

Access to Health Care News Update – 11.13.07

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

The Health Care "Table of Plenty": Who Gets a Chair?

NPR, *Interfaith Voices* – 11.8.07 – Listen: <http://interfaithradio.org/>

This week, it's the ninth in our series, Conversations on the Common Good, a concept at the heart of the social teachings of faith traditions across the board.

We devote our entire hour to a discussion of one of the most exasperating challenges facing the United States: universal health care. At a time when at least 47 million Americans went uninsured last year, according to the U.S. Census Bureau, the problem of health care just won't go away. To shed some light on this issue, we brought in four guests with a medley of mindsets: an economist, a moral philosopher, a public health professor, and a minister. All four take a hard look at universal health care from an *ethical*, rather than policy-minded, point of view.

Join us as our round table of thinkers consider key questions, including: Is health care a basic human right or something to be bought and sold? An individual responsibility or a social concern? How does the current system violate the common good? And what needs to happen to change it?

"Who should be allowed to sit at our health care table of plenty?" asks Dr. Len Nichols, the health care economist. "To me, that's a question of community."

Related Link: Faithful Reform in Health Care - http://www.faithfulreform.org/index.php?option=com_frontpage&Itemid=73

Kids' Health Advances in DC, But Tobacco Tax Nixed in Ore.

Wall Street Journal Health Blog – 11.8.07 (Posted by Shirley S. Wang)

A revised bill to expand children's health coverage is nearing completion in Congress, the Associate Press reported.

But President Bush, who vetoed a previous measure, has said he will veto any bill that would fund an increase in coverage of the State Children's Health Insurance Program through a hike in tobacco taxes. Congressional negotiators hope to attract two dozen more Republicans in the House to achieve a veto-proof majority on a bill to expand SCHIP by \$35 billion, the AP said. The bill would tap tobacco taxes.

Yesterday in Oregon, voters on defeated a state measure to fund a children's health-care program through higher tobacco taxes, reports the [WSJ](#). Sixty percent of voters said no dice to the 84-cent-a-pack increase. Altria Group and Reynolds American threw \$12 million into opposing the ballot measure, a record amount in Oregon.

"They know that cigarette taxes are popular with the voters," William Corr, executive director of the [Campaign for Tobacco-Free Kids](#) said to the WSJ, "and what they have done is change the subject to anything but raising tobacco taxes to fund health insurance for children or to fund tobacco prevention."

Payers Propose to Boost Primary Care

Wall Street Journal Health Blog 11.7.07 (Posted by Shirley S. Wang)

Everyone knows that primary care docs are pinched for time and money these days. Now comes a proposal to steer patients to the best primary care doctors and to pay them to spend *more* time with their patients, the New York Times reports.

The model, proposed by the [National Committee for Quality Assurance](#), will be presented today at a meeting of insurers, employers and health-care providers in Washington. **The idea is to shore up primary care as a means to boost health-care quality.** The plan calls for rewarding doctors to communicate with patients outside the office and to spend more time dealing with patients' chronic health conditions. Who can argue with that?

Several doctors' groups have already accepted some of these measures and are working to get them adopted by big insurers, such as [Wellpoint](#), [United HealthGroup](#), [Aetna](#), [Humana](#), and the [Blue Cross and Blue Shield Association](#). Pilot programs based on the model appear to save money by decreasing visits to emergency rooms and hospitals.

Helen Darling, president of the National Business Group on Health, told the Times that her members, some of the largest employers in the country, were willing to pay more for primary care as long as their overall medical costs didn't rise as a result. "It has to be budget neutral," she said.

Diverse Coalition Promotes the Issue of Affordable Health Care

Cover the Uninsured, from [Los Angeles Times](#), 11/1/07

Divided We Fail, a coalition of diverse organizations working to put the issues of health care and retirement security "at the top of the presidential candidates' domestic agendas," recently added to its membership the **National Federation of Independent Business (NFIB)**, "a lobbying juggernaut that helped kill President Clinton's health plan in the 1990s," reports the *Los Angeles Times*.

The "strange bedfellows," which include AARP, the Service Employees International Union (SEIU) and the Business Roundtable, "are trying to forestall the kind of political polarization that doomed Clinton's healthcare plan, as well as President Bush's effort to overhaul Social Security," according to the *Times*. While members do not agree on how to reform the health care system--NFIB prefers "market-based solutions instead of government programs" while AARP and SEIU do not--they do agree on the need for action. "We have an obligation to at least actively listen to one another and engage with one another, instead of talking past one another or at one another," said Todd Stottlemeyer, president of NFIB.

Roughly 60 percent of the 47 million uninsured are small-business employees, owners and their family members. "Access to affordable health insurance is the No. 1, No. 2 and No. 3 issue for small business across the United States," said Stottlemeyer. "For us not to be at the table in any serious conversations makes no sense."

Web Link:

Voice for the Uninsured (AMA) - <http://www.ama-assn.org/ama/pub/category/17712.html>

Drug Imports From Canada Decline

Wall Street Journal Health Blog – 11.5.07 (Posted by Nick Timiraos)

Canadian drug sales to U.S. patients are falling, reports the Philadelphia Inquirer. The U.S. dollar's decline against the Canadian loonie and price increases up north are two reasons why.

But the biggest factor behind the drop in Canadian drug imports appears to be the nearly two-year-old Medicare prescription-drug benefit. Sales by Canadian Internet pharmacies fell to \$221 million Canadian last year, from \$420 million Canadian in 2005, according to IMS Health.

The Inquirer's story highlights the FDA's attempt to restrict such sales, focusing on Ann Griffith, an 81 year-old resident of Plymouth Meeting, Pa., who has bought thyroid medication from a Canadian Internet pharmacy for three years. The FDA detained three of her packages this summer when they entered the U.S. at Seattle-Tacoma Airport and told her to write or travel personally to Washington state to prove the packages were legal.

The drug industry strongly opposes imports and has been fighting an effort on Capitol Hill to ease restrictions on drug imports. The Senate passed a bill by a 63-28 vote, but the measure was shelved in May.

Giving Back: Michigan Optometric Association

Free Press – 11.4.07

The cause: Helping infants establish a lifetime of healthy vision.

The tactic: The InfantSEE program is a public health initiative by the optometric association to ensure that eye and vision care become a part of infant wellness. Participating members of the Michigan Optometric Association provide an eye assessment within the first year of life at no cost.

