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## Access to Health Care News Update – 12.12.07

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

### Blue Cross urged to use its surplus

*Free Press – 12.12.07*

LANSING — A former Michigan insurance commissioner Tuesday testified that Blue Cross Blue Shield of Michigan should use \$30 million of its \$2.8 billion surplus to offset planned rate hikes and make its insurance more affordable to the growing number of state residents who need it.

Nancy Baerwaldt, commissioner of the Michigan Office for Financial and Insurance Services from 1980 to 1985 testified at a consumer rate hike challenge here that Michigan's dismal economy necessitates the unprecedented action of using surplus funds to avoid a proposed average rate hike of 24% for some 19,000 people with seven individual Blue Cross policies. The proposed rate hike doesn't affect some 33,000 other Michiganders in five of the insurer's most basic or best value policies that require the largest out-of-pocket expenses.

Baerwaldt called Blue Cross individual policy holders as "the heart and soul" of the insurer that best underscore why the state Legislature in 1939 created Blue Cross as a non-profit charitable and benevolent organization that would provide affordable insurance to all applicants. Blue Cross' request to raise rates, spelled out in a thick binder, is notably absent of references to this social mission, she said, calling Blue Cross' reserve fund excessive.

But Robert Kasperek, Blue Cross deputy general counsel, challenged Baerwaldt, saying that 13 insurance commissioners who have held the same job since her never required Blue Cross to use its reserve funds to offset rate hikes. Blue Cross would continue to incur higher losses—beyond \$52 million it has lost on these policies in the last 10 years — if it held down rates. It also would likely get droves of sicker, elderly people that in turn would cause greater losses to Blue Cross because they require more medical care. Baerwaldt, in rebuttal, said that using surplus money to offset rate hikes likely would add sicker, older people, but also might draw younger subscribers who would help stabilize otherwise money-losing policies.

Earlier the attorney for Ron and Ghada Abraham, a Livonia couple challenging the rate hike for Blue Cross individual policyholders, drilled down to find out if the company's \$1.2 billion in annual administrative expenses is excessive. Northville attorney Joe Aoun, a health care attorney who represents many hospitals, doctors and commercial insurers, argued that all Blue Cross customers pay for a "bloated administrative expense," including generous compensation for executives.

In a series of questions to Blue Cross' top accounting and rate-setting executives, Aoun attempted to determine if spending for lobbyists, entertainment tickets and advertising are considered administrative expenses and, if so, how is that cost paid for by individuals and corporations with Blue Cross policies.

In response, Margaret Myszkowski, director of management accounting, said \$4.2 million in salary and compensation paid to former Blue Cross chief executive officer Richard Whitmer in 2006 was paid by all lines of business. Myszkowski also testified that salaries and benefits are the biggest part of the \$1.2 billion Blue Cross will spend in 2007 on administrative costs. But she could not answer for certain whether lobbying

and advertising costs are part of administrative expenses, or if payment of those costs is distributed as a portion of the amount of claims each line of business generates.

Administrative costs are expected to grow to no more than 5% this year, from an average rate of increase of 2.6% from 2004-2006, she said. These costs are reasonable and considered low when compared to other insurers, Blue Cross executives say.

A statement released to the Free Press late Tuesday by Blue Cross spokeswoman Helen Stojic clarified that Blue Cross does not charge non-group policy holders for advertising and lobbying expenses. She described the surplus as an emergency fund that provides only 1.7 months of money, about \$523 per member.

In testimony Tuesday, John Dunn, corporate actuary for Blue Cross, said a mathematical formula the insurer used to set guidelines for whether its surplus fund falls within legal limits overestimated losses by \$777,113 in its rate hike proposal, but that the amount was less than 1% of the amount Blue Cross is seeking in its rate hike. Subsequent changes are lowering the surplus this year, he said. Dunn acknowledged that some Blue Cross business is subsidized. Individual policy holders, like other Blue Cross customers, are assessed a 1% charge to pay a \$110 million subsidy to offset Blue Cross Medigap policies for senior citizens and another \$26 million to offset losses for people with so-called group conversion policies, he said. Those are people who once had workplace Blue Cross coverage.

Ron Abraham, 42, a self-employed contractor, also testified Tuesday, saying he "wasn't looking for attention" but filed the rate hike challenge as a matter of principle. "Blue Cross is a money-making machine," he testified. "I'm probably the only person in this room paying for his own health care. I just paid \$200 for a prescription," he said, a reference to his plan that mostly pays for catastrophic coverage, but no pharmacy or routine medical care. "When you think of a non-profit charity you think of a headquarters with '70s shag carpet with wallpaper coming down, held up with duct tape," he said. Instead, he found Blue Cross' corporate headquarters in Detroit more suitable to a corporate giant.

The Abraham's monthly premiums would be increased from \$458.79 a month to \$568.63 a month, or \$6,623.56 a year, if Blue Cross makes the case for increased rates. If the Abrahams win, consumers in the seven individual plans that are affected would get refunds.

Administrative law judge David Lick will make his decision after the hearing, which is expected to end Friday. The final decision will be made by the director of Michigan's Office of Financial and Insurance Services, currently headed by interim director Ken Ross. A hearing in 1997 took nearly two years to finalize.

Contact by telephone about comments at the hearing, both Richard Murdock, executive director of the Michigan Association of Health Plans, a Lansing organization representing HMOs, and Debbie Lantz-Talpos, head of Michigan markets for Aetna, said insurers each use different standards to assess what is included as an administrative cost. "One of the difficulties of trying to compare administrative fees across health benefit companies is that often it is not an apples-to-apples comparison," Murdock said.

## **OPINION: It's time for a checkup for the Blues**

*Free Press – 12.12.07*

There's no minimizing the impact of Blue Cross Blue Shield of Michigan on health care in this state. With 4.6 million members and covering 70% of the state population that has health insurance, the Blues are so big that whatever changes for them changes the health care landscape. All of Michigan also has an interest in the Blues being healthy.

So it was disappointing that the state House took such a minimalist approach to major legislation affecting the Blues in October. The four bills were the subject of a single two-hour hearing before lopsided floor votes sent them to the Senate. Embroiled at the time in overdue tax and budget matters, Speaker Andy Dillon, D-Redford Township, concedes the Blues bills did not get the attention they deserved in the House. In the Senate, Health Policy Committee Chairman Sen. Tom George, R-Kalamazoo and a physician, is promising a more thorough examination in the context of health care statewide. His hearing schedule remains uncertain, and no action is likely before next month at the earliest.

George appears determined to be suitably deliberative, although the Blues -- with a political action committee that has given money this year to nearly 90% of the Legislature -- are applying pressure and CEO Daniel Loepp says the insurer will be in a "death spiral" if the bills don't pass. That kind of ultimatum is not conducive to the process needed for such significant legislation.

