Health & Retirement Services Of Illinois
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OUR NEWS LETTER

Lung cancer deaths in women decline for the first time in 40 years

By Thomas H. Maugh II, Los Angeles Times

5:06 p.m. CDT, March 31, 2011

For the first time in four decades, lung cancer deaths have begun to decline in women, according to a government report released Thursday. The drop follows a similar decline in men by about 10 years, a lag generally attributed to the fact that women took up smoking later than men and began to give it up later as well.

Overall, cancer incidence rates fell about 1% per year and cancer death rates by about 1.6% per year from 2003 to 2007, according to the annual report to the nation **published online in the Journal of the National Cancer Institute.** The absolute number of cancer cases and cancer deaths continues to increase, however, because the proportion of the population over 65 is growing, and the elderly are the most vulnerable to cancer. The over-65 population is expected to double by 2030 compared with 2000.

Among men, the incidence of liver, kidney and pancreatic cancer and melanoma increased from 2003 to 2007, and death rates increased for three of them: melanoma, liver and pancreatic cancer.

Among women, the incidence of kidney, thyroid and pancreatic cancer increased during the period, as did that of leukemia and melanoma. Death rates increased for pancreatic and liver cancer. Death rates for uterine cancer, which had fallen for the 20 years preceding 1997, rose slightly in the ensuing decade.

Black men and women had the highest death rates from cancer overall, but also had the steepest declines in death rates, indicating that the group is getting more treatment than before. Black men had the highest overall incidence rate for new cancers, while white women had the highest rate among women.

The report included a special section on brain tumors. The researchers found that nonmalignant brain tumors were twice as common as malignant tumors among adults. Brain tumors were much rarer in children, but were twice as likely to be malignant in that group. The most common nonmalignant tumor was a meningioma, and it was 2.3 times as common among women as among men.

The report was compiled by researchers from the National Cancer Institute, the North American Assn. of Central Cancer Registries, the Centers for Disease Control and Prevention and the American Cancer Society, using data from the CDC's National Center for Health Statistics.

In Our Newsletter

High-end medical option prompts Medicare worries

Associated Press

By RICARDO ALONSO-ZALDIVAR, Associated Press Ricardo Alonso-zaldivar, Associated Press – Sat Apr 2, 8:45 am ET

WASHINGTON – Every year, thousands of people make a deal with their doctor: I'll pay you a fixed annual fee, whether or not I need your services, and in return you'll see me the day I call, remember who I am and what ails me, and give me your undivided attention.

But this arrangement potentially poses a big threat to Medicare and to the new world of medical care envisioned under President Barack Obama's health overhaul.

The spread of "concierge medicine," where doctors limit their practice to patients who pay a fee of about $1,500 a year, could drive a wedge among the insured. Eventually, people unable to afford the retainer might find themselves stuck on a lower tier, facing less time with doctors and longer waits.

Medicare recipients, who account for a big share of patients in doctors' offices, are the most vulnerable. The program's financial troubles are causing doctors to reassess their participation. But the impact could be broader because primary care doctors are in short supply and the health law will bring in more than 30 million newly insured patients.

If concierge medicine goes beyond just a thriving niche, it could lead to a kind of insurance caste system.

"What we are looking at is the prospect of a more explicitly tiered system where people with money have a different kind of insurance relationship than most of the middle class, and where Medicare is no longer as universal as we would like it to be," said John Rother, policy director for AARP.

Concierge doctors say they're not out to exclude anyone, but are trying to recapture the personal connection shredded by modern medicine. Instead of juggling 2,000 or more patients, they can concentrate on a few hundred, stressing prevention and acting as advocates with specialists and hospitals.

"I don't have to be looking at patient mix and how many are booked per hour," said Dr. Lewis Weiner, a primary care physician in Providence, R.I., who's been in a concierge practice since 2005.

"I get to know the individual," Weiner said. "I see their color. I see their moods. I pick up changes in their lives, new stressors that I would not have found as easily before. It's been a very positive shift."

Making the switch can also be economically rewarding. If 500 patients pay $1,500 apiece, that's gross revenue of $750,000 for the practice. Many concierge doctors also bill Medicare and private insurance for services not covered by their retainer.

Patients and family members say the fee is worth it.

Linda Popkin lives in New York, far from her 97-year-old mother in Florida. With their mother in a concierge practice, Popkin says she and her siblings have direct access to the doctor as needed.

"If one of us calls the doctor, he calls us back," she said. "We are involved in all the decisions. We definitely have peace of mind that Mom is seeing a doctor she can speak to if we have any questions. I'm sure you've heard the horror stories about people calling the doctor and they can't get in for three weeks."

Popkin's mother didn't lose her Medicare. She's still covered for medications, specialist visits, hospitalizations and other services. But she has an additional level of personalized attention.

Her doctor is affiliated with a Florida-based management company called MDVIP, a wholly owned subsidiary of consumer products giant Procter & Gamble that represents the largest group of concierge physicians in the country.

MDVIP marketing executive Mark Murrison says its doctors do not sell access, but a level of clinical services above what Medicare or private insurance cover. The cornerstone is an intensive annual physical focused on prevention. About half the patients are Medicare beneficiaries.

Retainer fees range from $1,500 to $1,800 a year, and MDVIP collects $500 of that for legal, regulatory and other support services.

Murrison said the fee is affordable for middle-class households when compared with the cost of many consumer goods and services. "One of our goals is to democratize concierge medicine," he said.

For now, there may be fewer than 2,000 doctors in all types of retainer practice nationally. Most are primary care physicians, a sliver of the estimated 300,000 generalists.

The trend caught the eye of MedPAC, a commission created by Congress that advises lawmakers on Medicare and watches for problems with access. It hired consultants to investigate.

Their report, delivered last fall, found listings for 756 concierge doctors nationally, a five-fold increase from the number identified in a 2005 survey by the Government Accountability Office.

The transcript of a meeting last September at which the report was discussed reveals concerns among commission members that Medicare beneficiaries could face sharply reduced access if the trend accelerates.

"My worst fear — and I don't know how realistic it is — is that this is a harbinger of our approaching a tipping point," said MedPAC chairman Glenn Hackbarth, noting that "there's too much money" for doctors to pass up.

Hackbarth continued: "The nightmare I have — and, again, I don't know how realistic it is — is that a couple of these things come together, and you could have a quite dramatic erosion in access in a very short time."

Another commissioner at the meeting, Robert Berenson, called concierge medicine a "canary in the coal mine."

Several members said it appears to be fulfilling a central goal of Obama's overhaul, enhancing the role of primary care and restoring the doctor-patient relationship.

Yet the approach envisioned under the law is different from the one-on-one attention in concierge medicine. It calls for a team strategy where the doctor is helped by nurses and physician assistants, who handle much of the contact with patients.

John Goodman, a conservative health policy expert, predicts the health care law will drive more patients to try concierge medicine. "Seniors who can pay for it will go outside the system," he said.

