



Access to Health Care News Update – 8.20.07

From: Nancy Mathews, Program Coordinator 906.233.0210 x 103 nmathews@uphealthaccess.org

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

Fewer American children are dying

Free Press from McClatchy Newspapers – 8.3.07

WASHINGTON — Things are looking up for Dr. Catherine Webb, a pediatric cardiologist at Northwestern University in Chicago. “When I was in training in the ‘80s, this was a pretty depressing specialty,” she said. “But it’s not anymore.”

True enough. The death rate from heart disease among children is about half what it was in 1980, according to a compendium of federal child-health statistics released last month. Also down by roughly half are children’s death rates from birth defects, cancer, heart disease, pneumonia and flu, as well as injury-related child deaths from motor vehicle accidents, drowning, fires, falls, firearms and suffocation.

Death rates from all causes dropped 53% among children ages 1 to 4 and 45% among children ages 5 to 14. It adds up to survival for about 8,000 children a year who would’ve died in 1980.

“It’s terrific news,” said Harry Rosenberg, retired chief of the Mortality Statistics Branch of the National Center for Health Statistics, which is part of the Centers for Disease Control and Prevention.

Better medicine and new safety measures get much of the credit. So does expanded government health-insurance coverage for disadvantaged children, which gives them better access to medical care.

Parents deserve credit, too, said Dr. Frederick Rivara, a professor of pediatrics at the University of Washington in Seattle who specializes in injury reduction. They’re drinking and smoking less, for example, which reduces birth defects, fires and car crashes.

Death rates from each leading cause are reported in “**America’s Children: Key National Indicators of Well-Being, 2007**,” which can be read online at www.childstats.gov. Its tables describe trends for leading killers annually from 1980 through 2004.

Study: Less than Half of Americans Are Happy with Their Health Care

From: The Commonwealth Fund newsletter, 8.1.07

Less than half of Americans are fully satisfied with their medical care, according to a report released this week by the Agency for Healthcare Research and Quality.

Only 48 percent of Americans age 18 and over who had gone to a doctor or medical clinic within a year of being surveyed rated their health care nine or 10, on scale of zero to 10, according to report.

The findings are based on data from the 2006 National Healthcare Quality Report, which examines the quality of health care across America in four key areas: effectiveness of health care, patient safety, timeliness of care, and focus on the patient.

According to the report, the perception of quality of the health care varied by the individual's race, ethnicity, and the type of insurance held. Among Asians, 31 percent of individuals rated their health care nine or 10, along with 37 percent of American Indians and Alaska Natives. The report found that less than half of white Americans—49 percent—and black Americans—46 percent—gave a nine or 10 rating to their health care. Among Hispanics, 43 percent of individuals reported receiving high quality health care, according to the study.

Other findings include: Slightly less than 60 percent of people age 65 and older who have Medicare, with or without additional private or public health insurance, rated their care the highest, compared with 46 percent of privately insured patients and **39 percent of uninsured Americans**. Less than half of men and women—46 percent and 49 percent, respectively—saw their care as excellent.

Senate Passes Kids' Health Bill, But Doctors Left Out

WSJ Health Blog (posted by Jacob Goldstein) – 8.3.07

If you're a kid without health insurance, last night's Senate vote on a health insurance bill may be good news. If you're a doc who treats Medicare patients, not so much. The Senate passed a bill to increase funding for children's health insurance by **\$35 billion** over five years. But, unlike a House bill passed Wednesday, the Senate was mum on Medicare.

For starters, **the Senate bill skips over the House's pledge to cut funding for the Medicare Advantage plans offered by private insurers that have come under scrutiny for some controversial sales practices. And — more importantly for doctors who see Medicare patients — the Senate bill doesn't include the House's extra \$19 billion over five years to offset proposed cuts in Medicare reimbursements to doctors.**

Next the House and Senate will huddle to work out the differences in their bills. Will the bill Congress sends to the President include more money for Medicare reimbursement? It may not matter. Whatever they hammer out is likely to be met with a **veto**. And that could stick.

The Senate bill got a fair bit of bipartisan backing and passed with 68 votes — enough to override a veto. The House bill, on the other hand passed by much thinner margin — 225 to 204 — that wouldn't be enough for an override.

