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## Access to Health Care News Update – 1.4.08

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(Note: salient Access to Health Care related materials highlighted in **RED** in longer sections for quick reading. Order generally is most current first; background to current articles may appear later in list.)

### U.S. Curtailing Bids to Expand Medicaid Rolls

*New York Times – 1.4.08*

WASHINGTON — **The Bush administration is imposing restrictions on the ability of states to expand eligibility for Medicaid, in an effort to prevent them from offering coverage to families of modest incomes who, the administration argues, may have access to private health insurance.**

The restrictions mirror those the administration placed on the [State Children's Health Insurance Program](#) in August after states tried to broaden eligibility for it as well.

Until now, states had generally been free to set their own Medicaid eligibility criteria, and the Bush administration had not openly declared that it would apply the August directive to Medicaid. **State officials in Louisiana, Ohio and Oklahoma said they had discovered the administration's intent in negotiations with the federal government over the last few weeks.**

The federal government has leverage over states, because it pays a large share of the costs for Medicaid and the State Children's Health Insurance Program, and states have to comply with federal standards to get federal money. The insurance program was created for children whose families have too much income to qualify for Medicaid but not enough to buy private insurance.

On Dec. 20, the Bush administration rejected a proposal by Ohio to expand its Medicaid program to cover 35,000 more children. Ohio now offers Medicaid to children with family incomes up to twice the poverty level, or about \$41,000 a year for a family of four. The state had proposed increasing the limit to three times the poverty level, to about \$62,000.

"Federal officials told us that they would apply the criteria set forth in the Aug. 17 letter to our proposal for expansion of Medicaid," said Cristal A. Thomas, the Ohio Medicaid director.

Dennis G. Smith, the director of the federal Center for Medicaid and State Operations, confirmed that account. "To be consistent and logical, you have to apply the criteria to Medicaid and CHIP," Mr. Smith said in an interview.

The same concern, about the substitution of government health care for private insurance, is present under both programs, he said, and states will not be allowed to "sidestep the Aug. 17 policy directive" by expanding Medicaid.

Jeff Nelligan, a spokesman for the Medicaid agency, said Ohio officials "were trying to get around the Aug. 17 policy directive." Under that policy, states had to enroll 95 percent of eligible children below 200 percent of the federal poverty level before they could expand their programs, a criterion that many state health officials said would be impossible to meet.

Tony Fratto, a spokesman for President Bush, defended the administration's stance.

"We want states to focus on enrolling their neediest population before they consider expanding Medicaid and CHIP to middle-income families," Mr. Fratto said. "This policy demonstrates the president's compassion. He wants to direct scarce tax dollars to those with the greatest needs."

Administration officials say government health programs start to "crowd out" private insurance when they cover families with incomes from 250 percent to 300 percent of the poverty level — about \$51,600 to \$62,000 for a family of four.

Some state officials complained about both the substance of the Medicaid policy and the way it was adopted.

"The Aug. 17 letter is a CHIP policy, not a Medicaid policy," said Mike Fogarty, chief executive of the Oklahoma Health Care Authority. "But it's being applied in a much broader way. We are seeing many more roadblocks."

The new federal policy reflects a significant shift. In the first four years of the Bush administration, [Tommy G. Thompson](#), the secretary of health and human services, often boasted that he had approved record numbers of waivers, allowing states to decide who got what benefits under Medicaid and the child health program. "Our goal is to give governors the flexibility they need to expand insurance coverage to more Americans," Mr. Thompson said in 2001.

## November Jobless Rates Up Seasonally in Most MI Regional Labor Markets

*Michigan News Wire – 1.3.08*

Seasonally unadjusted unemployment rates increased over the month in 12 of Michigan's 17 major labor market areas, according to the Michigan Department of Labor and Economic Growth. In November, total employment and labor force levels advanced in most regions.

Unemployment rates declined over the month in four areas, most notably in the Monroe and Detroit-Warren-Livonia Metropolitan Statistical Areas (MSAs), due to recalls from October layoffs in the auto industry. The jobless rate in the Battle Creek MSA was unchanged over the month.

"Minor jobless rate increases in the southern part of Michigan and large rate increases in northern Michigan are typical for November," said Rick Waclawek, director of the Bureau of Labor Market Information & Strategic Initiatives. "The seasonal loss of tourism and construction jobs this month was compensated by holiday related hiring in the retail sector."

*From October to November, the majority of the state's 17 major labor markets showed little movement in their respective jobless rates, with nine areas recording rate changes of 0.2 of a percentage point or less. With the exception of the state's three northernmost labor markets, increases were limited to half of a percentage point or less. Typical seasonal jobless rate hikes of over a full percentage point occurred in both the Northeast and Northwest Lower Michigan Regions along with the Upper Peninsula.*

## Poor Get Short Shrift on Drug Samples

*Wall Street Journal Health Blog – 1.3.08*

Samples of prescription drugs — like almost any interaction between docs and drug reps — are controversial. Critics say the freebies can warp physicians' prescribing patterns, favoring brand-name drugs over generics. **Supporters of samples say they can help the poor and uninsured get medicine.**

A study in the American Journal of Public Health aimed to put the latter claim to the test. Its conclusions: The poor and uninsured are actually *less* likely to get free medicine than their wealthier, insured neighbors. But it may not be for lack of effort by doctors.

The study, from physicians at the Cambridge Health Alliance hospital system and Harvard Medical School, looked at data collected on more than 32,600 Americans in a federal survey of consumer health spending. They homed in on a question of about whether they had received “any free samples of prescribed medicines from a medical or dental provider.”

About 12% of patients got free samples in 2003, the study found. But you were less likely to get them if you earned less than \$36,800 for a family of four or were uninsured, non-white, Hispanic, born outside the U.S., or if you didn't speak English. (Plenty of overlap, naturally.) Medicaid patients were among the least likely to get free samples, at just 4.1%.

But many docs seem to try to target free prescriptions to the neediest patients. Among those who get medical care in a doctor's office, as opposed to a clinic or emergency room, uninsured patients were in fact *more* likely to get free samples, the study found. In other words, the uninsured probably get fewer free samples because they see the doctor less often, and typically do so in clinics or an ER.

In short, the neediest patients aren't going where the samples are, Sara L. Cutrona, a hospitalist and the lead author, told Health Blog while on a break during what was shaping up to be a 12-hour stint at the system's Somerville campus. Put another way, she said, “perhaps the places the drug reps are targeting are not where the needy patients go.”

The upshot is that some poor and uninsured individuals certainly benefit from drug giveaways, but “on a nationwide scale, that's not what free samples are doing,” Cutrona said.

The drug trade group PhRMA disputed the findings. Ken Johnson, a PhRMA spokesman, said in a statement, “Instead of second-guessing motives, Harvard researchers would better serve patients by examining health outcomes. Clearly, free samples often lead to improved quality of life for millions of Americans, regardless of their income.”

## READERS' COMMENTS ON HEALTH CARE ARTICLES –

*Free Press, 12.29.07*

### Michigan deserves better health plans

The support of Catholics and other people of faith will be essential in making sure everyone in Michigan has affordable and comprehensive health care coverage (“Universal health coverage sought; Petition to ask voters to amend state Constitution,” Dec. 19). This petition drive is a defining moral test of whether our government serves the common good, or the interests of lobbyists and insurance companies. The U.S. Conference of Catholic Bishops and the Michigan Catholic Conference support health care as a human right.

Building a culture of life takes more than political rhetoric. It requires public policies that reflect our values of caring for neighbors as ourselves. Up to 1 million citizens in our state have few options other than a hospital emergency room when they are sick. In the richest country in the world that's an intolerable moral and political failure.

Let's make sure everyone in Michigan has access to the kind of healthcare our president and lawmakers are guaranteed.

**Vicki Kovari**, *Field Director, Catholics in Alliance for the Common Good, Detroit*

### An exciting ballot proposal

It was indeed exciting to see your recent story on the healthcare ballot proposal for Michigan voters to voice and show our political will before our leaders in 2008.

This is a Michigan plan, not a revision of the Massachusetts plan. This proposal does not come with an already designed plan. The ballot initiative simply allows for the voice of the people to be heard and forces the will of Michigan voters to be placed before our leaders in Lansing to devise a plan which begins to fix a completely dysfunctional healthcare system.