MedPAC's Hackbarth declined to be interviewed. But Berenson, a physician and policy expert, said "the fact that excellent doctors are doing this suggests we've got a problem."

"The lesson is, if we don't attend to what is now a relatively small phenomenon, it's going to blow up," he added.

When a primary care doctor switches to concierge practice, it means several hundred Medicare beneficiaries must find another provider.

Medicare declined an interview on potential consequences. "There are no policy changes in the works at this time," said spokeswoman Ellen Griffith.

City, town health plans most costly, report says

By Sean P. Murphy
Globe Staff / April 5, 2011

Health insurance plans to cover city and town employees cost 37 percent more than similar plans for workers at private companies, mostly because municipal employees pay minimal copayments or deductibles when they get care, according to a new statewide survey.

The 20-page report from the Boston Foundation and Massachusetts Taxpayers Foundation concludes that cities and towns must substantially increase the amounts their employees are required to pay in out-of-pocket expenses for medical office visits and other services and to significantly increase their deductibles. Otherwise, municipalities will see insurance eat up an ever-in creasing share of their budget.

"The issue is cost-sharing, and right now the cost-sharing of municipal employees is minuscule,'' said Bob Carey, author of the report. "Cost sharing must go up. It's way out of synch with the rest of the employer market.''

Taking the report's advice would force tens of thousands of municipal employees statewide to pay hundreds or even thousands more annually for health care. The rising costs, in turn would probably influence those employees to choose less costly insurance plans and medical services and, in some cases, to forgo some services, the report says.

Currently, the average annual family health insurance premium in municipalities is 21 percent higher than the state plan, 33 percent higher than the federal government employee plan, and 37 percent higher than in the average private sector, the report says. The cost of these premiums is paid jointly by employers and employees. However, in many municipalities, the government pays 60 to 85 percent of the premium.

The report, which focused on 14 municipalities, found that city and town workers typically pay only $11 to see their primary care physician, half the amount typically paid by workers in the state, federal, and private sectors.

The report also found that nine of the 14 municipalities studied charge no copayment for most other medical services, including high-tech imaging such as an MRIs, outpatient surgery, and inpatient hospitalization, the three largest drivers of medical cost increases, the report says.

By contrast, private workers pay $75 for high-tech imaging, $150 for outpatient surgery, and $250 for inpatient hospitalization, the report found.

In addition, the report found that municipal workers paid no up-front share of their health costs each year, called a deductible.

"Amazingly, no municipal plan includes a deductible,'' the report says. "In the other public and private plans, members are responsible for minimum deductibles of $250 for individuals and $700 for families.''

The report calls on the Legislature to pass a law that would allow municipalities to change plan copayments and deductibles without getting the approval of municipal unions.

Currently, state law requires mayors and town managers to bargain with the unions if they want to change office-visit charges or any other aspects of their health insurance benefits.

Unions have for years resisted such changes, saying municipal employees earned those benefits over the years in collective bargaining by giving up wage increases.

But the rapid escalation of health care costs, an average 10.8 percent increase annually since 2001, has left some cities paying more than 20 percent of their budget for health insurance.

Governor Deval Patrick's newest budget proposal squarely takes on the municipal health care issue. Patrick included a provision that would force municipalities to join the state's less expensive health insurance program or create less expensive plans on the local level.

Yesterday, Ed Kelly, president of the state firefighters union, said unions are willing to take on more of the financial burden of health insurance, noting that public unions have steadily made concessions on health insurance since 2005.

But, he said, "it is imperative that unions continue to have collective bargaining rights to give a voice to workers and working families.''

Jeffrey D. Nutting, Franklin town manager, said his town is still facing unsustainable health care costs, even though employees there have made such concessions three times in the last six years.

"Every dollar we spend on health care insurance is a dollar we don't spend on jobs,'' he said. "This is all about saving jobs. When insurance costs go up I have cut police, firefighters, or teachers.''

Nutting said about 10 percent of the town's $88 million budget now goes to health care costs, and he is facing a double-digit increase for next year.

In Medford, Mayor Michael J. McGlynn said the city's public union leaders have shown little interest in even talking about changes in health insurance benefits.

"But now I give the unions credit,'' he said yesterday. "Now, they are saying, 'Let's sit down and talk about it.' They are very much aware of the seriousness of the situation.''

The report echoes a series of stories published in the Globe last year. The Globe survey of 25 communities found that they devoted, on average, 14 percent of their budget to health care, up from 8 percent a decade ago.

The report compares the most popular plans of 14 cities and towns with two plans offered by the Group Insurance Commission, the federal government's Federal Employees Health Benefits Plan, and Massachusetts private employer-sponsored plans, according to a survey that was conducted by Associated Industries of Massachusetts.

Carey, a former manager for the state commission and the Commonwealth Health Insurance Connector Authority, found that "municipalities provide employees with far most costly and generous health care benefits than those offered by other employers in both the public and private sectors.''

Besides low out-of-pocket expenses, many municipal employees enjoy more generous cost splits with the employer, compared to other public and private sector employees.

Most cities pay 80 percent or more of premiums in some plans, with Boston, Peabody and Somerville covering up to 85 percent of some plans' premiums. At the other extreme, towns such as Marshfield covered as little as 50 percent of costs.

The commission's plans included in the report require the state to pay 80 percent of premiums, while the federal employee plan requires 68 percent government funding. Private employers typically paid 71 percent of premiums, the report says.

Self-employed workers can reduce health insurance costs

By Sandra Block**, USA TODAY**

There are lots of advantages to working for yourself. You don't have to endure soul-scorching commutes or mindless meetings. And if the weather is unseasonably warm, you can take the day off.

By **Sandra Block**

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  By Richard J. Carson, for USA TODAY

  Swapna Patel of Katy, Texas, works from home with daughter Raina, 9 months, at her side.

By Richard J. Carson, for USA TODAY

Swapna Patel of Katy, Texas, works from home with daughter Raina, 9 months, at her side.

There are drawbacks, too. You don't get paid vacation or sick leave. Days are often long and lonely. And you probably pay a lot more for health insurance than your salaried brethren.

This year, though, a new tax break could significantly lower the cost of buying your own health insurance. If you haven't filed your 2010 tax return, make sure you don't overlook it.

Self-employed taxpayers have long been able to claim an above-the-line deduction for the cost of health insurance premiums, says Mark Luscombe, federal analyst for tax publisher CCH.

However, in the past, they had to claim that deduction after they calculated their 15.3% self-employment tax, which is the amount self-employed taxpayers must pay in Medicare and Social Security taxes.

Taxpayers who work for a company pay 7.65% for Medicare and Social Security, and their employers pay the other half.

The Small Business Jobs and Credit Act of 2010, which was signed into law last fall, changes the calculation for 2010 tax returns. The law allows self-employed taxpayers to deduct their health insurance premiums against their self-employment income before calculating the payroll taxes. This should reduce the amount you owe in payroll taxes on your 2010 tax return.

