



Access to Health Care News Update – 10.25.07

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(Note: Access to Health Care related materials highlighted in **RED** in longer sections for quick reading)

Do hospitals offer enough free care?

Free Press Special Report – 10.23.07

Vivian Glenn of Detroit fretted about the \$5,000 she owed to Detroit Receiving and Harper University hospitals.

The bills demanded that she call to arrange payment, making no mention of the free care available to low-income people like her, a single mother who cares for a 21-year-old daughter with cerebral palsy. Unable to pay and fearing she would be denied future care, Glenn, 49, ignored the bills for nearly four months, until she asked the hospital to send forms to seek free care after she talked to a reporter about her case.

Though U.S. hospitals provide billions of dollars worth of free care, stories such as Glenn's are among the issues that are putting nonprofit hospitals and their tax-exempt status under scrutiny as never before in an important debate for Michigan and the nation.

State Sen. Hansen Clarke, D-Detroit, U.S. Sen. Chuck Grassley, R-Iowa, and activists around the country are among those asking whether health systems provide the level of charity care they should to deserve \$12.6 billion in tax exemptions nationwide each year. Michigan hospitals receive at least \$600 million in breaks.

Critics point to high bills sent to people like Glenn, lack of publicity about charity care, long waits at community clinics and hospitals' flights to the suburbs, where costly, state-of-the-art facilities are being built to cater to insured patients.

Hospitals say the exemptions allow them to fill a critical need in the health system as employers reduce or stop health benefits and, in Michigan, unemployment remains high, at 7.5% in September.... **Full story at:** <http://www.freep.com/apps/pbcs.dll/article?AID=/20071023/BUSINESS06/710230350/1002/>

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Oversight lacking in hospital charity care

Free Press special report, part 2 – 10.24.07

Michigan's high unemployment and a steady decline in employer health benefits are taking a hefty toll on hospitals. More people are ignoring their bills. Thousands need free care. Institutional spending on free and

discounted community health programs is growing as support from state and federal governments disappears.

"We believe it's only going to get worse over time as people lose insurance and employers are covering less," said Nick Vitale, chief financial officer of Beaumont Hospitals, Royal Oak.

While no one questions the key role Michigan hospitals play in their communities, it's virtually impossible to determine which provide the most free care or how much Michigan gives them in tax breaks, according to a review of charity care and community health spending by the Free Press. That's because Michigan remains a state with little scrutiny of charity care spending by its nonprofit hospitals as calls increase for greater accountability in a dozen states and from a key U.S. senator.

The Free Press review found:

- Different hospitals count in different ways what they spend on free care. Some hospitals include uncollected bills and so-called Medicare losses in their estimates. The Henry Ford Health System doesn't tabulate how much it spends on community health programs, though it hopes to do so in the future. Public health groups favor the method recommended by the Catholic Hospital Association, stipulating that hospitals count only free care, Medicaid losses and spending on community health programs -- but not uncollected bills.
- No state agency routinely measures how much Michigan hospitals get in tax breaks. The last audit was done in 1996 by Michigan's Department of Treasury. Michigan hasn't required nonprofit hospitals to report spending to the Attorney General's Office since 1975, when the Legislature exempted hospitals from scrutiny.

With help from the Senate Fiscal Agency, state Sen. Hansen Clarke, D-Detroit, revised the 1996 figures to estimate that Michigan hospitals get at least \$600 million in tax breaks from the state each year. Clarke wants stricter accounting standards on free care. He also favors requirements that hospitals spend a minimum percentage on community health benefits. He and five other Democratic Detroit legislators asked Attorney General Mike Cox earlier this year to investigate the tax-exempt status of the Warren-based St. John Health system after it closed in-patient care at its Detroit Riverview Hospital.

Cox said at the time he has no authority to investigate hospital spending on free care. But in a written response to Free Press questions, Cox said that his department is "considering the issue of hospitals filing more financial data with the state."

"Nonprofit hospitals have an obligation to local communities, if only because they are not taxed," Cox said in the statement.

In July, the Internal Revenue Service released a report that found big differences in the amount of uncompensated care hospitals provide. Of 472 hospitals surveyed, 45% spent 3% or less of their total revenue on uncompensated care, while 41% reported spending 5% or more.

(Full Story at: <http://www.freep.com/apps/pbcs.dll/article?AID=/20071024/BUSINESS06/710240353/1002/>)

Related article: **Metro Detroit hospitals' charity care** -- <http://www.freep.com/apps/pbcs.dll/article?AID=/20071024/BUSINESS06/71024010/1002>

Nonprofit hospital oversight history (From Free Press series)

1969: IRS changes tax-exemption requirements for nonprofit hospitals. Since then, the IRS has not required charity care but allowed a broader community benefit standard that hospitals provide services that aid their communities. Community benefits include health education and screening services, such as free diabetes tests.

1975: Michigan Legislature exempts nonprofit hospitals from filing annual financial statements with the Attorney General's Office, as most charities are required to do.

May 2006: IRS begins tax-exempt hospital compliance project, mailing questionnaires to 544 tax-exempt hospitals.

September 2006: U.S. Senate Finance Committee holds hearings on charity care and community benefits at nonprofit hospitals.

March 2007: California, for the first time, requires a nonprofit hospital system to make specific charitable contributions as a condition for approval of a \$910-million bond package.

July 2007: IRS releases interim report that nearly a quarter of U.S. nonprofit hospitals spent less than 1% of their revenue on uncompensated care. One in five spent 10% or more.

September 2008: Full IRS report is due.

Zagat Gets Into Doctor Ratings Business

Wall Street Journal Health Blog – 10.23.07 (Posted by Vanessa Fuhrmans)

If getting an appointment with Dr. Smith “can take weeks” but his great bedside manner is “worth the wait,” wouldn’t you like to know?

Diners are well-acquainted with the [Zagat Survey](#) approach to rating restaurants, hotels and bars. But now the consumer guide and rating company is [teaming up](#) with WellPoint to tackle the world of physicians.