Besides, nobody at the state level is going to let the Blues go under and if that happened, the inclination would be to blame Loewen, whose operation is sitting on \$2.84 billion in reserves. The rhetoric is similar from other insurers, who say the Blues bills, as passed by the House, will force them to curtail coverage or even get out of Michigan, leaving thousands of consumers at the mercy of the big, bad Blues.

In a nutshell, the bills would let the Blues end their one-size price system for individual subscribers in favor of a 10-tier rate system -- using age, health history, county of residence and other factors, much the way private insurers do. The Blues say they now lose more than \$100 million a year in health care payouts for individual subscribers.

The coverage rates would be monitored by the state insurance commissioner, but not subject to advance approval, as they are now. This seems like a bad idea, considering the Blues' tax-exempt status. If they expect to be treated more like a commercial company, maybe it's time to become one. As it stands, the state has more than a monitoring stake in what the Blues do to their subscribers.

Also, the Blues are in the middle of a request to raise rates by 24% for individual coverage. Their timing is not coincidental, with the individual market expected to grow as more employers drop coverage or opt out of group plans in favor of stipends for employees to buy their own insurance.

Other aspects of the legislation would enable the Blues to more broadly diversify their for-profit arms, including the Accident Fund, which sells workers' compensation insurance.

Assuming the Legislature is up to the debate that ought to come, the Blues bills offer an avenue to see what the state and the Blues can really do to a) hold down health care costs; b) reduce the number of uninsured people in Michigan, now estimated at more than one million, and c) keep the Blues healthy and measuring up to their benevolent mission.

The extent to which the Blues can convince the Senate they are doing all they can on costs and access should be a factor in determining how much of what they want, they really deserve.

## Slowing Hospitals' Revolving Door

*Wall Street Journal Health Blog – 12.12.07 (Posted by Joe Mantone)*

A few hospitals are striving for health care's Holy Grail, reducing costs while improving care by keeping chronically ill patients from being re-admitted after treatment.

These programs aim to lower readmissions to hospitals by doing such things as: identifying patients at risk for return, scheduling follow-ups, checking on patients at home and educating patients and families on how adhere to medication requirements, WSJ's Laura Landro [reports](#).

Close to one-fifth of Medicare patients are readmitted to hospitals within 30 days of discharge, accounting for \$15 billion in spending, according to the Medicare Payment Advisory Commission. But beyond money, readmissions can also be a mental strain on patients and their families.

"We have to start paying attention to people's needs beyond the hospital door," says Mary Naylor, a professor at the University of Pennsylvania's School of Nursing. She adds: "The experience of multiple hospitalizations can take a devastating toll on the human psyche and the quality of life for patients and their caregivers."

Naylor has developed a transitional-care model, but traditionally, hospitals haven't coordinated these types of services because they don't get paid for them. For one thing, the very success of these programs can cut into hospital revenues and profits as they reduce admissions.

However, insurer Aetna and managed-care giant Kaiser Permanente are using Naylor's model to develop pilot programs. Randall Krakauer, an Aetna medical director, says if pilots in Chicago and Philadelphia succeed in reducing readmissions for Medicare members, such programs could be rolled out more broadly. "We believe this can improve the quality of care for members and more than pay for itself by reducing the costs of care by a larger amount than the cost of the home visits," Krakauer says.

## **A Fifth of Americans Are Going Without Needed Health Care**

*Cover the Uninsured, from Washington Post, 12.3.07*

A report from the Centers for Disease Control and Prevention (CDC) shows that 20 percent of Americans or 40 million adults--many of whom have insurance--could not afford services such as medical care, prescription medicines, mental health care, dental care and eyeglasses, reports the *Washington Post*.

"People tend to equate access to care with insurance," said Amy Bernstein, chief of the analytic studies branch at the CDC's National Center for Health Statistics and the author of the report. "But access to care is more than insurance." Other barriers to health care include places without an adequate number of doctors, lack of transportation to providers and shortages of organs for transplants, according to the article. Still, lack of insurance remains a major barrier to accessing care. "We have a lot of evidence that people who don't have health insurance are much less likely to receive services than people who do," said Bernstein. "Health insurance is critical."

In 2005, 10 percent of adults were unable to afford prescription drugs and 10 percent postponed getting needed medical care, reports the Post. However, according to CDC Director Julie Gerberding, "There has been important progress made in many areas of health, such as increased life expectancy, and decreases in deaths from leading killers such as heart disease and cancer. But this report shows that access to health care is still an issue where we need improvement."

## **Physician Group Backs Single-Payer System**

*Cover the Uninsured, from Philadelphia Inquirer, 12.4.07*

The American College of Physicians (ACP), the second-largest physician group in the nation, has endorsed a single-payer health care system in order to achieve universal coverage but also suggested that expanding the current system could yield similar results, reports the *Philadelphia Inquirer*.

"After analyzing health care in the United States and 12 other industrialized countries, the group concluded that universal coverage had been successfully achieved elsewhere through single-payer and pluralistic systems," according to the article. The ACP said that simply reforming the current system "leads to higher administrative costs and inequalities" but will be "less of a political challenge," while going with a single-payer system will result in lower administrative costs but will be less "politically popular." The country's largest doctor group, the American Medical Association, does not endorse a single-payer system, instead proposing the use of tax incentives and insurance regulation changes to expand coverage.

According to Thomas E. Getzen, a professor of insurance and health management at Temple University, doctors, particularly specialists, have resisted a single-payer system "for fear it would give the government more control over them." But the American College of Physicians said such a "change was necessary because access to health care had deteriorated," reports the *Inquirer*. David Dale, the group's president, stressed that the U.S. system was not performing as well as those in other countries. "Part of our call is, 'Look around, guys, and see how other people are doing,'" he said, "and they're doing better than us."

## **OPINION: Runaway Spending Is the Main Problem with the Health Care System**

*Cover the Uninsured, from Washington Post, 12.6.07*

*Washington Post* columnist Robert J. Samuelson writes that while "covering the 47 million uninsured already looms as the centerpiece" of the health care debate, out-of-control spending is the real problem, but it is not being adequately addressed by politicians, who only "pay lip service" to the issue.

According to Samuelson, politicians would rather cater to the public's belief that everyone should have adequate health care than address the hard questions, such as "How much will health spending increase taxes, depress take-home pay and crowd out other government spending--on schools, roads, parks, defense?" He argues that "the politics of health care rests on a mass illusion: Most Americans think that someone else pays for their care." Because people believe that either employers or the government pay for health care, they have no incentive to control costs.