Your savings will depend on how much you spent on health insurance premiums last year. To calculate how much you'll save, multiply your health insurance premiums by 15.3%. (Your savings will be lower than that calculation if you earned more than the maximum wage subject to self-employment tax. For 2010, the maximum was $106,800.)

The National Association for the Self-Employed (NASE) estimates the provision will save self-employed business owners $456 to $968 in taxes, based on average health insurance premiums.

Keith Hall, national tax adviser for the NASE, says the law addresses an inequity in the way health insurance is taxed. Employers are allowed to deduct their health insurance costs as a business expense, thus lowering the amount they pay in payroll taxes. Meanwhile, employees who have employer-provided health insurance can pay their share of the premiums with pre-tax dollars, Hall says. "For the first time, we are on the same basis for deductibility as everybody else."

"We talk over and over again about access to health care, but the biggest issue for small-business people is affordability," Hall says. "This is a 15.3% savings on the cost of health insurance premiums."

If you're self-employed, here are some other things you should keep in mind:

•To qualify for this deduction, you must file a Schedule C or Schedule E with your 1040. Taxpayers who are required to file these forms include sole proprietors, single-member limited liability companies, or sole owner S-corporations, according to the NASE.

•Only health care insurance premiums can be claimed as an above-the-line deduction. Deductibles, co-payments and other out-of-pocket expenses can be claimed as an itemized deduction, but only to the extent that they exceed 7.5% of your adjusted gross income, says Jackie Perlman, tax analyst with H&R Block's Tax Institute.

•This deduction is limited to business owners who bought individual health insurance for themselves or their families in 2010. You can't claim it if you were covered by a spouse's employer-provided insurance, Perlman says.

•If you file your tax return on paper — and frankly, that is not a good idea — you'll need to take extra steps to claim the credit. To claim the deduction, write the amount you paid for health insurance premiums on Line 3 of Schedule SE, Perlman says. The number should match the figure on Line 29 of your Schedule C.

Tax software should automatically calculate the new deduction, Hall says. A reputable tax preparer will also make sure you get the full benefit of the tax break.

•Don't increase your health insurance coverage in hopes of claiming a larger deduction when you file your 2011 tax return. The tax break is limited to health insurance purchased in 2010. The

one-year provision was designed to spur the economic recovery by putting extra cash in the pockets of small-business owners, Luscombe says.

Small-business groups are lobbying Congress to extend the law. You can learn more at the website for the National Association for the Self-Employed, **nase.org**.

11 things you should buy organic

- by Health.com, on Tue Mar 22, 2011 11:37am PDT

By Sara Reistad-Long

By now, we all know there's a benefit to buying some stuff organic. But these days you're faced with the option of getting *everything* organic—from fruits and veggies to mattresses and clothing. You want to do right by your body, for sure, but going the all-natural route en masse can be pricey.

So we wondered: What's really essential for our health? That's why we came up with this definitive list. Here's what should be in your cart—and what you don't have to worry about.

Beef
You've probably read plenty of stories about the risks of eating chicken. But the most important protein to buy organic may well be beef. "Research suggests a strong connection between some of the hormones given to cattle and cancer in humans, particularly breast cancer," says Samuel Epstein, MD, professor emeritus of environmental and occupational medicine at the University of Illinois at Chicago School of Public Health. Specifically, the concern is that the estrogen-like agents used on cattle could increase your cancer risk, adds Ted Schettler, MD, science director at the Science and Environmental Health Network.

Though there are strong regulations about the use of hormones in cattle, "not all beef producers are following those regulations strictly, and some studies continue to find hormone residue in cattle," Dr. Schettler says. When you buy beef that's been certified organic by the United States Department of Agriculture (USDA), you're not only cutting out those hormones, you're also avoiding the massive doses of antibiotics cows typically receive, which the USDA says may lead to the development of antibiotic-resistant bacteria in people.

Strawberries
Strawberries may be a superfood—but they pose a potential risk unless you go organic. In addition to having up to 13 pesticides detected on the fruit, according to an Environmental Working Group (EWG) analysis, conventional "strawberries have a large surface area and all those tiny bumps, which makes the pesticides hard to wash off, so you're ingesting more of those chemicals," explains Marion Nestle, PhD, a professor of nutrition and public health at New York University and author of *What to Eat*.

If you can, also skip conventional peaches, apples, blueberries, and cherries, which are typically treated with multiple pesticides and usually eaten skins-on.

Cookware
Your pots and pans are just as crucial to upgrade as the food you cook in them: "Most nonstick cookware contains a

fluorochemical called PTFE that breaks down to form toxic fumes when overheated," says Olga Naidenko, PhD, a senior scientist at the EWG. "Those fumes can coat the inside of the lungs and cause allergy-like symptoms."

Tests commissioned by the EWG showed that in just two to five minutes on a conventional stove top, cookware coated with nonstick surfaces could exceed temperatures at which the coating emits toxic gases. Switch to stainless steel, ceramic, or cast iron cookware.

Popcorn

The linings of microwave-popcorn bags may contain a toxic chemical called perfluorooctanoic acid, or PFOA, which is used to prevent the food from sticking to the paper. According to the Environmental Protection Agency (EPA), PFOA is a likely carcinogen. "We don't know all of the hazardous effects of PFOA yet, but we have some evidence of a link to cancer, as well as to effects on the immune, nervous, and endocrine systems," says David Carpenter, MD, director of the Institute for Health and the Environment at the University at Albany.

Pick up an air-popper or make your popcorn in a pan on the stove top.

Yard pesticides

Some lawn and garden pesticides contain suspected carcinogens, according to EPA data. Long-term pesticide exposure may be related to changes in the brain and nervous system, the Fred Hutchinson Cancer Research Center reports. "Not only are you breathing the chemicals in, but you bring them indoors and onto carpets via your shoes," says McKay Jenkins, PhD, a journalism professor at the University of Delaware and author of *What's Gotten Into Us?*

Healthier brands like BurnOut and EcoClear are made from vinegar and lemon juice, and are effective weed-killers.

All-purpose home cleaners

Time for spring-cleaning? Using common household cleaners may expose you to potentially harmful chemicals. Ammonia and chlorine bleach can irritate the skin, eyes, and respiratory tract. And some cleaners contain phthalates, some of which are endocrine disruptors, meaning they interfere with normal hormone activity, says EWG senior scientist Becky Sutton, PhD.

Although there's no definitive proof that phthalates cause problems in humans, "the greatest concern is how early-life exposure will affect male [reproductive] development," Dr. Carpenter says. There's weaker evidence, he adds, that phthalates affect the nervous and immune systems. Go natural with the cleaner you use the most frequently and in the most places, such as kitchen-counter spray—look for brands approved by Green Seal or EcoLogo, two organizations that identify products that have met environmental label guidelines.

