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## Access to Health Care News Update – 11.28.07

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

### **To Push Healthier Choices, Reset the Default**

*Wall Street Journal Health Blog – 11.27.07 (Posted by Shirley S. Wang)*

How might people be steered toward better health decisions? Make the default choice the healthier one, behavioral economists suggest in a commentary published today in JAMA.

Make water rather than soda the default combo-meal drink. Automatically schedule routine medical procedures, such as colonoscopies, rather than ask people to remember to make the appointment. For certain high-risk medical procedures, make a second opinion the default option, say the authors from Carnegie Mellon University, Aetna and the Philadelphia Veterans Affairs Medical Center.

The concept, which the authors term “asymmetric paternalism,” plays off individuals’ natural bias to prefer the default position. Protecting people from themselves by exploiting this tendency should improve health and preserves the freedom of choice because less healthy options remain available.

People make poor choices to begin with because of another bias, our inclination to place more importance on present costs and benefits compared to future ones, the authors argue. “We’re happy to go on a diet tomorrow, but we’re not ready to impose that suffering on ourselves today,” lead author George Loewenstein of CMU told the Health Blog.

Changing the costs and benefits of health choices in the present is another way to improve health: Have cold water near check-out lines and soda machines in out-of-the-way corners.

### **Could Grapefruit Juice Cut Drug Costs?**

*Wall Street Journal Health Blog – 11.27.07 (Posted by Jacob Goldstein)*

An enzyme that lives in the gut, charmingly named CYP3A4, breaks down drugs before they enter the bloodstream. So people with lots of CYP3A4 may have less medicine enter their blood than people who don’t have so much. Enter the grapefruit.

Grapefruit juice has a compound that temporarily gets rid of CYP3A4 — which allows more of a drug to enter the bloodstream. That can be a bad thing in some cases. Patients shouldn’t take statins (such as Pfizer’s Lipitor or Merck’s Zocor) with grapefruit juice, because doing so can cause the drug to build up to unhealthy levels in the body.

But, the WSJ reports, some researchers are now trying to use grapefruit juice to their advantage. A University of Chicago study is pairing grapefruit juice with rapamycin, which is sold by Wyeth as an immunosuppressant and is being studied to treat cancer. Normally, only about 14% of the drug is absorbed into the blood, but give it a bit of juice and the absorption rate increases several fold.

It's too early to tell how far this sort of thing might go, and standardizing grapefruit juice as part of a drug regimen could be tricky. But some docs think the grapefruit effect could ultimately allow patients to take lower doses of drugs.

"Oral oncology therapies are costing \$3,000 to \$5,000 a month. So it's almost like a new world when it comes to drugs costs," Ezra Cohen, the University of Chicago oncologist studying rapamycin, told the WSJ. "If we can lower the costs of those by 50%, you're talking about hundreds of millions of dollars saved."

## **Report links higher rates of uninsured and suicide**

*Free Press, from USA Today, 11.28.07*

The higher the percentage of residents in a state who say they can't afford health care, the greater the prevalence of serious depression and the higher the suicide rate in that state, suggests a report released to USA TODAY.

The state-by-state analysis also links fewer suicides to more adults receiving mental health treatment, greater availability of psychologists and psychiatrists, and "parity" laws requiring equal insurance coverage for physical and mental illness.

The report doesn't prove that lack of care causes depression or suicide, says senior author Tami Mark of Thomson Healthcare. "But it suggests we should be monitoring mental health care and comparing outcomes," she says.

Mark used federal data on mental health and state databases to develop a "depression index," ranking states and the District of Columbia on seriousness and prevalence of depression, as well as suicide rates. When both depression and suicide rates are considered, states that ranked the best are Maryland, New Jersey, Illinois and Hawaii. Among the worst off: Utah, West Virginia, Idaho and Nevada. Suicide rates in states ranked lowest were two to four times higher than those with the most favorable records.

Major depression strikes 17% of Americans, and about 30,000 a year commit suicide, government figures show.

States with more affluent residents tend to have better mental health ratings, but the tie between barriers to treatment and increases in depression can't be accounted for by different average incomes in the states, says David Shern of Mental Health America, an advocacy and education group that commissioned the survey. It was funded by pharmaceutical company Wyeth, which had no influence on the design or outcome, Shern says. The results underscore the importance of health insurance as a presidential campaign issue and of a mental health parity bill before Congress, he says. "There are consequences of no mental health treatment; it can cost lives."

But the report may be oversimplified "because there are so many differences between states, it's hard to capture them all," says health policy researcher Ronald Kessler of Harvard Medical School. For example, many rural, Western states have high suicide rates. "Isolation raises the risk of suicide, and so does more households having guns, which is the case in these Western states," says Paula Clayton, medical director of the American Foundation for Suicide Prevention.

Also, the analysis compares states by expenditures for mental health services, but some spend heavily on administration, and others offer better programs with less money, says Lee Carty of the Bazelon Center for Mental Health Law.

The report hasn't been carefully scrutinized and published yet, cautions John Holahan, director of the Health Policy Center at the Urban Institute, "but it's pretty interesting and important because it suggests that having insurance and improving access to care has an impact on mental health and suicide."

## **Overburdened and Overwhelmed: The Struggles of Communities with High Medical Cost Burdens**

*The Commonwealth Fund publication – 11.28.07 – Full Report at:*

[http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=583414&#doc583414](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=583414&#doc583414)

### Overview

The number of people with potentially high medical cost burdens varies widely across the nation, reflecting differences in the number of people who lack health insurance coverage and people who have coverage but nevertheless have high costs relative to their income. To address this problem, many states are undertaking expansions of insurance coverage, but federal support will be critical, particularly in states with large numbers of low-income residents.

## **FDA's Behind-the-Counter Drug Plan Riles Docs**

*NPR, All Things Considered – 11.26.07*

Listen: <http://www.npr.org/templates/story/story.php?storyId=16630779>

The Food and Drug Administration is considering creating a new category for drugs — a class that would sit on shelves behind the register.

These would be drugs that need to be used carefully but aren't complicated enough to require a prescription. The idea is that pharmacists could help people decide whether these drugs are right for them.

Some doctors are opposed to the plan, saying pharmacists don't have all of the qualifications needed to give out medical advice.

## **U.S. adult obesity rates level off, report says**

*Associated Press – 11.28.07*

ATLANTA — **U.S. adult obesity rates seem to have leveled off**, at least temporarily, the government reported Wednesday. About 33% of adult men and 35% of U.S. women were obese in 2005-2006, according to a comprehensive survey by the federal government that includes physical examinations. That's more than 72 million people, according to the U.S. Centers for Disease Control and Prevention.

The new rates were slightly higher than the 31% and 33% reported in the 2003-2004 survey, the CDC said in a report released Wednesday. However, the increases were not considered statistically significant, health officials said.