Samuelson suggests making people "see and feel health costs" by making "Medicare beneficiaries pay more;" creating a "dedicated federal health tax to cover all government health spending" that would rise and fall according to spending levels; and getting rid of "the income tax exclusion for employer-paid insurance and replac[ing] it with a tax credit of lesser value" so "workers would have more pretax income, but they'd have to spend more after-tax dollars for insurance." However, Samuelson says that such proposals are not likely to be adopted because they "would inflict 'pain,' and candidates who embraced them would invite political ruin."

## **Doctor Saved Michigan \$100 Million**

*NPR, All Things Considered 12.9.07 Listen: <http://www.npr.org/templates/story/story.php?storyId=17060374>*

Dr. Peter Pronovost saved the state more than \$100 million and 1,500 lives over an 18-month period by teaching doctors and nurses to use checklists for intensive care unit procedures. Andrea Seabrook talks to Dr. Provonost, as well as Atul Gawande, a surgeon who wrote about the success of the checklist in *The New Yorker* magazine.

## **Michigan Health Plans Rank High As Top Performers**

*Michigan News Wire – 12.10.07*

In a recent U.S. News & World Report issue, 13 Michigan-based health plans were ranked as top performers. The U.S. News & World Report and the National Committee for Quality Assurance (NCQA) collaborate annually to rank the nation's health plans. The rankings, unveiled in the Nov. 5, 2007 U.S. News & World Report issue, "Best Health Plans 2007 Search: Medicaid", placed all 13 Michigan health plans in the top 70 nationwide.

"We are pleased that Michigan health plans are recognized as some of the best in the country," said Janet Olszewski, director of the Michigan Department of Community Health (MDCH). "Our residents deserve quality health care services and this ranking demonstrates that Michigan's health plans are providing citizens with good benefits and choices."

In the rankings, hundreds of commercial, Medicare, and Medicaid health plans included detailed information about their performance in selected areas. The rankings were compiled from data collected and analyzed by the NCQA, the accrediting body for MDCH's Managed Care Plan Division.

MDCH is very pleased with the Michigan Medicaid representation in this report. The state of Michigan contracts with 13 Medicaid Health plans to provide care and service for more than 950,000 Medicaid beneficiaries. It is important to note that Michigan has six plans in the top 20 and 11 plans in the top 50. The following are Michigan plans that appeared in the rankings: M-Care (Name has changed to BlueCaid of Michigan), Health Plan of Michigan, Physicians Health Plan of Mid-Michigan, HealthPlus of Michigan, Upper Peninsula Health Plan, Priority Health, McLaren Health Plan, Total Health Care, OmniCare Health Plan, Midwest Health Plan, Molina Healthcare of Michigan, Great Lakes Health Plan, and Community Choice Michigan.

## **Expenses at issue in Blues rate hike case**

*Free Press – 12.11.07*

LANSING — The attorney for a Livonia couple challenging a proposed 24% average rate hike for Blue Cross and Blue Shield individual policyholders drilled down Tuesday to discover if the company's \$1.2 billion in annual administrative expenses is excessive.

Northville attorney Joe Aoun argued that all Blue Cross customers pay for a "bloated administrative expense," including generous compensation for executives. In a series of questions to Blue Cross' top accounting and rate-setting executives, Aoun attempted to determine if spending for lobbyists, entertainment tickets and advertising are considered administrative expenses and, if so, how is that cost paid for by individuals and corporations with Blue Cross policies.

In response, Margaret Myszkowski, director of management accounting, said \$4.2 million in salary and compensation paid to former Blue Cross chief executive officer Richard Whitmer in 2006 was paid by all lines of business. Myszkowski also testified that salaries and benefits are the biggest part of the \$1.2 billion Blue Cross will spend in 2007 on administrative costs. But she could not answer for certain whether lobbying

and advertising costs are part of administrative expenses, or if payment of those costs is distributed as a portion of the amount of claims each line of business generates.

Administrative costs are expected to grow to no more than 5% this year, from an average rate of increase of 2.6% from 2004-2006, she said. These costs are reasonable and considered low when compared to other insurers, Blue Cross executives say. Myszkowski appeared in the second day of testimony before administrative law judge David Lick.

The hearing is the first in 10 years challenging Blue Cross rate hikes. Ron and Ghada Abraham of Livonia sought the hearing, seeking refunds for some 19,000 policyholders of seven so-called non-group policies.

Their monthly premiums would be increased from \$458.79 a month to \$568.63 a month, or \$6,623.56 a year, if Blue Cross makes the case for increased rates. The rate hikes do not affect consumers in seven nongroup policies.

Lick will make his decision after the hearing, which is expected to end Friday. The final decision will be made by the director of Michigan's Office of Financial and Insurance Services, currently headed by interim director Ken Ross.

A hearing in 1997 took nearly two years to finalize. **Consumers in the five plans that are affected could receive refunds in the Abrahams win. Otherwise, their rates will go up an average of 24%, ranging from 23.9% to 41%, depending on how much in co-pays a policyholder pays. Consumers with the lowest co-pays face the biggest rate hikes.**

## **Couple fights insurer's rate hike**

*Free Press – 12.10.07*

In a rare public confrontation between a consumer and the state's largest insurer, a Livonia couple and their attorney begin their challenge today to a request by Blue Cross Blue Shield of Michigan to raise rates an average of 24% for individual policy holders.

Ron Abraham and his wife, Ghada, pay \$510.45 a month for one of Blue Cross' plans. Their premiums would increase to \$568.63 a month -- \$6,823.56 a year -- if the rate hike is approved.

If the Abrahams prevail, many of the 60,000 Michiganders with individual Blue Cross policies would get refunds.

The hearing is significant for several reasons:

- It is the first consumer challenge to Blue Cross individual rate hikes since 1997.
- It pertains to policies increasingly purchased by individuals as employers drop their coverage.
- It could be the last chance consumers or the Attorney General have to challenge a Blue Cross rate hike because four bills promoted by Blue Cross and approved by Michigan's House of Representatives on Oct. 24 would eliminate future rate-hike challenges.

The bills would allow Blue Cross to set its own rates, subject to monitoring by the Office of Financial and Insurance Services, a system now used for commercial insurers. The bills also would eliminate a one-step rate system, to be replaced by 10 tiers of rates based on age, health issues and other factors.

Pending a decision in the Abrahams' hearing, the Office of Financial and Insurance Services, a division of the Michigan Department of Labor and Economic Growth, granted Blue Cross a 10% average interim rate hike June 1. A final decision on the 24% rate hike will be made after the state's insurance commissioner reviews a decision by Lansing lawyer David Lick, the hearing officer overseeing the Abrahams' challenge.