Water bottles

You've probably heard that many hard, reusable plastic water bottles could be bad for you because they may contain BPA, or bisphenol A, another endocrine disruptor according to the National Institute of Environmental Health Sciences.

"For adults, the biggest concern with BPA is that it may increase the risk of breast cancer in women and reduce sperm counts in men," says Dr. Carpenter, who explains that BPA can leach out into the water in the bottle. To be safe, sip from an unlined stainless steel or BPA-free plastic bottle.

Food-storage containers

BPA strikes again: Many food-storage containers are made of the hard, clear polycarbonate plastic that may contain BPA. As is the case with water bottles, the BPA can leach out of the plastic in these containers and seep into your leftovers.

"The leaching is increased during heating, but it also leaches to a smaller degree even when cold foods are stored," Dr. Carpenter explains. Glass containers are your safest—not to mention planet-friendly—bet. Both Rubbermaid (at left) and Pyrex make glass ones with BPA-free plastic lids.

Milk

The milk you're drinking may not be doing your body good: Dairy products account for a reported 60 to 70 percent of the estrogens we consume through our food. If that seems like a shockingly large number, it's mainly because milk naturally contains hormones passed along from cows. What worries some experts is that about 17% of dairy cows are treated with the hormone rBST (or rBGH), which stimulates milk production by increasing circulating levels of another hormone called insulin-like growth factor (IGF-1).

"Elevated levels of IGF-1 in people are associated with an increased risk of cancer, including breast cancer," Dr. Schettler explains. In fact, the use of rBGH is banned in Europe and Canada. Although research has yet to definitively conclude whether drinking rBGH-treated milk increases your IGF-1 levels high enough to cause concern, Dr. Schettler says it's advisable to buy milk that hasn't been treated with it. So pick up milk that's labeled rBGH-free,

rBST-free, or is produced without artificial hormones.

Celery
When researchers at the EWG analyzed 89,000 produce-pesticide tests to determine the most contaminated fruits and vegetables, celery topped the chart. "In terms of the sheer number of chemicals, it was the worst," says Sonya Lunder, senior analyst at the EWG. Celery stalks are very porous, so they retain the pesticides they're sprayed with—up to 13 of them, according to the EWG analysis. Lunder also advises buying organic bell peppers, spinach and potatoes because they scored high for pesticides, as well.

Tomato sauce
When picking up tomato sauce or paste, choose the glass jar or box over the can. "The lining on the inside of food cans that's used to protect against corrosion and bacteria may contain BPA," explains Cheryl Lyn Walker, PhD, a professor of carcinogenesis at MD Anderson Cancer Center and past president of the Society of Toxicology.

In 2009, Consumer Reports tested BPA levels in a variety of canned foods and found it in nearly all of the brands tested, suggesting that the chemical leaked in. "What can happen is that BPA in the lining can leach into the food," Walker explains.

Health care reform takes toll on jobs

By Janet Trautwein

4:15 p.m. EDT, April 6, 2011

In recent testimony before the House Budget Committee, Medicare's chief actuary, Richard Foster, was asked whether **President Barack Obama's** new health care law would allow Americans to keep their existing coverage.

His response? "Not true in all cases."

In fact, the health care law is not only causing many businesses to drop or scale back their insurance plans — it's also preventing them from creating jobs.

A new National Association of Health Underwriters survey of nearly 2,400 insurance agents and brokers — who interact on a daily basis with employers who provide health insurance — hammers home the stark reality of the new law. More than half of brokers — 52 percent — report that some of their clients have dropped coverage altogether because of increased costs, which they attribute to health reform. Seventy percent have watched employers decrease the amount of coverage they provide, and a whopping 90 percent of firms have increased premiums for their employees.

Health reform has also caused employers to lay off workers or avoid hiring new ones. Forty percent of brokers state that their clients have eliminated jobs because of health reform, and 57 percent have seen businesses reduce hiring.

The country's half-million licensed health insurance agents and brokers are feeling the pinch as well. More than 70 percent say they have witnessed their business incomes decline as a result of **health care reform**'s new rules. These reductions in income haven't led to savings for consumers, as the law's proponents claimed they would. Instead, 21

percent of agents have been forced to cut jobs themselves, and 26 percent have had to reduce the services they provide to their clients.

With 13.5 million people still out of work, according to the Bureau of Labor Statistics, Americans certainly cannot afford to have the health care law add more fuel to the unemployment wildfire.

Why are so many jobs disappearing, both inside and outside the insurance industry?

The primary culprit is the law's medical loss ratio (MLR) requirement, which mandates that insurers spend at least 80 percent to 85 percent of premium dollars on medical claims. Proponents of these rules believe that they'll force insurance companies to spend more on patient care and less on administration and profits.

Unfortunately, there's not much fat to trim from insurers' budgets. The health insurance industry posted a slim 2.2 percent profit margin in 2008 — one-fifth the margin enjoyed by the securities industry, and one-tenth that of the pharmaceutical sector.

Further, the MLR rules are quashing competition in the insurance marketplace. Iowa-based **Principal Financial Group**, for instance, has decided to stop offering health insurance altogether, as it can't afford to comply with the new regulations. Its 840,000 customers will have to find new policies — and consumers will have one less choice for insurance.

Insurance commissioners in Maine, Nevada, Kentucky and New Hampshire have already applied for waivers from the medical loss ratio rules, as they're concerned that the regs will destroy their insurance markets. Only three insurers sell individual policies in Maine — and one threatened to pull out if the state did not receive a waiver. Without a semblance of competition, insurance prices will skyrocket.

And as prices rise, fewer and fewer businesses will be able to afford health insurance for their employees — or to hire new ones.

Many groups have run the numbers and discovered that they can't live within the health care law's constraints. More than 1,000 organizations — from small towns to labor unions to chain restaurants like **McDonald's** — have received waivers from the federal government from the law's minimum annual benefit requirement. Without them, they'd have to quit providing insurance to their employees or lay off scads of workers, as each additional employee would simply cost too much to insure.

But the waiver system does not solve the problems created by health care reform. The waivers are awarded arbitrarily, with no set criteria for exempting states or businesses. And the system is inevitably politicized.

Health reform was supposed to expand Americans' access to coverage. Thus far, it's accomplished just the opposite.

Janet Trautwein is CEO of the National Association of Health Underwriters.

