You may carry it around thinking you need a back-up source of ID, but these days you don't really need it," says Maria Lin, editor in chief at Learnvest. If your Social Security card gets in the wrong hands, someone could open a credit card, apply for a loan, or even buy a car with the information. It's nine digits, just memorize it.

Your Passport

If you're traveling internationally, of course you can't leave your passport at home, but you can leave it in the hotel safe. When you are abroad, make a photocopy of your passport to have in your wallet for identification along with your driver's license. "If you lose your passport or get mugged in a foreign country, it's such a horrible hassle," says Lin. "You have to go to the embassy, and it's a vacation nightmare." If you're traveling in the U.S., use your driver's license instead. "Your passport is such a primo document for your identity, if someone gets a hold of it, you can really put yourself at risk for identity theft," says Lin.

Passwords/Pass codes

Although most PIN numbers are only four digits long, some people still write them down so they don't forget. "If you store any type of ATM password or even a code for your home alarm in your wallet, you have basically gifted a thief with access to your life," says Lin. If you absolutely can't remember important pass codes, store them digitally on a password-protected phone, but never write them down and leave them in your wallet or purse.

©Reuters

A Non-Password Protected Phone

Today, many people have smart phones that allow them instant access to bank accounts, PayPal accounts, medical records, and more. Even if your phone only accesses e-mail, a thief could easily search for banking or ATM passwords or addresses, according to Lin. "Think about all the things you have digitally stored on your phone. You have to have it behind password protection. This way a thief can still erase your phone's memory and use it for themselves, but they won't have access to your data."

Your Checkbook

"As innocuous as it seems, your checkbook has your bank account number and routing number on it, your address, and possibly imprints of your signature," says Lin. Lin says that if you know you're going to need to write a check one day, peel off one check out of your book and take it with you. If you know you're going to need to write multiple checks in one day, go ahead and take your checkbook, but don't get into the habit of carrying it around with you all the time, Lin says. "You want to prevent someone's ability to just start writing out your blank checks and cashing them."

Too Many Credit Cards

"A lot of people put all their cards in their wallet and carry them with them at all times," says Lin. "But if your wallet gets lost or stolen, that means you're going to have to sit and cancel every single one, and wait a week without any credit cards before you receive a replacement." Only carry the one or two cards you use on a daily basis and a backup, and leave others at home. Also make sure you keep photocopies of the front and back of each card at home, Lin advises. The 1-800 number to call and report a lost or stolen card is very often on the back of your card -- which doesn't do you a lot of good once the card is no longer in your possession.

Too Much Cash

Lin offers the following rule of thumb when it comes to carrying cash: Bring only as much with you as you're willing to lose. "It's good to have a little cash on you at all times for emergencies, but you don't want to carry so much that you're going to feel a real hit if your wallet gets stolen." For people on a "cash diet," Lin recommends bringing only as much cash to cover the day's expenses.

Gift Cards/Certificates

"A lot of people carry these around thinking, 'I never know when I'm going to be passing this store,' but chances are, you're going to forget about it anyway, and if your wallet gets stolen, it's one of the first thing thieves are going to use," Lin says. Gift cards and gift certificates are just like cash -- they don't require ID for use. "Try to leave it at home and take it with you only when you are consciously going to shop at that store," Lin says. "Make it a special excursion; it's a treat to have free money to spend."

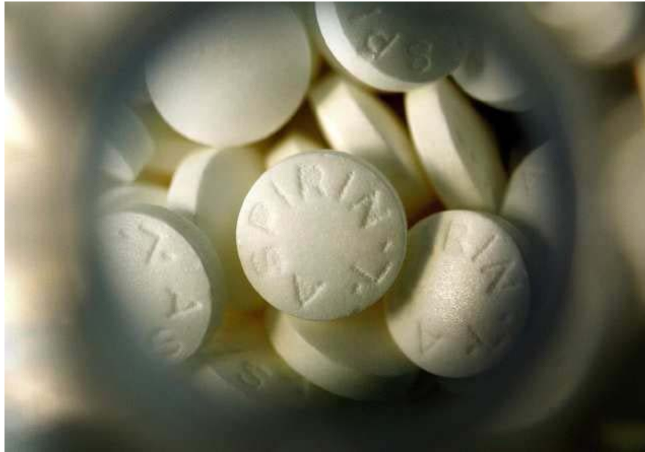
Jewelry or USB Devices

"It may sound silly, but if you're changing earrings or heading from a business meeting, it's very possible you may forget and toss these things in the zipper compartment of your wallet," says Lin. USB devices can be bad news in the hands of thieves if they contain confidential files. "It would be horrible to get your wallet stolen any day, but if you're also losing your grandmother's earrings or a presentation you've been working on for months, it's even worse!"