**The Rev. Patrick P. Gahagen**, *Immanuel Lutheran Church, Detroit*

### A cause worth helping

That MichUHCAN group has it exactly right; we need universal health care coverage in Michigan. Universal health care coverage and cost control would help all families -- those of us without health insurance, and the

rest of us who worry about losing our health insurance. It would also help the auto companies. They have to compete against countries that have low-cost universal health coverage. It would also help our local governments and school districts, which are getting killed by health costs. Get involved. Go to [www.MichUHCAN.com](http://www.MichUHCAN.com) and sign up as a volunteer. I did.

**Tom Regan**, *Royal Oak*

### **The costs of Blue Cross**

We have paid Blue Cross Blue Shield for non-group coverage since 1945. The non-group subscribers have continually paid far more than groups in that 62 years time.

The non-group subscribers have always held up their side of the contract, and it is expected that the Blues will hold up theirs.

Further, the head spokesman for the Blues said, "the original charter did not say anything about accounting for pennies." They are not talking about pennies here! They are talking about \$1.2 billion dollars! Since when is a billion dollars "pennies"?

**Jean Dembeck**, *Wixom*

### **No preventive care**

The Free Press should comment on the abuses the Blues impose on non-group subscribers: Preventive care is not covered. Routine care is not covered. Doctor visits are not covered. This means that women have to pay for their mammograms initially and subsequently, unless an abnormality is detected, and that they must pay for their Pap smears.

My adult children in other states have individual policies with preventive care included by companies that cannot offer coverage in Michigan because of the monopoly the Blues have developed. Ask the elderly if they have access to the AARP policies in other states.

**Sonia Just**, *Birmingham*

## **The Fight Over Making Employers Pay For Health Insurance**

*Wall Street Journal Health Blog 12.31.07*

A judge's ruling on [San Francisco's plan to offer universal health insurance](#) could have implications throughout California and beyond.

U.S. District Judge Jeffrey White last week struck down a provision in a city ordinance that would have required businesses with at least 20 employees to either offer health insurance or pay a fee to the city to subsidize insurance, the San Francisco Chronicle reported.

White found that the provision, which would have taken effect on Jan. 1, violated the federal Employee Retirement Income Security Act (aka ERISA), which says the feds — not state or local governments — hold sway over employer-provided benefits.

As the Christian Science Monitor points out today, [Gov. Arnold Schwarzenegger is working with the state legislature to push a statewide health-reform plan](#) that would also require minimum contributions from employers — and could also run into legal troubles because of ERISA.

The Rocky Mountain News also picks up on the ruling today, in an editorial that says the "implication for Colorado is that [our lawmakers might be wasting their time](#) if they craft reforms that affect employer medical plans." (Colorado's legislature is set to consider health reform early next year, according to the editorial.)

Meanwhile, the LA Times reports, San Francisco is [appealing White's ruling](#) and plans to continue with other elements of its [health insurance plan](#).

## **Retiree-benefit rule gets mixed reaction**

*USA Today – 12.28.07*

Retiree advocates gave a mixed reaction Thursday to a new regulation allowing employers to provide more limited health care benefits for retirees who are 65 and older, though some critics called the change tantamount to discrimination.

The regulation from the Equal Employment Opportunity Commission (EEOC) says that employers can spend more on retirees under 65 than those older than 65 without breaking age-discrimination laws, so they can cut or reduce benefits for retirees when they become eligible for Medicare. That could mean more expansive benefits for retirees under 65 than those who are over 65, says the AARP, which represents older Americans.

But the EEOC says the policy change, announced Wednesday, is aimed at protecting retiree benefits. The EEOC proposed the rule after a 2000 U.S. Court of Appeals decision that required that the health [insurance](#) benefits received by Medicare-eligible retirees be the same, or cost the employer the same, as the benefits for younger retirees.

Labor unions and employers told the EEOC that complying with the decision would force companies to cut or end retiree health benefits -- potentially leaving millions of retirees 55 and older with less health insurance or none at all, the EEOC says.

Even some groups who say the change will hurt some older retirees agree there is a major benefit: "Some employers are likely to retain health benefits for workers under age 65," said Robert Hayes, president of the New York-based Medicare Rights Center.

More than 10 million retirees rely on employer-sponsored health plans as a primary source of coverage or as a supplement to Medicare, according to the EEOC.

But the percentage of employers offering coverage to those who retire before Medicare kicks in has dropped from an average of 21.6% of private-sector employers in 1997 to about 12.7% in 2005, according to the Employee Benefit Research Institute.

## **Children's Health Insurance: Same As It Ever Was**

*Wall Street Journal Health Blog – 12.31.07*

After months of political posturing and brinkmanship, [we end the year with the same State Children's Health Insurance Program we started with. On Saturday, President Bush signed a bill that will keep the current SCHIP program in place through March, 2009, the AP reported.](#)

That's a pretty anticlimactic end one of Washington's [biggest health policy fights of the year](#). Most Democrats and many Republicans were fired up to pour an extra \$35 billion into the program over five years to expand the number of children covered. But the president, who proposed a smaller expansion, argued that Democrats' plan would have unwisely extended government-subsidized health insurance to children who could afford to be covered by private insurance.

The Dems thought the [political wind was in their favor](#), and they passed their bill in the fall with much fanfare, just before the old SCHIP program was set to expire. The president [vetoed](#) it. Congress failed to override the veto then re-passed a similar bill, which the president [also vetoed](#). SCHIP muddled along on temporary extensions, and Congress ultimately passed the status-quo bill the president signed during the weekend.

[Look for both sides to use the SCHIP fight in next year's elections, with the Democrats likely to say the Republicans left millions of children without health insurance, and the Republicans likely to counter that the Democrats were unable or unwilling to compromise in order to get things done.](#)

## **New Census Estimates Show Michigan Remains Nation's Eighth-Largest State**

*Michigan News Wire – 12.27.07*

New population estimates released today by the U.S. Census Bureau indicate that Michigan's population has decreased by 30,500 from 2006 to 2007. Michigan remains the nation's eighth-largest state with a population of 10,071,822.

"Although Michigan's net out-migration is up, it is not the highest in the nation and not nearly as high as it was in the 1980's," said State Demographer Ken Darga. "Our share of the nation's population is down, but only by about the same amount as the decrease from 2005 to 2006."

According to the new estimates, Michigan had the nation's third-highest rate of net domestic out-migration in 2007, surpassed only by New York and Rhode Island. Michigan has the nation's seventh-highest rate for the entire period since the 2000 Census, surpassed by New York, the District of Columbia, Louisiana, Massachusetts, New Jersey and Illinois.

A chart showing [Michigan's net migration from 1960 through 2007](http://www.michigan.gov/census) is available online at [www.michigan.gov/census](http://www.michigan.gov/census).

Michigan had 3.34 percent of the nation's estimated population in 2007, which is down from 3.38 percent in 2006 and 3.53 percent in the 2000 Census.

Michigan's share of the nation's population for 2007 is lower than in 2006 because of significant population loss through migration. According to Darga, other factors contributing to lower growth in Michigan than the U.S. as a whole include a lower birth rate, a lower rate of immigration from other countries, and a larger number of military personnel who are stationed in other states.

## **Feds: Companies Can Cut Retiree Health Benefits at 65**

*Wall Street Journal Health Blog – 12.27.07*

That sweet early-retirement health-care package could sour when you turn 65. [A federal agency ruled yesterday that companies can cut health benefits when retirees turn 65 and qualify for Medicare.](#)

The AARP had sued to block the rule, issued by the Equal Employment Opportunity Commission, arguing that it conflicted with the Age Discrimination Act, the New York Times [reports](#).

The U.S. Court of Appeals for the Third Circuit found in favor of the federal government. But, the court added, “we recognize with some dismay that the proposed exemption may allow employers to reduce health benefits to retirees over the age of 65 while maintaining greater benefits for younger retirees.”

The underlying issue is the rise in health costs, which has hit companies that offer generous retiree health plans particularly hard. The U.S. auto industry is the poster child on this one, and earlier this year [GM cut a deal with the United Auto Workers](#) that allowed the company to move \$50 billion in retiree health obligations off its balance sheet.

A lawyer for the EEOC told the Times that many companies said “if they had to provide identical benefits for retirees under 65 and over 65, they would just drop retiree health benefits altogether for both groups.”

## **Should People In Their 50s Be Allowed to Buy Into Medicare?**

*Wall Street Journal Health Blog – 12.26.07*

If you don't have health insurance, turning 65 — and qualifying for Medicare — is good for your health, according to a [Journal of the American Medical Association](#) study [published](#) this week.