AARP'S SUPPORT OF HEALTHCARE SCRUTINIZED

Robert VerBruggen on AARP's Borderline Scam Robert VerBruggen has read a recent Congressional report about the AARP and observed some interesting details he thinks retirees should know. "They most certainly should be concerned about how AARP benefited when Obamacare gutted Medicare Advantage, about how much AARP is paying its executives, and about how AARP refused to fully cooperate with the committee's investigators," he writes. He points out that "AARP supported Obamacare, and specifically the cuts to Medicare Advantage [a program that is popular with seniors], to line its own pockets." AARP has been accepting payments for more insurance endorsement deals, about which, VerBruggen writes, they are not picky. Furthermore, AARP's executives are significantly overpaid and offered a luxurious travel policy, all without being subjected to standards of transparency. VerBruggen insists that all of these factors prove AARP's tax-exempt status should be revoked, something he notes will be no easy task. "But this report does accomplish something that's very important: It lays bare some of the inner workings of AARP, so that potential members can see what they're signing up for."

WHERE TO RETIRE FOR UNDER $500 MONTH

5 Places to Retire for Under $500 Per Month

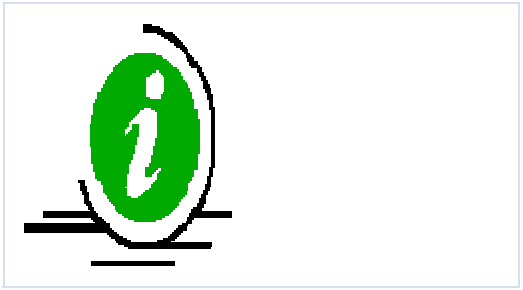
by Kathleen Peddicord
Friday, April 15, 2011

provided by

Housing is likely to be one of your biggest retirement expenses. One way to approach your search for the ideal overseas retirement haven is to focus on retire-overseas choices where housing is cheap.

It's important to note that, for these bargain rents, you won't be getting a palatial or luxurious abode. I'm limiting my picks to places where you could rent something modest and cozy but reasonably outfitted from a North American's perspective. Here are five places where you could rent for as little as $500 per month.

Leon, Nicaragua. Nicaragua has suffered serious bad press as a result of its troubled past and current president. Those unfortunate realities aside, this beautiful land of lakes and volcanoes has a great deal to offer the would-be retiree, including a new program of special benefits for resident retirees. There is also a growing and welcoming community of expats from around the world, top-notch health care in Managua thanks to the international-standard Vivan Pellas Hospital Metropolitano, and bargain-priced rentals.



Leon is the second of this country's two colonial cities, and generally less developed and recognized than its sister city, Granada. In many ways, Leon is preferable. It's a university town with museums and theater that sits less than a half-hour from the coast. Because it's been largely ignored until recently, it's also a more affordable place to rent than higher-profile Granada. You could rent a two- or three-bedroom colonial house here for as little as $500 or $600 per month.

Medellin, Colombia. The downside to Leon is the climate. Mornings and evenings can be pleasant, but midday temperatures are often brutal. If that bothers you, consider the mountain city of Medellin instead. This pretty city built almost entirely of red brick boasts a spring-like climate year-round. Like Leon, Medellin is an emerging retirement haven, meaning the existing expat community is small but growing and the costs of living and of renting are temptingly low. One friend is renting a small studio in a non-central neighborhood for the equivalent of $210 per month. You can rent a two-bedroom apartment in a new building at a central address for $700 or $800 per month.

Las Tablas, Panama. My top recommendation for a beachfront retirement where the cost of renting is low enough to accommodate almost anyone's budget is Las Tablas, a city on the Pacific coast of Panama's Azuero Peninsula. Panama has first-class and affordable medical care and facilities, a *pensionado* program of special benefits for foreign retirees, and well-established expat communities. The city also has a developed infrastructure, many user-friendly options for establishing foreign residency, and can be a tax-haven for those wishing to minimize their taxes.

Not all of Panama qualifies as bargain-priced. As this country has become increasingly favored by retirees and investors, the costs of both living and of real estate have been rising, particularly in discovered areas such as Panama City. But Panama offers a number of appealing lifestyle possibilities beyond its capital city, including Las Tablas. The downside to Las Tablas is its distance from Panama City. It's about a four-hour drive away. However, the cost of living can be half that of Panama City and you can rent a small house within walking distance of the beach for $300 or $400 per month.

Chiang Mai, Thailand. I know of a single American man who lives in Chiang Mai on $200 a month, with half that going for rent. He gets around on a bicycle and eats at low-cost noodle stalls or for free when a temple offers lunch. He makes a sport of spending as little as possible. I also know a Thai American

woman who bought an apartment in a small town 15 kilometers from Chiang Mai. She manages on $600 a month from Social Security and, as she is Thai and over 60, she enjoys free government health care. It wouldn't cost you very much more to live and rent in Chiang Mai. House and apartment rentals in Chiang Mai can vary dramatically, from perhaps $150 per month for a small home and garden in the country to $400 or $500 monthly for a larger, newer place in town.

Languedoc-Roussillon, France. If you're willing to look beyond Paris, the southwest of this country can be highly affordable. Cessenon-sur-Orb, in the Languedoc-Roussillon region of southwestern France, is colorful, eclectic, and very open to retirees. The village dates from prehistoric times, but the feel is medieval, with the church dominating the center and the tower of Le Donjon looking down from above.

Here in this quintessentially French country corner, you'll find many expats of several nationalities. They've sought out this unsung region because it offers everything you need for a comfortable life, yet boasts a small, charming, typically French village atmosphere, with centuries of history and lots to do and see. As a result, this town is growing and attracting both more French people and expats. Perhaps the most appealing part is that the cost of renting in this picture-postcard corner of France can be modest, certainly relative to Continental Europe in general. A monthly rental of 400 to 600 euro is realistic.

Type 2 diabetes, like Type 1, may be an autoimmune disease, researchers say

By Thomas H. Maugh II, Los Angeles Times

1:16 p.m. CDT, April 18, 2011

Type 2 diabetes, like Type 1, may be an autoimmune disease, but the immune system's target cells are different, Stanford researchers said Sunday. The discovery sheds new light on how obesity contributes to the onset of Type 2 diabetes and could lead to new types of treatment for the disorder, the researchers reported in the journal Nature Medicine.

Diabetes is a growing problem in the United States, triggered in large part by the obesity epidemic. An estimated 27 million Americans are now thought to have diabetes, with the vast majority of them -- all but about a million -- afflicted with Type 2 diabetes. That disorder strikes in adulthood and is marked by a growing inability of cells to respond to insulin in the bloodstream, which necessitates using drugs to increase the output of the hormone by the pancreas. Intriguingly, not everyone who becomes obese develops diabetes, however, and researchers have never been sure why.

Dr. Daniel Winer, an endocrine pathologist now at the University of Toronto, and his twin, Dr. Shawn Winer of the University of Toronto's Hospital for Sick Children, reasoned that the death of excess fat cells might trigger an autoimmune reaction. In an earlier study with senior author Dr. Edgar Engleman of the Stanford University School of Medicine, they demonstrated in mice that, as fat accumulates in the tissues surrounding organs, it outstrips its blood supply, leading to the death of cells on the periphery of the fat deposits. When that occurs, the body mobilizes its immune system to break down and carry off the dead cells. But that produces antibodies against the cells and many of the proteins normally found only inside the cells.