**Blue Cross wants to raise rates for seven of 12 plans purchased by individuals. The average rate hike is 23.9%. The most generous plans, with the smallest out-of-pocket expenses, face 41.9% rate hikes. Five plans that require the biggest out-of-pocket expenses have no increases.**

Helen Stojic, spokeswoman for Blue Cross, said Friday the insurer had no choice but to request the rate hikes because it is losing millions of dollars each year on the policies, which pay out more for medical bills than it gets in monthly premium charges. "We know it is very difficult for many people," she said. "But right now, our rates are significantly below the cost of medical care."

Blue Cross is required by state law to have each type of insurance it sells be self-sustaining, Stojic added. The company's \$2.8-billion reserve fund, which critics think should be used to keep premiums low, "only would pay 1 1/2 months of claims before we'd go out of business," she said. "These financial standards are here to protect our members, to make sure we can weather an unexpected influx of claims," Stojic said.

Blue Cross reserves fall 25% below the maximum allowed by state law, she added. Blue Cross needs to be able to set its own rates, like commercial insurers, she said. Allowing consumers and the Attorney General to challenge rate hikes is "process ... fraught with delays," she said.

The Abrahams and Joe Aoun, the Northville attorney representing the couple, say Blue Cross should offset losses for individual policies by using the reserve fund, earnings from its for-profit subsidiaries or its investment income, which came to \$150 million in 2006.

Instead, Aoun says, Blue Cross and its subsidiaries have bought four companies since 2005, for \$365.9 million. A fifth purchase, of a California insurance company that could cost as much as \$100 million, is pending.

Blue Cross has received composite rate hikes each year since 2003, from 23% in 2003 to 10% in 2006, said Aoun, who is a partner in the health care law firm of Nuyen, Tomtishen and Aoun. The firm represents hospitals, doctors' groups and commercial insurers.

Ron Abraham is Aoun's cousin. But the case, Aoun said, represents the concerns of dozens of Blue Cross policyholders.

To Aoun, [the real issue is that Blue Cross was set up by a 1939 Michigan law as a nonprofit charitable organization to provide access to health care services "at a fair and reasonable price."](#)

[With 4.6 million policyholders, it represents seven of every 10 Michiganders who have health insurance. "Blue Cross is too big to not be part of the solution," Aoun said.](#)

## **WSU president to lead discussion on health care reform**

*Free Press – 12.7.07*

Wayne State President Irvin D. Reid will host a discussion on a new book about health care reform Dec. 14.

The book is called ["Taking Care of the Uninsured: A Path to Reform"](#) and it was written by Herbert C. Smitherman Jr., assistant dean of community and urban health at WSU's School of Medicine. Smitherman and coauthors James D. Chesney, Cynthia Taueg, Jennifer Mach and [Lucille Smith](#) will be at the discussion to sign copies of the book.

The event is free to the public and starts with a continental breakfast at 9:15 a.m. in the Spencer M. Partrich Auditorium at the Law School.

## **Granholtm Announces New Federally Qualified Health Centers**

*Michigan News Wire – 12.7.07*

LANSING - Michigan Governor Jennifer M. Granholm today announced that the federal government has approved the Detroit-based The Wellness Plan as a federally qualified health center (FQHC) in Detroit, offering citizens increased access to quality, comprehensive health care services.

["A critical part of our plan to transform Michigan's economy is to expand access to high quality and affordable health care services throughout Michigan," Granholm said. "This new health center is a step in the right direction toward ensuring that Detroit residents have greater access to the much-needed health care services they deserve."](#)

With the FQHC designation, The Wellness Plan will provide expanded access in three locations to preventive and primary medical care services while maintaining financial stability, allowing it to continue its mission to provide quality health care, mental health care, and dental care for the community well into the future.

With services to more than 22,000 patients, The Wellness Plan is now the largest FQHC in the city of Detroit and one of the largest in the state, Granholm said. Since the governor took office, 16 FQHCs have been

approved in communities across the state, including Saginaw, Grand Rapids, Battle Creek, Detroit, [Marquette](#), Muskegon, Jackson, [Brimley](#), Westland, and Lincoln. With the addition of the three new centers, the city of Detroit is now served by 25 FQHC locations.

The FQHC designation allows centers to better serve uninsured and underinsured citizens by allowing them to have health services the centers provide reimbursed by Medicare and Medicaid.

"As a federally qualified health center, The Wellness Plan will provide Detroit residents with a reliable way to get comprehensive, quality health care services at a price they can afford," said U.S. Senator Carl Levin.

"I congratulate the Wellness Plan for bringing these new, much-needed centers to Detroit and Oak Park," said U.S. Senator Debbie Stabenow. "I am proud to have helped lead the effort to fund community-based health centers and will continue to fight to ensure these critical primary care providers have the resources needed to continue to serve families across Michigan and across the country."

"I am delighted that The Wellness Plan will continue to provide much needed health care to the people of Detroit," said Congressman John Conyers. "The decision to make The Wellness Center a federally qualified health care center look-alike not only prevents the loss of vital health care services in Detroit but expands the number of treatment options available to local residents.

## **UAW joins ranks of opponents to 4 Blue Cross bills**

*Free Press – 12.7.07*

The UAW added its name Thursday to a list of opponents of four bills promoted by Blue Cross Blue Shield of Michigan to alter rates for Michigan's individual health insurance market.

The legislation "[would be a backward step in achieving meaningful reform](#)," the UAW said in a position paper sent late Thursday to House and Senate leaders of the Michigan Legislature. "These bills construct a field that is more focused on the bottom line for insurers than a framework for comprehensive reform for the citizens of Michigan," the statement said.

The bills would allow "a radical expansion" of Blue Cross' authority, particularly into products in which it has no expertise, the statement said. And by allowing Blue Cross to drop its one-size-fits-all rating policy, and to charge more for people who are older or sicker, the chronically ill and aged could be hit with higher health costs, the statement said.

The bills would change how Blue Cross sets rates for about 130,000 people who purchase their own insurance. That market is expected to grow from 6% to as much as 25% of Michigan's health insurance policies in five to seven years, according to Blue Cross estimates. The bills would allow Blue Cross to delay from six months to 12 months the time it has to provide insurance for people with pre-existing conditions; eliminate challenges by consumers and the Attorney General to proposed rate hikes; and let the Accident Fund, a for-profit Blue Cross subsidiary headquartered in Lansing, sell more than workers compensation insurance.

Blue Cross says the changes are needed to offset mounting losses on its individual policies. Opponents say Blue Cross should use profits from its subsidiaries and a \$2.8-billion reserve fund to help pay for losses in one of the few areas where it loses money.

The bills passed the House Oct. 24 by large margins. [On Wednesday, the Senate Health Policy Committee is scheduled to hear an expert discuss Michigan's individual health insurance market, but it won't discuss the actual bills until next year, said Sen. Tom George, R-Portage, chairman of the committee.](#)

On Monday, Attorney General Mike Cox, the Michigan chapter of the AARP and the Consumer's Union, a health advocacy and research organization, announced their opposition to the bills.