Those who were insured before they turned 65 don't see the same improvement, [suggesting that uninsured adults, particularly those with chronic conditions like diabetes and cardiovascular disease, weren't getting all the health care they needed before Medicare kicked in.](#)

[The findings raise the question of whether Medicare-like coverage should be offered to adults younger than 65, especially those with chronic medical conditions, the authors suggest. Ideas of this sort aren't limited to academic medical journals: A few presidential candidates have suggested allowing people in their mid 50s and early 60s to buy into Medicare.](#)

In the study, those without health insurance before turning 65 suffered from poorer health compared to adults who had health insurance all along. But after receiving coverage, previously uninsured individuals reported they were able to maintain their health status.

This study looked at data from over 7,000 Americans from 1992 to 2004. The Harvard-based authors acknowledge that it's possible that factors other than Medicare coverage could have occurred around age

65 and influenced the health results. But at least two other changes that often occur around that age, start of social security and retirement from work, didn't seem to explain the findings.

(Full study from The Commonwealth Fund web site:

[http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=628864](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=628864) )

## **UAW looks to influence debate on health care**

*Free Press – 12.24.07*

WASHINGTON -- The UAW's gamble that it can manage the health care costs of up to 700,000 people comes with a side wager over how much the union can boost its influence in the health care debate in Washington.

That debate will be key to whether the union can contain health care costs enough to keep its \$52-billion fund for retiree health care solvent. And the union's deal with Detroit's automakers includes a boost to its lobbying efforts through a \$30-million pledge toward a new think tank called the **National Institute for Health Care Reform**.

While the sheer scope of the UAW's health care plan will make it one of the largest buyers of health care in the United States, experts say its sway over future health care reform may hinge more on which party wins the White House in 2008.

The UAW's new role as health care shopper is "a very interesting development, and it has some potential for getting a handle on costs," said Bill Vaughan, senior policy analyst for Consumers Union in Washington. Health care reform has been a key part of the UAW's political goals for decades. In 1968, the UAW's then-president, Walter Reuther, set up the Committee for National Health **Insurance**, denouncing what he called a "disorganized, disjointed, antiquated, obsolete nonsystem" of health care that left tens of millions of people without health insurance.

During the 1970s, the committee helped write several bills to expand **insurance coverage**, when presidents Richard Nixon and Gerald Ford supported the idea of national health care plans. But those bills failed to get through Congress, and the committee sharply cut back its efforts after Ronald Reagan's election in 1980.

The UAW still supports some form of a national health care system and backed the Clinton administration's efforts in 1994. But with the second Bush administration steadfastly opposed to any such move, the UAW has focused its lobbying on other health care problems, such as controlling costs, expanding Medicare and seeking government aid for automakers' retiree health-care costs.

In many of those topics, the UAW found itself lobbying against insurance and drug companies and other powerful corporate interests. But with the union set to assume control of the health care costs for 540,000 retirees and their families, and 180,000 active workers when they retire, the UAW will become one of the largest buyers of health care in the nation, behind the federal government and the California Public Employees' Retirement System.

"I think people will be sitting up and taking notice," said UAW chief lobbyist Alan Reuther, a nephew of Walter Reuther. "It doesn't alter the fact that we still need fundamental reform."

Reuther said **the UAW is still in the process of setting up the new National Institute for Health Care Reform**, but that the retiree health care trust fund would not change its political priorities. He said the trust fund -- technically a voluntary employee beneficiary association or VEBA -- could let the UAW experiment with ways to contain costs, such as a program with General Motors Corp. that allows doctors to use electronic prescription forms to reduce drug interactions. The VEBA is expected to begin negotiating benefits in 2010. But it first must go through a court-approval process, which is expected to begin early in 2008.

Although the union will become a big health care buyer, it's already a big political donor. The UAW has given more than \$2 million in every election cycle since 1990 to the Democratic Party. And Democrats appear to be listening: All three of the leading Democratic presidential candidates have proposed some form of national health care insurance.

Republican candidates have not made health care as central to their campaigns. Those who have addressed health care say they favor solutions such as health savings accounts that the UAW opposes.

But it may take more than political will to solve the problems. The Congressional Budget Office estimates that Medicare and Medicaid could consume up to 12% of the nation's economic output by 2050. Meanwhile, estimates of Americans without health insurance stand at 47 million, with another 33 million who go without health insurance for at least part of the year.

## IRS Stuffs Hospital Stockings

*Wall Street Journal Health Blog – 12.21.07*

Christmas came a few days early for nonprofit hospitals, and from an unlikely source: the Internal Revenue Service.

Amid pressure from lawmakers, the taxman scared hospital bigwigs [this summer](#), with a proposed overhaul to the tax form that all not-for-profit entities file, the venerable [Form 990](#).

A special schedule just for hospitals, in particular, provoked considerable anxiety. But [the holiday treat came yesterday when the IRS said it would roll back some of the elements hospital groups found most troubling, noting that it had received some 3,000 pages of written comments since summer.](#)

The American Hospital Association praised the change, with the group's [CEO applauding the elimination of "burdensome questions,"](#) paying special attention to a daunting sounding chart on "Billing Information" that some hospitals estimated would take 1,000 or more hours to complete.

[Among the industry's gains: A more palatable collection of figures to demonstrate "community benefit" – the nebulous requirement for nonprofit hospitals to operate tax-free. Specifically, the new IRS form lets hospitals tally unpaid patient bills and Medicare "underpayments" among their "community benefit" contributions. \(Federal law has for years failed to define the requirement particularly well, but lawmakers may get around to it soon.\)](#)

The tax agency also let hospitals tout their missions and good works high up on the form, before listing a variety of cold facts; and dropped a summary page that would have provided at-a-glance stats on compensation, revenue sources, fundraising and an asset-to-expenditures ratios. [Much of the new hospital-specific form won't apply until hospitals file for 2009 in little more than two years.](#)

The new forms are generally an improvement over this summer's proposal, says Michael Peregrine, a nonprofit-tax lawyer in Chicago with McDermott Will & Emery. But the new regime will still be considerably tougher than what hospitals and other nonprofits currently file, he added, particularly when it comes to disclosing governance procedures and potential conflicts of interest.

[Not everyone was entirely pleased. Sen. Chuck Grassley, whose inquiries into charity care and compensation practices at nonprofit hospitals helped spur the IRS changes, praised the agency for "a clearer, more uniform definition of community benefit."](#)

Still, he said he was "disappointed" that the IRS won't require better disclosure on how charities spend their money. "The IRS easily could have done more to help donors readily understand where their money goes," Grassley said in a statement. "I plan to revisit that issue."

## Democrats Suffer Loss as House Extends SCHIP

*NPR, All Things Considered, 12.19.07*

Listen: <http://www.npr.org/templates/story/story.php?storyId=17416046>

The Democratic-led Congress on Wednesday officially waved the white flag of surrender on its top domestic issue: the State Children's Health Insurance Program, or SCHIP. [Eleven months and two presidential vetoes after vowing to expand its reach, the House instead passed and sent to President Bush a bill that will essentially continue the program in its current form until 2009.](#)

Democrats had little choice in the matter. With Christmas fast approaching, they were in a fix. They had two health funding emergencies. First, temporary funding for SCHIP — whose authorization technically expired

Oct. 1 — was about to run out once again. Second, on Jan. 1, a 10 percent cut in pay to doctors under Medicare was set to take effect — something Democrats, Republicans and the Bush administration agree shouldn't be allowed to happen.

But President Bush and Republicans had nixed most of the ways Democrats wanted to pay for either the Medicare changes or the SCHIP expansion. That basically gave Republicans the upper hand, and left the majority Democrats with little more to do than fume.

"What we have before us gives the lowest common denominator a bad name," said Rep. Pete Stark (D-CA), chairman of the House Ways and Means health subcommittee. "It shows the Republicans in their truest form: Help the rich at the expense of the poor and deny government services to anyone and only help the profit industries who pay them so generously through their campaign contributions."

And, adding insult to injury, Republicans insisted on continuing SCHIP at its current funding levels not just until September — as Democrats had wanted — but until March 2009, four months after the November 2008 elections. "I think this 18-month extension gives us the time we need to make SCHIP an even better program," said House Republican Whip Roy Blunt. "It extends the current program. It increases funding for the current program. It helps the states that have a shortfall."

Nearly half of the states would suffer such funding shortages, according to the Congressional Research Service. It calculated that 21 states will run out of money under the current funding formula by September; 10 of them by March. So the bill includes \$800 million for those states.

But that doesn't mean that every child now enrolled in SCHIP could stay on the program; the bill doesn't cancel controversial Bush administration eligibility rules issued last August. As a result of those rules, "if you live in 14 states in the U.S. ... kids in those states will actually come off the rolls in August," said Rep. Rahm Emanuel (D-IL). "The governors will have to begin to develop plans to notify kids and their parents."