Receipts

Sometimes receipts can have your credit card information on them, as well as your signature, which thieves could do a lot of damage with. Additionally, if you've just purchased a big-ticket item like a new computer or jewelry, you may need that receipt for warranty purposes. "If you're planning to use your receipts for expense purposes at work, those few hundred dollars of business receipts can just vanish and your employer might not be so understanding," says Lin. "Get in the habit of taking out your receipts every night instead of carting them around with you."

Aspirin wards off heart attack--just don't stop taking it, study warns



People who take daily low doses of aspirin to prevent heart attacks, but stop the regimen, have a short-term higher risk of having a heart attack than those who continue the treatment, a study in people with a history of heart disease found. (Tim Boyle / Getty Images)

2:37 p.m. CDT, July 21, 2011

For people who've suffered a heart attack or are at risk for one, low doses of aspirin are a commonly prescribed apple-a-day to ward off future heart attacks.

But for some patients on the regimen, it's a treatment that should be taken ... seriously. In a new study, patients with a history of heart disease who had recently stopped low-dose aspirin were more likely to have a heart attack.

European researchers tracked nearly 40,000 people with a history of heart disease, age 50 to 84, who had just started taking between 75 and 300 milligrams of aspirin per day.

Within up to eight years of follow-up, some adhered to the treatment, while others stopped refilling their aspirin prescriptions. Of those who stopped, some patients switched to new treatments or non-prescription aspirin, had safety concerns over aspirin or, most commonly, didn't have a clinical reason.

Those who had recently quit the regimen (within the previous one to six months) were 63% more likely to suffer a non-fatal heart attack than those who continued.

Even stopping aspirin for 15 days was associated with the short-term risk. And the heart attack risk existed regardless of how long the patient had been taking aspirin. The study was published Tuesday in the British Medical Journal.

Why patients stop taking the aspirin treatment, and how to encourage patients to stay on it, needs further research, the authors conclude. The Mayo Clinic has more here about who can benefit from daily aspirin.

Medicare Drug Premiums Won't Increase in 2012, U.S. Says

By Drew Armstrong - *Aug 4, 2011 10:58 AM CT Thu Aug 04 15:58:38 GMT 2011*

Premiums for Medicare prescription drug plans run by private insurers won't go up in 2012, the U.S. said in a press release.

Beneficiaries will pay $31.08 in 2012, on average, for access to the drug plans, compared with $30.76 in 2011, according to the program. UnitedHealth Group Inc. (UNH) led enrollment in the drug benefit plans by publicly traded companies in the first quarter of 2011, followed by Humana Inc. (HUM) and Universal American Corp., according to data compiled by Bloomberg.

Medicare Administrator Donald Berwick said that the largely unchanged premiums, combined with drug discounts in the 2010 health overhaul, will lower out-of-pocket spending by Medicare beneficiaries.

"It's a competitive market and we're seeing the effect of good competition among Part D plans take its effect," Berwick said on a call with reporters announcing the rates.

The steady or decreasing premiums are being driven by competition among the private plans as well as increased use of generic drugs and drugs coming off of patent protection, said Berwick and Sherry Glied, the assistant secretary for planning and evaluation at the Department of Health and Human Services.

New York-based Pfizer Inc. (PFE)'s top-selling drug Lipitor loses patent protection in November. The heart drug accounted for the second-most spending by Medicare in 2009, according to the program.

CMS adds new quality metrics on care

By Sam Baker - 08/05/11 03:31 PM ET

The Medicare agency announced new programs Friday to help consumers compare hospitals based on quality.

The Centers for Medicare and Medicaid Services launched a new website that allows users to compare not just hospitals, but also doctors and nursing homes. The site compares facilities based on several criteria, including the satisfaction of previous patients.