In the new study, the team turned its attention to B cells, the lymphocytes or white blood cells that manufacture antibodies against foreign invaders. They genetically engineered mice so that they could not produce B cells and found that the rodents never became diabetic, no matter how fat they became. They next looked at normal mice that were prone to becoming diabetic when they became obese. One group they treated with a biological drug called anti-CD20 that binds to B cells and blocks their activity. The second group received no treatment. The mice that received the drug did not become diabetic when they became obese, while those that did not receive it did become diabetic. The effect lasted only about 40 days, however, and then needed to be repeated.

The group finally studied a group of 32 obese men, half of whom were diabetic and half who were not. They found that the diabetic men had a distinct group of antibodies against cellular proteins that were not present in the healthy men, suggesting that an unusual autoimmune reaction was taking place. The findings suggest that some people are genetically more susceptible to the immune reaction, which is typical of autoimmune diseases.

"We are in the process of redefining one of the most common diseases in America as an autoimmune disease, rather than a purely metabolic disease," Daniel Winer said in a statement. "This work will change the way people think about obesity, and will likely impact medicine for years to come as physicians begin to switch their focus to immune-modulating treatments for Type 2 diabetes." The researchers speculated, for example, that a form of anti-CD20 already used in humans might block the onset of diabetes, particularly if treatment is begun early in the course of the disease. The drug is sold under the brand names Rituxan and MabThera for the treatment of leukemias, lymphomas, transplant rejection and certain autoimmune disease. But they cautioned that the drug has some strong adverse side effects and that it can leave the patient susceptible to a variety of infections. Other approaches to modulating the immune system might thus be safer, they said.

FEE-FOR-SERVICE POLICY, NOT MEDICARE ITSELF, SAID TO BE CAUSING U.S. HEALTHCARE COST INCREASES

Medicare isn't the problem — it's the solution

By ROBERT REICH

Yes, we have a long-term budget crisis. And, yes, Medicare costs are at the heart of it. But don't be fooled into believing Medicare itself is the problem.

House Republicans want to get rid of Medicare. Instead they offer vouchers to be cashed in with private insurers. That's nuts. It would leave seniors with less health care and insurers with fatter profits.

The president, on the other hand, wants an independent commission to recommend cuts if the yearly costs of Medicare rise half a percent faster than the national economy. That's better but still assumes Medicare costs are the problem. They're not.

The problem: the soaring costs of health care. Those costs force us to pay more and more for health insurance.

Each American spends almost two and a half times more on health care than people in other advanced nations. Yet Americans don't live as long as those people, and have the highest infant mortality rate.

The reason: Here, doctors and hospitals have every incentive to spend on unnecessary tests, drugs and procedures. But they have little incentive to keep people healthy.

You have lower back pain? Almost 95 percent of such cases are best relieved through physical therapy. But doctors and hospitals routinely do expensive MRIs, and then refer patients to orthopedic surgeons who often do even more costly surgery. Why? There's not much money in physical therapy.

Your diabetes, asthma or heart condition is acting up? Go to the hospital and 20 percent of the time you're back there within a month. A healthier alternative is an at- home nurse visit to answer questions and ensure medications are taken. This is common practice in other advanced countries. So why don't nurses visit acute condition patients here? Hospitals and nurses aren't paid for it.

America spends $30 billion a year fixing medical errors — the worst rate among advanced countries. Why? Among other reasons because we keep patient records on computers that can't share the data. Patient records are continuously rewritten on pieces of paper, and then re-entered into different computers. That spells error.

Meanwhile, administrative costs are eating up 15 percent to 30 percent of all health-care spending in the United States. That's twice the rate of most other advanced nations. Where does this money go? Mainly into collecting money: Doctors collect from hospitals and insurers, hospitals collect from insurers, insurers collect from companies or from policyholders.

At some hospitals, billing clerks outnumber physicians. Nurses spend a third of their hours documenting care so insurers have proof.

The GOP plan makes things worse. It simply funnels money to for-profit insurers. Their administrative costs are far higher than Medicare.

The president's approach is smarter but doesn't address the underlying problem. It just limits the amounts seniors would receive for Medicare insurance. As health-care costs continued to rise, seniors would get less care. (As a practical matter this won't happen because seniors — whose clout will grow as boomers are added to the ranks — will demand the limits be increased.)

So what's the answer? First, allow anyone at any age to join Medicare.

Medicare's administrative costs are in the range of 3 percent. That's well below the 5 percent to 10 percent costs borne by large companies that self-insure. It's even further below the administrative costs of companies in the small-group market (amounting to 25 percent to 27 percent of premiums).

And it's way, way lower than the administrative costs of individual insurance (40 percent). It's even far below the 11 percent costs of private plans under Medicare Advantage, the current private-insurance option under Medicare.

Second, allow Medicare — and its poor cousin, Medicaid — to use their huge bargaining leverage over doctors and hospitals to change the incentives driving the health-care system. Instead of reimbursing doctors and hospitals for the costly tests, drugs and procedures, pay them for keeping people healthy.

Estimates of how much would be saved by extending Medicare to cover the entire population range from $58 billion to $400 billion a year. More Americans would get quality health care, and the long-term budget crisis would be sharply reduced.

Medicare isn't the problem. It's the solution.

Medicare to Pay for MRIs in Patients With Pacemakers

By Chris Kaiser, Cardiology Editor, MedPage Today
Published: April 26, 2011

WASHINGTON -- The Centers for Medicare & Medicaid Services (CMS) has determined that the evidence is strong enough to reimburse for MRI exams in Medicare patients who have permanent pacemakers.

"We propose to change the language ... of the NCD Manual to remove the contraindication for Medicare coverage of MRI in beneficiaries with implanted PMs [permanent pacemakers] when the PMs are used according to the FDA-approved labeling for use in an MRI environment," the agency's proposed decision memorandum states.

The FDA approved the first MRI-conditional pacemaker (Medtronic Revo MRI SureScan Pacing System) on Feb. 8, but CMS specifically noted that the change in payment policy "does not include any coverage determination about the Medtronic Revo MRI SureScan Pacing System itself or any other pacemaker."

The proposed coverage is not limited to any specific disease or condition.

The new decision broadens one announced on Feb. 24, when CMS said it would cover MRI exams only for patients with pacemakers if they were enrolled in approved clinical studies of MRI.

The next day, CMS received a request letter from Medtronic referencing the randomized controlled trial of 464 pacemaker patients demonstrating the safety of the device in the MR environment and provided CMS with a reference to the journal in which the study was published.

"The requester asked that CMS remove completely the contraindication in the MRI policy for patients with pacemaker devices that have been approved by the FDA for use in the MR environment," according to the CMS decision memorandum.

Following a 30-day public comment period regarding coverage of MRI scans in patients with pacemakers, CMS concluded that "this use of MRI is reasonable and necessary."