## **Romanian puts face on immigrant care issues**

*Free Press – 12.7.07*

Dumitru Nistorescu, a Romanian worker who came to Detroit seven years ago to begin a new life, is alone in his Rochester hospital room, paralyzed and unable to breathe on his own. He is miles from the underground

network of friends he kept as an undocumented immigrant, living undetected on a passport that expired two years ago.

So far, Crittenton Hospital Medical Center has paid \$540,000 for his care since he was admitted Aug. 13 following a massive stroke. For more than three months, no one would take him. Not nursing homes. Not his home country.

But today, or at the latest Saturday, Nistorescu, 53, is to go home, adding a \$65,000 expense for an air ambulance from Pontiac to Bucharest.

Hospitals all over the United States, as well as doctors and clinics serving immigrant communities, are familiar with the problems of caring for -- and paying for -- the medical treatment of undocumented immigrants.

"All the time they come here," said Adnan Hammad, PhD, director of community health for the Arab Community Center for Economic and Social Services, which runs a large clinic in Dearborn. Many come in with serious health problems, even advanced cancer, and can't understand why ACCESS can't pay for their operations, Hammad said.

He said he coaxes physician friends to take some of the patients and charge them reduced rates. He works with hospitals to care for the others.

Medicare has a \$1-billion budget for emergency care for undocumented immigrants through 2008. But the bulk of the funding goes to states such as California, Texas and Arizona, which have larger percentages of immigrants than Michigan, hospital officials say.

Crittenton applied three months ago for those funds for Nistorescu and never heard from Medicare, Marilyn Messina, director of quality outcomes for Crittenton, said Thursday. Medicare's media relations office did not return a call for comment Thursday.

Crittenton also will attempt to get some money from the Romanian government and Nistorescu's family -- his father, who is 71, a daughter and an ex-wife -- who live in the Black Sea town of Tulcea, Messina said. "When all else fails, we just absorb the expense," she said.

Federal law requires hospitals to accept all patients needing emergency care.

Full story: <http://www.freep.com/apps/pbcs.dll/article?AID=/20071207/BUSINESS06/712070388/1002/>

## **Aetna may reduce Michigan business; insurer opposes rate law Blue Cross backs**

*Free Press – 12.6.07*

The nation's third-largest health insurer, which has invested \$400 million to expand its business in Michigan in the past two years, plans to significantly scale back if rate-altering legislation promoted by Blue Cross Blue Shield of Michigan becomes law.

Mark Bertolini, executive vice president and head of business operations of Aetna, said Wednesday the legislation would force the company and others to reduce Michigan operations, resulting in fewer choices for consumers and, eventually, higher costs for health insurance.

"Over time, we'd die a slow death," Bertolini said in a telephone briefing from Lansing and later in an interview with the Free Press.

Richard Murdock, executive director of the Michigan Association of Health Plans, representing 21 health maintenance organizations with 2.2 million members in the state, predicted a shrinking of the options consumers will have when buying their own insurance. "People have to make business decisions," Murdock said. "In the end, there will be fewer carriers."

Helen Stojic, spokeswoman for Blue Cross, dismissed the predictions as baseless threats. A study released in May by Michigan's Office of Financial and Insurance Services concluded that changes in small business insurance policies several years ago resulted in more competition that reduced business for Blue Cross but increased it for others, she said.

"I wonder whether Aetna's apparent loss of commitment to its existing Michigan customers should make them feel any more comfortable being with Aetna?" she asked. "We invite them to go to Blue Cross. We're not going anywhere."

Aetna, based in Hartford, Conn., provides health insurance to 17 million Americans, including 1.2 million in Michigan. About 300,000 of those have individual policies; the rest are insured through PPOM, a Southfield-based health plan Aetna bought two years ago for \$400 million. **It is the state's second-largest network of doctors and hospitals, after Blue Cross.**

Aetna never would have bought PPOM if the legislation sought by Blue Cross had been law then, Bertolini said. Bertolini, a native Michigander and Wayne State University graduate, said **Aetna's current plan is to expand its Medicare, Medicaid and corporate products in Michigan.** The market is growing as baby boomers age and states anticipate more federal funds to expand programs that serve children in low-income households, said Bertolini, former chief of the now defunct SelectCare HMO. The insurer wants reforms in health insurance laws, he said. "But the way this is outlined, it is purely for the benefit of one player in the marketplace and not for the public," he said.

Two of the proposals would allow Blue Cross to eliminate a one-size-fits-all pricing system for individual policies bought by consumers with no workplace coverage. It would let Blue Cross set 10 tiers of rates based on age, county of residence, health problems and other factors, as commercial plans now do. The other two proposals would let the Accident Fund, a for-profit Blue Cross subsidiary based in Lansing, to sell more than workers' compensation policies.

Blue Cross says the changes are needed to offset more than \$100 million a year in losses for its individual policies, which cover about 135,000 people in Michigan. The market is expected to grow from 6% to as much as 25% of the entire health insurance market in five to seven years.

Opponents say Blue Cross is a rich company that should use the \$2.8 billion it has in reserves and profit from its subsidiaries to offset losses in the small individual market. As a nonprofit, Blue Cross' \$82 million a year in tax breaks should require it to take all applicants as the insurer of last resort, the opponents say. **The legislation passed the Michigan House of Representatives Oct. 24 by overwhelming margins.** But opposition is growing. On Monday, Attorney General Mike Cox, the Michigan chapter of the AARP and Consumers Union, a national health research and advocacy group, weighed in against the bills.

## **OPINION: Get it right on prison health care**

*Free Press – 12.6.07*

The state will have to delay for at least six months its plan to reform prison health care with regional managed-care contracts -- in effect, HMOs for inmates. The Department of Corrections received only three bids for eight contracts that the state had hoped to award next month. Seeking more qualified bidders, Corrections will now rework its proposal with the help of health care providers.

The delay, while unwelcome, is another opportunity to get it right, including a better plan for independent oversight of prison health care and the potential removal of the current, primary provider of prisoner health care, Correctional Medical Services Inc., of Missouri.

The new bidding process will also include recommendations from the independent review of prison health care ordered last year by Gov. Jennifer Granholm. That study should wrap up late this month.

Whatever new system is in place, strong, independent oversight is essential, since Granholm and the Legislature have failed to restore the Office of Corrections Ombudsman. Effective oversight could come from an independent medical monitor appointed by the governor. In any case, the Legislature and governor must step up and oversee the prison health care system if they really want change.