Starting in January, members in some of WellPoint’s Blue Cross and Blue Shield plans will be able to go online and review and rate their experiences with doctors. The health insurer, which has 35 million members nationwide, first plans to make the rating tool available to 1 million, though where exactly remains to be disclosed.

Patients using the online tool will get to apply the same 30-point scale that has helped make or break plenty of restaurant reputations. In place of familiar food, décor, service and cost categories, though, doctors will be rated on trust, communication, availability and cost. WellPoint says each entry will display contact information, the 30-point scale ratings in each category, plus the percentage of members who recommend the physician.

Dems propose bills cracking down on pharmaceutical marketing

Michigan Public Radio/WKAR – 10.23.07

Michigan Democrats want more restrictions on how drug companies market their products in the state. The bills are modeled on laws in place in eight other states.

The legislation would require drug companies to reveal how much they spend on marketing versus research and development each year. The legislation would also ban doctors from accepting more than \$100 a year in gifts from drug companies.

Democrats attacked the integrity of drug companies during the 2006 election. Officials at Pfizer say modest gifts like lunch are a proper reimbursement for the time doctors take to learn about new products.

Making Payment Reform Possible

The Commonwealth Fund/President’s Column (by Karen Davis) – 10.22.07

Any discussion of payment reform in health care raises a fundamental question: **What do we want out of our health system?** Our current fee-for-service system reimburses “inputs”—hospital stays, physician visits, and procedures—rather than the most appropriate care over an episode of illness or over the course of a year. Fee-for-service payments create incentives to provide more and more services, even when there may be better, lower-cost ways to treat a condition. **What most of us want is a health system that offers the best possible outcomes at an affordable price.**

Changing the Incentives: The unfortunate consequences of fee-for-service play out clearly in hospitals. As hospital patients, we naturally want safe and effective care—and to avoid an unnecessary repeat stay. But there are no incentives for hospitals to ensure we won’t come back through their doors, despite compelling evidence that appropriate discharge instructions, home visits, and other follow-up care can help reduce hospital readmissions.

Similarly, **in primary care settings, there are few financial incentives to avoid hospitalizations through preventive measures and high-quality, ongoing care for chronic conditions.** Chronic care management systems, in which nurses reach out to patients to check symptoms and adherence with recommended treatments, can be more cost effective than emergency room visits or doctor's office care. But most insurance plans don't cover these services, so providers that offer them have to cover the costs themselves.

The potential for lowering health costs by reducing the number of hospital stays is significant. As demonstrated by the Fund's [State Scorecard on U.S. Health System Performance](#), if all states reached the low levels of potentially preventable admissions and readmissions achieved in the five best-performing states (Hawaii, Utah, Washington, Alaska, and Oregon), hospitalizations among Medicare beneficiaries could be reduced by 30 to 47 percent and save Medicare \$2 billion to \$5 billion each year.....(Full column at: http://www.commonwealthfund.org/aboutus/aboutus_show.htm?doc_id=559687&#doc559687)

Tiered Vaccine Plan Puts Military, Infants First

Pandemic Flu Vaccine Plan: Pandemicflu.gov
NPR Morning Edition, 10.24.07

Government officials are thinking ahead about how to ration vaccines if and when a flu pandemic hits. After holding four public meetings and consulting with ethicists, officials have devised a new, tiered system for distributing limited supplies of vaccine.

Vaccine planner Benjamin Schwartz of the Department of Health and Human Services presented the plan Monday. Schwartz explained that the highest tier will balance vaccination for critical military personnel, health-care and emergency medical responders, police, firemen, pregnant women, infants and toddlers. The next-highest tier will include people who keep the nation's communications systems, power systems and water supply operating; it also will include children between the ages of 3 and 18.

Priority for the elderly depends on the severity of the epidemic: The more severe, the lower their priority. The authors of the plan made that decision because during public hearings, older people said they would rather that their grandchildren get vaccinated.

"The group that's in the last tier for vaccination is healthy adults between the ages of 19 and 64 years," Schwartz said, explaining that they are least likely to die or infect others.

The new draft plan earns high marks from bio-preparedness experts, but they foresee inevitable problems.

Dems Roll Out Kids' Health Bill Again

Wall Street Journal Health Blog – 10.24.07 – (Posted by Jacob Goldstein)

The long-debated, [once-vetoed](#) plan to expand the State Children's Health Insurance Program will return to the House floor this week, *The Hill* [reports](#). And Democrats, who overwhelmingly supported the first bill, say they're open to some changes that could reduce the risk of a second veto.

In particular, Democrats are responding to complaints that their plan went too far. One criticism was that federally subsidized insurance for children would be allowed for families earning up to \$83,000 a year. But as *The Hill* points out, only the state of New York asked to insure families with that income level; the Bush administration subsequently rejected that proposed waiver.

House Majority Leader Steny Hoyer (D-Md.) says the earlier bill wasn't designed to cover those families, and Democrats are willing to make that clear in revised legislation. There "was a somewhat Alice-in-Wonderland approach to it, but we are willing to address that, because that was not our intent," Hoyer said, according to *The Hill*. Democrats also want to make clear that the bill wouldn't allow for coverage of illegal immigrants, another complaint levied by some Republicans.

But they say they will insist that any bill expand coverage to include 10 million children. "We will pass this bill this week," said Rep. John Larson (D-Conn.), vice chairman of the Democratic Caucus, according to The Hill. "And if the president vetoes and we can't override it, then we'll pass it again."

Democrats Unyielding on Health Plan Cost

Associated Press – 10.23.07

WASHINGTON -- House Democrats, convinced that President Bush blundered by vetoing an expansion of a children's health care program, plan to approve a very similar bill this week even as the administration offered new concessions Tuesday.

The Democrats' revised bill would reduce the number of adults and higher-income families potentially eligible for the health insurance subsidies, presumably making it easier for Republicans to back it while saving face. But on the key issue of spending, Democrats say they will not budge from the original \$35 billion pricetag.