Advice: "Between the ages of 6 to 12 months, many attributes of a baby's vision can be measured," said Dr. Mark Swan, president of the Michigan Optometric Association. "To ensure the baby has healthy vision for their continued development, I recommend parents include a trip to an optometrist as a part of their well-baby checkups."

Results: The Michigan Optometric Association will conduct more than 500 assessments this year with plans to provide even more next year. Severe hyperopia (farsightedness) and myopia (nearsightedness) are common findings, especially in premature and minority babies. Additionally, more severe but less common conditions such as retinoblastoma (eye cancer), glaucoma and cataracts also have been identified.

Contact: Parents of infants can find a participating Michigan optometrist by calling toll free 888-396-3937 or by visiting www.infantsee.org.

NYC Mandates Reporting of Diabetes Test Results

NPR All Things Considered, November 4, 2007 · [Listen Now](#)

New York City's health department is requiring doctors to report the results of blood sugar tests for those with diabetes. Officials say it will help residents manage the disease. Critics call the move one more step toward a nanny state.

Another Kids' Health Bill Heads for Another Veto

Wall Street Journal Health Blog – 11.2.07 (Posted by Jacob Goldstein)

Congress has been feeling its way toward a compromise with the White House on expanding the State Children's Health Insurance Program, but it looks as though any deal will take a while longer.

Yesterday, the Senate voted 64-30 to pass a version of the bill that the House has already passed and that the president has promised to veto, The Hill [reports](#). The president recently [vetoed](#) an earlier version of the bill.

There are some tweaks in the bill — clarifying a lower income cap for eligibility, preventing coverage of adults, excluding illegal immigrants — meant to address Republican concerns. But those changes didn't give the bill enough Republican support in the House to override a veto.

Legislators from both houses were discussing further changes yesterday to win over more Republicans when Senate Minority Leader Mitch McConnell forced a vote, The Hill writes.

Senate Majority Leader Harry Reid has said he'll continue the negotiations, and ask the House not to vote to override the coming Bush veto, instead focusing on another compromise bill that can get the support of more Republicans. A group of 38 House Republicans that has opposed the bill has been negotiating for changes that they say would swing their votes.

WHO Aims to Balance Drug Companies, Poor

Associated Press – 11.5.07

GENEVA -- The U.N. health chief urged countries on Monday to come up with new ways to make medicine for HIV/AIDS and other diseases more affordable in the world's poorest countries, without stifling innovation among pharmaceutical companies.

The World Health Organization's 193 member states are hoping to forge a global strategy on the highly divisive issues of drug development, patenting and pricing by the end of the week.

"People should not be denied access to lifesaving and health-promoting interventions for unfair reasons," said Dr. Margaret Chan, WHO's director-general, in opening the agency's first meeting devoted to the subject since May, when the United States walked out of a negotiating session and dissociated itself from a WHO resolution.

Chan said she was aware that the "price of medicines and other products can be prohibitive, effectively blocking access to care." But, she added, public health needs innovation.

"Resistance develops and drugs fail, creating an urgent need for second- and third-line medicines," she told the meeting in Geneva. "We have seen this problem most acutely with HIV/AIDS. We are seeing it again with the spread of extensively drug-resistant tuberculosis, which is far more costly and difficult to treat."

Under rules agreed by the World Trade Organization, countries can issue so-called "compulsory licenses" to disregard patent rights, but only after negotiating with the patent owners and paying them adequate compensation. If they declare a public health emergency, governments can skip the negotiating.

The international aid group Oxfam says compulsory licensing almost never occurs because developing countries face pressure from rich governments acting on behalf of their drug companies. Its report last year on drug access cited WHO statistics that 74 percent of AIDS medicines are still under monopoly, and that 77 percent of Africans still lack any access to AIDS treatment.

McCain: Not Everyone Wants Health Coverage, Shouldn't Be Forced to Have It

The Commonwealth Fund newsletter – 10.31.07

Republican presidential candidate Sen. John McCain, R-Ariz., said Wednesday that cost is not the reason many of the 47 million Americans without health insurance have not tried to get it; it's simply because they choose not to have it.

Many healthy people decide not to have insurance policies because they don't think they need it, and mandating health insurance for all Americans, therefore, is unnecessary, McCain said.

"I'm not going to force Americans to buy insurance," McCain said. "But if we bring down the cost, I'm convinced more and more will take advantage of it," he said. And since individuals with insurance are generally healthier, lower-cost coverage could even persuade those who have eschewed health insurance so far to sign up.

The Arizona Republican, speaking at a health care forum organized by the Federation of American Hospitals and Families USA, reiterated his belief that the government should not mandate health insurance for all Americans, but instead offer tax breaks that allow individuals, employees, and families to choose the health care plans they want from anywhere in the United States.

In what appeared to be a new stance, McCain said there is "no reason to remove employer tax incentives . . . that should stay as it is." He proposes that individuals be given a tax break of \$2,500 to invest in health care policies of their choosing, while families receive a tax break of \$5,000.

When a moderator said premiums for family coverage now top \$12,000 annually, McCain responded that his plan was "not a perfect solution;" however, for those currently getting no tax breaks for health care insurance, "something is better than nothing" at all.

McCain said he believes the biggest problem in American health care is not the quality, but the cost. He said he encourages allowing the government- and privately run sectors to compete to insure Americans, so that the consumer is guaranteed the best quality care for the lowest cost.

When asked whether he would favor health care plans such as New York Democratic front-runner Hillary Rodham Clinton's, which allows people to keep their private plan or opt into a government-sponsored one, McCain said he doesn't think the government should sponsor health care for all Americans. While he favors maintaining a "safety-net" of coverage, such as what is provided to seniors or low-income Americans in Medicare and Medicaid, he said he does not believe that all Americans should be required to participate in government-sponsored health care.

McCain also defended his decision to vote against measures (HR 976, HR 3963) to reauthorize the State Children's Health Insurance Program (SCHIP) and the 2003 Medicare Prescription Drug, Improvement, and Modernization Act (PL 108-173).

He said he could not support the 2003 law since it allowed prescription drug costs to be lowered for millionaires as well as low-income seniors. When questioned about his vote against legislation to reauthorize SCHIP, McCain said that he refuses to support a government-funded health care program that is eligible for everyone, rather than targeted at those who truly need the help.

European Health Care--No Longer an Epithet?