The adult obesity rate has generally been climbing since 1980, when it was 15%. There have been occasional plateaus, as occurred between 1999-2000 and 2001-2002.

In the new report, obesity was most common in adults aged 40 to 59. There were large differences by race for women — the female obesity rates in the 40 to 59 age group were 39% in white women, 51% in Mexican-American women and 51% in black women. However, there were no racial or ethnic disparities in the male obesity rates, the CDC said.

The report also found that about a third of obese adults had not been told by a doctor or health care provider that they were overweight, although women heard such an assessment more often than men.

## **Presidential Candidates Discuss Health Care Plans**

*NPR, Morning Edition 11.26.07- Listen: <http://www.npr.org/templates/story/story.php?storyId=16612704>*

Presidential candidates share their health care plans during a forum that focuses on a single but complex issue. The candidates, who participate in the forum at different times, are able to go beyond the usual sound-bite and give their rationale for supporting their positions. (Sound bites from Edwards, McCain,

Biden, Clinton, Kucinich...more to be interviewed. Transcripts of 2008 Presidential Candidate Health Care Proposals: Side-by-Side Summary found at: <http://health08.org/> )

## Just Off Insular Senate Floor, Life of the Uninsured Intrudes

*New York Times*, 11.25.07

Full story: <http://www.nytimes.com/2007/11/25/washington/25health.html?ref=health>

WASHINGTON — When senators debate health care, they usually speak in abstract terms about soaring health costs and the plight of the uninsured.

But just 20 feet from the Senate chamber is a young man who knows those problems all too well from personal experience. The man, Sergio A. Olaya, runs the Capitol elevators on which the senators ride. Whenever the Senate is in session, he is on duty.

Mr. Olaya, 21, is struggling with \$255,000 of medical bills incurred by his mother before she died in April from an aggressive form of brain cancer.

A local hospital and its collection agency have been hounding him in an effort to collect from his mother's estate, Mr. Olaya said. To pay the bills, he is selling the Maryland home where he lived with his mother, Clara Ines Olaya, 61.

His experience highlights the problems of the uninsured, from which members of Congress are usually insulated. The leading Democratic presidential candidates say all Americans should have coverage as good as what Congress has.

As a government employee, Mr. Olaya has health insurance. But his mother, like 47 million other Americans, was uninsured.

"I wonder how many senators have been in the elevator with Sergio, talked to him, shared a smile with him, but had no idea of the terrible burden he and his mother were carrying," said Senator [Richard J. Durbin](#) of Illinois, the Senate Democratic whip, who learned of Mr. Olaya's problems from an aide....

## Health Care: Solutions Without Borders

*The Commonwealth Fund – President's Column by Karen Davis – 11.26.07*

At a time when [most Americans favor an overhaul of the health care system](#), it's important to look closely at what other countries are getting right. A growing number of health care stakeholders, including policymakers and insurance industry officials, are recommending that we look across the Atlantic to explore the health systems in countries that cover all of their citizens.

The Commonwealth Fund's 2007 International Health Policy Survey released in October—our 10th annual international survey—reveals that, while no one health system provides an ideal model, we have much to learn from the other countries. The complete results of the survey of 12,000 adults in Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States were published as a *Health Affairs* Web Exclusive. (Full column at:

[http://www.commonwealthfund.org/aboutus/aboutus\\_show.htm?doc\\_id=597055&#doc597055](http://www.commonwealthfund.org/aboutus/aboutus_show.htm?doc_id=597055&#doc597055)

Comparisons at: [http://www.commonwealthfund.org/usr\\_doc/Int\\_Country\\_Profiles\\_final.pdf?section=4036](http://www.commonwealthfund.org/usr_doc/Int_Country_Profiles_final.pdf?section=4036) )

## Fresh Pain for the Uninsured

**As doctors and hospitals turn to GE, Citigroup, and smaller rivals to finance patient care, the sick pay much more**

*Business Week – 11.21.07 – full story at:*

[http://www.businessweek.com/bwdaily/dnflash/content/nov2007/db20071120\\_397008.htm](http://www.businessweek.com/bwdaily/dnflash/content/nov2007/db20071120_397008.htm)

In a lucrative new form of fiscal alchemy, [a growing number of hospitals, working with a range of financial companies, are squeezing revenue from patients with little or no health insurance](#). April Dial's dealings with Hot Spring County Medical Center in Malvern, Ark., illustrate how [the transformation of medical bills into consumer debt means quicker cash for medical providers but tougher times for many patients of modest means](#).

Dial, a 23-year-old truck-stop waitress who earns \$17,000 a year plus tips, suffers from Type 1 diabetes. Sudden drops in her blood sugar level have sent her to the emergency room four times in the past three years. In September she spent three days at Hot Spring, including two in intensive care, fighting complications from her ailment. The bills came to more than \$14,000. Dial's job offers no health insurance.

Until recently her mother, Carolyn, who waits tables at the same roadside diner, sent Hot Spring \$100 a month under the nonprofit hospital's longstanding zero-interest payment plan. Dial says she couldn't make payments herself because she spends more than \$150 a month for other treatment and insulin.

In October she learned that Hot Spring had transferred her account to a company called CompleteCare, one of the many small firms fueling the little-known medical debt revolution. **Enticed by the enormous potential market of uninsured and poorly insured patients, financial giants such as General Electric (GE), U.S. Bancorp (USB), Capital One (COF), and Citigroup (C) are rapidly expanding in the field or joining the fray for the first time.** CompleteCare informed Dial that under the complicated terms of her newly financed debt, her minimum monthly payment had shot up more than fourfold, to \$455. Dial says she doesn't have anywhere close to that amount left over after rent, food, and other doctor visits: "Every extra dime I have goes to paying medical bills."

Collecting from "self-pay" patients like Dial has long been the bane of medical administrators. When they don't get paid immediately, hospitals typically recover around 10¢ on the dollar owed, even when they hire collection specialists. **So hospitals and clinics are bringing in more sophisticated help. They are transferring patient accounts wholesale to finance experts, banks, credit-card companies, and even private equity firms. Many of these third parties use credit scores and risk-analysis software to price the debt and impose interest rates as high as 27% on past-due bills.**

Among hospitals, nonprofits like Hot Spring County Medical Center are more likely than for-profit rivals to join forces with finance firms. Fewer nonprofits have effective in-house collection departments, and in many regions a higher proportion of patients at nonprofits lack insurance. "Hospitals can't just be an interest-free finance vehicle," says Todd Cole, director of patient accounting at TriHealth, a \$2 billion pair of nonprofit hospitals in Cincinnati. "The world of \$5 sent to the hospital and they will never send me to collections, never sue me—that world has gone away," he adds. TriHealth sells patient accounts at a steep discount to firms that specialize in collecting delinquent consumer debt. "Hospitals need their cash," Cole says. "It is the lifeblood that supports the doctors, the nurses."