CMS also added new metrics to its **comparison tool** for hospitals. Users can now compare hospitals based on how well they protect against surgical infections and how well they treat possible heart attacks.

“These efforts are designed to also encourage providers to deliver safe, patient-centered care that consumers can rely on and will motivate improvement across our health care system," CMS Administrator Don Berwick said in a statement.

CBO REPORTEDLY UNDERESTIMATED HEALTHCARE OVERHAUL COST BY $50 BILLION/YR.

Fox News' Special Report (8/9, Baier) reported, "The price tag for President Obama's healthcare law may be bigger than anyone anticipated -- $50 billion bigger every year." According to Fox, the National Bureau of Economic Research "claim[s] a simple accounting maneuver led the nonpartisan Congressional Budget Office to significantly underestimate the cost of the new healthcare law. According to the report, the Joint Committee on Taxation told the CBO to calculate cost by taking only individual workers in account, and not the family members that would also need to be insured." Fox noted that the "is disputing" the claim.

THE TRUTH ABOUT PROTEIN IN YOUR DIET

How much protein do you really need?

- by Yahoo!Green, on Mon Aug 8, 2011 2:48pm PDT

(Photo: Getty Images)

By Sarah B. Weir and Lori Bongiorno
Posted Mon Aug 8, 2011 2:04pm PDT More from Green Picks blog

Guess how much protein is in a juicy, 8-ounce cheeseburger washed down with a milkshake? This single meal contains two to three times as much as most people need *per day*.

It's no great surprise that Americans chow down on a lot of protein. We love beef and consume about 67 pounds per capita annually (that's four times the international average). The popularity of low-carb regimes such as Atkins has also made meat the go-to food for dieters.

In fact, the average person eats about double the amount of protein that their body requires, according to the results of 2007-2008 National Health and Nutrition Examination Survey conducted by the Centers for Disease Control and Prevention.

How to fulfill your daily protein requirement

The human body uses protein to repair damaged cells and to build new ones. Marion Nestle, professor of nutrition at NYU and author of *What to Eat*, estimates that the average adult man needs about 65 grams of protein a day and the average adult female needs about 55 grams. Some sources, such as the Centers for Disease Control and the World Health Organization say you can maintain a healthy diet with even less.

What does this actually mean in terms of food choices? The National Institutes of Health explains that most people can meet their daily protein requirement by eating two to three small servings of a protein-rich food a day.

Examples of a single serving of protein include:

- 1 egg
- 2 tablespoons of peanut butter
- 2-3 ounces of red meat, poultry, or fish (about the size of a deck of cards)
- ½ cup of cooked dried beans such as black beans or chickpeas

Whole grains, seeds, and some vegetables also contain protein, so consuming enough is not difficult even if you don't eat meat. Vegetarians and vegans can easily get what they need by balancing complimentary proteins such as corn and beans or rice and tofu. Nutritionists used to recommend combining foods at the same meal, but research now shows that is unnecessary.

Are there drawbacks to eating more protein?

Eating large amounts of red and processed meats is associated with higher rates of heart disease and cancer, and most nutritionists such as Marion Nestle recommend cutting back on meat, especially on fatty cuts.

However, it's less well known that your protein choices can have a substantial impact on the environment. Meat and dairy production requires tremendous amounts of fuel, pesticides, and chemical fertilizers, and generates greenhouse gases. The Environmental Working Group's (EWG) recently published Meat Eater's Guide points out that if you ate once less burger a week it would be the environmentally-positive equivalent of taking your car off the road for 320 miles.

Meat is also expensive. Not all proteins are created equal -- neither at the doctor's office, nor the cash register. Here's a comparison of three typical proteins:

Porterhouse steak
Serving size: 4 ounces
Protein: 22 grams
EWG carbon footprint rating: 2 nd worst out of 20 analyzed
Cost: 4 dollars
Fat: 22 grams
Saturated fat: 9 grams

Farm-raised salmon
Serving size: 4 ounces
Protein: 22 grams
EWG carbon footprint rating: 5th worst
Cost: 3 dollars
Fat: 10 grams
Saturated fat: 2 grams

Lentils
Serving size: 1 cup
Protein: 17.9 grams
EWG carbon footprint rating: best
Cost: 20 cents
Fat: zero
Saturated fat: zero

Many people find meat to be a delicious and satisfying component of their diet that they don't want to sacrifice. But if you want to save money, eat a nutritionally sound diet, and are concerned about the impact meat and dairy production has on the planet, consider reducing your consumption.