The Commonwealth Fund newsletter – 10.31.07

With Michael Moore's documentary "Sicko" as the impetus, much of this year's media buzz about universal health care coverage focused at first on government-run systems in other countries as models for change. As the months have gone by, however, presidential hopefuls have weighed in with plans they say are more oriented to the United States and the major role the private sector plays domestically in health care delivery. At a press briefing Wednesday, U.S. insurance industry officials sought to sharpen that focus on private sector approaches, insisting they favor universal coverage while pointing to European countries that require citizens to buy private coverage as potential overhaul models.

Shifting the focus back to Europe may seem ironic given the scorn heaped on the British health care and Canadian systems by many conservative politicians and business executives in the United States. But George Halvorson, CEO of Kaiser Permanente, one of America's largest health plans, said "it makes a huge amount of sense for us to understand what is going on in Europe."

There is a misconception that European health care in general is like Canadian and British government-run systems, when in fact countries like the Netherlands and Switzerland center their systems of universal coverage on the private sector, he said.

"In the U.S. there is a confusion between 'universal coverage' and 'government-run,' " noted Karen Ignagni, president of American's Health Insurance Plans (AHIP), which sponsored the briefing along with Kaiser. AHIP opposes single-payer government-run systems, but "we are fully committed to the concept of universal coverage," Ignagni said.

AHIP and Kaiser Permanente said their aim is not to endorse a particular system, but they flew in insurance executives from Switzerland and the Netherlands to talk Wednesday about the approach taken by those two countries. With a growing number of U.S. proposals focusing on mandates that individuals buy private coverage as well as relying on government subsidies to lower the cost in some cases, the two countries seem particularly apt....

Full story at:

http://www.commonwealthfund.org/healthpolicyweek/healthpolicyweek_show.htm?doc_id=574931&#doc574933

Bush calls children's health insurance bill a 'trick'

CNN – 11.1.07

WASHINGTON -- President Bush on Wednesday again vowed to veto a renewed push to expand a popular children's health care program, saying it would play a "trick" on Americans by moving the country closer to a federalized health system.

Bush vetoed a previous version of the legislation that congressional Democrats have deemed a top priority.

"Halloween's an appropriate day to talk about it because there's a bill moving through Congress that's disguised as a bill to help children, but I think it's really a trick on the American people," the president told attendees of the Grocery Manufacturers Association/Food Products Association's fall conference.

Bush was referring to the State Children's Health Insurance Program, or SCHIP, the state-run, federally funded program that was set to expire September 30 but was extended at current levels until the passage of new legislation. The president has criticized Congress, saying lawmakers are wasting time on revisions they know he will veto again.

Last week's 265-142 vote in the House of Representatives was short of the two-thirds margin needed to override another Bush veto. The Senate could consider the revised bill as early as Tuesday.

"If they keep passing this legislation, I will keep vetoing it," Bush vowed, saying the latest version is even more expensive than the first, which he vetoed October 3. The current program covers about 6 million children whose parents earn too much to qualify for Medicaid, the federal health insurance program for the poor, but who can't afford private insurance.

The new version would expand the program by nearly \$35 billion over five years -- the same level as the previous bill, according to Democrats. They want to extend the program to another 4 million, paying for it with a 61-cent-per-pack increase in the federal tax on cigarettes.

"I'm going to use my veto pen to prevent" Congress from raising taxes, the president promised, saying his proposed budget increases SCHIP funding by 20 percent over five years.

Democratic leaders said the new legislation addresses Republican objections by tightening restrictions on illegal immigrants receiving SCHIP benefits, capping the income levels of families that qualify for the program and preventing adults from receiving benefits.

Senate Considers SCHIP for Third Time

NPR, *Morning Edition*, 11.1.07 - Listen: <http://www.npr.org/templates/story/story.php?storyId=15835063>

More than 20 states will run out of money for the State Children's Health Insurance Program, or SCHIP, program sometime this year unless Congress and the White House can resolve a dispute over funding for the measure, a new study shows.

Following a presidential veto, the Senate is working on its third version of the bill, which the White House has promised to veto once again. The bill has been a major source of tension between the White House and Congress, with President Bush recently chastising Democrats for making what he called cosmetic changes to the to expand the SCHIP program.

"I made it perfectly clear that if you keep passing this piece of legislation, I'm going to keep vetoing it, unless, of course, it's a piece of legislation that focuses on poor children and does not expand the reach of the federal government into health care," the president said in a Washington speech to the Grocery Manufacturers Association on Wednesday.

On the Senate floor, where the bill was under consideration, Democrats such as Robert Menendez of New Jersey were happy to return the president's fire. "This is a president who doesn't see the irony in sticking out one hand to ask for \$200 billion in Iraq this year while using the other to veto health coverage for poor American children," he said.

In the meantime, Congress and the president have agreed to temporarily continue funding SCHIP at last year's levels. Only there's a problem: SCHIP rolls have grown by so much that last year's funding is not enough to cover this year's children.

But a new report by the Congressional Research Service says 21 states will run out of money for the program sometime during the year, with 10 exhausting their funds by March.

Maine is one of those states. Kirsten Figueroa is the state's deputy commissioner for finance in the Department of Health and Human Services. She said her staff has not figured out yet what they would do. "We currently have 4,500 kids in that program. ... We couldn't just pick certain kids and say 'you're not covered as of today,' because how do you pick one over the other," Figueroa said.

Iowa will also run out cash for the SCHIP by March. Like Maine, Iowa does not cover adults and only covers children up to two times the poverty line, or \$41,000 for a family of four. Kevin Concannon, Iowa's head of Health and Human Services, said the state plans to "look at extending or making changes in our Medicaid program to pick up some of those children who are in what's called the Medicaid expansion program." That would cost the state more money, he said, but at least it would prevent those children from losing their coverage.

But stepping in with state money would not be an option in Georgia, another state projected to run out of funds in March, said Community Health Commissioner Rhonda Meadows. "This state has actually laws on books that actually prevents the program to be funded 100% by the state," she said.

Georgia's program, called PeachCare, already went through one funding shortfall earlier this year, requiring it to freeze enrollment and take other cost-cutting measures. Meadows said that turning the on again, off again funding of the program is having an adverse impact on the covered children. "We are talking about a disruption for children who are in the middle of (chemotherapy), who are in the middle of surgeries, who are in the middle of getting much-needed treatment for diabetes and asthma," Meadows said.

Nov. 16 is when the latest short-term funding runs out. Congress is likely to extend that for the rest of the fiscal year, but it is not clear whether there will be additional money for the states, such as Georgia, that will run out in March. And Meadows says if the money ends, so will the coverage.

Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries, 2007

The Commonwealth Fund – 11.1.07 – Study at:

http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=568237&#doc568237

A new Commonwealth Fund survey finds that, compared with adults in six other countries, U.S. adults are most likely to go without health care because of the cost and more likely to say that the health care system needs to be rebuilt completely. In addition to cost concerns, the survey analysis, by Fund Senior Vice President Cathy Schoen and colleagues, finds the U.S. has multiple symptoms of less-efficient care.

"[Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries, 2007](#)" (*Health Affairs* Web Exclusive, Oct. 31, 2007), highlights the critical role of having a "medical home" that is accessible and coordinates care. In each of the countries surveyed, patients who had such a medical home reported more positive care experiences than those lacking one. The survey included approximately 12,000 adults in Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States.

Among adults in the seven countries, U.S. adults reported the highest overall error rates, including lab and medication errors. One-third of U.S. patients (32%) with chronic conditions reported a medical, medication, or lab test error in the past two years, compared with 28 percent of patients in Canada, 26 percent in Australia, and fewer patients in the other countries. Patient-reported errors were highest in every country for those seeing multiple doctors or with multiple chronic illnesses.

In the U.S., 37 percent of all adults surveyed—and 42 percent of those with chronic conditions—skipped medications, did not see a doctor when sick, or did not obtain recommended care in the past year because

of the cost. These rates are well above those found in the other six countries. Few people in Canada, the Netherlands, and the U.K. reported skipping care because they could not afford it.

A high proportion of U.S. adults also have serious problems paying medical bills—nearly one-fifth (19%), more than double the rate in the next highest country. Nearly one-third (30%) of U.S. survey respondents spent more than \$1,000 in the past year in out-of-pocket medical costs. Nineteen percent of Australians and 12 percent of Canadians spent this much; rates were even lower elsewhere.

Affordability concerns may well be the reason that a third (34%) of U.S. respondents said the health care system needs to be rebuilt completely. This was the highest rate of any of the seven countries.

All the countries surveyed, except the U.S., have universal health insurance systems. Despite arguments that such systems result in long waits for care, or even rationing, half or more adults in Germany, the Netherlands, and New Zealand reported having rapid access to physicians. Yet in the U.S., only 30 percent of adults said they could get same-day appointments with their doctors when sick. Moreover, two-thirds of U.S. adults—as well as two-thirds of adults in Canada and Australia—reported difficulty getting care on nights, weekends, or holidays.

Adults in the U.S. also reported high rates of coordination problems and billing hassles. For example, 23 percent of U.S. adults said that either test results were not available at the time of an appointment or doctors ordered duplicate tests. Nineteen percent of Germans and 18 percent of Australians reported these problems; rates were lower elsewhere.

Cross-national and U.S.-specific studies find an association between access to comprehensive primary care and both better health outcomes and lower medical costs. In light of such evidence, a movement has emerged to transform primary care practices into "medical homes" that provide an array of patient services in an efficient manner.

To determine if respondents had a medical home, the survey asked if they had a regular doctor or source of primary care; if their provider had information about their medical history; if their provider could be contacted by phone during office hours; and if the provider coordinated their care.

According to these criteria, only about half of adults in all seven countries have medical homes. In each country, patients with medical homes reported more positive care experiences than those who did not, including more time spent with their doctors and greater involvement in care decisions.

In the U.S., the uninsured were at high risk of missing such a connection to the health system: just 26 percent of uninsured adults under age 65 had a medical home, versus 53 percent of the insured.

Those with a medical home were also much less likely to report medical errors, receive conflicting information from different doctors, or encounter coordination problems.

"Achieving better care coordination will likely require designs that include a mix of formally integrated organizations, co-locating or sharing services, and connecting through information systems," the authors conclude. "Developing medical home approaches offers the potential to move toward higher performance."

Nonprofit hospitals work miracles in tough times

Comment - Free Press - 10.31.07 (BY SPENCER C. JOHNSON)

Between the nation's highest unemployment rate, a record number of residents with inadequate or no health insurance, and chronic government underfunding of many essential services, Michigan citizens are caught in a perfect storm. But even in bleak times, residents will find a nonprofit hospital in or near their community that will treat them 24 hours a day, seven days a week.

Providing efficient and high-quality care to all -- even those who are unable to pay -- is the mission of all 146 Michigan nonprofit community hospitals. As recently reported by the Detroit Free Press, Michigan hospitals will proudly and voluntarily provide about \$1.7 billion in uncompensated care -- charity care and bad debt -- to residents this year. This staggering level of uncompensated care is 80% higher than just six years ago, a sobering consequence of Michigan's troubled economy.

While critically important, providing charity care is only one of many essential roles the state's nonprofit hospitals play in communities throughout the state. It also is one of the fundamental differences between for-profit and nonprofit organizations. For-profit companies are owned by investors who want to make a return on their money. By contrast, any margin (profit) earned by nonprofit community hospitals is reinvested in the institution to boost the quality of care, to attract and retain staff, and to improve the health of the community. While for-profit boards are made up of investors intent on increasing shareholder returns, nonprofit hospitals have voluntary governing boards composed of community leaders.

Every Michigan hospital also conducts community benefit and outreach programs that extend far beyond the hospital walls and campus. Among those efforts, hospitals adopt schools, provide community nurses, hold well-baby care clinics, coordinate meals on wheels, help people quit smoking and maintain healthier lifestyles, collect food for the hungry, and have employees who volunteer in countless community activities.

Furthermore, Michigan hospitals are struggling with a growing number of insured patients who are unable to pay co-pays and deductibles as they are wrestling with rising gas prices and mortgage rates.

To compound the problem, neither the state nor federal governments reimburse hospitals for the actual costs of treating Michigan's more than 3 million Medicaid and Medicare patients. In fact, state funding for Medicaid hospital patient care has been slashed nearly \$686 million since 1996. Meanwhile, employers are demanding lower health care costs, and while insurance premiums rise at double-digit rates, hospitals rarely receive annual increases from payers that cover the costs of patient care and operating expenses.

Michigan's hospitals are proud of our nonprofit heritage and honor our charity care obligations steadfastly. During these difficult economic times and beyond, hospitals continue to be the health care safety net for all Michigan residents. Hospitals remain committed to our unique charity care programs and other voluntary efforts, such as disclosing hospital pricing and quality information, initiating smoke-free hospital campuses, and pioneering our nationally acclaimed Keystone Center for Patient Safety and Quality.

Michigan hospitals will continue to seek ways to improve our patient care services and the future of our state, alongside our more than 205,000 employees and the countless patients and their families who depend on hospitals for treatment every day.