## **California may take plunge on universal health care**

*Free Press – 11.25.07*

LOS ANGELES -- About one in five Californians, 6.6 million people, are uninsured -- more than any state. A trendsetting state on issues from cleaning up smog to banning toxic plastics in toys, **California now could become a prime test bed for universal health care.**

The sheer size of California and its volume of uninsured, plus the state's and governor's political clout, could help rev up the momentum for a health-reform discussion at the national level, said Drew Altman, head of the Henry J. Kaiser Family Foundation.

A special legislative session on health-care reform was called in September by Gov. Arnold Schwarzenegger, and negotiations appeared deadlocked for weeks. However, a compromise from Democrats announced Nov. 6 appears to have infused new life into the quest for a deal. The Democrats' proposal was approved last week on a party-line. The stumbling blocks have been who pays and how much.

The Democrats' proposal stops short of requiring all Californians to carry insurance, as it would exempt those who don't qualify for public programs but whose coverage costs would exceed 6.5% of their income. Schwarzenegger wants a mandate for all. Both sides agree that employers must provide insurance or pay into a state trust fund, which would be used to help lower-income workers buy their own policies. Democrats have proposed to assess employers who don't provide insurance on a sliding scale up to 6.5% of payroll, but Schwarzenegger wants to cap an employer's contribution at 4%.

While both sides agree on a 4% tax on hospital revenue to partially subsidize costs of the overhaul, the Democrats propose to make ends meet with a \$2-a-pack cigarette tax. Schwarzenegger, meanwhile, wants to lease the state lottery.

## Health care is destined for overhaul

*Free Press – 11.25.07*

As medical costs soar and 47 million Americans remain uninsured, **the political momentum for national health-care reform appears unstoppable.** Democrats and Republicans are readying for a philosophical battle over how to handle what could prove to be the No. 1 domestic policy issue of the 2008 presidential race.

More than a dozen years after then-first lady Hillary Clinton's health-care initiative collapsed, the Democratic push for universal health care has achieved such critical mass that Republican White House candidates are touting their own reform plans, which rely more on free-market dynamics than expanding government regulation.

An October poll by the nonpartisan Henry J. Kaiser Family Foundation indicated that health care ranks second behind the Iraq war as the public's most pressing issue. Although the public tends to associate health-care reform with Democrats, the fact that GOP contenders have signaled they intend to compete on the issue indicates how the political landscape has changed.

The major Democratic proposals seek to preserve customer choices and would create purchasing co-ops that give small businesses and individuals some of the bargaining leverage enjoyed by large employers. Employers likely would have to provide health coverage or help pay for it, and expanded government programs and subsidies would try to keep their costs in control.

On the Republican side, the major candidates are proposing plans that oppose government-mandated insurance, stress the need for competition and favor tax credits and deductions to help pay for insurance.

"I don't think any of the Republicans are really aiming for universal coverage," said Larry Levitt, a vice president of the Kaiser foundation. "Their goal is deregulation of the insurance market."

## Faster, Cheaper Broadband Internet Coming to Michigan Health Care Providers

*Michigan News Wire – 11.21.07*

LANSING - Governor Jennifer M. Granholm and members of the Michigan congressional delegation announced that **Michigan will receive \$20.9 million over the next three years from the Federal Communications Commission (FCC) to extend high speed broadband internet to 390 public hospitals, primary care clinics, and other health care providers that serve critical populations in rural and tribal areas.** This program will dramatically expand the use of telemedicine throughout the state, which will allow Michiganders in rural areas to stay closer to home when in need of medical treatment.

Michigan was awarded the 4th largest amount of funding nationwide by the FCC as a part of their Rural Health Care Pilot Project. The Michigan Public Health Institute (MPHI) and the Michigan Departments of Community Health and Information Technology submitted Michigan's proposal to the FCC earlier this year.

"This initiative will improve the quality of care in rural areas while saving rural residents substantial travel costs when smaller hospitals and clinics are unable to perform necessary medical services," said Granholm. "This is another step we are taking to ensure that our health care industry uses technology to vastly improve the system, reduce costs, and protect our privacy."

This award will allow Michigan to offer competitive bids to the private sector to extend high speed broadband internet to health care providers in underserved areas of the state. The new network infrastructure will connect existing state health networks to each other and Internet2 at speeds ranging from 1.5 Mbps to 100 Mbps. Funding will first be allocated to increase broadband availability and affordability in rural clinics and small hospitals. Then funding will increase the amount of bandwidth to regional and referral hospitals so they can handle the increase in telehealth traffic. For example, a single MRI can require many megabytes of bandwidth, which is currently not available at these facilities.

**Also as a part of this award, rural health care providers will see their rates for access to high-speed broadband internet reduced to be competitive with the cost in urban areas. The cost for high speed internet in rural areas is typically more expensive than in urban areas.**

Granholm thanked members of the Michigan congressional delegation for their support. "This award is the

result of a bipartisan effort, and I applaud the members of the Michigan congressional delegation for their work to make this happen," said Granholm. "Without the support of Senators Stabenow and Levin, and Representatives Stupak, Dingell, Upton, Miller, Ehlers, Walberg, Kildee, Camp and Hoekstra, this would not be possible."

"As co-chair of the Senate Health Care Quality and Information Technology Caucus, I have fought to make sure doctors and hospitals, regardless of where they are located, have information technology to improve their patients' care," said **Senator Debbie Stabenow**. "Over the years, I have seen the tremendous benefits of telehealth. This funding is an investment in our state's ability to provide high-quality and affordable health care to every region of Michigan."

"This funding will help Michigan provide the high-quality health care services that millions of rural citizens depend on," said **Senator Carl Levin**. "Expanding broadband technology is a win-win situation, bringing rural residents closer to the care they need and helping providers serve their patients more efficiently."

"I commend the FCC for choosing Michigan as one of the awardees for the Rural Health Care Pilot Project, which will provide Michigan with the opportunity to continue to develop and strengthen health information exchange within the state," said **Congressman John Dingell**. "I would also like to acknowledge the leadership of Governor Granholm; because of her hard work and dedication, both Michigan residents and rural health care providers will benefit from reduced healthcare costs and broadband internet rates."

"Already in northern Michigan, we have seen how telemedicine can link rural health care providers together to provide greater health care service," said **Congressman Bart Stupak**. "Thanks to broadband technology, health care practitioners in Ironwood - on the far western end of the Upper Peninsula - can instantaneously benefit from the expertise of their colleagues in Sault Ste. Marie, over 300 miles away. I am pleased that the FCC has approved this funding, which will help bring the benefits of broadband and telemedicine to more rural health care providers in my district and across Michigan."

Michigan was one of the first states in the nation to develop a blueprint outlining a plan that will improve the quality, safety, and efficiency of health care delivery by accelerating the adoption and use of health information technology and health information exchange (HIE). Michigan has been recognized as a national leader in health information technology, and our efforts were highlighted at the National Governors Association meeting in Traverse City earlier this year. The report and more information about MiHIN can be found by going to [www.mihin.org](http://www.mihin.org).