Children's Insurance Legislation Faces Critics, Veto

NPR Weekend Edition – 8.5.07 - Listen: <http://www.npr.org/templates/story/story.php?storyId=12512997>

Both the House and Senate passed bills to extend and expand a popular program, known as S-CHIP, that provides health insurance to children of the working poor. President Bush has vowed a veto. Now, as members retreat to their districts for the August recess, the real politicking begins.

But some of the claims being made about the measure don't stand up to scrutiny.

The single biggest complaint opponents have about both the House and Senate bills to expand the State Children's Health Insurance Program is that they would expand the program too much. Critics say the bills would cover kids who are wealthier than those the program was designed to serve.

Another heated issue is whether the bills allow coverage of illegal immigrants.

But critics of the bills aren't the only ones playing fast and loose. **For Democrats, the hardest part of assembling their bills was figuring out how to offset the added S-CHIP costs — \$35 billion over five years in the Senate bill and \$50 billion in the House version — so as not to add to the federal deficit.**

State can't pay hospitals

Free Press – 8.4.07

Cash-strapped Michigan has postponed \$54 million in state and federal payments to hospitals, promising to pay on Sept. 26 money that was due in April and July, an unprecedented delay.

The late payments have not posed serious problems, hospital finance officers said. But at least one hospital delayed construction projects and others paid graduate medical education students from cash reserves, which could affect borrowing or bond-rating problems down the road, officials said.

"Any time a payer delays payment, it is detrimental," said Tom Salisbury, director of revenue integrity for Holland Hospital, a 213-bed independent hospital in Holland, which is awaiting \$70,000.

Still, late is better than never, hospital officials say.

"While cash-flow delays are not good for any organization, temporary delays are not as disruptive as cuts in payments," said Patrick McGuire, senior vice president and chief financial officer for the Warren-based St. John Health system.

In fiscal 2007, the Michigan Department of Community Health will distribute to hospitals \$196 million for graduate medical education and **\$50 million for those serving a disproportionate share of poor patients. So far, Michigan has given out \$162 million in graduate education money and \$30 million for service to poor people**, according to Brian Keising, manager for hospital regulations and reimbursement for the health department.

The cash-strapped Detroit Medical Center was the only hospital to get its disproportionate-share money because it is emerging from several years of huge losses and is the state's largest Medicaid provider. It also is a large academic training center for medical residents.

The DMC is awaiting as much as \$15 million for doctor training, said Jay Rising, chief financial officer. The bigger issue, Rising said, is whether the state will cut Medicaid payments more next year, given the revenue problems. "We're paying very close attention to it."

T.J. Bucholz, spokesman for the Michigan Department of Community Health, said, "At a time when the state is facing a \$1.8-billion fiscal crisis ... we have worked hard to maintain these funds. Our full intent is to make the additional payments Sept. 26."

Peter Schonfeld, senior vice president, policy, for the Michigan Health & Hospital Association, a Lansing-based coalition, said he **could not recall another instance in more than 20 years when Michigan failed to make Medicaid payments as scheduled.**

Testing program is short on cash

Free Press – 8.4.07

A state and federal program that provides free mammograms and Pap smears each year to low- and moderate-income women already has run out of money in some Michigan counties.

Nationwide, money for the program is so limited that only 13% of the 3.3 million women who qualify for free mammograms and Pap smears. It serves women 18-64 whose incomes fall below or 2 1/2 times the federal poverty level. For a single woman, that's \$25,525 a year.

Statewide, Michigan has \$1.1 million for the program this year, up from \$998,683 in fiscal 2006, according to T.J. Bucholz, spokesman for the Michigan Department of Community Health.

Federal money for the program amounted to \$977,950 this year with the state's general fund contributing the rest. That's enough for tests for 21,000 women, down from the 22,310 women last year, Bucholz said. The program faces possible federal cuts, or is likely to be held to the same budget for the 2008 fiscal year beginning Oct. 1, he said.

Why Young Adults Become Uninsured and How New Policies Can Help

The Commonwealth Fund issue brief – 8.8.07

Young adults (ages 19 to 29) are one of the largest segments of the U.S. population without health insurance: 13.3 million lacked coverage in 2005.

Young adults often lose coverage at age 19 or upon high school or college graduation. Nearly two of five college graduates and one-half of high school graduates who do not enroll in college will be uninsured for a time during the first year after graduation.