Bush had recommended a spending increase of \$5 billion over the next five years in the State Children's Health Insurance Program, enough to cover children in families generally with incomes at twice the federal poverty level — \$41,300 for a family of four. Health and Human Services Secretary Mike Leavitt said Tuesday that the administration is now willing to support, with conditions, covering children in families at up to three times the federal poverty level — \$61,950.

Leavitt would not say specifically how much more money the administration would recommend for SCHIP, but he acknowledged that an additional \$15 billion increase was "a rational number." "We're willing to put substantially more money into covering the policy that we hear members of Congress advocate," Leavitt told the Associated Press.

House Majority Leader Steny Hoyer, D-Md., told reporters Tuesday that the Democrats' new bill would still expand the program from 6 million children now covered to 10 million. As for the proposed \$35 billion increase, "you can't do the 10 million without that," he said.

Democrats would still pay for the expanded program with a 61-cent increase — to \$1 — in the federal excise tax on a pack of cigarettes. Leavitt said Bush would continue to oppose that or any other tax increase. He also said states should have to assure that low-income children are covered first, before eligibility is expanded to cover more middle-income families.

The administration's overtures would become moot if Democrats picked up just seven more House members who last week supported Bush's veto. House Democratic leaders decided to hasten action on the bill Tuesday after dozens of colleagues told them the issue is extremely popular in their districts and should not be allowed to cool down.

"There's a big sentiment in our caucus to do it right away," said Rep. Jim Clyburn of South Carolina, the Democratic whip. Rep. David Price, D-N.C., said: "There's a sense that we have the high ground here, and we need to press ahead with it."

Republican negotiators, however, warned Hoyer that they may need several days to win over enough converts to the new bill.

Democrats said a revised bill could reach the House floor Thursday. Senate approval would come some time later, lawmakers said.

Rep. Heather Wilson, R-N.M., one of the GOP negotiators who backed the vetoed bill and is trying to help craft a veto-proof revision, said she believed Democrats would agree to capping income eligibility at three times the poverty rate. Childless adults would be phased out of the program in one year under the proposed compromise, which is subject to change, she said. The revised bill also would give states greater leeway to check the validity of applicants' Social Security numbers, she said, in a bid to counter criticisms that illegal immigrants might obtain health benefits.

The Senate, which passed the original bill by a veto-proof margin, is seen as likely to do so again if another House bill is approved.

Diabetes Care Sometimes Hangs by a Thread

Wall Street Journal Health Blog – 10.23.07 (Posted by Theo Francis)

New York's public hospitals have their work cut out for them when it comes to [treating diabetes](#), but sometimes it's the small stuff that counts the most.

Behind the scenes, the hospital system has an extensive electronic medical-record system that can help track key tests for thousands of patients. By looking at the data for the system's 50,000 diabetics as a group, hospital administrators and doctors can zero in on trouble spots.

During a pilot project at two hospitals in the borough of Queens, a doctor named Rand David spotted a problem in late 2005. Just 20% of 4,500 diabetics had received a simple [monofilament test](#) for nerve degeneration, in which doctors brush the soles of patients' feet with a thread. And the number had barely budged in four months.

David, the chief of ambulatory medicine at [Elmhurst Hospital](#), soon found the culprit: Doctors were running out of the threads, so many gave up on doing the test altogether. So he turned supply-clerk, stocking exam rooms and emailing doctors to make sure they had adequate supplies. Soon, almost half of diabetic patients were getting the test, and by last fall nearly two-thirds were being tested regularly.

Hospitals Prefer Suppliers That Offer Insurance

Wall Street Journal Health Blog – 10.23.07 (Posted by Chad Terhune)

Hospitals complain regularly about the burden of treating uninsured patients who can't pay their medical bills. [Should hospitals and the local governments that support them send a message by steering their money to vendors that provide employee health insurance?](#)

A handful of hospital systems such as [Baptist Health South Florida](#) think so. Some politicians are intrigued by the idea as well. Baptist Health, a not-for-profit based in Coral Gables, Fla., with five hospitals (including Baptist Children's Hospital, pictured), adopted a preference a year ago for vendors and suppliers that offer health benefits. The hospital system hasn't changed who it does business with yet. But it is preparing to survey vendors soon about their health coverage and based on those responses may seek alternative companies. Some Catholic hospitals in the U.S. have a similar policy in purchasing.

In 2006, a task force in Texas examining that state's large number of uninsured recommended, among other things, that state and local agencies give preferential treatment to contractors and subcontractors who offer health insurance. Texas officials haven't enacted that proposal, but some lawmakers are interested.

"I think it's a good idea and worth a look," Texas state Rep. Jim Jackson tells the Health Blog. Jackson, a Republican from Carrollton, has worked on health-care reform.

Some critics dismiss the idea as a gimmick that does little to help the nation's 47 million uninsured. Other policy experts say hospitals may find it difficult to enforce. [Many of the small physician practices that contract with hospitals don't offer health benefits to their office staff—in much the same way other small businesses skip coverage due to the high cost. For big state contracts, like road construction, much of the work is done by small subcontractors who typically don't offer benefits either.](#)

San Francisco Health Plan Tackles Uninsured Crisis

Source: Cover the Uninsured, from [Los Angeles Times](#), 10.22.07

A *Los Angeles Times* profile of Healthy San Francisco, the "groundbreaking city health plan that provides a network of care to residents regardless of their ability to pay, immigration status or existing medical conditions," offers a glimpse of [a local solution to a national problem: "how to provide the poor and middle class with affordable healthcare."](#)

The program was launched in July with two pilot clinics and now has 22 participating health clinics. Healthy San Francisco is not insurance, members can only be treated at participating clinics or the public hospital, and it is free for those who can't pay and those who can pay sliding-scale fees. [Program managers hope to enroll all of the city's more than 82,000 uninsured residents over the next two years.](#)

In 1998, voters endorsed universal health care in a citywide referendum, but not until Mayor Gavin Newsom took office in 2004 did the program truly begin to take shape. "For years, people here beat their head against the wall figuring out how to provide universal health insurance to the uninsured," said Newsom. "Then we asked another question: How do we provide universal health care? That made all the difference." [The goal of the program is to provide "preventive care for city residents before chronic illnesses become serious enough to require hospital care at the county's expense,"](#) according to the article.