Is Your Dentist Ripping You Off?

by Sarah Lorge Butler for CBS MoneyWatch.com

A person near and dear to me came home from the dentist with an ugly diagnosis. He has two cracked crowns and needs replacements. I'm not sure what's more painful — what's been going on in his mouth or the bite out of the family finances.

Cost of the crowns: $1,395 apiece. Cost of foundation fillings, or "cores" to put the crowns on: $326 apiece. Total bill, if you're scoring at home: $3,442.

His dentist sold him membership into an office savings plan for $319 for the year. So that saves him 20% on all dental procedures and gives him two free cleanings. Knock off 20% (but add back in the $319) and we're down to $3072.60 on this bit of drilling.

When I look at this bill, I wonder why I obsess about the weekly price fluctuations of Cheerios or the shrinking size of a can of tuna. All the economical choices a family makes in a year can be wiped out by a trip to the dentist. No wonder people are going to Thailand and Mexico for dental work.

Out of curiosity I called two other dentists within five miles of the first guy. One charges $950 for a crown. Another charges $797. According to 2009 figures from the American Dental Association, the national average among a survey of 8,085 dentists was $945.27. So how can the first guy explain why his price is $450 higher? The office assistant told me "not all dentists are created equal," and of course, this dentist is one of the best in the area, using a great lab.

I'm not satisfied with that answer. The patient, however, trusts this dentist, and only this dentist, to drill in his mouth, and I'm not going to argue. But how can someone who is not a medical professional know if their dentist is worth their fees? I spoke to Dr. Matthew Messina, D.D.S., a dentist in Fairview Park, Ohio, and a spokesman for the ADA, about this question. (His price of a crown is usually in the high $900 range.) Here's what I learned:

- It's fair to comparison shop. If your dentist is more expensive than everyone else in the area, "ask the dentist to explain the differences in their fees. That's a perfectly reasonable thing to do," Messina says. "It might be different laboratories, it might be different materials in the crown. It's worth asking the question."
- But don't select a dentist on price alone. "With crowns, we're talking replacement body parts, if you will," Messina says. "There's a tremendous emotional component to it — besides having someone in your personal space. It's important to see someone you trust."
- Rely on word of mouth. Get referrals from friends and neighbors. Fees are one part of evaluating a dental practice, but you want to have confidence in the office, the people in there, how they sterilize their instruments, and the training and continuing education of the dentist. Does he or she seem to be looking out for your best interests over the long haul? What's the dentist's philosophy for keeping your teeth healthy for a lifetime?
- Prevention saves a boatload of money. Brush, floss, and use your fluoride rinse. Messina's top three no-no foods for patients: Sour Patch Kids, popcorn, and chewing ice. "Ice is a crystal. Tooth enamel is a crystal," he says. "When you push two crystals together, one of them breaks. Most of the times it's the ice. Sometimes it's the tooth."
- Interrogate. Why do I need this? Why is this investment important for me in the long run? What do you project my ongoing needs to be? Ask these questions. When you understand the value, you might not cringe at the cost so much.
- Is the work guaranteed? Messina says five to seven years is typical for a crown. Will your dentist stand behind his or her work for that time?
- Is your dental insurance worth it? Do the math. Sometimes, what the patient gets back in benefits is less than what they pay in premiums. "There are situations where we'll talk to people about that," Messina says. "Based upon their past history and projected future needs, they may be better off using a health savings account."

ADMINISTRATION ENCOURAGES STUDENTS TO EXPLORE COVERAGE OPTIOINS

News Release

FOR IMMEDIATE RELEASE
Wednesday, April 20, 2011

Contact: HHS Press Office (202) 690-6343
ED Press Office (202) 401-1576

Secretaries Duncan and Sebelius launch outreach effort to help make graduating students aware of the new health coverage options under the Affordable Care Act

Secretaries reaching out to college presidents and student leaders;

new tools available at *www.HealthCare.gov*

Today, Education (ED) Secretary Arne Duncan and Health and Human Services (HHS) Secretary Kathleen Sebelius launched a new initiative to help educate graduating college and university seniors about their new health insurance options under the Affordable Care Act. Thanks to the new law, many young adults will be eligible to remain on their parent's health insurance plan until their 26th birthday. The Secretaries sent letters to college and university presidents as well as student body presidents encouraging them to help spread that information to college students.

"Young adults shouldn't have to lose their health insurance on graduation day," said Sebelius. "Under the Affordable Care Act, many young adults have more health coverage choices, including the opportunity to stay on their parent's health insurance plan until they are 26 years old."

It is estimated that approximately 1.2 million young adults may be eligible to stay on their parent's health plan, thanks to the Affordable Care Act. In the past, many young adults were removed from their parent's health plan when they graduated from college.

"Americans in their twenties are almost twice as likely to go without health insurance as older adults, making them vulnerable to debt from high medical bills," Duncan said. "We want to work with college and university presidents and campus leaders to ensure more young adults can get the coverage and care they need to stay healthy, even if they are unemployed or looking for a job."

The letter outlined several ways university officials and student leaders can reach out to graduating students:

- Universities or student groups can post a new "badge" on their website that automatically links to information about how students can remain on a parent's health insurance plan. Download the badge by visiting **www.healthcare.gov/stay_connected.html#ya**.
- Flyers outlining the new benefits can be distributed to students and are available for download at **www.healthcare.gov/center/brochures/new_benefits_for_graduates_and_young_adults.pdf**.
- HHS and ED will help colleges or student groups host a session to explain insurance options.
- Information for young adults and parents about coverage for individuals under age 26 is available on a Facebook page that can be found at: **www.facebook.com/youngadultcoverage**.

The letter to university presidents can be found at **www.HealthCare.gov/center/letters/under2604202011a.html**. The letter to student body

presidents can be found at **www.HealthCare.gov/center/letters/under2604202011b.html**.

FUTURE OF MEDICARE AT CENTER OF BUDGET DEBATE

What to do about Medicare is at heart of budget debate

By DAVID LIGHTMAN

McClatchy Newspapers

WASHINGTON -- Congress and the White House are engaged in the most far-reaching debate about Medicare in the health program's 46-year history, an epic struggle that could bring significant changes in how the government helps seniors and others pay for their care.

Medicare faces a daunting financial crisis, forcing lawmakers to confront stark choices. Should younger people pay more to support the program? Should they assume that Medicare won't be around in its current form when they're ready for its coverage? Should seniors pay higher deductibles? What's the government's responsibility to the very ill and elderly who live on fixed incomes and need acute care?

In many ways, this is a debate about one generation's obligations to another - and about the role of government in caring for society's most vulnerable people. It's a struggle whose outcome may not be resolved for years, until a consensus is forged.

"Right now people are just beginning to position themselves to debate an issue that's been brewing for at least two decades," said Gail Wilensky, the director of the Medicare and Medicaid programs from 1990 to 1992.