But Emanuel says that may not be such a bad thing for the Democrats, particularly when children start getting bumped off the program. "August '08 is two months before the election, and I don't think that's a problem," he said. "As a matter of fact, we can't protect the American people from the consequences of the president's decision and a number of Republicans to stand by him. We did right, there was a bipartisan bill to resolve a major problem and give 10 million children health care. We didn't accomplish it. We'll be back. And we'll get it done."

The SCHIP debate, however, might not be over just yet. Congress will be forced to pass yet another health funding bill by next June, because the Medicare doctor payment fix they just passed lasts only six months. And some Democrats say they may try to bring back the SCHIP issue then.

## Insurers Seek Bigger Reach in Coverage

*New York Times* — 12.19.07

Acknowledging that too many people simply cannot obtain [health insurance](#) on their own, the insurance industry plans on Wednesday to propose a series of steps the companies say would let more individuals, even those who have health problems, obtain coverage.

The proposals, approved by a board of the industry's main trade group, would make it harder for insurers to cancel policies or deny coverage to people with pre-existing medical conditions. The steps would also limit the premiums that could be charged for such people. The trade group also called on states to provide individual coverage for people who were likely to incur very high medical bills.

The effort is meant to help address the problem of 47 million Americans without health coverage. And it signals a willingness by insurers to abandon practices that have seemed aimed at excluding all but the healthiest individuals.

"We are taking responsibility for ensuring that no one falls through the cracks," said Karen Ignagni, the chief executive of the trade group, America's Health Insurance Plans, which is based in Washington. While the

group is proposing that the states cover the most costly individuals, private insurers would offer policies to everyone else. "We are providing essentially a coverage safety net," she said.

It is far from certain whether any of the specific proposals will be enacted or states will finance the cost of broader coverage. **But the industry's position indicates a willingness to move toward a system in which everyone can find coverage.**

"The individual market is recognizing that we need to improve the way we do business today," said Don Hamm, the chief executive of Assurant Health, a Milwaukee insurer, who was among the executives who drafted the proposals.

The industry's announcement comes at a time when dozens of states are already considering some kind of health reform and insurers are increasingly being vilified by the Democratic presidential candidates. This month, former Senator [John Edwards](#) pledged to take on the insurance companies, saying "the American health care system is broken because wealthy insurance corporations and their lobbyists have rigged the system against the American people."

Much of the discussion has also focused on whether insurers should be forced to cover anyone who applies, which is a requirement in only a handful of states. The industry is also pledging to address criticism that some insurers have inappropriately canceled policies, by proposing that decisions to rescind coverage be subject to third-party review. "The health insurance is coming to grips with the fact that practices that are clearly driven by market forces are giving the industry a black eye," said Paul B. Ginsburg, the president of the Center for Studying Health System Change, a Washington research group.

But the industry is also trying to have a greater say in any state changes that may be enacted. Many insurers chafe, for instance, over what they consider an overly regulated approach in Massachusetts, which has created an agency to oversee the market for individual insurers as part of a new law requiring everyone to buy coverage. "This is advice to the states on how they can create functioning and viable marketplaces," said George C. Halvorson, the chief executive of Kaiser Permanente, the California insurer, who chairs the trade group.

**Insurance executives acknowledge that these proposals are only part of the changes necessary in health care. But they say the suggested steps are a way in which states and private insurers can work together to provide coverage in which insurers try to address shortcomings of the individual market.**

"This is a far-reaching proposal that responds to the concerns that people have appropriately raised," said Jay M. Gellert, the chief executive officer of [Health Net](#), a California insurer, another executive involved in the proposals. As long as the group of people covered was large enough, private insurers could make the market work, he said. "If a state or the government is committed to universal participation, you can have a viable market and take all comers."

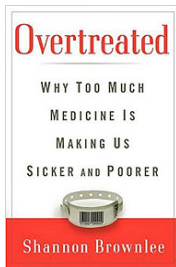
How many people would be able to obtain coverage under these proposals was unknown. Currently, about 11 percent of all individuals who apply for coverage are not offered a policy after the insurers review their medical conditions, according to a new survey of the trade group's members that is also to be released Wednesday. And nearly 30 percent of individuals who are in their 60s but too young for [Medicare](#) are denied coverage. To extend coverage to high-risk people with expensive medical problems, or likely to incur them, would cost money, and states might not go along. In states that already have programs for high-risk individuals, significant numbers of people still do not obtain coverage because the premiums are high.

"Few states are willing to come up with the money to subsidize them so they can cover enough people," Mr. Ginsburg said.

In fact, only about 180,000 people around the country were covered by existing high-risk pools, said Katherine Swartz, a Harvard professor who studies health insurance issues.

The new proposals call for states to provide affordable coverage to anyone whose medical costs are expected to be at least twice the average. For other higher-risk patients who do not meet those criteria, the insurers would agree to cap the premiums at 150 percent of the market rate.

The insurance executives say that the proposals represent a real avenue to overhauling health coverage. “I have optimism that the states and the country will step up to the issue,” said [Ronald A. Williams](#), the chief executive of [Aetna](#), a large insurer in Hartford.



### **No. 1 Book, and It Offers Solutions** - *New York Times*, 12.19.07

In 1967, Jack Wennberg, a young medical researcher at Johns Hopkins, moved his family to a farmhouse in northern Vermont. Dr. Wennberg had been chosen to run a new center based at the [University of Vermont](#) that would examine medical care in the state. With a colleague, he traveled around Vermont, visiting its 16 hospitals and collecting data on how often they did various procedures.

The results turned out to be quite odd. Vermont has one of the most homogenous populations in the country— overwhelmingly white (especially in 1967), with relatively similar levels of poverty and education statewide. Yet medical practice across the state varied enormously, for all kinds of care. In Middlebury, for instance, only 7 percent of children had their tonsils removed. In Morrisville, 70 percent did.

Dr. Wennberg and some colleagues then did a survey, interviewing 4,000 people around the state, to see whether different patterns of illness could explain the variations in medical care. They couldn't. The children of Morrisville weren't suffering from an epidemic of tonsillitis. Instead, they happened to live in a place where a small group of doctors — just five of them — had decided to be aggressive about removing tonsils.

But here was the stunner: Vermonters who lived in towns with more aggressive care weren't healthier. They were just getting more health care.

Dr. Wennberg would eventually move to Dartmouth and, **over the last 30 years, has done versions of his Vermont study for the entire country**. Again and again, he has come up with the same broad result. And that result holds the key to health care reform — **how to spend less on health care while not making the population any less healthy**.

Dr. Wennberg's story forms the backbone of “**Overtreated**,” by **Shannon Brownlee**, which is my choice for the economics book of the year. ....

Full review of book at: <http://www.nytimes.com/2007/12/19/business/19leonhardt.html?ref=health>

## **Michigan's November Jobless Rate Declines**

*Michigan News Wire – 12.19.07*

**Michigan's seasonally adjusted unemployment rate in November decreased by three-tenths of a percentage point to 7.4 percent**, according to data released by the Michigan Department of Labor & Economic Growth (DLEG). Total employment rose by 25,000 as unemployment declined by 17,000. As a result, the state's labor force edged upward by 8,000 over the month.

Michigan's November 2007 jobless rate is three-tenths of a percentage point above the state's November 2006 rate of 7.1 percent. The national rate rose by two-tenths of a percentage point in the same period.

*Monthly Labor Force Trends & Highlights:*

- November marked the first monthly unemployment rate decline for the state since May.

- Michigan's labor force has declined in 2007. With 11 months of data in, the year-to-date average 2007 work force in the state totaled 5,044,000. This was a reduction of 37,000 from the 2006 annual average work force of 5,081,000.
- Since November 2006, statewide unemployment increased by 10,000 or 2.8 percent, which compares favorably to the 5.0 percent rise in national unemployment in the same period.
- From November 2006 to November 2007, total employment in Michigan fell by 71,000 or 1.5 percent. Total employment nationally increased by 0.7 percent in the same time frame.
- The national jobless rate in November was unchanged over the month at 4.7 percent.

## Universal health coverage sought

*Free Press – 12.19.07*

A campaign that claims support from key Michigan labor and religious groups, the AARP and Lt. Gov. John Cherry plans to launch [a petition drive next month to ask Michigan voters to approve statewide, universal health care.](#)

The coalition would amend the state constitution to require the Legislature to enact "affordable and comprehensive health care coverage" in the same way the constitution mandates state support of free public education.