Linda Bien, president of North East Medical Services, which is participating in the San Francisco program, said: ["Across the country, even people with medical insurance have trouble receiving care. The system is broken. And new models have to be put out there so we can reconsider: What does work?"](#)

Health Blog Q&A: Parity for Substance Abuse Care

Wall Street Journal Health Blog – 10.24.07 (Posted by Heather Won Tesoriero)

[Patient advocates have long campaigned for making coverage of care for mental health problems equal with that for other health conditions. As Congress bats around plans that might bring that notion a step closer to reality, the coverage of treatment for substance abuse remains contentious.](#)

A Senate bill on parity wouldn't include such treatment, while a House bill puts care for both mental health and substance abuse on equal footing with other medical care.

Colleen Barry, an assistant professor at the Yale School of Public Health, examines the issues in a [paper](#) that appeared in the Web edition of Health Affairs. Barry and a co-author conclude that ["the argument for inclusion of \[substance abuse\] services under federal parity appears to be as compelling for substance abuse as it is for mental health."](#) The Health Blog spoke with Barry about the analysis.

Can you help us understand the parity debate?

In the health insurance market, we know that both mental health and substance abuse benefits are provided at a much lower level than insurance for general medical care. For years, mental health advocates have made the case that that's discriminatory. While most employer-based health insurance policies have some level of mental health coverage, it looks like the level of coverage has become more restrictive over time. Mental health advocates want equity that's on par with what's offered for general medical care.

What's the root of the problem?

There are economic incentives at play, but advocates have worried this is a sign of discrimination or stigma.

What do insurers say about this?

One of the reasons why mental health and substance abuse insurance is offered at a lower level is that health insurers worry about attracting really expensive people to be part of their health plan. The worst thing you could do is to get the rep for being the best provider of mental health care. We know that people with mental health and substance abuse disorders can be expensive. These are often chronic conditions that can be expensive year to year. Insurers have an incentive to provide minimal mental health and substance benefits.

Can you explain the concerns about moral hazard?

Moral hazard refers to the tendency of individuals to use more services when they face lower out-of-pocket prices. And this is viewed as inefficient. Moral hazard is absolutely a problem, and there is some good older evidence from the pre-managed care world that shows that response to an increase in benefits for mental health care was double that of the response for general care. It led to the concern that broad mental health benefits would lead to overuse. In a managed care environment, moral hazard no longer constitutes a justification for limiting benefits. This recent evidence of the effects of parity suggests that expanding benefits won't drive up costs.

What does your research suggest should be done about parity to substance abuse?

We find that the justification for substance abuse parity is just as compelling as for mental health parity. The benefit of mental health and substance abuse parity is that it provides important financial protections for people with these disorders. Research tells us that in the context of managed care, comprehensive parity would have little impact on total mental health care spending and would lower out of pocket costs for individuals seeking treatment.

House Fails to Override Bush's Veto of Children's Health Bill

The Commonwealth Fund newsletter – 10.18.07

The House failed to override President Bush's veto of legislation to expand a children's health insurance program, despite weeks of pressure from Democrats and outside advocacy groups.

The tally Thursday was 273–156, or 13 votes short of the two-thirds majority needed to override the president's Oct. 3 veto of the bill (HR 976). Although the override attempt drew eight more votes than the 265–159 final passage vote on Sept. 25, all of the additional votes came from Democrats. Not a single Republican vote was switched.

The Senate passed the measure last month by 67–29, more than the two-thirds majority required to overcome a veto. But with the House failure to override, the legislation dies.

House Speaker Nancy Pelosi, D-Calif., said Democrats would immediately begin work on another SCHIP bill to send to the Bush. Pelosi would not offer details about how the bill might change except to say that Democrats will not consider a different funding offset, and will demand that a new bill cover 10 million children, up from an estimated 6.6 million currently covered.

"In the next two weeks, we intend to send the president another bill that insures and provides health care for 10 million children in our country," Pelosi said. "The president and his allies in Congress today may have stopped the SCHIP bill today but we still will not allow that to deter us from our goal.

On the veto override attempt, 44 Republicans joined 229 Democrats in voting to override.

Republicans called for negotiations on a more restrictive, less costly program renewal. "Now that the veto has been sustained, it's time to move forward with a serious plan to extend health coverage for those SCHIP was meant to cover: low-income children," declared Senate Minority Leader Mitch McConnell, R-Ky., in a statement. House Majority Whip James E. Clyburn, D-S.C., said they would hold fast to their demand that the program be expanded enough to serve 10 million children.

Mammogram prices vary widely

Free Press – 10.19.07

It pays to shop around for a mammogram. Though costs continue to inch upward in Michigan, some centers, particularly in Wayne County, dropped their prices this year.

Cost and other consumer information about 287 mammography centers in Michigan comes from an annual survey, conducted since 2001, by the Detroit Free Press and the American Cancer Society's Great Lakes division. (For details about the survey, visit www.cancer.org/michiganmammogram.)

The survey found that in metro Detroit, a mammogram performed with standard film screen technology typically costs \$232 in Oakland County, \$295 in Macomb and \$209 in Wayne. Costs of digital mammograms -- pricey technology with added benefits -- vary at the 38 centers offering them.

At a time when many employers are reducing health benefits and more people lack health insurance, higher mammography prices may help explain why fewer women are getting the very tests that are recommended as the best breast cancer prevention tool, said Vicki Rakowski, executive vice president of the cancer society's Great Lakes division.

Last year, 79.9% of Michigan women had a mammogram, compared to 81.7% in 2000, the peak in the past decade, according to the cancer society. Nationwide, mammography use dropped to 66% in 2005, from 70% in 2000, said a study in the June 15 issue of *Cancer*, a journal of the cancer society.