SPENCER C. JOHNSON is president of the Michigan Health and Hospital Association.

Bush won't accept health bill with tobacco tax hike, officials say

CNN from Associated Press – 10.31.07

WASHINGTON -- **President Bush told Republican lawmakers on Tuesday he will not agree to legislation expanding children's health insurance if it includes a tobacco tax increase, a decision that virtually ensures a renewed veto struggle with the Democratic-controlled Congress.** The president also suggested he would not be willing to sign other types of tax increases that Democrats have attached to major legislation, including an energy bill, according to numerous officials who attended a closed-door meeting at the White House.

Bush's remarks represented a hardening of the administration's public position in a running veto showdown over Democratic-led attempts to enact legislation that provides coverage for 6 million children who now lack it. The officials who disclosed his comments did so on condition of anonymity, saying they were made in a closed-door meeting. The White House had no response Tuesday night to the report of the president's comments.

The president vetoed one children's health bill, and Democrats failed to override him in the House. His threat to veto a replacement measure that cleared the House last week has led to a hurried round of negotiations among lawmakers in both parties and both houses.

Their goal is to reach a compromise that can command enough votes to gain the two-thirds majority needed in both houses to override the president's veto, if necessary.

The negotiations were private, but in an ominous sign for the White House, Republican leaders said during the day they might defy a White House veto.

House Republican Leader John Boehner of Ohio, asked if he might support a bill that the president would not sign, he replied: "That's always a possibility."

In a similar vein, House Minority Whip Roy Blunt, R-Missouri, said he would "have to see the bill" before deciding.

Their comments were the clearest sign yet that even Bush's most loyal House allies are eager for an end to the impasse, which many Republicans see as politically damaging to the GOP.

The White House has said previously it opposes tobacco tax increases that Democrats included in the health care legislation, but only after first detailing numerous other objections. Additionally, the president's press aides have declined repeatedly to say whether he would sign a bill that raised taxes.

Budget bills move despite disputes

Free Press – 10.30.07

LANSING -- Bearing down on a midnight Wednesday deadline to set a new state budget, lawmakers agreed Monday to protect the state's three research universities from future budget cuts, **maintain Medicaid coverage for everyone who gets it now** and delay until January a decision to raise hunting and fishing license fees.

But disagreements remained over how much of the state's foster care and juvenile justice programs should be placed under private agencies. The Legislature has until the end of Wednesday to set a budget that shows about \$435 million in spending cuts. That's the second part of an Oct. 1 deal that raised the state income tax to 4.35% and levied the 6% sales tax on some services.

How that \$435 million in cuts is achieved came down to a few contentious points as conference committees approved most of the 17 budget bills. Four then were approved by the House and Senate and sent to Gov. Jennifer Granholm for signing -- budgets for the departments of State Police, Military and Veterans Affairs, Labor and Economic Growth and History, Arts and Libraries...

... Also, **a conference committee signed a \$12-billion Community Health budget that increases Medicaid payments by \$373.2 million. The agreement retains Medicaid coverage for 19- and 20-year-olds and child caretakers.** The Community Health budget includes a 4% raise for union and nonunion employees, as previously negotiated.

State budget highlights

Free Press – 11.1.07

MEDICAID

The money: \$8.5-billion budget is up \$373 million. Of that total, \$2 billion comes from state tax dollars, the rest from federal government.

The impact: **Keeps coverage for eligible 19- and 20-year-olds, as well as nonparental child caretakers,** such as grandparents.

Something new: \$5 million more for adult home care services.

CORRECTIONS (PRISONS)

The money: \$2-billion budget reflects \$66 million in spending cuts.

The impact: **Three prisons close.**

Big change: About 2,000 prisoners already have been paroled earlier than planned.

Access to Specialty Care and Medical Services in Community Health Centers

Study, The Commonwealth Fund – 10.29.07

Full study at:

http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=564080&#doc564080

Community health centers (CHCs) provide primary health care services to more than 15 million Americans, many of whom are members of racial or ethnic minorities, have low income, are uninsured, or have coverage through Medicaid. To improve access to care in underserved communities, the federal government recently increased the number of CHCs.

There are concerns, however, that CHCs lack adequate capacity to provide a full range of services to their patients. **A Commonwealth Fund-supported study has found that CHC patients — particularly those who are uninsured or covered by Medicaid — have difficulty obtaining off-site specialty services, including referrals to medical specialists, diagnostic testing, and mental health and substance abuse treatment.**

In "**[Access to Specialty Care and Medical Services in Community Health Centers](#)**" (*Health Affairs*, Sept./Oct. 2007), a research team led by Nakela Cook, M.D., M.P.H., of Massachusetts General Hospital and Harvard Medical School, surveyed 814 medical directors of federally qualified CHCs to better understand the challenges centers and patients face in obtaining access to off-site specialty services. The survey focused on two issues: the relationship between access to specialty medical and mental health services and patients' insurance status, and other factors associated with access to off-site specialty services for uninsured and Medicaid patients.

The researchers received completed surveys from approximately half the medical directors. About 75 percent of the CHCs had on-site mental health services, about 80 percent had on-site diagnostic testing, and about 50 percent had diagnostic x-ray services available. Medical directors reported that about 25 percent of CHC visits resulted in medically necessary referrals for services not provided by the centers, regardless of patients' insurance category.

Getting specialty medical care outside the CHC usually posed little problem for patients with Medicare or private insurance. **However, access to off-site specialty services was difficult for patients who were uninsured or covered through Medicaid and was even more challenging for patients who needed off-site mental health and substance abuse services. Such access was difficult for uninsured patients even if the CHC was affiliated with a medical school or a hospital. Access to off-site mental health services was somewhat easier if the CHC had on-site mental health services.**

Barriers to care most often cited by the medical director included providers unwilling to take patients of certain insurance types, patients who could not pay up front as required, and patients lacking full coverage for needed services. "The effect of these barriers varied significantly by insurance status," the authors note.

Revised SCHIP Bill Unable to Defeat Veto, Again

NPR Morning Edition, 10.26.07 Listen: <http://www.npr.org/templates/story/story.php?storyId=15655310>

The children's health insurance bill known as SCHIP came up for a vote again in the House. It was revised a bit by Democrats to try to gain enough Republican votes to override President Bush's promised veto. But they fell short once again.