Here are some tips from the EWG's Meat Eater's Guide:

- Reduce portion sizes by eating one less burger or steak each week, or participate in Meatless Mondays by skipping meat (and cheese if you can swing it) just one day a week.
- Choose the healthiest protein sources when you can. Beans, low-fat yogurt, and nuts are all high in protein and low-impact.
- When you do eat meat and cheese, eat the highest quality that you can afford. (One way to save money is to eat less, but better quality meat and dairy products.) Here's a guide decoding the labels, from cage-free to grass-fed.
- Don't waste meat. Uneaten meat accounts for about 20 percent of meat's greenhouse gas emissions.

You don't have to become a vegetarian or go to other extremes. These small changes will help reduce your impact, while providing plenty of protein in your diet.

Seniors brace for cuts to Illinois drug program

Nearly 43,000 people will lose state drug assistance

Joyce Pennington, 62, with her dog, Honey, in her home in Midlothian , worries about what will happen after she is cut off from the state's prescription coverage on Sept. 1. "I know everybody's hurting, and I don't like to ask for help," she says. "But now, it seems like I have nothing." (Zbigniew Bzdak/Chicago Tribune)

By Judith Graham, Tribune reporter
August 14, 2011

Joyce Pennington opened a letter from the state recently and got some unexpected news: At the end of this month, she will be dropped from an Illinois program that helps pay for prescription medications.

The 62-year-old Midlothian woman, who has severe lung and heart disease, broke into tears. "I thought, wait a minute, I've worked my whole life and now that I need some help they're treating me like this?" she said.

Nearly 43,000 low-income seniors and people with disabilities are finding themselves in similar straits as they learn they no longer qualify for Illinois Cares Rx, a popular program whose funding was slashed in half, to $53.7 million from $107.4 million, in the new state budget.

They represent residents who are deeply vulnerable as the economy flounders and the state pulls in the reins on spending: people with limited incomes who aren't among the poorest of the poor but who rely on some aid to meet living expenses they wouldn't otherwise be able to afford. Many are afraid that state and federal budget crises will prompt lawmakers to continue to cut programs that provide medical support.

Illinois Cares Rx is a lifeline for these individuals, filling in expensive gaps in Medicare prescription coverage for

some, covering Medicare drug plan premiums and co-payments for others, and subsidizing the cost of medicine for everyone in the program.

With reduced funding, the state has narrowed the ranks of people who are eligible for Illinois Cares Rx to those earning no more than 200 percent of the federal poverty level; previously, people with incomes up to 240 percent of this standard qualified. For an individual, the new threshold for eligibility is now $21,780, down from $27,610.

The change will take effect Sept. 1; at that point about 173,500 people will remain on Illinois Cares Rx and face higher co-payments for prescriptions — in some cases, double the amount they were previously paying.

Hit even harder will be tens of thousands of vulnerable seniors and people with disabilities who are being eliminated from the program and who have to scramble to come up with alternative ways of paying for their medicine. Many are distraught and overwhelmed by that prospect.

Pennington was one of the few willing to speak openly about the hardship she faces.

She takes 14 medicines for her various ailments. The cost of filling most of those prescriptions will triple when Pennington leaves Illinois Cares Rx, and one will jump to $42 a month, up from $6.30 a month. Where she'll get the money is unclear. Pennington said she already owes $900 to the company that delivers her oxygen supplies and hundreds more to the hospital where she goes when her lung or heart problems flare up.

"I know everybody's hurting, and I don't like to ask for help," this grandmother said. "But now, it seems like I have nothing."

The situation is causing tremendous "fear and anxiety," as well as significant confusion, said Terri Gendel, director of benefits and advocacy for AgeOptions, the area agency on aging for suburban Cook County. "Some people are panicked, to the point of almost being hysterical. Others just say, 'I've been in this program for years so it must be a mistake.' They're in denial."

That's a problem because what people losing Illinois Cares Rx coverage need to do, above all else, is "come up with a plan" for dealing with their medicine needs, Gendel said.