Experts hope the trend changes with technological advances. Some women are demanding digital technology because they consider it a superior, quicker, sometimes less painful test, with half the radiation dose of a standard mammogram.

Digital machines turn X-ray pictures into images that can be magnified for easier viewing and stored and transmitted electronically. But the machines are costlier, requiring a significant investment by a health system, and the cost of the tests sometimes are not fully covered by insurance. Medical centers are awaiting national studies to see if the investment saves more lives over traditional mammograms.

Blue Cross Blue Shield of Michigan pays \$108.76 for a traditional mammogram and \$177.65 for a digital one. Specialists suggest women ask ahead of time, to be sure insurance covers the cost, and then negotiate a lower cost if possible.

Report Recommends Mixed Approach for Universal Coverage

The Commonwealth Fund newsletter 10.18.07

Health care overhaul that incorporates both private and public insurance is the best approach to achieve universal coverage, according to a [report](#) released Thursday by The Commonwealth Fund Commission. The report endorses the mixed approach to address the increasing number of uninsured Americans, as opposed to implementing either a solely private or public system.

"Health insurance reform plans that build on a mix of private and public health insurance, where costs are shared among government, employers, and enrollees, would have great potential to move the system to high performance and would be the most practical to implement," the report found.

The report found a mixed approach would minimize federal budget outlays and dislocation of patients by allowing individuals with employer-based coverage to retain the insurance if they met certain benefit and affordability standards. Such an approach also would address the shortcomings of the current system, such as "gaps in coverage and the absence of the incentives, organization, and infrastructure required for a high performance health system," the report found.

The analysis noted the mixed universal coverage plans that have been enacted in Massachusetts and proposed by California Republican Gov. Arnold Schwarzenegger and Democratic presidential hopefuls Gov. Bill Richardson of New Mexico, former Sen. John Edwards of North Carolina, as well as Sens. Hillary Rodham Clinton of New York, Christopher J. Dodd of Connecticut, and Barack Obama of Illinois. Most of these plans include expansions in Medicaid and the State Children's Health Insurance Program, as well as "new group insurance options with financial support for premiums and out-of-pocket expenses for lower- and middle-income households" designed to fill coverage gaps.

The report also noted the proposals offered by President Bush and GOP presidential candidates Sen. John McCain of Arizona, former New York Mayor Rudy Giuliani, and former Gov. Mitt Romney of Massachusetts that comprise private plans that "would create tax incentives for people to gain coverage through the individual insurance market." Those plans, however, are "unlikely to achieve universal coverage" if not coupled with other changes, according to the analysis.

Public plans, meanwhile, would "offer the greatest potential for automatic and continuous enrollment and the ability to cover everyone" and move the health care system toward high performance, the report said. However, such plans would create dislocation and be financed largely by "federal income and payroll taxes or new taxes, such as a value-added tax or consumption tax."

Dallas Salisbury, president and CEO of the Employee Benefit Research Institute and chairman of the Commission's Coverage Workgroup, said "The most important takeaway of this report is that [universal coverage is essential to improve access, quality, equity, and efficiency in the U.S. health care system.](#)"

UAW-run plan may serve as model

Free Press - 10.22.07

AT&T Inc., the biggest U.S. phone company, and No. 2 Verizon Communications Inc. may follow General Motors Corp. in trying to [shift retiree health care liabilities to a union-run fund](#), a move that has helped boost GM's shares 39% this year.

The largest U.S. automaker reached a landmark agreement with the United Auto Workers last month to transfer \$50 billion in such obligations to a [Voluntary Employee Beneficiary Association, or VEBA](#). The telecommunications companies, which will negotiate new contracts with their unions in the next two years, reported a combined \$71 billion in retiree liabilities last year.

"We'll be watching" how the GM union-run fund develops, said Alberto Canal, a spokesman for New York-based Verizon. He declined to give additional details. Verizon spends \$3.5 billion a year for health care coverage for 900,000 active workers, retirees and dependents, he said. Verizon and AT&T both have a union that may set a precedent for so-called VEBAs in separate talks with GM. The Communications Workers of America's industrial unit is considering a union-run fund for a GM plant it represents in Ohio. Michael Coe, a spokesman for San Antonio-based AT&T, declined to comment.

"Telecommunications are the next big group that will be looking at VEBAs," said Howard Silverblatt, an analyst at Standard & Poor's in New York. The ratings service estimates companies in the S&P 500 had \$387 billion in retiree health care and insurance commitments at the end of last year.

Report: State of Women's Health Poor Nationwide

The Commonwealth Fund newsletter 10.17.07

The health of women in America is unsatisfactory, and compared with three years ago, it's growing worse, according to the latest "report card" on women's health released Wednesday by the National Women's Law Center (NWLC).

The 2007 edition of "Making the Grade on Women's Health: A National and State-by-State Report Card," which measured 27 benchmarks, found that the United States now fails to meet 12 of the benchmarks, three more than it did not meet in 2004. Two benchmarks—reducing obesity and providing Pap smears to women age 18 and up—were met in 2004, but are no longer met by any state, according to the analysis.

The report is a project of the NWLC and Oregon Health and Science University and assesses women's health in each of the 50 states and the District of Columbia by using health benchmarks designated by the Department of Health and Human Services' "Healthy People 2010" agenda.

[The report found that no individual states received an overall grade of satisfactory for the health care services they provided to women.](#) Vermont, Minnesota and Massachusetts met the most benchmarks, while Arkansas, Mississippi, and Louisiana met the fewest.

[The national percentage of women who lack health insurance increased by 1.7 percent, the analysis found. Meanwhile, the rate of uninsured American Indian/Alaska Native women is more than double that of white women without insurance, the analysis noted. According to the report, 22.7 percent of black women are uninsured and 37.8 percent of Hispanic women are uninsured, compared with 16.9 percent of white women.](#)

The percentage of women who are obese increased in all 51 states, the only benchmark on which every state's performance dropped.

While the most improved benchmarks among states were death rates for stroke and coronary heart disease, the United States still received an overall "F" grade in both indicators because so much improvement is still needed, the report stated.