The health care community has long been seeking ways to stabilize the system's finances, since the long-anticipated surge of baby boomer retirements was certain to drive up costs.

Now the federal government's broader budget deficit and debt crisis "has added urgency," said Wilensky, a senior fellow at Project HOPE, an organization that works to make health care available around the world.

Republicans in the House of Representatives have offered the most dramatic alternative. They took the politically risky step April 15 of voting to radically revamp Medicare so that after 2021, new beneficiaries would get government aid to pay for private insurance plans, rather than have the government cover the costs directly, as it does now.

Democrats branded the proposal an irresponsible dismantling of an effective safety net. They conceded that the current system - a complex network of hospital, physician and prescription-drug benefits that the government pays providers for directly - needs to be modified, but not radically overhauled.

As long as President Barack Obama is in office and Democrats run at least one house of Congress - they now control 53 of the Senate's 100 seats - Medicare is likely to survive largely in its current form.

But some changes are inevitable, because the financial warning signs are growing more ominous. Medicare is an obvious target, said John Holahan, the director of the Health Policy Research Center at Washington's Urban Institute, a centrist policy-research center.

The increasingly dismal fiscal ledger:

-The federal budget deficit is projected to reach a record $1.65 trillion this fiscal year, which ends Sept. 30. According to the nonpartisan Congressional Budget Office, under current policies the government will run up about $7 trillion in budget deficits over the next 10 years. The national debt is already a whopping $14.3 trillion.

-Medicare cost about $521.1 billion in the last fiscal year. Program officials expect the figure to reach $569.3 billion this year, and to grow at a 5.6 percent annual rate through 2021, far more than the anticipated growth in the overall economy.

-Medicare is expected to serve 48.5 million beneficiaries this year; by fiscal 2021, the total's projected to be 64.9 million.

-Medicare's hospital trust fund, which pays for inpatient hospital and related care, can't cover costs. It "still fails the test of short-range financial adequacy ... the fund also continues to fail the long-range test of close actuarial balance," the Medicare trustees' 2010 report said.

The Washington debate turns on two very different approaches to Medicare's future; they reflect the two political parties' rival visions of government's role in society.

Democrats would shave about $507 billion from Medicare spending between 2012 and 2021, according to the Congressional Budget Office. Changes could be significant, though not all that visible to consumers. Among them: establishing a mechanism to cut Medicare's spending if its growth rate rises above a set amount, penalizing hospitals for "excessive readmission rates" and creating new, potentially more efficient ways for people to get medical care.

But there's a big asterisk attached to these initiatives: What if too many doctors, hospitals and other providers stop taking Medicare patients because they're not getting paid enough to treat them?

Congress consistently has shown a willingness to bow to such pressure. For the past nine years, Medicare spending on doctors and other health care providers was supposed to be limited to a set schedule, but, facing political heat, Congress prevented the scheduled pay cuts from taking effect.

Under the formula, payments to doctors would go down about 23 percent next year. But next year's an election year, and Congress is likely to continue its tradition of enacting the "doc fix."

"There is general consensus that fee cuts of that magnitude would be detrimental to beneficiary access to care," said Glenn Hackbarth, the chairman of the Medicare Payment Advisory Commission, a nonpartisan congressional agency that advises lawmakers on Medicare policy.

The solution, Democrats say, is to make medical care more efficient, perhaps by "bundling" services. Beneficiaries could work with teams of providers, perhaps doctors, nurses or social workers, coordinating strategies that minimize routine office visits and target treatment where it's most effective.

While many health care experts like such a system, "no one really knows how much money will be saved" under it, although most think it would save money, said John Rother, the executive vice

president of policy and strategy at AARP, which represents seniors.

Skeptics of the Democratic approach think the projected savings are too speculative, the "doc fix" problem will persist and the Democrats' plans won't trigger the scale of change that's needed to curb costs.

Under those or current policies, "you're not going to see the bubble burst all at once. What you'll see is a creeping problem with access," said Robert Moffit, a senior fellow at the Center for Policy Innovation at the conservative Heritage Foundation.

Some conservatives call the Democratic proposals little more than gimmicks to sustain a wheezing system. The GOP takes special aim at the Independent Payment Advisory Board, a yet-to-be-appointed panel created by the 2010 health care law to oversee Medicare spending. Obama said last week that he wants the board to have even more cost-cutting clout, which conservatives oppose as oppressive central-government control.

In contrast, the Medicare overhaul drafted by House Budget Committee Chairman Paul Ryan, R-Wis., and approved by the Republican-dominated House in mid-April - with no Democratic votes - would create a new system, shifting costs over time from government to elderly beneficiaries.

People who retire after 2021 would choose from a list of private "guaranteed coverage options" and get federal help with the cost. The federal payments to 65-year-olds in 2022 would average $8,000, about the same as projected average provider reimbursements per typical 65-year-old patient under traditional Medicare that year. The payments would increase at the rate of general inflation in future years, though health care costs historically have risen faster than inflation.

Ryan defends the new program vigorously, saying, "It's choice, it's competition, it's protection."

Counters Rother: It endangers the elderly.

"Medicare is essential financial protection for older people and the disabled," he said, particularly older seniors on fixed incomes.

Under current Medicare, a typical 65-year-old can expect to spend $6,150 of his or her own money on health care in 2022. Under Ryan's plan, that figure would jump to an estimated $12,500, according to figures derived from CBO estimates.

Republicans say that seniors wouldn't be left without care, or without bank accounts, because the government would help those in need. Without such sweeping changes, they argue, Medicare won't be able to pay its bills.

"We don't want to ration Medicare. We don't want to see Medicare go bankrupt," Ryan said.

Is there middle ground?

One debt-reduction panel chaired by former Federal Reserve Vice Chairman Alice Rivlin and former Republican Sen. Pete Domenici proposed last November to limit growth in federal support for Medicare beneficiaries to a formula: the rate of growth in the gross domestic product plus 1 percentage point. The cost per enrollee grew at GDP plus 1.7 percentage points annually from 1985 to 2008.

If costs were higher, beneficiaries could remain in the Medicare system and pay additional

premiums, or they could buy coverage from private insurers.

The betting is that the government's elaborate role in Medicare will persist, but there will be tinkering with formulas, more financial burdens on younger people and perhaps higher deductibles or payments from wealthier beneficiaries.

"The Obama approach puts all of the responsibility to contain costs on providers, while the Ryan approach puts it all on beneficiaries," said Paul Ginsburg, the president of the Center for Studying Health System Change, an independent research group. "Given the magnitude of our debt problem, we will need some of each."

But when?

"Nothing terrible is going to happen this year or the year after that," Wilensky said.

Meanwhile, the public needs to be educated; in an April McClatchy-Marist poll, 80 percent said they opposed any cuts in Medicare.

"The surveys are daunting," Wilensky said, "but we have to do something."