Meeting in Lansing last week with representatives of about 30 health care providers, Corrections officials acknowledged that they had moved too fast and should have met with medical providers before seeking the first round of bids. Still, on this matter, the department rates some slack. It is moving into new territory, expecting to become the first state to use health maintenance organizations for inmate care.

Michigan spends roughly \$300 million a year to deliver physical and mental health care to 50,000 inmates in 42 prisons. The proposed managed-care system, similar to the one used by the state's Medicaid program, is

no panacea. Still, it lays the groundwork for a more accountable, cost-effective, efficient and humane system.

A Free Press editorial page investigation, "Neglect in Custody," showed systemic failures in how Michigan delivers prison health care, including misdiagnoses, delayed or denied treatment, poor record keeping, withheld medications, and inadequate accommodations for the mentally ill and disabled. In one case, Timothy Joe Souders, a 21-year-old mentally ill inmate sentenced to 1-4 years for shoplifting and resisting arrest, died of heat and thirst.

Unfortunately, because of the necessary rebidding, the state will now likely have to extend its contract with CMS by at least six months. CMS has compiled a dismal record here and around the country, taking up to \$90 million a year from Michigan taxpayers while operating in near secrecy. Under the original bid proposal, only licensed HMOs qualified, which probably would have excluded CMS. But the state could now toss that requirement.

CMS has been part of the problem too long. The health care contract, assumed by CMS in 1998, has not been put out for bid since 1997. Based on past performance, CMS should not be awarded a new contract. [Michigan's prison health care system needs a fresh start with strong oversight. Corrections should take the opportunity provided by an unexpected delay to make sure that happens.](#)

## Big Pharma's Bitter Pill

Wall Street Journal Health Blog – 12.6.07  
(Posted by Joe Mantone )

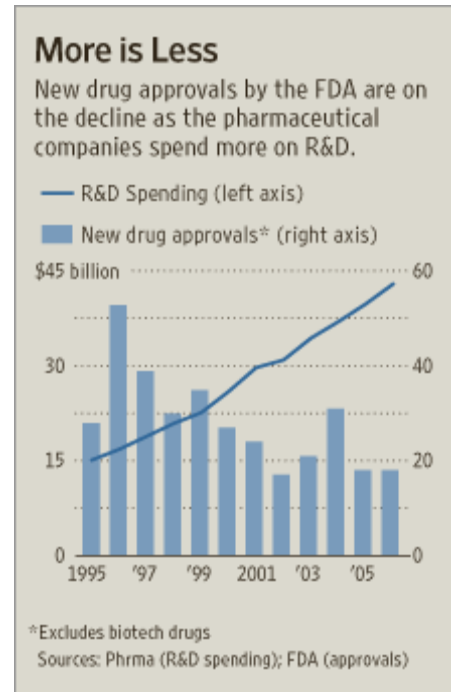
Shed a tear for the pharmaceutical industry. Its golden age is on the wane.

Many of the top companies are already seeing patents expire on their leading products, and the worst is yet to come. On their way are generics that will eat away at \$67 billion in annual U.S. sales of drug makers between 2007 and 2012, says a bracing [story](#) on the WSJ's front page. Pfizer's Lipitor is the doomed whale, but Merck's got a bunch of blockbusters, including osteoporosis pill Fosamax, that won't be big brands much longer. (Click [here](#) for a chart of some of the biggies heading for a fall.)

Compounding matters is the fact that the industry's researchers have been so slow in developing new medicines—43% fewer new chemical-based drugs were brought to the market from 2002 through 2006 than in the last five years of the 1990s. "I think the industry is doomed if we don't change," says Sidney Taurel, chairman of Eli Lilly.

But don't worry yourselves to death pharma fans. The sector, despite its growth problems, remains highly profitable. And the prescription for renewed growth may lie in a shift toward biotech from chemistry-based drug development. "For all our amazing advances in the last 50 years, we are still working with the tools of the first pharmaceutical revolution...using advanced chemistry to treat disease symptoms," Lilly's Taurel said in a 2003 speech.

No doubt, Big Pharma's been trying to make the shift. Old-line companies have spent \$76 billion since 2005 snapping up biotech firms. The added incentive for Big Pharma and biotechnology: "No regulatory pathway yet exists in the U.S. for bringing to market generic biotech," the story says.



## Depression More Deadly for Diabetics

New York Times – 12.5.07

[Treating some diabetic patients for depression may help prolong their lives](#), according to new research.

Investigators at the University of Pennsylvania divided 600 older patients with depression, including 123 who also had diabetes, into two groups. One group received care from primary care doctors, including drug therapy, counseling or both. The other group received a more focused treatment coordinated by a depression case manager.

Five years later, 110 patients had died. The leading cause was heart attack; only one patient had committed suicide. Notably, **the researchers found that treatment of depression did not influence death rates among the otherwise healthy patients. But death rates among the diabetic patients were affected: the group who had received care from case managers were half as likely to die as those who had received less intensive care,** the researchers discovered. The report appears in the current issue of Diabetes Care.

Although previous studies have demonstrated a link between depression and diabetes, this research is the first to show that aggressive treatment of depression can prolong the lives of diabetic patients. Hillary Bogner, assistant professor of family medicine at the university and the study's lead author, says that even though both groups were under the care of a primary care doctor, the depression case managers likely were instrumental in helping their patients remember to take medications and attend therapy, and in monitoring side effects and advising doctors on patients' progress.

Other studies have linked depression and heart attack risk. Among the more than 93,000 women participating in the Women's Health Initiative, depressed women were found to have a 50 percent greater risk of developing or dying from cardiovascular disease than women without signs of depression. Depression also has been associated with a greatly increased chance of dying in the months after a heart attack.

Nobody knows why depression seems to take such a toll on physical health. It may be that people who are depressed don't take care of themselves, exercising less and eating poorly. Some researchers believe depression may increase stress hormones or affect the inflammatory process, raising the odds of cardiovascular problems.

In patients with diabetes, depression may cause even more harm by interfering with a patient's self-care, which requires regular glucose monitoring, medications, dietary changes and exercise.

"We know that patients who are depressed and have diabetes do worse," said Dr. Bogner. "More resources are needed in the primary care setting to treat depression."

## **'A crisis for Mich. families' - Medical bills high for many, study says**

*Free Press – 12.5.07*

**More than 2.5 million Michiganders with health insurance spend far too much of their household income on health bills, forcing them to pick between medical needs and other essentials and driving many into debt,** a national report released Tuesday said.

The report from Families USA, a Washington, D.C., health research and advocacy organization, estimates that more than 2 million Michiganders will spend more than 10% of their income in 2008 on health care, and another 537,000 Michigan residents will spend 25% of their household income on doctor visits, prescription and generic drugs, co-pays and other health-related expenses.