March of Dimes joins chorus to expand kids' health program

CNN/Associated Press – 10.20.07

WASHINGTON -- The head of the March of Dimes expressed her organization's support of legislation that would expand the children's health program to 10 million people in the Democratic Party's Saturday radio address.

[Dr. Jennifer Howse said health insurance is the single most important factor in determining whether a child gets needed health care.](#) The March of Dimes is dedicated to improving the health of babies by preventing birth defects, premature birth and infant mortality.

"Every child needs preventive care," Howse said. "It helps them become healthy, productive adults." Howse's address marks the fifth consecutive week in which the Democrats' radio address focused on the State Children's Health Insurance Program.

On Thursday, the House failed to override President Bush's veto of a bill that would increase spending on the program to \$60 billion over five years, double what Bush has proposed. SCHIP provides government-subsidized health insurance to low-income families. The vast majority of the 6.6 million participants are children.

The March of Dimes was among the scores of advocacy groups that lined up in support of the legislation. Howse said health insurance coverage for babies born prematurely is a matter of life and death, as well as a family's financial survival.

Howse also said the bill gives states an option to cover more pregnant women who meet the program's income guidelines. "Maternity care allows health providers to detect and manage conditions early, often preventing more serious health consequences," Howse said. "Coverage for the full spectrum of maternity care services -- prenatal through postpartum care -- improves the health of both mothers and their babies."

Poor stretching paychecks to breaking point

CNN/Associated Press – 10.19.07

NEW YORK -- **The calculus of living paycheck to paycheck in America is getting harder.** What used to last four days might last half that long now. Pay the gas bill, but skip breakfast. Eat less for lunch so the kids can have a healthy dinner.

Across the nation, Americans are increasingly unable to stretch their dollars to the next payday as they juggle higher rent, food and energy bills. It's starting to affect middle-income working families as well as the poor, and has reached the point of affecting day-to-day calculations of merchants like Wal-Mart Stores Inc., 7-Eleven Inc. and Family Dollar Stores Inc.

Food pantries, which distribute foodstuffs to the needy, are reporting severe shortages and reduced government funding at the very time that they are seeing a surge of new people seeking their help.

While economists debate whether the country is headed for a recession, some say the financial stress is already the worst since the last downturn at the start of this decade.

From Family Dollar to Wal-Mart, merchants have adjusted their product mix and pricing accordingly. **Sales data show a marked and more prolonged drop in spending in the days before shoppers get their paychecks, when they buy only the barest essentials before splurging around payday.** Wal-Mart, the world's largest retailer, said the imbalance in spending before and after payday in July was the biggest it has ever seen, though the drop-off wasn't as steep in August.

And 7-Eleven says its grocery sales have jumped 12-13 percent over the past year, compared with only slight increases for non-necessities like gloves and toys. Shoppers can't afford to load up at the supermarket and are going to the most convenient places to buy emergency food items like milk and eggs.

With the fastest-rising food and energy prices since the 1980s, low-income consumers are stretching their budgets by eating cheap foods like peanut butter and pasta.

Industry analysts and some economists fear the strain will get worse as people are hit with higher home heating bills this winter and mortgage rates go up.

It's bad enough already for 85-year-old Dominica Hoffman. She gets \$1,400 a month in pension and Social Security from her days in the garment industry. After paying \$500 in rent on an apartment in Pennsauken, New Jersey, and shelling out money for food, gas and other expenses, she's broke by the end of the month. She's had to cut fruits and vegetables from her grocery order -- and that's even with financial help from her children.

"Everything is up," she said.

Many consumers, particularly those making less than \$30,000 a year, are cutting spending on nutritious food like milk and vegetables, and analysts fear they're further skimping on basic medical care and other critical services.

Coupon-clipping just isn't enough.

"The reality of hunger is right here," said the Rev. Melony Samuels, director of The BedStuy Campaign against Hunger, a church-affiliated food pantry in Brooklyn.

The pantry scrambled to feed 5,000 new families over the past 12 months, up almost 70 percent from 3,000 the year before.

"I am shocked to see such numbers," Samuels said, "and I am really concerned that this is just the beginning of what we are going to see."

In the past three months, Samuels has seen more clients in higher-paying jobs -- the \$35,000 range -- line up for food as the fallout of the subprime mortgage woes takes hold.

The Regional Food Bank of Northeastern New York, which covers 23 counties in New York State, cited a 30 percent rise in visitors in the first nine months of this year, compared with 2006.

Maureen Schnellmann, senior director of food and nutrition programs at the American Red Cross Food Pantry in Boston, reported a 30 percent increase from January through August over last year.

Until a few months ago, Dellria Seales, a home care assistant, was just getting by living with her daughter, a hairdresser, and two grandchildren in a one-bedroom apartment for \$750 a month. But a knee injury in January forced her to quit her job, leaving her at the mercy of Samuels' pantry because most of her daughter's \$1,200 a month income goes to rent, energy and food costs. "I need it. Without it, we wouldn't survive," Seales said as she picked up carrots and bananas.

[John Vogel, a professor at Dartmouth College's Tuck School of Business, worries that the squeeze will lead to a less nutritious diet and inadequate medical or child care.](#)

In the meantime, rising costs show no signs of abating.

Gas prices hit a record nationwide average of \$3.23 per gallon in late May before receding a little, though prices are expected to soar again later this year. Food costs have increased 4.5 percent over the past 12 months, partly because of higher fuel costs. Egg prices were 44 percent higher, while milk was up 21.3 percent over the past 12 months to nearly \$4 a gallon, according to the Bureau of Labor Statistics.

The average family of four is spending anywhere from \$7 to \$10 extra a week -- \$40 more a month -- on groceries alone, compared to a year ago, according to retail consultant Burt Flickinger III.

And while overall wage growth is a solid 4.1 percent over the past 12 months, economists say the increases are mostly for the top earners.

Retailers started noticing the strain in late spring and early summer as they were monitoring the spending around the paycheck cycle.