Those being forced to leave the program fall, broadly, into two groups. The first consists largely of seniors and people with serious disabilities enrolled in Medicare who have prescription coverage through Medicare drug plans or managed care-style Medicare Advantage plans. In their case, Illinois Cares Rx "wrapped around" the Medicare plans, covering costs that consumers are required to pay out of pocket such as premiums, deductibles and co-payments.

Those can be considerable, with monthly Medicare drug plan premiums of $30, on average, and monthly co-payments for brand-name drugs starting at $38.25 and going as high as $91.

Pennington falls into this category: Despite her age, she qualifies for Medicare coverage and has a Medicare drug plan because she's permanently disabled and enrolled in Social Security's disability program.

Then there's the infamous "doughnut hole," a gap in Medicare drug plan coverage that opens up when an individual buys $2,840 worth of medicine in a year. (The amount will be slightly different next year.) Some relief is available to seniors, as medication charges to those in the doughnut hole have been reduced by 50 percent this year. Even so, the costs can be considerable, which is why Illinois Cares Rx aid to people who find

themselves in the Medicare doughnut hole is so helpful.

For this group, which has Medicare coverage, the most important immediate advice is "pay your monthly (drug plan) premium, because if you don't, you could lose your Medicare drug benefits," said Jim Parker, deputy administrator for medical programs at the Illinois Department of Healthcare and Family Services.

That's going to be a hardship for John Prykop, 80, and his wife, Helen, 73, who between them take eight drugs for heart disease, high cholesterol, vertigo, emphysema, rheumatoid arthritis and thyroid disease. The Hometown couple's income is $30,600 a year, just slightly above the new eligibility limits for Illinois Cares Rx.

"We don't have the money" to pay $62 monthly to cover premiums for Medicare drug plans for two people, John Prykop said. "We're between a rock and a hard place. What I have to do is find out from my doctor if any of these medications we're on can be stopped."

The second group being forced out of Illinois Cares Rx consists largely of people with disabilities who aren't on Medicare and don't have any drug coverage through that government health program.

Options for this group include discount drug cards, low-cost medicines available at retailers such as Target or Walgreens, drug company prescription assistance programs, and aid from organizations that advocate on behalf of people with specific illnesses, Gendel said.

Illinois is hardly the only financially pressed state scaling back its prescription assistance program; South Carolina shut down its program last year, Arizona did the same the year before, and several other states are eyeing or implementing cutbacks, experts said.

The program became a target as the state faced a gaping budget deficit but could not cut Medicaid benefits because of federal requirements that states maintain existing commitments to that program. "We were very limited in what we could do," said Parker of the Illinois Department of Healthcare and Family Services, referring to the need for budget cuts.

Because a large percentage of those being cut from the state drug program have Medicare coverage, the impact will be mitigated, Parker suggested. "Many people may think they have lost all their drug coverage, but that isn't the case" since their Medicare plans will still be in place, he said.

August 18, 2011, *11:25 am*

76 Cents Worth of Good News

By PAULA SPAN

In a slightly desperate hunt for good economic news, I've come up with this small consolation: Average premiums for Medicare Part D, the prescription drug benefit, will not rise in 2012. In fact, they will fall slightly.

The last time this happened was in 2007, the year after Part D took effect. Insurers weren't certain how to price the new benefit, so they had set the price high to protect their profit margins. They guessed wrong — the drug benefit continues to cost less than originally estimated, according to the federal Centers for Medicare and Medicaid Services — so premiums dropped sharply the following year. But each year since, they've crept up, by a buck here and three bucks there — until now, when the national average will drop to $30 from $30.76 a month next year. (Hey, I said it was small consolation.)

Even the comparatively small number of Medicare recipients with incomes of over $85,000 for an individual or $170,000 for a couple — at which point something called an income-related monthly adjustment amount kicks in — will see a little dip, to $11.60 a month from this year's $12 a month, charged in addition to the monthly premium.

The main cost-control factor is Medicare's heavy use of generic drugs, the agency says, along with competition, as insurers bid against one another to attract customers, plus the inflation-busting effects of lingering recession.

The other good Part D news is how many people in the infamous "doughnut hole" are getting some relief from the 50 percent discounts on covered name-brand drugs (and 7 percent on generics) that took effect this year. Through June, nearly 900,000 people had used the discounts, a number that will increase as the months pass, and each had saved $517 on average.