[Health Care for Michigan](#), headed by former state Rep. John Freeman, an Oakland County Democrat, is to appear today before a state elections panel to ask for approval of its petition forms. But the campaign is already well under way, spokesman Gary Benjamin said Tuesday. The group's polling shows broad popular support for the idea, he said.

The amendment would "create a duty to provide health care coverage for everyone," Benjamin said. "But it's not a plan; it's a constitutional amendment."

[An estimated 850,000 to 1.1 million Michiganders do not have health care insurance.](#)

Benjamin said passage of the amendment would create political pressure for the Legislature to act and a legal standing to compel action if political pressure wasn't enough.

Steve Gools, [Michigan director for the AARP](#), said passage of the ballot proposal would be the organization's top state priority in 2008, and that it was prepared to put \$100,000 into the campaign. AARP members, including many enrolled in Medicare for older citizens, won't necessarily benefit directly, Gools said, but "their concern is not so much for themselves as it is about their kids and grandkids."

He said the organization isn't wedded to a specific plan. Nor does universal coverage mean a government takeover of health care, he said; it just means that everyone is covered. But the broad language proposed for the constitution is exactly what concerned Bob LaBrant, an elections specialist at the Michigan Chamber of Commerce.

"Affordable is in the eye of the beholder ... and comprehensive is a term of art," LaBrant said. A constitutional amendment mandating health care coverage for every citizen could eventually mean that "we all get plastic surgery," he said.

[Benjamin said coalition members believe universal coverage can be achieved without adding to the overall cost of health care in Michigan. Michigan health care costs about \\$60 billion a year, or \\$6,000 per person, Benjamin said, easily enough to provide coverage to the state's 10 million residents.](#)

The campaign will need to collect the signatures of more than 380,000 registered voters to put the issue on the November ballot. Benjamin said the group's goal is 475,000 signatures in all to provide room for error, at a cost approaching \$1 million.

A spokeswoman for Gov. Jennifer Granholm said the governor is considering the proposal. Granholm supports the goal of universal, affordable care, but has not taken a position, spokeswoman Liz Boyd said. Boyd said she was not aware that Lt. Gov. Cherry's name was listed among the endorsements on a Web site linked to the campaign.



Elliott says TFAH won't take donations from the government or corporations because that would represent a conflict of interest in its role as a watchdog. The group was started when the nation needed a preparedness watchdog the most — in the middle of 2001. Shortly after TFAH was formed, Sept. 11 and anthrax attacks helped bring bioterrorism and other emergency issues into the forefront.

(NYT story at: [http://www.nytimes.com/2007/12/19/business/19health.html?\\_r=1&ref=health&oref=slogin](http://www.nytimes.com/2007/12/19/business/19health.html?_r=1&ref=health&oref=slogin) )

## California Moves Toward Universal Health Care

*New York Times* – 12.18.07

SACRAMENTO — [California](#) moved significantly closer to enacting a broad expansion of [health insurance](#) coverage Monday when the Democratic-controlled Assembly passed legislation that has the backing of the Republican governor, [Arnold Schwarzenegger](#).

But it is far from certain that the Legislature will give final approval to the measure, which **would provide coverage to an estimated 70 percent of the 5.1 million persistently uninsured Californians.**

The bill must first gain passage in the Senate, also controlled by Democrats, where there are deep concerns about the measure's impact on the state's widening budget gap. And even if the Senate ultimately joins with Mr. Schwarzenegger and the Assembly, state leaders then must persuade California voters to support billions of dollars in new taxes and fees in a November referendum.

## CBO Calls Rising Health Care Costs a Threat to Nation's Economy

*Cover the Uninsured*, [CongressDaily](#), 12.13.07

The Congressional Budget Office (CBO) warned that **due to skyrocketing health care costs, "the federal budget is on an unsustainable path," and major cuts in spending or revenue increases are needed or the rising federal debt "could seriously harm the economy,"** reports *CongressDaily*.

According to the federal budget forecast, "the major cause of the surge in spending is a nearly fivefold jump in the projected cost of Medicare and Medicaid," not the fact that Social Security outlays will increase by about 50 percent in 75 years due to the aging population. **"The heart of the problems is that healthcare costs will literally consume the U.S. economy,"** said House Budget Chairman John Spratt (D-S.C.), reports *CongressDaily*.

CBO Director Peter Orszag told the House Budget Committee that health care costs could be reduced without sacrificing quality. He pointed to data that showed "that health care in some parts of the nation cost half as much as in other areas, with no difference in quality." According to the article, Orszag said "the government could save substantial amounts if it would change the current 'strong financial incentives for more health care' to favor 'better care.'"

## OPINION: Americans Should Be Able to Buy Health Insurance from Any State

*Cover the Uninsured*, [Wall Street Journal](#), 12.12.07

In a *Wall Street Journal* commentary, Merrill Mathews, executive director of the Council for Affordable Health Insurance and a resident scholar with the Institute for Policy Innovation, writes that residents in one state should **be allowed to purchase health coverage that is available in another state because it "would create a competitive, 50-state market for health insurance, likely making it cheaper."**

The Health Care Choice Act, which is being reintroduced by Rep. John Shadegg (R-Ariz.), "would increase competition and consumer choices currently denied to residents in many states," according to Mathews. He says that states such as New Jersey, New York and Massachusetts have so over-regulated their individual health insurance markets that many of their residents are priced out and unable to get covered. He points to "expensive state-level regulations" such as guaranteed issue, "which requires insurers to sell insurance to anyone willing to buy it, regardless of their health, or other factors that may make it much more expensive to cover them." When this regulation was enacted in New Jersey in 1994, the cost of a family policy went from costing \$463 to \$1,076 a month to costing \$1,726 to \$14,062 a month. Mathews argues that New Jersey

residents, for example, should be able to purchase coverage from neighboring Pennsylvania, where similar policies are a third of the price.

According to Mathews, **state-imposed mandates such as chiropractic care and mental-health services also contribute to the difference in the cost of health insurance between states.** "These mandates can increase the cost of health insurance by as much as 50%, which can then force residents in many states to decide between 'Cadillac coverage'--insurance that covers nearly everything and costs a mini fortune--or no coverage at all," he writes. While such mandates "are justified by the belief that they make health insurance more comprehensive," Mathews writes that "many states are 'protecting' their residents right into the uninsured camp."

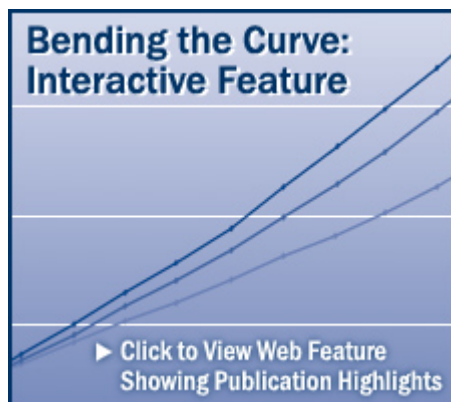
## Web Resource:

**MI Hospital Inform** web site from the Michigan Health and Hospital Association (<http://www.mihospitalinform.org/>) offers charge, payment and quality information on its 146 nonprofit member hospitals in the state, including 15 in the U.P.

## Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending

*The Commonwealth Fund report – 12.18.07*

### Overview



View [interactive Web feature](#) for report highlights.

U.S. health spending is projected to increase from 16 percent of GDP in 2006 to 20 percent in 2016—from \$2 trillion to \$4 trillion. Meanwhile, the number of uninsured Americans continues to rise.

In this report prepared for The Commonwealth Fund Commission on a High Performance Health System, the **authors examine 15 federal policy options that have the potential to lower health spending relative to projected trends.** They include policies that would: produce and use better information for health care decision-making, promote health and enhance disease prevention, align financial incentives with quality and efficiency, and correct price signals in health care markets.

**Combining policies would capture the synergistic benefits of individual changes. If implemented along with universal health insurance, a combination of selected options could save \$1.5 trillion in national health expenditures over 10 years, while also improving value in terms of access, quality, and health care outcomes.** Full study at: [http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=620087&#doc620087](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=620087&#doc620087)

## **Blue Cross hike called inadequate; expert says it isn't seeking high enough rate**

*Free Press – 12.15.07*

LANSING -- A national health insurance expert and longtime consultant to Blue Cross Blue Shield of Michigan testified Friday that the insurer's pending rate hike is not enough to offset losses in nongroup policies.