Wal-Mart and Family Dollar key on the first week of the month, when government checks like Social Security and public assistance generally hit consumers' mailboxes.

7-Eleven, whose customers are more diverse, looks at paycheck cycles in specific markets dominated by a major employer, such as General Motors in Detroit, to discern trends in shopping.

To economize, shoppers are going for less expensive food.

"They're buying more peanut butter and pasta. And they're going for hamburger meat," Flickinger, the retail consultant, said. "They're trying to outsmart the store by looking for deep discounts at the end of the month."

He said the last time he saw this was 2000-2001, when the dot-com bubble burst and the economy went into a recession after massive layoffs.

For now, low-price retailers are readjusting their merchandising and pricing.

Wal-Mart is becoming more aggressive on discounting. It announced Thursday it is expanding price cuts to 15,000 items, ranging from Motts apple juice and Progresso soups to women's fleece tops, heading into the holidays.

Family Dollar, whose food offerings were limited to candy and snacks until two years ago, has expanded its mix of groceries like fruit cups, cereal and such refrigerated items as milk and ice cream while cutting back on shoes. This summer the chain began accepting food stamps.

Food pantries are also getting creative. Samuels said her church, Full Gospel Tabernacle of Faith, just started offering free cooking classes to teach clients who are diabetic or have other health conditions how to prepare vegetables like squash. It's also offering free exercise classes.

"We are trying to make them health conscious," Samuels said. "It's not right to give them just anything. Our mantra is eat well and live well."

Primary Care Docs Go Direct With Pre-Paid Plans

Wall Street Journal Health Blog – 10.22.07 (Posted by Jacob Goldstein)

For 125 bucks a month, Vic Wood will take care of you and your family. You'll get unlimited primary and urgent care, including office visits, lab work, X-rays and certain generic drugs.

Wood is one of [several hundred doctors across the country now offering pre-paid primary care plans](#), the WSJ [reports](#). It's not supposed to replace insurance — the deal doesn't include any specialist or hospital care, and it doesn't cover branded drugs or serious procedures. But for those without insurance, the pre-paid approach could represent an affordable stopgap.

Though still experimental, proponents argue that the pre-paid approach tackles two problems in U.S. health care: a decline in the number of primary care doctors and the growing number of Americans who are either uninsured or underinsured.

Regulators and insurers aren't sure what to make of the development, though. Soon after Wood first started advertising his plan, the insurance commissioner in West Virginia, where he's based, said he was basically acting as an unlicensed insurer and asked him to stop offering the plan. But Wood was ultimately able to get the governor's ear, and wound up getting his program reinstated. [Now some insurers in the state are looking for ways to combine more comprehensive coverage with pre-paid plans like Wood's](#). The local Blue Cross Blue Shield plan is considering a hybrid that would allow patients to apply Wood's monthly fee toward deductibles in their regular insurance.

Strange Bedfellows on Health Privacy: ACLU & Microsoft

Wall Street Journal Health Blog – 11.19.07 (Posted by Theo Francis)

What do the ACLU, Gun Owners of America, the Free Congress Foundation and Microsoft have in common? A hankering for [patient privacy](#), it seems.

With some 40 other groups, they sent congressmen a [letter](#) yesterday urging them to "establish basic privacy protections" for health records, and soon.

They complain that no federal statute establishes [a right to health privacy](#) and dismiss the [HIPAA](#) privacy regulation as "really a 'Disclosure Rule'." Their letter charges that forging "national privacy standards is a job for Congress, not unelected agency appointees." A similar group — marrying the Christian Coalition and the National Center for Transgender Equality, among others — lobbied [last year](#) as well.

For Microsoft, it may be no coincidence that its political activism comes soon after the company unveiled [HealthVault](#), [online software and a service that would let patients store what medical information they want in a central place, giving health-care providers ready access \(through Microsoft-compatible applications, naturally\)](#). Microsoft edged out Google in the online health-records race, as the Health Blog [noted](#) earlier this month.

Along the way Microsoft [consulted with](#) privacy advocates such as Deborah Peel, an Austin, Texas psychotherapist and founder of Patient Privacy Rights, one of the groups at the center of the lobbying campaign. Microsoft got Peel's support in part by agreeing to a host of privacy guidelines, including external audits to ensure its privacy protections are what they advertise. (Peel says her group is funded by donations from individuals and honoraria for her speeches.) "We know that consumers are very concerned about the

privacy of their private health data," Peter Neupert, vice-president of Microsoft's Health Solutions Group, said at the product's [launch](#) in Washington, D.C., earlier this month.

Few in the health-care business dismiss patient privacy concerns outright. But many argue that there's a trade-off between privacy and good care. Too many restrictions on what medical providers can see may blunt the advantages of electronic records — and could even hurt patient care. Privacy advocates counter that there's a big gulf between that scenario and today's HIPAA rule, which lets thousands of third-party vendors see patient data by signing hard-to-enforce contracts promising not to further divulge it.

Backlash Against Bosses on Strict Health Rules

Wall Street Journal Health Blog – 10.18.07 (Posted by Scott Hensley)

Most Americans say employers shouldn't have the right to require that their workers participate in programs to stop smoking or shed pounds, says a poll by The Wall Street Journal Online/Harris Interactive.

More and more companies are adopting stricter wellness policies to keep health-care costs in line. But the moves are meeting resistance.

Sixty-five percent of respondents believe employers shouldn't have the right to mandate smoking-cessation programs or to fire someone who is unwilling to quit smoking, the survey results say. Two-thirds say bosses shouldn't be able to require attendance in weight-loss programs or to fire someone who doesn't lose weight.

While nearly a third of those polled say it's OK for employers to require attendance in smoking-cessation or weight-loss programs, few participants in the poll said they believe employers have the right to fire employees for smoking (7%) or for being seriously overweight (4%).