Of course, one might argue that small consolations are outweighed by the misery of falling into the doughnut hole, which won't close completely until 2020, in the first place. Or outweighed by the fact that this is an average of many plans in many regions, so some people may actually find their 2012 Part D premiums rising slightly.

So it makes sense, as Medicare officials always caution, to evaluate those plans carefully before making a choice. The Part D enrollment period comes earlier than usual, too. It starts on Oct. 15 and ends Dec. 7.

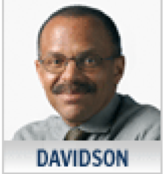
SENIORS IN MEDICARE GAP TWICE AS LIKELY TO DISCONTINUE PRESCRIBED MEDICATIONS

Seniors In Medicare Gap Twice As Likely To Discontinue Prescribed Medications.

MedPage Today (8/17, Walkers) reports that seniors "caught in the Medicare Part D coverage gap known as the 'doughnut hole' are twice as likely to stop taking their medication," according to new study in the Aug. 16 issue of PLoS Medicine. Researchers followed "more than 663,850" seniors enrolled in either Medicare Part D or a CVS Caremark plan in 2006 and 2007. They found that 33% of "Medicare enrollees reached the coverage gap threshold in about mid-August, leaving those with no financial assistance to pay for all of their drug costs either until they spent enough money on prescriptions ($2,250 in 2006 and $2,400 in 2007)" or until their "benefits reset." Moreover, seniors "paying 100% of their costs in the coverage gap were. ... 2.6 times more likely to stop taking" name-brand cardiovascular drugs, and nearly "two times more likely" to discontinue generic heart treatments.

Postal Service health benefits decision could have wide impact

By Joe Davidson



If the U.S. Postal Service is successful in its plan to withdraw from the Federal Employees Health Benefit Program (FEHBP), it would have ramifications for the entire federal workforce.

Pulling out of the program was one of the key points in a new set of proposals the Postal Service is pushing to deal with structural financial problems that have led to $20 billion in net losses over four years, including an $8.5 billion loss for fiscal year 2010.

A key question for USPS is “how do you control health care costs going forward,” Postmaster General Patrick R. Donahoe said in an interview. “Currently, the Postal Service spends $7.3 billion on heath care for about 1 million employees, retirees and their dependents.”

FEHBP , which is administered by the Office of Personnel Management, has a reputation for providing employees a choice among a broad range of private insurance plans, while keeping costs in check. Acknowledging FEHBP’s reasonable fees, Donahoe said the large number of people in the postal contingent of FEHBP “holds the prices down for everyone else. And we’d rather take advantage of that going forward.”

“If we take over our own plan, cover 1 million people, employees and retirees, the experts tell us you can cut your costs by somewhere between 8 to 10 percent.”

Any savings to the Postal Service, however, could mean greater costs to postal employees, through higher insurance premiums or lower benefits.

Donahoe’s assertions do not go unchallenged, with one expert calling them nonsense.

Walt Francis, a health economist and primary author of Checkbook’s annual “Guide to Health Plans for Federal Employees,” predicted the Postal Service “will be less competent and less efficient than OPM, by far, in trying to run their own insurance program. Anything they propose to do, if it will help them financially, will necessarily involve reducing benefits, reducing their share of premiums, or playing some financial game like stripping reserves.”

But if the postmaster general is correct, then it could open up FEHBP to much greater scrutiny, particularly by members of Congress looking for ways to save federal workforce dollars.

Donahoe recognizes that a Postal Service withdrawal from FEHBP would cause a reexamination of the entire program that serves about 8 million people.

“If we were successful pulling out, they would have to look at how they run the plan from a cost perspective and they have to take a look at something similar to what we are proposing, a more limited number [of plans], a more competitive environment,” he said..

"To maintain all the plans, it's a fairly expensive administrative process, plus you've got to keep reserves for all those plans. So, there's a lot of money that gets tied up in that."

But Francis said, "The administrative costs of the FEHBP are incredibly low. " The reserves come from plan premiums and the cost to administer them is "essentially zero," according to Francis.

The large number of private health insurance companies, more than 200, that compete each year to sign up federal employees often is credited with keeping the cost of FEHBP plans competitive, if not lower than those in the private sector.