William Bluhm of the Minneapolis-based Milliman consulting firm called Blue Cross' pending average 24% rate hike "materially inadequate." Given high costs of medical claims for such policies, there are "no reasonable expectations that these lines of business will be profitable in the near future," he said.

Bluhm's testimony prompted Joe Aoun, the Northville attorney for a Livonia couple who sought the rate-hike hearing, to ask administrative law judge David Lick to grant a summary decision, which would result in throwing out the Blue Cross rate-hike request.

Aoun argued that state law requires Blue Cross to file for rates that are fair and adequate and that Bluhm's testimony, saying the rates were insufficient, showed the rate request did not meet legal standards. Lick said he would consider the motion.

Bluhm, who has held top board and executive positions with three leading insurance actuarial organizations, testified on the fourth day of a hearing in a case brought by Ron and Ghada Abraham challenging the rate hikes. If they win, about 19,000 Blue Cross policyholders in seven nongroup plans would benefit.

Blue Cross has asked the Michigan Office of Financial and Insurance Services to be allowed to raise rates for so-called moderately priced nongroup plans by 23.9%, and by 41.9% in its so-called high value plans with the smallest co-pays. The rate hikes would generate \$30 million. Blue Cross says it lost \$24 million on its nongroup policies through Oct. 31 this year. Over 10 years, it said it has lost \$52 million on the policies.

Under the rate hike, the Abrahams would see their premiums rise from \$510.45 a month to \$568.63.

Aoun, their attorney, earlier this week brought in his own national expert, James Geyer, a former chief actuary of Aetna Inc., to challenge the way Blue Cross determined the pending rates. Geyer also testified that Blue Cross has about \$500 million more than it needs in its surplus fund. Bluhm disputed Geyer's calculations. He said Blue Cross' accounting methods were appropriate for a nonprofit organization subject to state regulations, and calculations Geyer proposed are better suited to large insurers that offer more than medical insurance.

Blue Cross is backing legislation already passed by the Michigan House and pending Senate committee hearings to allow it to charge nongroup policy holders different rates, depending on their age, health, county of residence and other factors, and to end consumer and attorney general challenges to rate hike proposals. Attorney General Mike Cox, the UAW and several consumer organizations have objected to the bills. Friday concluded with the end of oral arguments. Both sides are to make closing arguments in late January.

## **Does Flex Time Lead to Better Health?**

*New York Times – 12.13.07*

A flexible schedule makes it easier to juggle job and family demands, but new research shows there's an added benefit: improved health.

Researchers at Wake Forest University talked to 3,200 workers at a major pharmaceutical company about their health habits, quizzing executives, support staff and warehouse and production employees about sleep, exercise and the overall healthfulness of their lives. The employees also were asked whether their jobs provided the flexibility needed to meet work, personal and family commitments.

Workers who strongly agreed that they had job flexibility also were more likely to engage in healthful behaviors, the researchers report in the current issue of *The Journal of Occupational and Environmental Medicine*. **Employees with flexible schedules exercised more and attended more employer-sponsored health classes. They also were more likely than those with more regimented routines to describe themselves as living a healthful lifestyle. Surprisingly, workers who felt they had job flexibility also reported getting more sleep.**

The study wasn't designed to determine how job flexibility might contribute to longer sleep. But lead author Joseph G. Grzywacz, an associate professor of family and community medicine at the university, said that workers with flexible schedules may not be working as late as others, or they may be less stressed and sleeping better at night. Or, he said, it may be that these employees are able to structure their work lives in such a way that sleep time is protected.

The researchers also checked in with the workers a year after the first survey. They found that if an employee's job flexibility improved over the year, so did healthy habits. When flexibility grew, workers reported better sleep, attended more health classes and were more likely to describe themselves as having a healthful lifestyle. **Yet improving a worker's schedule didn't automatically lead to more exercise, the study showed. It may be that a year was just too soon to see the full effect of improved flexibility.**

## States at the Center of Health Information Exchange

*The Commonwealth Fund bimonthly innovation report – November-December, 2007*

States are in a unique position to encourage health information exchange (HIE), or the electronic transfer of health care information across organizations. [1] They are critical to the federal vision for an interoperable National Health Information Network and have considerable leverage to influence local investments in health information technology. **About half of the states have an executive order or legislative mandate to stimulate the use of health information technology, and 35 states have initiated the planning process. Still, only seven states have plans in place and implementation under way.** [2]

**States can encourage health information exchange in their roles as policy leaders, funding sources, data collectors, facilitators, or neutral conveners.**[3] **They can leverage their roles as major health care purchasers and policymakers to drive collaboration—reaching across public and private sectors to build support among the many stakeholders that are needed to create, operate, and sustain HIE networks.**

"The states that are leading health information exchange have several things in common," says Neva Kaye, policy director at the National Academy for State Health Policy (NASHP). "They all have a clear vision for making the system better, political support for that vision, and a clear sense of the state's responsibility to bring about change."

We examine two states, Arizona and Florida, that have played active roles in promoting health information exchange and building effective public/private partnerships. Arizona and Florida started out with a similar vision—to improve patient care by expanding electronic health records and health information exchange—but they followed different strategies to fit the circumstances of their state.

**Arizona's Statewide HIE Utility and Florida's "Network of Networks" – see report at:**

[http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=614718&#snapshots](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=614718&#snapshots)

## National Federation of Independent Business Introduces Health Care Principles

*The Commonwealth Fund newsletter – 12.12.07*

The National Federation of Independent Business (NFIB) introduced 10 principles to overhaul the health care system on Wednesday and announced a major research initiative with the Lewin Group, a health care consulting firm.

"For 25 years, our members have been telling us their top issue is health care costs," NFIB Spokeswoman Stephanie Cathcart said. In the coming years, she said she expects that both the president and Congress will play an important role in addressing health care concerns. **"We're asking [presidential] candidates and members of Congress to use these principles as a starting point,"** Cathcart said.

NFIB developed these ten principles in the fall with health care experts from across the political spectrum. That group included representatives from the Heritage Foundation, the Urban Institute and the Cato Institute. NFIB said in a press release that it specifically sought out perspectives from broad philosophical

campus, and that the representatives and their organizations did not necessarily endorse the health care principles.

NFIB President Todd Stottleyer highlighted **the need for universal and affordable health insurance — two major elements of the 10 principles**, he said — on a press conference call. Small businesses make up the largest segment of the uninsured population, and those that do provide insurance for their employees share risk among a smaller pool, making coverage more expensive. Either the business or the employees must absorb the added cost, he said.

**Portability** is another major aspect of overhauling health insurance that the NFIB supports. Potential entrepreneurs may not be able to start their own businesses if they cannot afford to leave their old jobs and lose their health insurance, Cathcart explained.

The NFIB also believes **a health care system should be: competitive, transparent, efficient, unbiased and evidence-based**. In addition, the **NFIB supports private insurance over government coverage whenever possible, and notes that any changes to U.S. health care must proceed at pace that allows firms and individuals to adjust**.

The research initiative with the Lewin Group will focus on specific policy options and preferences of small businesses with regard to health care, Cathcart said. NFIB has established a health care advisory board of small business owners. In addition, **the NFIB recently joined the Divided We Fail Coalition**, which includes the AARP, the Service Employees International Union and the Business Roundtable. This group works with citizens, non-profits, businesses and elected officials to address health care issues.

## **2 polls, 2 views on Blue Cross rate-hike legislation**

*Free Press – 12.14.07*

Two separate polls released this week from Blue Cross Blue Shield of Michigan and a coalition of commercial insurers reach opposite conclusions about how Michigan citizens view pending rate-changing legislation.

One poll from Greenberg Quinlan Rosner Research of Washington, D.C., concluded that 81% of those asked support the Blue Cross bills. It was conducted Sept. 6-10 among 604 voting-age Michigan residents. The other poll from Lansing's Marketing Resource Group (MRG) found that 69% of Michiganders asked oppose the legislation, which passed the House by an overwhelming margin Oct. 24 and awaits Senate action next year. The MRG poll was conducted Nov. 13-18 among 800 "likely voters."

Each poll asked about a four-bill legislative package promoted by Blue Cross to alter how it sets rates among individual policy holders and ending consumer and attorney general challenges to those rate hikes. The release of the polls prompted public sparring by two largely Republican public relations firms that often work together.

Besides conducting the poll, Marketing Resource Group is handling public relations for **the Coalition for Access and Affordability in Michigan**, a group of commercial insurers opposed to the Blue Cross legislation. Denise DeCook, spokeswoman for the coalition, is vice president of public affairs for MRG.