Money, coverage remain hurdles to SCHIP passage

CNN, Associated Press — 10.29.07

WASHINGTON -- **President Bush and other critics of a \$35 billion spending increase for children's health insurance say they'll support expanding coverage to families of four making as much as \$62,000 a year, but they want to limit states' ability to go beyond that level.**

About three dozen states ignore certain income when determining who can get government-subsidized health coverage. For example, many states exclude child support payments. Others deduct expenses for child care when determining who qualifies for the State Children's Health Insurance Program.

Congress is considering the renewal of SCHIP for an additional five years, but differences remain over who the program should cover and how much money should be spent. The flexibility that states have in defining income is one of the differences that will probably need to be resolved for Democrats to override a promised veto from Bush.

So far, the issue of "income disregards" has received little attention, but that started to change in last week's debate on the House floor.

"You leave it up to the states to say you can't have an income level over 300 percent (of poverty), but you can deduct \$20,000 for a housing allowance or you can deduct \$15,000 for shelter or whatever," said Rep. Joe Barton, R-Texas. "So, what you've got here is the classic bait and switch."

Rep. John Dingell, D-Michigan, said that allowing states to exempt some income helps to ensure that low-income families don't have to resort to welfare to get [health care](#) for their children.

Another disagreement over the program's future is over the coverage of adults, even though the Bush administration approved most of the waivers that allowed adults into the SCHIP program. Now, the administration wants to remove those adults from the SCHIP rolls more quickly than called for in the bill that passed the House last week.

Under that bill, states would have to move an estimated 200,000 childless adults off SCHIP within one year. Also, by 2010, waivers covering about 500,000 parents would be paid from a separate fund. States that perform well on covering low-income children could continue covering parents through that fund, which would get a lower federal matching rate than under current policy, Dingell said.

Just last year, administration officials testified during congressional hearings that extending SCHIP coverage to parents increased the likelihood that their children would get health insurance too. But Health and Human Services Secretary Mike Leavitt now calls the coverage of parents an experiment that took resources away from poor kids. About a dozen states received waivers to cover parents through SCHIP.

"All adults should be moved off SCHIP when their state waivers come up for renewal or within one year, whichever comes sooner," said a policy statement issued by the White House last week.

The bill that passed the House on Thursday would allow about 3.9 million more uninsured children into SCHIP by 2012 -- on top of the 6 million now enrolled. An additional 2 million children would leave private coverage by then and enroll in SCHIP, according to the Congressional Budget Office.

The president had recommended spending an additional \$5 billion for SCHIP over the next five years. The bipartisan bill before Congress calls for a \$35 billion increase, bringing total spending to \$60 billion.

Edwards Would Ban Consumer Drug Ads for 2 Years

Wall Street Journal Health Blog – 10.29.07 (Posted by Jacob Goldstein)

Add one more health-policy prescription to a presidential campaign that's been full of [health talk](#). John Edwards yesterday rolled out a plan to impose tighter rules on the direct-to-consumer drug ads that have played an increasingly important role in the drug industry's marketing arsenal.

Under Edwards's plan, a drug would have to be on the market for two years before it could be pitched directly to consumers. The plan would also require prior FDA approval of "major ad campaigns" and beef up rules about disclosing how well a drug stacks up against a placebo, according to Edwards's [Web site](#).

"You've seen these ads. You know who's paying for them, right? You are," Edwards said yesterday at a speech in New Hampshire, the AP [reported](#). He added that the ads are "driving up demand for the most expensive and most profitable drugs."

Edwards may be trying to distinguish himself a bit on health care. Although he was among the first major candidates to release a detailed health-care plan, he's since seen his rivals steal some of his thunder by releasing plans that are [pretty similar](#) to his own. His would require every American to get health insurance and provide a number of mechanisms to make it easier for people to get insurance.

Grumpy Old Docs Not Quite As Grumpy

Wall Street Journal Health Blog – 10.26.07 (Posted by Jacob Goldstein)

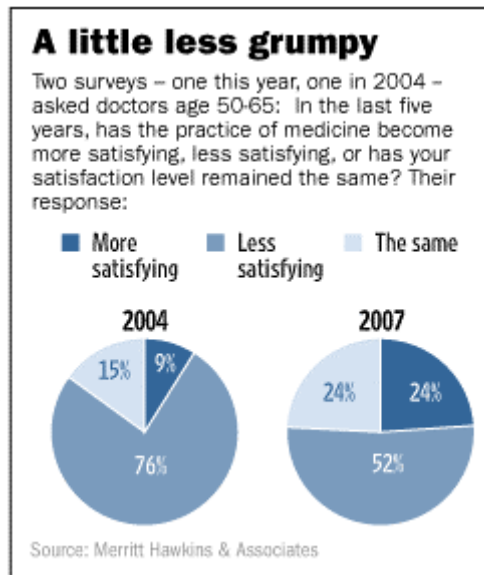
Sure, old docs say things aren't like the good old days. But veteran M.D.s may not be quite as sour about the state of doctoring as they were a few years back.

Look closely at the graphic at right and you'll see that in a recent survey of docs age 50 to 65, just over half of respondents said the practice of medicine has become less satisfying in the past five years.

Not great, you say, but that's a heck of a lot better than the 76% who answered that way in a similar survey in 2004. And the group of docs who actually said things got better jumped to 24% this year from 9% in 2004.

"That one's a head scratcher," Phil Miller, spokesman for Merritt Hawkins, the physician headhunter firm that did the surveys, told the Health Blog. But he was able to suggest a few possible reasons for the improvement — legal reforms have made malpractice less onerous in some states, and docs have a little more autonomy in some managed-care settings these days.

The survey went out to 10,000 docs, and 1,175 responded. It included several sections, including one that queried the older docs about young M.D.s entering the profession today. Answers on that front didn't change much between 2004 and 2007. In both cases, more than 60% of docs said young physicians are less dedicated and hard working than the older generation. [Hippocrates'](#) teacher probably said the same thing. But the surveys don't go back that far.



Wildfires vs. Kids' Health Insurance

Wall Street Journal Health Blog — 10.26.07 (Posted by Jacob Goldstein)

The House of Representatives yesterday passed a modified version of the State Children's Health Insurance bill President Bush [vetoed](#) earlier this month. But the bill, passed 265-142, again failed to garner a veto-proof majority.

And this time only 43 Republicans joined in support, no gain over two prior votes. Democrats appear to have hit a wall that could force them to rethink their tactics, the WSJ [reports](#).