In a document released earlier this month, USPS said FEHBP does not meet "the private sector comparability standard," meaning it is more generous that private sector insurance offerings.

The Postal Service argued that "a legislative change that allows the Postal Service to establish its own health benefits program would allow the Postal Service to fully incorporate private sector best practices, saving money while also providing comparable benefits to employees."

But, according to Francis, "there is no evidence to support any of the FEHBP conclusions of the so-called 'White Paper' of the USPS. Anyone who is expert in health insurance will recognize that it is nonsensical propaganda, written by someone who didn't even know what he or she was talking about."

"This proposal is not about better health insurance," he added. "It is about finding ways to get money from someone, whether that be the public, the Treasury, or the employees. It is not about delivering an equivalent health insurance product at lower costs, since that is not within their competency."

Expanding Waistlines May Boost U.S. Health Cost $66 Billion a Year by 2030

By Andrea Gerlin - *Aug 25, 2011 5:42 PM CT Thu Aug 25 22:42:27 GMT 2011*

Expanding Waistlines May Boost U.S. Health Cost $66 Billion

Cindy Yamanaka/Orange County Register/Newscom

A barber helps a customer through the door of his shop.

A barber helps a customer through the door of his shop. Photographer: Cindy Yamanaka/Orange County Register/Newscom

Aug. 26 (Bloomberg) -- U.S. health-care spending may rise by as much as $66 billion a year by 2030 because of increased obesity if current trends continue, researchers said. Shannon Pettypiece reports on Bloomberg Television's "In the Loop." (Source: Bloomberg)

U.S. health-care spending will rise by as much as $66 billion a year by 2030 because of increased obesity if historic trends continue, researchers said.

Almost 100 million Americans and 15 million Britons are already considered obese, based on body-mass index, a ratio of weight to height, Y. Claire Wang, an epidemiologist at Columbia University's Mailman School of Public Health in New York, said yesterday at a London news conference.

Another 65 million American adults and another 11 million British adults would join them in the next two decades based on past trends, said Wang, one of the authors of a four-part series on obesity published in today's Lancet. The increased cost represents about 2.6 percent of the U.S.'s annual health-care bill. In the U.K., costs would rise as much as 2 billion pounds ($3.3 billion) a year, or 2 percent of yearly health spending.

"We are in an obesity and chronic disease crisis although it doesn't feel like it," Boyd Swinburn, a professor at Deakin University in Melbourne and another of the authors, said at the press conference. "It's a little bit like the frog sitting in hot water -- it doesn't realize that it's going to boil until it's too late."

Obesity rates have increased globally since the 1970s as changes in the food supply affect what people eat, Swinburn said. The condition has been driven primarily by the "passive overconsumption" of more processed, affordable, available and promoted food, he said.

UN Meeting

The United Nations will hold its first high-level meeting on noncommunicable diseases in New York Sept. 19-20 and government leaders there need to address the worldwide obesity epidemic, the researchers said.

"Governments certainly need to lead obesity prevention but so far few have shown any leadership," said Steven Gortmaker, a professor at the Harvard School of Public Health in Boston and one of the authors of the Lancet report. "If we have no measures and don't set any targets we're not going to make a lot of progress."

Taxes on unhealthy foods and beverages, "traffic-light" style labels and reduced advertising of junk food and beverages to children are among the measures that governments should consider to improve health and save on costs, Gortmaker said. He said food manufacturers had resisted efforts that could help address the obesity crisis and compared them to tobacco companies fighting anti-smoking campaigns.

The authors said while national plans to combat obesity have yielded few results, two "positive signs for the future" are the U.K.'s cross-government strategy of marketing restrictions and improving school food and, in the U.S., first lady Michelle Obama's campaign to reduce childhood obesity. She has pushed to make food labeling easier to understand, encouraged schools to increase exercise levels and reached agreements with companies such as Wal-Mart Stores Inc., the nation's largest retailer, to sell healthier food.

Illinois granted $5.1M for insurance exchange

CHICAGO

The Illinois Department of Insurance has been awarded a $5.1 million federal grant to develop and maintain a health insurance exchange where consumers can shop for coverage.

The nation's new health care law requires the exchanges to be running in states by 2014

Insurance exchanges will allow people and small businesses to comparison shop online for insurance. The concept has been described as Travelocity for health insurance.