The poll was conducted by the firm's Paul King, who has also done surveys for John Truscott, a Blue Cross consultant and head of the Lansing-based John Truscott Group, a public relations and lobbying firm. DeCook attacked the Blue Cross poll as outdated and said it used leading questions.

Truscott, onetime spokesman for former Michigan Gov. John Engler, sent an e-mail Thursday attacking the MRG survey as a "phony poll." He later referred questions about the poll to Blue Cross. King, with MRG, said he found it odd that Truscott would attack the poll since "John is a client of mine. I have worked for at least three of his clients," he said.

Andy Hetzel, vice president of corporate communications at Blue Cross, said he considered the Blue Cross poll relevant because it measured more general consumer opinions about the need to limit rate hikes at the time of renewals. He said the Greenberg firm conducting the poll is well regarded and was clear about the methods it used.

Neither Blue Cross or MRG would give the Free Press a full list of questions used in the surveys.

The questions provided for both polls did not comprehensively describe the full scope of the legislation, but that's a difficult task given the complexity.

King said his poll cost \$25,000; Blue Cross would not disclose its cost, calling the information proprietary. Michael Traugott, chair and professor of communications studies at the University of Michigan, and a nationally regarded survey research specialist and author, explained that polls about political stances and legislation often divide polling companies that have represented the same clients before. Key questions about these kinds of polls include "who was spoken to, when, and what questions they were asked," Traugott said.

Questions can be worded to lead a respondent to a certain answer, or "stacked in favor of a positive response," he said. And, he added, likely voters more typically are Republicans, who vote more.

## **Cholesterol Curbed, But Blood Pressure Runs Rampant**

*Wall Street Journal Health Blog - 12.14.07*

The day after the Centers for Disease Control and Prevention said that the national average for total [cholesterol dropped below the target of 200](#), an FDA advisory panel yesterday gave a [thumbs-down to Merck's](#) proposal to sell its pioneering cholesterol-lowering pill Mevacor to consumers without a prescription.

The panel that just rejected prescription-free Mevacor wasn't persuaded that consumers could be relied on to manage their cholesterol problems with medicine without advice from their doctors..

Meantime, Christopher Cannon, a cardiologist at Harvard and Brigham and Women's Hospital in Boston welcomed the nation's progress on cholesterol. "The cholesterol message has gotten through," he told the Health Blog. "But [we're still getting fatter. And blood pressure hasn't changed over time.](#)"

Indeed, he says, "despite decades of data," hypertension continues to run rampant among Americans. "It is basically a disaster of the medical field," he says. "[The newest numbers speak to success with cholesterol, but we need to turn our attention to make sure people get their blood pressures to the goals we set.](#)"

## **Mass. To Cut Payments to Docs & Hospitals**

*Wall Street Journal Health Blog – 12.14.07*

[Massachusetts's universal health-care plan is turning out to be more expensive than predicted. Now the state is looking at cutting payments to docs and hospitals next year to make ends meet.](#)

That fiscal reaction, which some critics of the plan warned about, sends a stark message to those of us in the other 49 states. Massachusetts has become something of a model for the national plans proposed by Hillary Clinton and John Edwards, among others.

The state requires everybody to buy health insurance. A subsidized health plan offered to the poor as part of the program has proved more popular than expected, and that's helping to push costs 20% over what the state had budgeted. The tab could run \$619 million for the current fiscal year, \$147 million over budget, the Boston Globe [reports](#).

Now the board that oversees the plans has approved cuts of 3% to 5% in reimbursements for to health-care providers caring for those in the subsidized plan. The article suggests the cuts will bring reimbursement in line with Medicaid.

The board postponed a decision on a more controversial issue: whether to raise co-pays and other out-of-pocket costs for those whose income is above the poverty level. Doctor visits, prescription drugs and hospital care cost "much less" for those with subsidized insurance than for those with private insurance, according to the article.

## **Hospital Charges Keep Rolling Higher**

*Wall Street Journal Health Blog – 12.14.07*

The nation's hospital bill has arrived, and it's a doozy: \$873 billion in 2005, up 89% since 1997, according to work by the Agency for Healthcare Research and Quality.

The federal [AHRQ](#) study measured charges — the hospital equivalent of a car's sticker price, which few actually pay in full. Still, [the prices show the upward trend for hospital spending](#). The [annual increase in hospital charges](#) was 7% compared with 2004.

But the Health Blog was struck by some of the big-ticket conditions.

The data from 2005, the most recent year available, show that pregnancy and delivery ranked No. 2 among line items, at \$43.9 billion, while newborn infants came next at \$35.3 billion. The secret is volume, says Roxanne Andrews, a senior researcher for AHRQ. "They're not really that much per hospital stay, there's just a lot of them." (Coronary artery disease ranked No. 1, at \$46 billion.)

But the highest-charge categories are growing more slowly than other costs. Newborn care rose 78% since 1997, while pregnancy rose 75% and coronary artery disease rose a relatively modest 44%.

So what about billing per discharge? Back-pain has shot up 124% since 1997, and sepsis by 117%. By contrast, pregnancy and delivery charges per hospital discharge rose 61%, while infant care rose 57%. As a group, the top-20 conditions — which account for about half of all hospital charges — rose 67%.

## **Get Ready for *Cover the Uninsured Week* 2008, April 27-May 3!**

*Cover the Uninsured* – 12.13.07

Forty-seven million Americans, including more than 9 million children, are living without health care coverage. It's time to start planning for the sixth annual [Cover the Uninsured Week](#) and help get America covered.

There are many ways for you and your community to get involved in *Cover the Uninsured Week* 2008: Host an [enrollment event](#) at a hospital, community center or school; [organize a health coverage forum](#) with community, business and faith leaders; plan a seminar for [small business owners](#); distribute [information about available low-cost and free health coverage programs](#) to uninsured individuals and families.

[Planning materials](#) are available to help you get started. And we'll help you stay up to date on the most current [facts](#) and latest [news](#) on the issue. [Sign up](#) for the latest news and updates on the *Week* at <http://covertheuninsured.org/>.

## **Charity Gift Cards Gain Popularity for Holidays**

NPR, *Morning Edition* – 12.14.07- - Listen: <http://www.npr.org/templates/story/story.php?storyId=17246541>

Sales of gift cards are forecast to exceed \$26 billion this holiday season. One tiny, but growing type of card is the [charity gift card](#). It is meant to address a yearning for more socially conscious giving and receiving. The funds on the card go to a charity of the recipient's choice.

## **Bush vetoes 2nd version of kid health benefits**

*Associated Press* – 12.13.07

WASHINGTON -- President George W. Bush vetoed legislation Wednesday that would have expanded government-provided health insurance for children, his second slap-down of a bipartisan effort in Congress to dramatically increase funding for the popular program.

It was Bush's seventh veto in seven years -- all but one coming since Democrats took control of Congress in January. Wednesday was the deadline for Bush to act or let the bill become law. The president also vetoed an earlier, similar bill.

In a statement notifying Congress of his decision, Bush said the bill was unacceptable because -- like the first one -- it allows adults into the program, would cover people in families with incomes above the U.S. median and raises taxes.

"This bill does not put poor children first, and it moves our country's health care system in the wrong direction," Bush's statement said. "Ultimately, our nation's goal should be to move children who have no health insurance to private coverage, not to move children who already have private health insurance to government coverage."

Bush urged Congress to extend the program at its current funding level before lawmakers leave Washington for their holiday break.

Congressional leaders had said earlier Wednesday that they will try for the extension of the State Children's Health Insurance Program, or SCHIP, well into 2008 in basically its current form. Their comments signaled they have given up on major expansion.

The bill passed the Democratic-controlled Senate by a veto-proof margin, but the same was not true in the House. A two-thirds vote is required in both chambers.

## **Blue Cross surplus is called big; expert says rate hike could be avoided**

*Free Press – 12.13.07*

LANSING -- A former executive for Aetna [insurance](#) company and a well-regarded insurance consultant testified Wednesday that Blue Cross Blue Shield of Michigan has \$450 million to \$500 million more than it needs to stay financially viable in its \$2.8-billion surplus fund.

In studying trends and costs to determine the rate hike, Blue Cross used a flawed model, said James Geyer, a Manchester, Conn., former chief actuary for Aetna Inc.

In critical testimony in a hearing for a Livonia couple challenging rate hikes averaging 24% in seven so-called nongroup policies, Geyer's testimony and cross-examination provided a tutorial on how insurance companies set rates and accumulate surpluses to pay future claims or to buy other companies.