## Medical Industry Shifts Records Online

*NPR, Morning Edition, 11.26.07* – Listen: <http://www.npr.org/templates/story/story.php?storyId=16612715>

**Paper records in hospitals and doctors' offices are starting to be replaced by digital ones.** The items going online range from lab results and daily blood pressure readings to a patient's allergies and the medications taken to treat them.

But privacy advocates warn against the trend. Dr. Peter Gabriel is a primary care physician at the University of Pennsylvania and an expert in using technology in a clinical setting. When he meets patients in the examining room he types his notes directly into the computer. **And he looks forward to the day when patients will put their information online in a secure, personal health record that he can review and add to.** "That's very exciting — the possibility to do things like that," Gabriel said.

Gabriel and other doctors at the University of Pennsylvania can share computerized information about patients they have in common. But, he says, **when patients aren't in that system, getting information about them isn't so easy. A personal health record, or PHR, could help.**

"If one of my patients had a PHR that they updated with information from other doctors that they see, it would help me get access to information I might not get or I could get it more quickly," he said. It could also help in an emergency if you ended up in a hospital that had no medical history or information about you.

Microsoft is one of the companies with a system for creating online health records. Google is working on a system, too. Consumers aren't charged for entering and storing their personal health information.

"We make money on search advertising," explains Sean Nolan of Microsoft. Microsoft gets about 6 billion search queries a month. An estimated 3 percent to 7 percent of those are health-related. Microsoft hopes online health records will drive even more search traffic and allow for more health-related ads.

Online personal health records are still in their infancy. Only a tiny number of individuals have them. Further, the widespread ability to easily share information between doctor and patient is probably years away. Still, it's a system with a future and that has privacy experts worried. Among their concerns: Who would have access to the records and who would control that access?

"The sponsors of these personal health records are largely unregulated," says Joy Pritts, who heads a center for medical privacy at Georgetown University. She urges people to be very careful before putting any health information online and that they read the small print.

"Hardly anyone does that, especially online," she said. "We all just scroll through and click 'I agree.'"

Not all systems put a premium on security and privacy; and worse, some firms may sell the data put online. Hackers could have a field day, and government officials and employers could learn things about you that you didn't intend to share. Privacy rights advocates will be lobbying hard for safeguards as this technology gains ground.

## **Americans Over 50 Have Tough Time Getting Insured**

*Cover the Uninsured, from San Francisco Chronicle, 11.2.107*

Americans between the ages of 50 and 64, "people just shy of Medicare eligibility," have a particularly difficult time getting covered through the individual insurance market due to their advanced age and the likelihood that they have experienced some type of medical problem, reports the *San Francisco Chronicle*.

About 14 percent of people in this age group -- more than 7 million Americans -- were uninsured in 2005, most often due to the loss of employer coverage because of "early retirement, a layoff or other life changes," according to the article. Because insurance companies are free to cherry-pick members and set their own rates, those aged 50 to 64 "are either priced out of insurance or they just can't get it," said Mark Beach of AARP in California.

Some insurers, however, see early retirees as "a potential growth market" and have created products specifically for them. "We're looking for ways to expand our business, and we saw we weren't penetrating this segment of the business as much as we'd like," said Steven DeRaleau of Humana Inc. But older people will have to "pay more for their coverage because they are more likely to need it," reports the *Chronicle*. "You absolutely have higher utilization of the health care system and greater exposure to more conditions at higher ages," DeRaleau said.

## **Romney: Cap Malpractice Awards, Create Health Courts**

*Wall Street Journal Health Blog – 11.21.07 (Posted by Jacob Goldstein )*

Health policy keeps making headlines in the presidential race. This time it's Mitt Romney, who argued yesterday for a cap on malpractice awards.

"I believe we have to enact federal caps on non-economic and punitive damages related to malpractice," Romney said during a speech at an Iowa med school, [according to](#) the AP. "These lottery-sized awards and frivolous lawsuits may enrich the trial lawyers but they put a heavy burden on doctors, hospitals and, of course through defensive medicine, they put a burden on the entire health care system."

He also said he'd encourage states to create health courts with judges who specialize in hearing medical liability cases, an idea that's been around for awhile but never really taken off.

Romney's in a bit of an awkward position on health care. As governor of Massachusetts, he created a health-care plan that requires everyone to buy insurance, and provides subsidies to help lower-income people do so. That's been a model for national plans proposed by Hillary Clinton and John Edwards. But in

his race for the Republican presidential nomination, Romney has [shied away](#) from taking his Massachusetts plan nationwide, instead relying on Republican-friendly tactics like tax incentives and less regulation.

## **UnitedHealth Agrees to Cuomo's Report Card For Doctors**

*Wall Street Journal Health Blog – 11.20.07 (Posted by Theo Francis)*

[Patients just got a step closer to having a national standard for picking good doctors and avoiding the duds.](#)

United Health and two other large insurers, Group Health and Health Insurance Plan of Greater New York, which are both units of EmblemHealth, have agreed to follow New York Attorney General Andrew Cuomo's rules on how to rank doctors. They follow Cigna, Aetna and WellPoint's Empire Blue Cross and Blue Shield.

While many insurers have been developing their own systems to rank doctors, this summer Cuomo complained that their ranking systems could mislead consumers, who might not realize that cost, rather than quality, was driving some of the grades. Whatever their flaws, doctor plans get rave reviews from some consumer groups, who say they can help patients get better care, and keep costs down. In fact, some health plans and employers require patients to go to the higher-ranking doctors, or charge them more for visiting doctors with lower grades.

Not surprisingly, doctors gripe that the health plans have lousy data and have strong incentives to judge them not on quality but on cost, and some in Connecticut and Seattle have sued over the practice.

The agreements with Cuomo's office require the insurers to tell consumers how the ratings are derived, including how cost figures into it. They must also use established national standards to measure quality, allow doctors to appeal, and hire an outside examiner to ensure the plans stick to the rules. GHI and HIP agreed before having designed doc-ranking programs at all.

## **Action on SCHIP Bill Postponed Until December or Later**

*Cover the Uninsured from [CongressDaily](#), 11.16.07*

[With Congress adjourning for the Thanksgiving recess, a deal between Democrats and Republicans on the State Children's Health Insurance Program \(SCHIP\) bill will "have to wait until December," according to lawmakers and their staffs, or possibly next year, reports CongressDaily.](#)

Republicans submitted their "final offer" on Thursday, and Representative Nathan Deal (R-Ga.), a lead negotiator for House Republicans, said "there would be no adjustments to the GOP position," according to the article. "It's probably down to either we go ahead or we don't go ahead," he said. Democratic response to the offer was negative, with one aide describing it as a "disaster" because it "would not cover the requisite 10 million children, which is a deal-breaker," reports *CongressDaily*.