Plus, a new bone of contention appeared: Republicans argued that Democrats shouldn't have called the vote while several representatives were in California, touring the wildfires, the Washington Post [reports](#). "Everything from baptisms to bar mitzvahs, we've put off votes for here," Rep. Ray LaHood, an Illinois Republican who supported the bill, told the paper. "But they won't do it for the people of California."

The Democrats' have been said to hold the more popular political ground on SCHIP. But as a Beltway outsider, the Health Blog wouldn't want to guess how the political chips stack up in a wildfires-vs.-kids' health rumble. Plainly, there's plenty of suffering on both sides.

In any case, the bill was tweaked to address some Republican concerns — making it clearer, Democrats said, that illegal immigrants would not be covered, nor families making more than 3 times the federal poverty line (about \$60,000 a year). But Republican leaders said the changes weren't enough, and some resented the strong-arm tactics the Dems used to push the bill to a vote.

"They unite our guys by jamming us," a Republican leadership aide told the WSJ. "Sometimes the juice isn't worth the squeeze."

Update: [President Bush says he'll veto the SCHIP legislation again, if it gets to his desk in the present form.](#)

"With only a few weeks left on the legislative calendar, Congress needs to keep their promise to stop wasting time and get essential work done on behalf of the American people," Bush said Friday in brief remarks from the White House.

The administration's five-point critique of SCHIP can be found [here](#).

Universal Coverage Not Universally Supported

The Commonwealth Fund newsletter – 10.26.07

As universal health plans gain traction—through plans offered by Democratic presidential candidates and state-led initiatives—a panel on Friday examined the correlation between health care access and the quality of health care provided through universal coverage. The forum, which was sponsored by The Alliance for Health Reform, focused on state coverage initiatives to examine the effects of a trend towards universal coverage.

Sara Collins, assistant vice president for the Program on the Future of Health Insurance at The Commonwealth Fund, cited a recent [report](#) produced by The Commonwealth Fund which highlights the positive correlation between high rates of insurance and high quality of care.

"Health insurance coverage is the most important determinant of access to health care," Collins said. The Commonwealth Fund supports a mixed private and public approach to universal care.

However, Tom Miller, a resident fellow at the American Enterprise Institute, criticized the view that universal coverage would result in better access and quality of health care. He cautioned the audience to "curb your enthusiasm" for universal coverage. Miller presented a chart which compared states' rankings on health care access to their rankings on the number of residents with "healthy lives." Miller concluded that there is no correlation between access to health care and the general health of residents. Miller said, then, that states need different tools—besides money—to implement changes in health care.

Miller's fellow panelists, meanwhile, briefed the audience on the progress of state health initiatives that support universal coverage. Sarah Iselein, commissioner of the Division of Health Care Finance and Policy for Massachusetts, praised the progress that has been made in Massachusetts since the state committed to a universal coverage plan a year and a half ago. Iselein said the state has 56,000 new Medicaid enrollees and 127,000 residents newly enrolled in Commonwealth Care.

Massachusetts, Iselein said, was able to implement a successful plan in part because the state began with a broad Medicaid program, a highly regulated insurance market, and a relatively small number of uninsured—only six to seven percent of its population was uninsured before the state adopted its plan for universal care. By contrast, over 20 percent of California's population does not have health insurance.

Miller compared Massachusetts' situation to when "you start on third base and hit a triple," and he cautioned that the costs of Massachusetts' plan may undermine its effectiveness. "Where is the containment, where is the sustainability?" Miller said.

Iselein said polls have indicated that the "public is on board" in Massachusetts, and the state is still working on getting the word out about the relatively new plan.

Ann Torregrossa, deputy director and director of policy for the Pennsylvania's Government's Office of Health Care Reform, described Pennsylvania's plan for universal coverage, Prescription for Pennsylvania. The plan is based on an integrated approach based on quality, accessibility, cost, and affordability. Torregrossa said Pennsylvania started with an approach to cover all children in the state, and is now working to cover all Pennsylvanians.

GOP Advisors Emphasize Affordable Coverage as Health Overhaul Goal

The Commonwealth Fund newsletter – 10.25.07

Advisors to GOP presidential hopefuls played up affordable health insurance as the goal of their bosses' health overhaul plans at a Washington forum Thursday, with none spontaneously volunteering universal coverage as a priority.

Lanhee J. Chen, domestic policy director for the campaign of Mitt Romney, did say in response to a question about 90 minutes into the event that the former Massachusetts governor would like to cover every American during his presidency, but advisors to Arizona Sen. John McCain and former New York Mayor Rudolph Giuliani focused on cost control and tax code changes as priorities. They did say, however, that every American should have access to affordable coverage.

The remarks at Congressional Quarterly's Presidential Forum, sponsored by the Partnership to Fight Chronic Disease, contrasted with those made earlier in the week by Democratic presidential advisors, who were much more apt to name universal coverage as a goal. But there were some areas of overlap, with advisors on both sides of the aisle saying that competition among insurers would help restrain rising costs and that tax revisions would help pay for coverage.

But Giuliani advisor Don Moran said there is a bright line dividing the parties, with Democrats favoring centralized governmental solutions and Republicans urging market-based solutions. Giuliani's goal is to "reinvigorate the role of private insurance markets in health care," said Moran, a consultant who served as executive associate director for budget and legislation at the White House Office of Management and Budget from 1982 to 1985.

Democrats espouse the use of new or existing insurance "exchanges" or "markets" as the arena for competition, with tight regulations to ensure that people with costly illnesses have access to affordable insurance. GOP advisors at the forum acknowledged the need for regulatory changes, but were more vague about what they should be. Nevertheless, they rejected the Democratic charge that Republicans just want to give the uninsured tax deductions or credits to buy coverage on the "individual" market without making regulatory changes that would allow people with costly medical conditions to actually find affordable coverage. In the individual market, a single person or family buys coverage alone and not as part of a larger pool.

"There's nothing about the current insurance market that everybody should embrace and love," said McCain advisor Douglas Holtz-Eakin, former director of the Congressional Budget Office. "The current individual market is not a good place to live." Added Chen: "We recognize the market is broken."

The advisors said insurance could be made more affordable with regulatory changes that would make it easier for Americans in one state to shop for better insurance deals in another state, using the Internet, for example. However, they conceded that doing so might require a new way to conduct regulatory oversight of such sales. "You're going to have greater federal involvement—there's no way around that," said Holtz-Eakin. But both Moran and Chen expressed reservations about a greater federal role.