Blue Cross attorneys said Wednesday that a 2003 state law requires the insurer to reach minimum and maximum surplus standards set by the National Association of Insurance Commissioners. Blue Cross says its \$2.8-billion surplus is needed for emergencies and would pay only 1 1/2 months of claims, or about \$523, for each member.

Geyer said the surplus provides enough cushion to avoid the requested \$30-million rate hike for 19,000 Michiganders who buy their own health insurance. Geyer said if Blue Cross had performed a more precise analysis of growth in the value plans the insurer would break even or make \$1.3 million instead of incurring as much as \$13 million in losses from its nongroup line of business. He also questioned why the insurer did not seek to raise rates in the fastest-growing segment of its nongroup market.

Blue Cross says it held those costs steady to attract more customers and that the surplus is shrinking. Surpluses can take several years to grow or shrink as insurers factor in claims and other trend data and make acquisitions.

The 2006 purchase of M-Care and M-CAID, two HMO plans owned by the University of Michigan, reduced the Blue Cross surplus by \$118 million. Geyer said Blue Cross is likely to earn that money back, or more, in future years but for now the insurer is considering the acquisition a goodwill investment not counted as an asset, Geyer said. Blue Cross has spent \$365.9 million since 2005 to buy four insurance companies, including the two U-M plans, and a fifth purchase of a California [insurance company](#) is pending.

In a statement to the Free Press, Helen Stojic, Blue Cross spokeswoman, said: "The fundamental problem is that the marketplace needs reform because it pushes consumers with medical conditions to ultimately end up at Blue Cross, making the cost of paying for their medical care much higher than what for-profit carriers pay."

Stojic was referring to four bills pending in the state Legislature that would change how rates are set, from a one-size approach to 10 tiers of charges based on age, county of residence, health status and other factors. The legislation, sought by Blue Cross, also would end consumer and attorney general challenges to rate hikes. Blue Cross says rate challenges delay its ability to recoup losses by as much as several years.

Specifically at issue at this week's hearing in Lansing are \$30 million in rate hikes Blue Cross hopes to earn if the 24% rate hike it is seeking is approved. Former insurance commissioner Linda Watters earlier this year granted Blue Cross a 10% interim rate hike, which took effect June 1.

Blue Cross says the rate hikes are needed to offset growing losses in the nongroup business, which totaled \$52 million over 10 years. The rate hikes do not affect people in five so-called value plans that require the greatest out-of-pocket expenses by consumers. These value plans, which attract young, healthy people, now account for about 40% of the nongroup business while moderate and high-cost plans for people with smaller co-pays are holding steady or decreasing as a line of business. In fact, many of these moderate and higher cost plans are closed to new enrollment, another reason the value options are growing.

Ron and Ghada Abraham of Livonia sought the hearing to stop the rate hike sought by Blue Cross. If they win, the 19,000 people in the affected plans could get refunds. The hearing before David Lick, administrative law judge named by Watters, may end Friday.

## **Small Businesses Oppose Mandates for Health Plans**

*New York Times – 12.13.07*

The small-business lobbying group that had a big role in derailing Hillary Rodham Clinton's effort to overhaul health care in the early 1990s has staked out its position for the 2008 political season.

The group, [the National Federation of Independent Business, which says it has 350,000 members and lobbyists in 50 states, warned politicians and policy makers on Wednesday not to impose new health-benefit obligations on small employers.](#)

The group said in a statement of principles that "a health care system built on employer mandates or on play-or-pay taxes is unacceptable."

The Democratic presidential candidates, including Senator Clinton, Barack Obama and John Edwards, have generally called for requiring employers to provide coverage or to pay into a fund to help insure many of the 47 million people in the United States without coverage. Republican candidates have talked less about health care, usually supporting the Bush administration's proposals for tax incentives to help pay for coverage.

"We are opposed to payroll taxes," said Susan Eckerly, a vice president for the business federation. "They are the No. 1 job killer for the small-business owner."

The organization has been working on health care issues with a broad group of lobbying allies, including the Business Roundtable, a group of corporate chiefs; the Service Employees International Union; the National Restaurant Association; AARP, the advocacy group for older people; and the building contractors lobby.

In its statement of principles, [the federation called for universal health care, with a government safety net to help the neediest obtain coverage. But it opposed proposals to place health care under an umbrella of Medicare-style "single payer" financing.](#) Government safety nets should not be allowed to "crowd out private insurance and care," the federation said.

[A separate national survey released Wednesday by the Mercer benefits consulting firm found that both small and large employers were skeptical about "play or pay" proposals that would require them to offer a health plan or pay into a fund to provide coverage for the uninsured.](#)

Only 23 percent of small employers and 25 percent of large companies with 500 or more workers support play or pay, according to a telephone survey by Mercer. In Massachusetts, which introduced such a policy in October 2006, employer support was slightly higher, 30 percent.

Although small businesses say they are hard pressed by health costs, which are rising by double digit percentages each year for small companies, the federation said very few of its members that provide employee benefits had ended coverage. Only about half of the group's members provide employee health coverage.

Ms. Eckerly said the small-business group had joined with restaurant owners and contractors in inviting all the presidential candidates to discuss health care on conference calls with hundreds of their members. So

far, she said, four Republican candidates, Mitt Romney, Fred D. Thompson, Rudolph W. Giuliani and John McCain, have taken part in these calls. Senator Clinton's health policy advisers have briefed officials of the small business federation.

Todd Stottlemeyer, the group's president and chief executive, said that Mrs. Clinton's plan "recognizes the challenges facing small businesses" by excluding firms with fewer than 25 workers from her proposed requirement that employers provide health insurance or contribute to the cost of coverage. "We have not endorsed any candidate," Mr. Stottlemeyer added.

## Employer-Sponsored Coverage Not Vanishing, Experts Say

*The Commonwealth Fund newsletter – 12.6.07*

Employers are not backing away from offering health insurance to workers, according to a new study by the Employee Benefit Research Institute (EBRI), a business-focused research group. But companies do want workers to take more responsibility for their health care costs, something that will be hard for employees to swallow, experts told employers gathered at an EBRI-sponsored forum Thursday.

The EBRI study—released to coincide with the forum—found that although the number of firms offering health insurance has declined about 9 percent since 2000, about 59 percent of employers are still offering the coverage. That number is same as it was in 1996.

"We're essentially where we were back then," said study author Paul Fronstin, the director of EBRI's health research and education program. "Employer-sponsored health care is not vanishing."

Employers in the study also agreed they would only drop health care coverage if they lost government-sponsored tax breaks and said it would be "insane" for any large firm to be the first to slash insurance benefits, Fronstin said.

But employers do want to move away from traditional health insurance plans toward a new model, known as consumer-directed coverage, the experts said.

Under the relatively new kind of insurance plan, employees use a health reimbursement account or a health savings account to buy routine health services. Employers can contribute to these accounts, much like firms contribute to retirement savings plans. Other worker expenses are covered by traditional insurance, but only after workers pay a high deductible. Such plans are designed to put more of the burden of responsibility for costs on the employee, who, in turn, is supposed to receive more detailed information about health care costs and options for treatment and doctors.

Critics of the plans say they shift the cost-burden to employees and discourage them getting health care when they need it. A 2006 survey, conducted by the Kaiser Family Foundation, found that enrollees in such policies are twice as likely as individuals in traditional health care plans to say that they needed medical care in the past year but did not get it due to costs.

But Joe Bogdan, a representative of insurance firm CIGNA Healthcare, said Thursday that a comparison of workers enrolled in CIGNA's traditional plans versus their consumer-directed plan showed that people in the two plans spent about the same out-of-pocket amount on health care over two years.

At the same time, overall costs of health care went down: CIGNA saved 12 percent in the first year under the consumer-directed plan. In the second year, the insurer saved about 5 percent. People enrolled in the consumer-directed plan were also more likely to visit a doctor for preventative care, not just once they got sick, Bogdan said.

But convincing workers that a consumer-directed plan is preferable to traditional health insurance will not be easy for employers, said Jodi DiCenzo, a behavior specialist with Behavioral Research Associates.

Employees are unlikely to voluntarily enroll in the new plan, but employers could opt to enroll workers automatically, much like firms do with 401(k) retirement savings accounts, DiCenzo told forum attendees, which included representatives from Bank of America, American Express and the International Brotherhood of Teamsters.

DiCenzo stressed it is important that employers do not overwhelm their employees with too many health care choices, but that just giving employees a pamphlet or hosting a class about the health care options is not going to be enough. "People are not likely to do anything unless they get a kick in the pants," she said.