[It is still unclear whether there will be more support for the bill among House Republicans, "which stands at least a dozen votes short of the two-thirds majority needed to override an expected veto by President Bush,"](#) according to the article. Senator Orrin Hatch (R-Utah) said "the chances of reaching a deal will be much smaller in December."

## **Health Coverage Provided by Employers Continues to Decline**

*Cover the Uninsured, from [USA Today](#), 11.12.07*

[Employer-sponsored health insurance "is continuing to shrink,"](#) according to a survey by the Kaiser Family Foundation, leading workers to worry about losing their coverage and "invigorating a debate about whether insurance should be tied to jobs," reports *USA Today*.

According to the survey, ["the percentage of all employers offering health insurance in the past eight years peaked in 2000 at 69% and has fallen steadily since, hitting 60% this year."](#) The percentage is even lower for small businesses employing three to nine people, going from 58 percent in 2001 to 45 percent this year. Furthermore, "the number of uninsured U.S. workers rose by 3.4 million" from 2001 to 2005, with about 19 million workers being uninsured in 2005, or 17 percent of all employees, according to the article.

Not only are fewer employees getting coverage through their jobs, but they are paying more for the coverage they get. The amount a family pays in premiums rose from \$129 per month in 1999 to \$273 this year, which is an increase of 70 percent when adjusted for inflation. According to Len Nichols of New America Foundation, a Washington think tank, "People aren't so afraid of losing their jobs as (of) not being able to afford health insurance even with a good job," reports *USA Today*.

Proposals to reform America's health care system and possibly "sever it from employment" are being offered by everyone, "from presidential candidates to Congress to business groups," according to the article. Some proposals involve tax credits or deductions to help people purchase insurance in the private market and some involve the creation of "exchanges," wherein "groups of residents and employees could buy health insurance, regardless of where or if they work," and insurance companies "would be required to sell policies even to applicants with health problems."

"The nature of work is changing: Jobs are much more short-term and flexible," said Sara Horowitz of the Freelancers Union. "That's why we need to think about new kinds of models...and start building a portable benefits network." But "change is not likely soon," according to *USA Today*, with no "big changes" likely to happen until well after the election in November 2008.

### ***New Republic* Examines Whether Universal Coverage Stifles Innovation**

*Cover the Uninsured from The New Republic, 11.12.07*

Prompted by journalist Michael Kinsley's bout with Parkinson's disease and his treatment with a groundbreaking procedure, Jonathan Cohn of the *New Republic* addresses the question of whether a universal health care system would prevent patients with certain diseases from gaining access to innovative treatments.

The procedure, known as Deep Brain Stimulation (DBS), is costly and does not provide a cure for the disease, but rather is used "to suppress and delay the onset of symptoms," which might not meet the standards of care outlined in a universal system, according to the article. Cohn also suggests that the "huge, largely uncontrolled spending" of the United States "translates into large profits for health care companies, offering an incentive for them to do research and development -- the kind, presumably, that plays a significant role in breakthroughs like DBS."

However, Cohn discovers that DBS was actually developed by a French doctor. In addition, he finds that "The great breakthroughs in the history of medicine, from the development of the polio vaccine to the identification of cancer-killing agents, did not take place because a for-profit company saw an opportunity and invested heavily in research. They happened because of scientists toiling in academic settings." He notes that the "single biggest source of medical research funding" in the world is the National Institutes of Health (NIH), which is funded by the federal government and "is probably the primary explanation for why so many of the intellectual breakthroughs in medical science happen here."

Cohn concludes that as long as a universal health care system is properly implemented, with things such as "independent advisory boards, staffed by leading medical experts, to help decide whether proposed new treatments actually provide clinical value," medical innovation need not be compromised. He points out that DBS is actually covered in nearly every European country, and in the United States, Medicare covers it for the elderly. He writes: "You don't have to choose between universal access and innovation. It's possible to have both--as long as you do it right."

### **Richardson: Abolish Health-Savings Accounts**

*Wall Street Journal Health Blog – 11.19.07 (Posted by Jacob Goldstein)*

Bill Richardson would get rid of health-savings accounts, the tax-advantaged savings plans that go with high-deductible health insurance. "These are a step backward," he said at a health-care forum today. "They put working families at risk. Most families cannot afford to pay the ... out of pocket costs."

The accounts are popular with some health wonks, who think they'll turn people into more careful health-care shoppers. But, as the Health Blog has [noted](#), regular people don't seem so eager to sign up. Rudy Giuliani and Mitt Romney are both fans of the plans, as is President Bush, but the plans haven't figured prominently in the policy proposals from Democratic candidates.

Richardson, who has a day job as governor of New Mexico, also said he'd give people aged 55-64 the option of buying into Medicare — an idea that has appeared in similar form in the plans of some other candidates. But, a journalist asked, wouldn't that lead to frail people who couldn't get coverage elsewhere signing up for Medicare and driving up costs?

"Yeah, well what's wrong with that?" Richardson said. "There's 14 million human beings who are excluded [from coverage] because of a pre-existing condition, or they can only get limited coverage. That is gonna cost more but I think it's the right thing to do."

He said he'd pay for the higher costs of his plan (over \$100 billion a year) in a number of ways, including letting certain Bush tax cuts expire and allowing the government to negotiate lower prices on drugs purchased through Medicare.

The forum was the latest in a series organized by the Federation of American Hospitals and Families USA and hosted by the Kaiser Family Foundation.

## **Employer health costs are on rise, but workers are paying more, too**

*Free Press – 11.19.07*

Health expenses for employers climbed again this year in metro Detroit and across the state, but the rates were lower than the national average, in part because employees are paying for more of their health care.

The rate of increase for employer health spending in metro Detroit was 3.1%, compared with 4.5% statewide and 5.1% nationally, according to a yearly survey expected to be released today by Mercer. That's the third year of relatively stable increases, compared with a 15% increase in 2002 in the United States.

Detroit-area employers spent \$8,434 in 2007 for every active employee's health benefits, compared with \$8,730 per employee statewide and \$8,220 nationwide, the study found.

Next year, health spending is expected to rise 3.4% in metro Detroit, 4.3% statewide and 5.9% nationwide. A key reason for the slowdown in health spending is that employers are handing off more health costs to employees, the Mercer study found.

The average Detroit-area employee paid \$71 a month for benefits through a Preferred Provider Organization plan, or PPO. The average employee contribution to a PPO in the rest of Michigan was \$73 a month, compared with \$89 a month nationwide.

A PPO is the most common health plan arrangement in the workplace. Throughout the United States, 60% of the workforce is enrolled in one. PPO membership is even higher locally, accounting for 70% of Detroit-area employer health plans and 72% for the state.