Holtz-Eakin wasn't skittish about downplaying coverage as the needed focus of a major health care overhaul. It's more important to tackle the issue of rising costs, he said, by changing payments to reward higher quality and lower cost care and better management of chronic diseases. "The focus has to be on changing the practice of medicine in the U.S.," he said. "John McCain has decided to take this as the premier problem" in domestic politics, Holtz-Eakin added.

Part of tackling the cost problem should be reining in the costs of Medicare, in part by scaling back the Medicare prescription drug benefit to target it to low-income people, he said. Holtz-Eakin suggested that coverage can be a greater focus once costs are under better control. He added that a healthy dose of individual responsibility is also needed, with McCain favoring stronger messages to people to take better charge of their own health.

Chen emphasized the importance of coverage more than his fellow panelists. As governor of Massachusetts, Romney developed a track record on health care, reforming insurance markets to expand access to care, Chen said. "I'm just glad to see on the Republican side that we're all embracing the notion of expanding access to health insurance," Chen said. He suggested that without insurance coverage, people are less likely to get access to medical advice emphasizing the importance of exercise and preventive care.

But Chen joined his colleagues in arguing for a less centralized approach to overhauling health. **He said states should lead the way in widening coverage and lowering costs, and be given regulatory flexibility and greater control over Medicaid in order to do so.**

Biden: Feds Should Cover Catastrophic Care

Wall Street Journal Health Blog – 10.25.07 (Posted by Jacob Goldstein)

Taking his turn today at the rolling [health confab](#) for presidential candidates, Democratic Senator Joe Biden talked about part of his plan we neglected to mention in our pre-interview [Biden post](#): Government re-insurance for catastrophic care.

The idea is based on the notion that a single employee who gets very sick and needs hundreds of thousands of dollars worth of care can throw a small business's whole health plan out of whack. So Biden would create a government reinsurance pool to cover 75% of catastrophic costs greater than \$50,000. It would be offered to companies in the individual market that meet certain requirements, and to businesses that cover all employees. "That's the thing that's going to keep all the employers in" the system, Biden said.

His plan would expand the feds' role in health insurance in several other ways (described [here](#)) and would cost about \$100 billion a year. He said he'd pay for it by cutting defense spending and getting rid of a recent tax cut for the top 1% of incomes.

He also emphasized that, [unlike](#) Hillary Clinton and John Edwards, his plan wouldn't require all Americans to buy health insurance. "One word Americans don't like: mandate," he said. "I want to make this simple. I don't want Harry and Louise eating me alive."

If you don't know who Harry and Louise are, click [here](#). To watch the archived Biden video on the Kaiser Family Foundation's Web site, click [here](#). Biden's talk was part of a series organized by the Federation of American Hospitals and Families USA.

Kucinich: Abolish Private Insurance

Wall Street Journal Health Blog – 10.25.07 (Posted by Jacob Goldstein)

The Health Blog just tuned in to Dennis Kucinich's turn at the presidential health-care forums.

Kucinich is a liberal Democratic Congressman and a long-shot candidate calling for a pretty dramatic overhaul of the health-care system — abolishing for-profit insurance, for one thing, and instituting universal coverage.

"Is health care a right or is it a privilege?" he said. "If it's a right then it's appropriate for the government to have a role. If it's a privilege, then we're left to the predations of the market — if you can't pay for it, you're out of luck."

When the WSJ's Laura Meckler asked what would become of insurance companies, Kucinich said the government would buy them out. "Where there is a conversion of a for-profit institution to not-for-profit, there would be a market-value compensation," he said. "You're not going to have an expropriation here of resources." He didn't say how much that would cost, but said it would be funded with Treasury bonds.

His health plan would be paid for by a higher Medicare payroll tax, a tax on stock transactions and higher income taxes on top earners.

Kucinich's take is more radical than that of the other candidates in both parties, who are largely calling for incremental tweaks in the health-care system. Yet the plan he's calling for is modeled on the one that would be created by [this](#) bill in the House of Representatives — and that bill has the support of some 85 congressmen, about 20% of the House. To see a list of reps who've signed on to the bill, click [here](#).

Lawmakers Introduce Bill to Allow Medicare-Run Drug Benefit

The Commonwealth Fund newsletter - 10.24.07

House and Senate Democrats have introduced legislation that would allow Medicare beneficiaries to receive [prescription drug coverage administered by the Medicare program](#) rather than by private insurers.

The bill (HR 3932, S 2219) would permit the Medicare program to negotiate drug prices with pharmaceutical manufacturers and provide consumers with information about the safety and effectiveness of drugs.

"Under current law, Medicare beneficiaries are stuck with confusing, costly plans designed by insurance and drug companies. What seniors deserve is an affordable, straightforward drug benefit," one of the bill's cosponsors, Senate Majority Whip Richard J. Durbin, D-Ill., said in a statement. "This legislation will give them the choice of a drug plan operated directly by Medicare—just like all other Medicare benefits—and require the administration to negotiate on behalf of seniors to bring down the exorbitant costs of needed medications." Durbin, along with House sponsors Rep. Marion Berry, D-Ark., and Rep. Jan. Schakowsky, D-Ill., introduced similar legislation last year.

The bill's introduction Tuesday coincided with the release of a report from the Medicare Rights Center and Consumers Union that concludes a Medicare-administered prescription drug plan would give seniors a plan that is less expensive and easier to understand than those offered by the private sector. "We know that the private insurance companies aren't getting the best deals for consumers on prescription drugs," Consumers Union senior policy analyst Bill Vaughan said in a statement.

Medicare Rights Center President Robert M. Hayes said a Medicare-administered drug benefit "would benefit consumer's health and pocketbooks and bring down the program's cost for taxpayers." He added that many beneficiaries are unable to get the drugs they need due to the "confusing and exploitative marketplace that dominates the for-profit drug offerings from private insurance companies."

Centers for Medicare and Medicaid Services Spokesman Jeff Nelligan said the Medicare drug program has been a "solid success" because "fierce competition and wise consumer choices have resulted in reduced costs and enhanced savings." He said that beneficiaries are saving an average of \$1,200 annually on their drug costs and the program is coming in 30 percent—or nearly \$190 billion—under initial estimates.

In their report, [Consumers Union and the Medicare Rights Center said the current Medicare drug program is unnecessarily expensive, has coverage gaps, and leaves seniors vulnerable to marketing fraud because the number of plans offering such divergent benefit packages](#). The groups recommend a national evidence-based formulary for a Medicare-administered drug plan that would help guide doctors and patients on the best medicines to use and establish "a fair and efficient drug appeals system," which they said does not currently exist in the Medicare drug program.

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.