The grant will help Illinois design the information infrastructure. It will go toward hiring staff to plan and coordinate with consultants to create the design features.

Gov. Pat Quinn said in a statement released Tuesday that the grant will help create a strong exchange and develop tools to make it easy for everyone to use.

New law helps Illinois patients who've been denied health insurance claims

By Associated Press
3:03 a.m. CDT, August 27, 2011
CHICAGO (AP) — Gov. Pat Quinn has signed legislation to beef up protections for consumers who want to appeal health insurance claim denials.

The law, signed Friday, brings state law into line with consumer protections required by the federal Affordable Care Act.

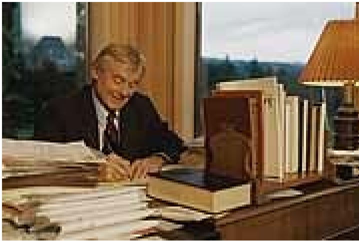
The new law also extends appeal rights to consumers whose coverage has been rescinded and consumers who've been denied a benefit due to a pre-existing health condition.

The measure was sponsored by Chicago Democrats Rep. Mary Flowers and Sen. Heather Steans. It's an initiative of the Illinois Department of Insurance and is based on model adopted by the National Association of Insurance Commissioners.

Quinn says the measure increases the fairness of the process of appealing a denial of a health insurance claim by turning it over to an independent review organization.

Some Older Americans Overwhelmed by Medicare Options, Study Says

Those experiencing mental decline may have the most trouble sorting through the options



MONDAY, Aug. 29 (HealthDay News) -- Although older Americans have many Medicare options to choose from, they may not be making good decisions about their coverage, according to a new study.

Some seniors -- particularly those with impaired brain function -- can become overwhelmed by the variety of complex Medicare Advantage plans available to them, preventing them from finding the best plan to fit their needs, according to researchers from Harvard Medical School's department of health care policy.

"We are providing the most complex insurance choices to the very population that is least equipped to make these high-stakes decisions," said Dr. J. Michael McWilliams, assistant professor of health care policy and medicine at Harvard Medical School and a general internist at Brigham and Women's Hospital, in a university news release.

"Most other Americans choose from just a few health plans, but elderly Medicare beneficiaries often have to sift through dozens of options," McWilliams said.

The Medicare Modernization Act of 2003 increased the number of private plans participating in the Medicare Advantage program, which purports to usher in more competition, lower premiums and result in better benefits, including prescription drug coverage.

In assessing how these changes affected enrollment in Medicare Advantage compared to traditional Medicare, researchers examined nearly 22,000 enrollment decisions made by more than 6,600 participants over the course of four years, taking into account their mental status and the plans available to them.

The study, published online and in the September print issue of *Health Affairs*, found that enrollment in Medicare Advantage increased when the number of Medicare Advantage plans available to seniors was fewer than 15.

When there were more than 30 plans available, however, enrollment dropped. The researchers pointed out that 25 percent of U.S. counties offer more than 30 Medicare Advantage options.

Elderly people with impaired brain function were much less likely to understand and take advantage of the wide array of benefits offered by Medicare Advantage plans and instead were more likely to choose the traditional Medicare program by default, according to the report.

Given the increasing numbers of older Americans with Alzheimer's and other forms of dementia, the findings should prompt policymakers to establish better ways to assist seniors in making the right choice for them, researchers said. That could include offering fewer choices or helping them make better decisions based on those options.

"Efforts to limit choice and guide seniors to the most valuable options could especially benefit those with cognitive impairments, who without more help appear to be leaving money on the table," said McWilliams. "Better enrollment decisions could in turn strengthen competition by rewarding high-value plans with more enrollees."

Not all experts would agree that the seniors who chose Medicare over Medicare Advantage were making the wrong choice, however.

Medicare Advantage plans have serious drawbacks compared to the original Medicare, according to the Medicare Rights Center (MRC), a non-profit consumer advocacy group.

Among the problems with Medicare Advantage the MRC cites are higher costs for skilled nursing care, home health care and in-patient hospital costs; unstable private plans that may suddenly stop coverage; restrictions in the choice of doctors, hospitals and other providers members can choose; and problems getting urgent or emergency care.

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