**"Health care that people used to take for granted increasingly is becoming unaffordable,"** said Ron Pollack, executive director of Families USA.

As examples, the report cites how a family earning \$60,000 a year, spending at least 10% or \$6,000 on health needs, would only have \$2,990 for medical expenses, after paying taxes and other household expenses. A family earning the same amount that spends 25% of its household budget on health care would pay \$15,000 in medical bills -- \$12,000 more than it had in its budget for those expenses, the report said.

Jan Judson, senior planning and research associate for the Michigan League of Human Services, said her nonprofit, Lansing-based organization is hearing more about families making painful choices between spending on health and other essentials, such as food and fuel, as companies drop coverage. "This is truly a crisis for Michigan families trying to do the right thing."

U.S. Sen. Debbie Stabenow, D-Mich., and Rep. Bart Stupak, D-Mich., said the report shows the need to expand government insurance programs for low-income children. Some 118,500 children are in Michigan's program but another 80,000 would be covered under legislative proposals before Congress, bills which President George W. Bush has threatened to veto.

The report, one of the first six state-specific analyses by the organization, hopes to spur discussion about issues in the 2008 election, Pollack said. The report is at [www.familiesusa.org.cq](http://www.familiesusa.org.cq).

## Clinton & Obama Spar Over Who'd Insure More Americans

*Wall Street Journal Health Blog – 11.25.07 (Posted by Jacob Goldstein)*

Hillary Clinton and Barack Obama keep [fighting](#) over whose health plan would cover more people.

Clinton says Obama's health care plan, which doesn't require everyone to get coverage, would leave out 15 million people. Clinton's own plan requires everybody to get coverage. But Obama says there's not enough money in Clinton's plan to pay for everybody to do so.

Both candidates are probably right, more or less, and which plan would cover more people is anyone's guess, according to stories this morning in the [WSJ](#) and the [New York Times](#). (For the Health Blog's wholly unscientific poll from yesterday on health insurance mandates, click [here](#). For what it's worth, more people favored mandates than opposed them, and a sizable minority voted for a single-payer system.)

The WSJ notes that both candidates say they'd spend roughly the same amount of money — about \$110 billion a year — on their plans, which share many similarities. The NYT points out that just because you have a mandate, it doesn't mean everybody will follow it, citing the fact that an estimated 15% of the nation's drivers flout the mandate for auto insurance.

## Docs' Group: Insure Everybody, One Way or Another

*Wall Street Journal Health Blog – 12.4.07 (Posted by Jacob Goldstein)*

This country can keep private insurance and require everybody to buy in. Or we can cover everybody with a government-funded, single-payer system. [But one way or another, the American College of Physicians argues in this new paper, we have to cover everybody.](#)

It makes sense that the nation's second-largest group of primary care docs should be pushing for everybody to have insurance. But as the Philadelphia Inquirer [notes](#), many docs have historically been wary of a single-payer system, which some have worried would give the government too much control.

Of course, primary care providers who are at the low end of the pay scale in the current system might have less to lose than specialists who are making a mint.

And [now that covering the uninsured has become a high-profile issue in the presidential race, the ACP may have figured the moment is opportune to jump into the public debate.](#) In fact, the ACP also put out [this guide](#) to where the candidates stand on health care.

## Young People Advocate for Universal Health Care Online

*Cover the Uninsured, from [Politico.com](http://Politico.com), 11.27.07*

[One-third of young Americans are uninsured and 42 percent of those ages 18 to 34 "are very worried about being able to afford the health services they think they need,"](#) according to a poll by the Kaiser Family Foundation, leading many to speak up about the issue of the uninsured and universal health care on Facebook, a social networking site, reports Politico.com.

[More than 20 groups, many with hundreds of members, are using Facebook to promote the cause of expanding government health coverage,](#) while only two groups, neither of which have more than 100 members, advocate against government-funded health care, according to the article. A recent poll by Rock the Vote found that health care was second to the Iraq war as the most critical issue among young

Americans. "Health care is a topic that young people are engaged in and interested in this campaign," said Molly Brodie of Kaiser.

While it is clear that young people are concerned about health care, with 56 percent saying "they want presidential candidates to present a plan that would provide health insurance to all or nearly all of the uninsured, even if it meant a substantial increase in spending," according to the Kaiser poll, some question whether such concern will "translate into a decisive factor at the ballot box," reports Politico.com. Andrew E. Smith of the University of New Hampshire Survey Center said, "Health care is certainly going to be the domestic issue that Democrats are going to be running on," but he "doubts people will base their votes on that issue alone."

## **Cox hits Blue Cross push to raise individuals' rates**

*Free Press – 12.4.07*

At a time when Blue Cross Blue Shield of Michigan, the state's largest health insurer, is sitting on a \$2.84-billion reserve fund and acquiring new for-profit companies, it is seeking legislation to significantly change and raise rates for people buying their own health insurance.

Michigan Attorney General Mike Cox and two consumer groups called Monday for the Legislature to defeat a four-bill package being promoted by Blue Cross. The bills passed the House on Oct. 24. "These changes promote profits over people," Cox said. "They should be stopped."

Blue Cross attributed Cox's position to "a disagreement on the effects of these bills." "This tells us we have more work to do to help the attorney general understand the important consumer protection provisions of the legislation," the company said in a statement.

The Senate Health Policy Committee is scheduled to discuss the bills Dec. 12.

If the bills pass, some 132,000 Michiganders who now buy their own insurance from Blue Cross are likely to pay more in the future, Cox said. People with existing health problems might pay as much as 80% more, he said, and his office and consumers would not be allowed to challenge the rates.

Blue Cross expects its business to grow from 6% of the individual market today to anywhere from 15% to 25% in five to seven years.

Joining Cox were AARP's Michigan chapter and Consumers Union, a nonprofit health advocacy organization.

Dan Loepp, chief executive officer of Blue Cross, told the Free Press last week that changes are needed to offset mounting losses for policies purchased by consumers and to strengthen the Lansing-based Accident Fund, a for-profit Blue Cross subsidiary.

The bills would:

- Create a guaranteed insurance pool to provide coverage for people who can't otherwise purchase health insurance, often because they are sick and costlier to cover. Rates for people in the pool would be set according to age, county of residence and health problems.
- Eliminate the ability of consumers and the attorney general to challenge requests by Blue Cross to raise rates. The state's Office of Financial and Insurance Services would monitor rate increases.
- Extend from six to 12 months the period during which Blue Cross can wait to cover people with preexisting health problems. Blue Cross must insure all applicants eventually, in exchange for \$82 million in annual state tax breaks.
- Let the Accident Fund, which sells workers compensation policies, sell auto, property and casualty insurance.