Other findings:

- Employers, particularly those with fewer than 200 employees, continued to drop health benefits. Only 61% are offering benefits this year, down from 69% in 2001.
- More than one-third of employers provide benefits for same-sex partners.
- Ten percent of companies, up from 8% in 2006, are limiting benefits to spouses with other health coverage.
- Smokers are paying higher premiums at large companies.
- Only 38% of employers in wholesale and retail industries offer health benefits to part-timers.

**Mercer will make available a fuller report in March to companies ordering the \$500 study. It includes breakdowns by industry, company size and region.**

## **Vaccines or Jail & Cost of Coverage**

Wall Street Journal Health Blog – 11.19.07 (Posted by Jacob Goldstein)

The Health Blog looked for stories you might have missed this weekend. Here's our short list.

**Parents faced jail time** if their children didn't receive mandatory vaccinations or get an exemption, a Maryland judge said. So more than 100 kids and parents lined up outside a Maryland courthouse Saturday

morning to work things out. More than 70 kids received their shots at the courthouse, [according to](#) the AP. Other parents, miffed at spending Saturday morning on the courthouse steps, said their kids had already been vaccinated but the school district had messed up on the paperwork.

**Massachusetts's health-insurance plan may cost more** than expected, the Boston Globe [reports](#). As part of its health plan, the state offers subsidized care to individuals making less than 300 percent of the poverty level, which is about \$31,000 for an individual. The state planned to sign up about 136,000 people for subsidized coverage by June 30, 2008. But 133,000 have already signed up, and an additional 40,000 could sign up by the end of June. The program may wind up costing \$619 million, but the state only budgeted \$472 million.

## **CBO Ramps Up Campaign to Target Rising Health Costs**

*The Commonwealth Fund newsletter – 11.13.07*

Relying on a new method of analysis, the Congressional Budget Office (CBO) estimated Tuesday that federal spending on Medicare 75 years from now will be 50 percent higher than previously projected in an already grim forecast released in April by Medicare Trustees. Without changes in current law, federal spending on Medicare and Medicaid combined will balloon to 19 percent of the Gross Domestic Product by 2082, up from 4 percent now, the CBO report added. **Total U.S. health care spending will rise to 49 percent of GDP, compared with 16 percent now.**

CBO Director Peter Orszag cautioned that media coverage of unsustainable health care spending growth focuses policy makers too much on the aging of the U.S. population. Instead, it should illuminate **a more fundamental cause: rising per capita health care expenses for Americans in general that too often go toward paying for unproven treatments.**

"The nature of our long-term fiscal problems has largely been misdiagnosed," Orszag said. "It is often referred to or described as being caused mostly by the coming retirement of the baby boomers and the aging of the population. That fact that the population is getting older does affect the federal budget and is a factor in our overall long term fiscal problems. But it is not by any means the main factor." **By far the main factor is the rate of cost growth per beneficiary, not the number of beneficiaries, he said.** "The first step is to get the long-term fiscal picture right, and not emphasize aging so much," Orszag told health reporters.

The report specifically identifies "excess cost growth" as the main culprit, defining that term as "the extent to which the increase in health care spending for an average individual exceeds the growth in per capita gross domestic product." Too little attention has been paid to what could bend the excess cost growth curve downward, he said. Excess cost growth accounts for about 90 percent of the projected growth in federal Medicare and Medicaid spending by 2082 and the aging population by only 10 percent. Aging accounts for higher proportions of spending growth in the shorter term, however—around 20 percent in 2050 and about 25 percent through 2030.

It's not news that long-term Medicare and Medicaid spending growth is unsustainable, but CBO's grimmer numbers are likely to call greater attention to the issue. **Senate Finance Committee Chairman Max Baucus, D-Mont., issued a statement Tuesday saying he will announce in January an extensive series of hearings on health care costs and a health system overhaul. "Finding ways to make the health care system more efficient and cost-effective will reduce costs for all health care users, public and private, and that will pave the way toward getting federal spending truly under control," Baucus said. "The Finance Committee will dedicate a great amount of time next year toward finding real solutions."**

Orszag is ramping up CBO efforts to help lawmakers do that. **Starting in December, CBO will start releasing long-term budget projections every year, rather than every two years, and health spending will be a component of those estimates,** Orszag said. Tuesday's report represents the health care portion of the December analysis. In coming months, CBO will release a series of reports evaluating "levers and options" for controlling cost growth, Orszag said.

## **Medicaid Issue Is Latest Sticking Point on Children's Health Bill**

*The Commonwealth Fund newsletter – 11.16.07*

**A dispute over Medicaid eligibility is now the major sticking point in negotiations on children's health legislation, two Republican senators said Friday.**

One of them, Orrin G. Hatch of Utah, said the Medicaid flap threatens to "blow up the bill"—a bipartisan measure that is intended to renew and expand the State Children's Health Insurance Program (SCHIP).

SCHIP covers about 6 million children whose families are low-income but not poor enough to qualify for Medicaid, the larger state-federal health care entitlement program for the poor. A bipartisan group of lawmakers from the House and Senate has been talking for about two weeks about changes to a bill (HR 3963) that would expand SCHIP by \$35 billion over five years, to \$60 billion — changes that might garner enough House Republican votes to overcome a promised presidential veto.

Lawmakers have not previously mentioned Medicaid as an issue in the talks, much less a major point of contention. But SCHIP and Medicaid are closely related. Efforts to find and enroll children in SCHIP often result in increased Medicaid enrollment, and some states operate the two as a single program.

On Thursday, House Republicans delivered a proposal to Senate Finance Chairman Max Baucus, D-Mont., and Sen. Charles E. Grassley of Iowa, the senior Republican on Baucus' committee, asking that the bill cap eligibility for Medicaid at three times the poverty level, or about \$62,000 for a family of three.

Hatch and Grassley said that Democrats have balked at that request. "They say this is a SCHIP bill, not a Medicaid bill," Grassley said. A spokeswoman for Baucus declined to comment.

"It's most assuredly one of the most significant issues," a House Republican leadership aide said.

The House Republicans also want to prohibit states from ignoring some kinds of expenses, such as rent and transportation, when calculating eligibility for SCHIP or Medicaid—a change from current law. Democrats say those proposals would cause states to drop children from Medicaid.

"Democrats feel that the proposals put forward by Republicans would undermine Medicaid and walk away from the bipartisan goal of covering 10 million kids," a House Democratic leadership aide said.

States are allowed wide latitude to set eligibility in both programs. The government requires states to provide Medicaid coverage to children under age 6 from families earning 133 percent of the federal poverty level or less, and to older children in families at or below the poverty level. There is no cap on eligibility for Medicaid, though few states are willing to go much above the federally mandated minimums because the federal government covers as little as half the cost. The exact federal share varies from state to state.

The government covers up to 85 percent of the costs of SCHIP, according to the Congressional Budget Office, as an incentive for states to enroll people in the program. Eligibility for SCHIP is also uncapped, although states must seek permission from the federal government to extend coverage to families above 200 percent of poverty or more than 50 percentage points above their Medicaid eligibility limits, whichever is higher.