The online survey of 2,267 adults, conducted Oct. 8-10, indicates declining public support for charging higher insurance premiums or out-of-pocket medical costs to people with unhealthy lifestyles. Forty-two percent of U.S. adults think it is unfair to ask people with unhealthy lifestyles to pay higher insurance premiums than people with health lifestyles, compared with 37% who say it is fair. And about a third believe those with unhealthy lifestyles should pay higher deductibles or co-payments for their medical care vs. 46% who disagree.

Michigan Signs Great Lakes Border Health Initiative's Public Health Data Sharing Agreement

Michigan News Wire - 10.19.07

Michigan Department of Community Health (MDCH) Director Janet Olszewski today signed the Great Lakes Border Health Initiative's (GLBHI) [Public Health Data Sharing Agreement and the Infectious Disease Emergency Communication Guideline](#). The Public Health Data Sharing Agreement and the Infectious Disease Emergency Communication Guideline are valuable new tools for Michigan and the other GLBHI partners to use in the event of an infectious disease outbreak.

GLBHI's five active members - Michigan, Minnesota, New York, Ontario and Wisconsin - have ratified the voluntary data agreement and accompanying guideline that will [assist in the early identification and notification of illnesses that could affect the residents of the member states and Canadian province](#).

Recent history has demonstrated with sometimes frightening consequences that diseases do not respect state and national boundaries. The SARS outbreak in Canada in 2003 is one example. Prior to 2003, a message regarding a local infectious disease outbreak would have to take a roundabout route involving 2 local health departments - both a state and provincial health department - and two federal health agencies before it was complete. There were no guidelines in place for a local health department in Michigan to talk to a local health unit in Ontario.

Opinion: President Bush wants to leave American families to the mercy of profit-run health care

Salon.com - 10.20.07 – Opinion by George Lakoff and Glenn W. Smith

George W. Bush doesn't want you to think of a sick child. Not Graeme Frost. Not Gemma Frost. Not Bethany Wilkerson. Not any of the real children affected.

He wants you straining your eyes on the fine print of policies, puzzling over the nuances of coverage -- whether you can afford premiums for basic, catastrophic, comprehensive or limited health insurance. Last week on "[Real Time With Bill Maher](#)," even Tucker Carlson kind of got it right, saying, "No one child is a metaphor -- he's a kid!" That's the point. They're all kids, each one, one by one. The question is, do you care?

The actuaries don't. And can't. Health insurance companies make their money by denying care. They maximize profit by authorizing as little care as they can get away with. That's what all those administrative costs -- as high as 30 percent -- and all that paperwork are mostly about. It takes a lot of people to justify denying care. ...**Full article** at: <http://www.salon.com/opinion/2007/10/20/sick/>

The healthcare war: More than just political child's play, what Bush's SCHIP veto portends for the 2008 elections and beyond

Salon.com – 10.18.07 (By Walter Shapiro)

WASHINGTON -- The headline could be written in advance: "HOUSE FAILS TO OVERTURN BUSH VETO." The fate of Thursday's vote on the children's health bill is as predictable as a [Rudy Giuliani](#) speech about 9/11. House Speaker [Nancy Pelosi](#) is destined to fall about 20 votes short -- even with a united Democratic caucus and the backing of about four dozen Republicans -- of the two-thirds majority necessary to enact the \$35 billion expansion of the State Children's Health Insurance Program [over the president's objections](#).

In political terms, which seem to be the measure of everything on Capitol Hill these days, the Democrats have dominated the public debate since George W. Bush issued one of his rare vetoes two weeks ago. [A USA Today/Gallup Poll released this week found that voters by a margin of 52 to 32 percent have more confidence in congressional Democrats than the president to provide healthcare for children.](#) As the campaign strategist for one vulnerable House GOP incumbent put it, "A lot of Republicans are saying, 'Where's our message on this?' The White House wasn't there. The Democrats framed it perfectly as Saving Kids versus Saving Money."

The fight over SCHIP serves as a reminder that a faint pulse still beats in the near-extinct congressional beast called reasonable Republicanism. With the unswerving support of such veteran GOP legislators as Utah's Orin Hatch and Iowa's Chuck Grassley, the bill to increase the number of children covered by SCHIP passed the Senate last month by a veto-proof 67-29 margin. Even in the more ideologically rigid House, many Republicans from marginal districts joined with the Democrats on the legislation. Democratic pollster Mark Mellman noted that the votes of these skittish Republicans "reflect the urgency that the public feels about the healthcare coverage issue."

[Few issues are more likely to be replayed in the endless loop of 30-second attack ads that will punctuate the 2008 congressional races ... Full story](#) at: <http://www.salon.com/news/feature/2007/10/18/schip/>

Drug Company Ties Common in Med Schools

Associated Press – 10.16.07

CHICAGO -- [Nearly two-thirds of academic leaders surveyed at U.S. medical schools and teaching hospitals have financial ties to industry, illustrating how pervasive these relationships have become,](#) researchers say. Serving as paid consultants or accepting industry money for free meals and drinks were among the most common practices reported by the heads of academic departments. Drug companies and makers of medical devices often use these connections to influence doctors to use products that aren't necessarily in the

patient's best interest, said Eric Campbell, the study's lead author. He is a researcher at Massachusetts General Hospital and Harvard Medical School.

Since academic department heads set the tone for appropriate conduct at their institutions, their actions signal to medical students and others that this is appropriate behavior, Campbell said.

The survey went to all 125 accredited medical schools and the nation's 15 largest teaching hospitals. About two-thirds of the department heads responded. The study gave no specific examples, nor did it name any institutions.

Many studies have examined doctor ties to drug companies. Campbell co-authored research last year that found company ties were common among hospital review boards that oversee experiments on patients. The new study shows that drug companies "are involved in every aspect of medical care," Campbell said.

Overall, 60 percent of department heads reported some type of personal financial relationship with industry. More than one-quarter — 27 percent — said they had recently served as a paid consultant. The same percentage reported serving on a company scientific advisory board; and 21 percent who headed departments of medical specialties closely related to patient care said they had served on speakers' bureaus for industry.

The results appear in Wednesday's Journal of the American Medical Association.