Loepp said last week that Blue Cross is losing more than \$100 million a year on its individual health policies. "The big picture is we're losing a lot of money in a marketplace that is growing," Loepp said. "And unless we level the playing field we'll lose a lot more money. We've got a business to run," he said. "This isn't a charity. It has a social mission and that's very important to the people of Michigan."

Loepp said the company gives back to Michigan five times the \$82 million it gets in tax breaks, including \$15.5 million a year to underwrite Michigan's insurance program for poor children and \$1 million to free clinics.

Cox said Blue Cross has abandoned its mission as a "charitable and benevolent institution," language used in the 1939 state law that created it.

As evidence, he pointed to a more than doubling of the Blue Cross surplus reserve fund since 2001; \$365 million in purchases since 2005 of four insurance companies, two outside of Michigan; and generous salaries for executives. Blue Cross by law is the state's insurer of last resort. It provides health insurance to 4.6 million Michiganders, about 70% of the individual and workplace market.

## **Zipskinny lets you profile your neighborhood**

*Free Press – 12.4.07*

The Web allows us to compare everything. So it is with a slick site called the [Zipskinny](http://zipskinny.com) (<http://zipskinny.com>) which takes data from the U.S. Census to let you pull together a demographic profile of your neighborhood.

## **Ohio HMO to buy Community Choice Michigan**

*Free Press – 12.4.07*

CareSource, Ohio's largest Medicaid HMO, has finalized the purchase of Community Choice Michigan, an 11-county Michigan Medicaid plan it has managed since 2003.

The purchase also must be approved by Michigan's Office of Financial and Insurance Services. A decision is expected by the end of the year, the company said Tuesday.

CareSource is a nonprofit company based in Dayton, with 553,000 members, making it the nation's fourth largest HMO. It plans to keep the Lansing office of Community Choice Michigan and expand its network of care through 2,000 doctors, hospitals and specialists in 11 Michigan counties. Dr. Gary Kirk is the new medical director of the company, CareSource also announced.

**Kirk, a graduate of the Massachusetts Institute of Technology, with advanced degrees in public health and health professions, had been director of the Michigan Department of Community Health's Bureau of Family, Maternal and Child Health Services, as well as director of clinical program management at Mott Children's Center, Flint.**

Community Choice Michigan was formed in 1995 by a network of 17 **Federally Qualified Health Centers**, a designation for centers that expand access to health services for poor and uninsured people.

## **Coverage dollars go farther in state**

*Free Press – 11.29.07*

There's good news for the growing number of Michiganders paying for their own health insurance: **It costs much less to buy health insurance in Michigan than in the nation as a whole or in most nearby states.** New data released this month by America's Health Insurance Plans' Center for Policy and Research show that:

- Michiganders buying their own health insurance pay \$1,878 for a single person a year in premium costs, compared with \$2,613 nationwide, \$3,949 in Pennsylvania, \$2,504 in Indiana, \$2,499 in Illinois, \$2,498 in Ohio, \$2,424 in Minnesota and \$1,254 in Wisconsin. A family health plan, on average, cost \$4,118 in Michigan, compared with \$5,799 nationwide.
- 94% of large employers and 50% of small ones offer health insurance, compared with 96% and 43% respectively nationwide.
- 10% of Michiganders have no health insurance compared with 16% in the nation.

- Michigan's Medicaid plans rank 33rd nationally in reimbursements, at \$3,741 in annual average payments per member, compared with \$4,072 nationally.

In other findings, commercial insurers paid \$249.5 million in taxes to Michigan. Nationally, firms paid \$14.8 billion in state taxes.

Overall, the health insurance industry accounts for 14,511 in direct jobs in Michigan. But insurance company employees in the state earn less, at an average wage of \$52,211 a year, compared with \$61,409 nationwide.

Dr. A. Mark Fendrick, director of the University of Michigan's Center for Value Based Insurance Design, said lower health premiums in the state reflect Michigan's strong union history that bargained for workplace benefits and made it "a national leader regarding the provision of generous and affordable health insurance." With health costs climbing, consumers and employers should "insist that our health plans provide incentives so money is spent on those medical services demonstrated to improve health."

The survey was compiled by a research agency that is part of a national association with nearly 1,300 companies providing health insurance coverage to 200 million Americans. For state-by-state data, go to [www.ahip.org](http://www.ahip.org).

See: <http://www.ahipbelieves.com/> for the AHIP plan for access to health care in U.S.

## **Even With Insurance, Hospital Stay Can Cost a Million**

*Wall Street Journal Health Blog – 11.29.07 (Posted by Joe Mantone)*

Soaring health costs are burdening many Americans with massive medical bills, and a few, like Jim Dawson, are left with a million-dollar tab — even though they have health insurance, the WSJ [reports](#).

Part of the problem is that insurance caps — the maximum amount of a patient's medical bill insurers will pay — haven't been keeping pace with rising costs. The story says the average cap is \$1 million per person, the same as it was in the 1970s.

Dawson's cap was \$1.5 million but after a staph infection spread throughout his body, he was still stuck with a \$1.2 million bill from California Pacific Medical Center. He and his wife were outraged to learn about the hospital's marking up of items.

"For instance, CPMC charged Mr. Dawson \$791 for stockings designed to improve blood circulation," the story says. "The same pair can be purchased on the Internet for as little as \$12."

Even more perplexing was the fact the Dawsons were told it would cost \$1,030 just to get an itemized copy of Jim Dawson's bill. The medical center was nice enough to send a letter — free of charge — seeking donations to the hospital.

Dawson's story does have a happy ending, sort of. After the hospital was contacted by the WSJ, CPMC called the Dawsons to say they qualified for financial assistance under the hospital's charity-care policy and wrote off his entire bill.

## **Poll: Electronic Med Records Are Worth the Privacy Risk**

*Wall Street Journal Health Blog – 11.29.07 (Posted by Jacob Goldstein)*

On the subject of electronic medical records, regular folks appear to agree with the health-wonk elite.

Yes, [electronic records make it tougher to keep patients' records private, most people said in a new poll from the WSJ Online and Harris Interactive. But the risk is worth it, because the records can also decrease errors and reduce health costs, according to a majority of respondents.](#)

Overall, 60% of 2,153 respondents said the benefits of electronic medical records outweigh the risks; 63% said electronic records can significantly decrease the frequency of medical errors, 55% said they can significantly reduce costs, and 51% said they make it more difficult to ensure patients' privacy.

A couple other interesting findings: 76% of respondents are confident that the doctor always “has an accurate and complete picture” of their prior medical history (we suspect a survey of docs would yield a less confident response to this one). And only 1% of respondents said they use a personal health record stored on the Internet — demonstrating that there’s plenty of room for growth in the ambitious personal-health Microsoft and Google are working on.