In the SCHIP legislation, lawmakers have agreed to cap SCHIP eligibility at three times the poverty level. Only one state, New Jersey, allows people from families making more than that to enroll in SCHIP. No state has expanded Medicaid eligibility above 300 percent of poverty.

Grassley said he does not believe Democrats are trying to leave the door open for Medicaid expansions above 300 percent of poverty. He said he does not understand why they object to writing a limit into law. "They say they don't want to [go above that level], and I believe them that don't want to," he said. "But they're not willing to put language into the bill that the House Republicans want that would guarantee that."

Grassley added, "It seems to me we all agree on the policy; why can't we write it?"

Hatch said he thinks the issue is the most significant remaining obstacle to a deal. "I think we can get it done if Democrats will not try to expand Medicaid above the 300 percent solid cap," he said. "If not, that will blow up the bill."

## **The Commonwealth Fund/Modern Healthcare Opinion Leaders Survey: Transparency of Health Care Quality and Price Information in the United States**

*The Commonwealth Fund – 11.19.07*

Report at: [http://www.commonwealthfund.org/surveys/surveys\\_show.htm?doc\\_id=590289](http://www.commonwealthfund.org/surveys/surveys_show.htm?doc_id=590289)

The 12th Commonwealth Fund/*Modern Healthcare* Health Care Opinion Leaders Survey found that increased transparency in the quality and price of health care is important, according to a diverse group of experts. **More than 80 percent of health care opinion leaders called for transparency on prescription drug prices and medical loss ratios (i.e., the share of premium dollars that private insurance companies spend on medical care).** Most respondents believe increased transparency would reduce health care spending, **primarily by stimulating providers to improve quality and efficiency and by allowing payers to reward such efforts.** Favored policy strategies for improvement of health care transparency include the creation of a new public-private entity to standardize and implement transparency in health care; widespread adoption of health information technology; shared responsibility for funding across government, insurers, and providers; and federal leadership to create a meaningful system of public reporting on quality and price.

Read an analysis of the findings in a [Data Brief](#), as well as two related commentaries, [A Historic Change](#) by Robert Galvin, M.D., director of global health care for General Electric, and [Patients Can't Do It Alone](#) by Paul Ginsburg, Ph.D., president of the Center for Studying Health System Change.

## Roadblocks to Health Care Thwart Insured

*Wall Street Journal Health Blog 11.15.07 (Posted by Joe Mantone)*

The uninsured may be a hot policy topic, but the personal toll that gaps in coverage take on those with insurance is often overlooked, John Carreyrou reports in a WSJ Page One story.

Take the case of Barbara Calder, who suffers from Ehlers-Danlos Syndrome, a rare genetic disorder that causes her joints to dislocate. Calder, who had been insured through her husband's plan, spent months **battling numerous roadblocks in order to get a diagnosis and treatment.**

When trying to see a specialist, she was told she needed a referral. When her husband got a new job, she was told he was in midst of a coverage gap. When a doctor prescribed a painkiller, her plan wouldn't cover the drug until she tried others first.

**"They put up roadblocks or hoops and you jump through them all," Calder says in a video that accompanies the story. "It's like a big game to see who will get frustrated first and who's going to win."**

## Hospitals Better on Quality, But Don't Ace Tests Yet

*Wall Street Journal Health Blog 11.15.07 (Posted by Theo Francis)*

More patients are getting the right treatment more often at hospitals. But, even so, hospitals could do a better job.

The Joint Commission – or as the Health Blog thinks of it, the organization formerly known as the Joint Commission on Accreditation of Healthcare Organizations — recently released its latest examination of hospital quality and safety, and calls the results encouraging.

The analysis shows that, overall, more patients got treated in line with certain accepted standards. Specifically, there's better uptake for a host of practices that have been shown to improve outcomes, primarily for heart-attack, heart disease and pneumonia. (See the [full results](#).) The JC's soon-to-retire president, Dennis O'Leary, says, "The improvements achieved have saved lives and resulted in better quality of life for thousands of patients."

But, broadly speaking, hospitals had a hard time getting things right consistently. The real measure of success is when a hospital can do the right thing nine times out of 10. We used to call that an "A". On that basis, 90% of hospitals consistently gave patients the right treatment on just four of 22 separate performance measures: measuring oxygen in the blood of pneumonia patients, advising heart attack patients to stop smoking and giving heart attack patients aspirin at arrival and on discharge.

Meantime, for 11 of those 22 performance measures, hospitals failed to hit the 90% target. Just 14.8% of hospitals manage to give pneumonia patients antibiotics within four hours of arrival nine out of the 10 times the treatment was indicated. Barely more than a third of hospitals consistently prescribe ACE inhibitors to

heart-failure patients, and less than half of hospitals do so for heart-attack patients. Just one hospital in five managed to discontinue antibiotics within 24 or 48 hours after surgery, as indicated.

As a group, the JC reports, performance is more consistent on the measures that have been in place for 2002 — and worse on those that have only been around since 2005. The pattern may underscore one mantra of medical quality-improvement — what isn't measured doesn't improve — but it also raises the question of whether the results speak to quality of care beyond the handful of measures that get graded.

## **Ford retirees must choose health plans**

*Free Press – 11.15.07*

After years of getting generous health insurance benefits, 40,000 Ford Motor Co. management retirees -- including about 22,000 in Michigan -- are to begin signing up today for Medicare plans in an all-out battle by insurers to challenge the longtime stronghold of Blue Cross Blue Shield of Michigan.

The benefit changes to what is called a **Health Reimbursement Arrangement** are to take effect Jan. 1. Retired Ford managers or their surviving spouses have until Dec. 31 to sign up for a Medicare plan. Each retiree gets \$1,800, and a spouse or same-sex domestic partner gets the same amount, to pay for a year of medical, dental, prescription, vision and other health costs.

ExtendHealth, a San Francisco benefits management company hired by Ford to help retirees choose new plans, gets as many as 3,000 calls for help a day, said Brian Tenner, senior vice president. Some retirees find that selecting new coverage from hundreds of options is overwhelming. Even highly educated, Web-savvy retirees say the task can be daunting.

"ExtendHealth estimates "the average Ford couple will save \$400 to \$500 a year," Tenner said, by purchasing targeted Medicare plans, compared with what they spent on premiums and co-pays this year. To get those kinds of savings, retirees have to study and compare notes. Several insurers, particularly Health Alliance Plan of Detroit and Humana Inc. of Louisville, Ky., see the Ford retiree pool as a big opportunity to pick up business from Blue Cross, the state's largest insurer, with 4.6 million members.

HAP has held nearly 200 community seminars for Ford retirees and plans up to 100 more. HAP and its Alliance Health and Life Insurance Co. subsidiary have 540,000 members, including 40,000 with Medicare coverage. HAP started in 1998, but 2008 is the first year it will offer a Part D, or prescription-only, Medicare plan. Humana, with 40,000 Michigan members when it began business in the state in 2004, now has 171,000 members, including 122,000 Medicare recipients. Its Part D prescription drug plan is Michigan's largest, covering about 1 in 5 people, Medicare statistics show. Blue Cross has held 20 seminars, mostly since Oct. 1, attracting 4,500 Ford retirees, said spokeswoman Helen Stojic.

## **Michigan's Oct. jobless rate hits 7.7%**

*Free Press – 11.15.07*

Bad news on the automotive front pushed Michigan's October unemployment rate up to 7.7%. **The jobless rate is the state's highest in 15 years**, two-tenths of a percentage point higher than September's rate, and it almost certainly guarantees that Michigan will continue to post the worst state unemployment rate in the nation.

"The October unemployment rate increase reflects short-term layoffs in the auto industry," said Rick Waclawek, director of the state's Department of Labor and Economic Growth's Bureau of Labor Market Information and Strategic Initiatives. "October layoffs in the auto sector were associated with reduced production schedules."

The national jobless rate in October was unchanged over the month at 4.7%.

Since October 2006, about 75,000 Michiganders have dropped out of the workforce, the state reported. "Those are really big numbers," said Ilhan Geckil, senior economist at the Anderson Economic Group consulting firm in East Lansing. "These show some people decided to stop looking for a job or left the state. This is a very bad signal for the economy. We really need to do more for job creation."

## **Widening Gaps in Health Insurance Coverage in the United States: The Need for Universal Coverage**

*Congressional Testimony by Sara R. Collins of The Commonwealth Fund – 11.14.07  
(Collins directs the Fund's Future of Health Insurance program.)*

Thank you, Mr. Chairman, for this invitation to testify on the impact of gaps in health coverage on income security. As rising health care costs and premiums are making it more difficult for many employers, particularly small firms, to provide affordable health insurance to their workers, increasing numbers of people under age 65 are finding themselves without access to employer-based coverage and ineligible for enrollment in public insurance programs. The number of uninsured people climbed to 47 million in 2006, and an estimated 16 million adults are inadequately insured. **Health insurance coverage is the most important determinant of access to health care. People who lack coverage have fundamentally different life experiences than those who have it; many die prematurely, and many suffer lost productivity and earnings.**

With so many people left outside the health care system, it is no wonder that the U.S. system performs poorly compared with systems in industrialized nations that have universal health insurance. It is critical on moral and economic grounds that the nation move affirmatively to guarantee affordable, comprehensive and continuous health insurance for everyone....

Full testimony at:

[http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=583404&#doc583404](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=583404&#doc583404)

## **Employers, Insurers Consider Overseas Health Care**

*NPR, All Things Considered – 11.14.07 Listen:*

<http://www.npr.org/templates/story/story.php?storyId=16294182>

Maybe you're going to have surgery, a serious but routine procedure like hip replacement, cataract removal, a heart bypass.

Would you prefer to have it done at your local hospital or at one in Singapore, Thailand or Costa Rica? That's a choice Americans are increasingly being asked to make.

"Medical tourism" — traveling overseas for medical care — was first embraced by consumers. But **it's now also being looked at by employers and health insurance companies.**

## **A High Performance Health System for the United States: An Ambitious Agenda for the Next President**

*The Commonwealth Fund report – 11.15.07*

*Executive Summary at:*

[http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=584834&#doc584834](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=584834&#doc584834)

### **Overview**

In this report, the Commonwealth Fund Commission on a High Performance Health System presents its views on what it would take for the U.S. to reach, and raise, benchmark levels of health system performance. The Commission commends the emphasis many presidential candidates place on extending health insurance to all and improving health care quality and efficiency. The Commission believes the U.S. must pursue a strategy of covering the uninsured while simultaneously improving quality and efficiency. It recommends five strategies: 1) **extending comprehensive, affordable, and seamless insurance coverage to all;** 2) **aligning incentives to reward high-quality, efficient care;** 3) **organizing the health system to achieve accountable, coordinated care;** 4) **investing in public reporting, evidence-based medicine, and the infrastructure necessary to deliver the best care;** and 5) **exploring creation of a national entity that set aims for health system performance and priorities for improvement, monitors performance, and recommend practices and policies.**

## **Wisconsin to Provide Affordable Coverage to All Kids, Regardless of Income**

*Cover the Uninsured, from Milwaukee Journal Sentinel. - 11.7.07*

Democratic Governor Jim Doyle of Wisconsin announced Wednesday "a sweeping restructuring of state health programs" that will take effect February 1, 2009 and will allow all parents, no matter their income level, to buy affordable coverage for their children, reports the *Milwaukee Journal Sentinel*.

The plan, **BadgerCare Plus**, would allow families with children who do not qualify for existing state programs to buy insurance. The cost will range from \$10 to \$68.53 a month and will depend on the family's income. The program will be paid for through "streamlining state programs; expanding the use of health maintenance organizations; and the premiums and co-pays paid by families," according to the article.

While "Wisconsin has one of the lowest rates of uninsured children in the country," it still had about 71,000 uninsured children in 2006, up from 63,000 in 2005. Because almost half of all uninsured children are eligible for state programs but not enrolled, the initiative will try to make it easier for families to enroll by doing things such as providing temporary insurance cards to children while their applications are being completed and only requiring families to report "significant changes in their income," reports the *Journal Sentinel*.

According to Bobby Peterson, an attorney for ABC for Health, a nonprofit law firm, "BadgerCare Plus is a move in the right direction." But he acknowledges that "implementation and execution are going to be critical." Emphasizing that the state will have to work to get kids enrolled and make sure they stay enrolled, Peterson said: "Let's not kid ourselves--it's still a complicated program," reports the *Journal Sentinel*.

### **OPINION: Successful Health Care Reform Requires Learning From Past**

*Cover the Uninsured, from [Los Angeles Times](#), 11.06.07*

A *Los Angeles Times* op-ed by Henry Aaron of the Brookings Institution argues that the United States has seemed on the brink of major health care reform many times in the past, but the same barriers keep standing in the way of success.

Aaron writes that "solid and stubborn minorities" believe their solution--whether it is "a nationally administered system" or providing tax incentives to individuals to buy insurance--is the best and only acceptable course of action, meaning that "doing nothing wins." Another problem, he says, is that the 85 percent of Americans who have insurance "fear change" and "regard any plan that threatens their current arrangements with suspicion."

Other issues addressed by Aaron include that some insurers, hospitals and doctors will block any reform that would threaten their finances; America's political system does not allow "action on large and controversial matters on which there is not overwhelming agreement"; and the health care situation varies from state to state, "making consensus hard to come by." He concludes by saying that **rather than health care reform coming from "a single bill that transforms a \$2.5-trillion industry," change is more likely to come about "from repeated legislation of modest scope enacted over many years" and from "state reforms already in the planning stages."**