Several states have passed laws to expand coverage of dependent young adults up to age 24 or 25 under parents' insurance policies. Three policy changes could further help uninsured young adults gain coverage and prevent others from losing it: extending eligibility for public insurance programs beyond age 18; extending dependents' eligibility for their parents' private coverage beyond age 18 or 19; and ensuring that colleges require full- and part-time students to have coverage, and that colleges offer coverage to them. Full issue brief "Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help" at: http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=514761&#doc514761

The Generics Are Coming!

Wall Street Journal Health Blog – 8.8.07 (posted by Jacob Goldstein)

The generics are coming! The generics are coming!

The New York Times plays Paul Revere this morning, riding through the streets [declaring](#) that [a tidal wave of generics is approaching](#) — good news, the paper suggests, for everyone except the pharmaceutical industry.

Some big generics have already hit the shore. Sanofi-Aventis's sleeping pill Ambien and Pfizer's blood-pressure medicine Norvasc both went off patent this year. Ambien sales fell from \$420 million in the second quarter last year to \$91 this year because of generic competition. (As the Health Blog noted [here](#), the fall-off came in spite of Sanofi's full-court press for Ambien CR, its branded, long-acting version of the drug.)

And in the next five years, drugs with total annual sales of \$60 billion will lose patent protection. The biggies include Merck's bone drug Fosamax (next year), TAP's heartburn pill Prevacid (2009), and, the biggest of them all, Pfizer's Lipitor (2011). Indeed, as we [here](#) and [here](#), Lipitor is already hurting because of generic competition from simvastatin, the generic version of Merck's Zocor.

With a lack of blockbusters waiting in the wings, it could be a tough few years for the drug industry. On the other hand, with generics often selling at a fraction of the price of branded drugs, [the arrival of a bunch of new generics is a rare exception to across-the-board rises in the cost of health care.](#)

3 OPINION Pieces on SCHIP (From Cover the Uninsured)

Bush Misled in Opposing SCHIP Expansion - *Los Angeles Times*, 8.1.07

President Bush should approve the Senate bill to expand the State Children's Health Insurance Program (SCHIP), as his arguments for vetoing the bill are "misleading and hypocritical," writes Ronald Brownstein in a commentary for the *Los Angeles Times*. He adds that Bush was portraying the program's expansion "as the first step on a slippery slope toward 'government-run health care,' as if senior senators in both parties were conspiring with Michael Moore to import Cuban doctors to inoculate and indoctrinate American children."

[Brownstein says the SCHIP expansion will be significantly cheaper than Bush's Medicare prescription drug benefit, created in 2003, and the SCHIP bill also involves concrete revenue plans](#), while the 2003 Medicare plan "just billed the cost to the next generation through higher federal deficits." Brownstein adds that the president's argument that the SCHIP expansion would "crowd out" private insurers does not hold true for a

couple of reasons: "Three-fourths of children covered under the current program receive their care through private insurance plans that contract with the states," and, "By limiting that spillover [privately insured families switching to state programs] to one-third of its cost, is actually more efficient than most alternatives for expanding coverage." The commentary concludes that the families affected "have been reduced to collateral damage" and those families "deserve something better from a president who once called himself a 'compassionate conservative.'"

Uninsured Numbers Vary Between Democrats and White House - *Washington Post*, 8.3.07

Instead of underestimating the number of children in need of health insurance, the Bush administration should use numbers generated by its own Agency for Healthcare Research and Quality, part of the Department of Health and Human Services, writes the *Washington Post* in an editorial.

The administration says that--according to a study by the Urban Institute--5 million American children are uninsured, and of those, 1 million are eligible for but not enrolled in government plans. But other institutions--among them the Agency for Healthcare Research and Quality--say 9 million children are uninsured and 5 million to 6 million are eligible but not enrolled. The main reason for this gap is that "experts are measuring different things." While the administration uses numbers that only count children who were uninsured for the whole year, the Agency for Healthcare Research and Quality included all children who were uninsured at a certain point of the year. The editorial asks, "Why doesn't the government believe its own experts? The administration appears to be attempting to solve the problem of uninsured children by defining the numbers downward." It concludes, "given a choice between dramatically underestimating the needs of low-income children and somewhat overstating them, we'd go with the latter."

Republicans Wrong in Not Supporting Health Insurance Bill - *Buffalo News*, 8.5.07

The majority of Republicans who did not vote in favor of the reauthorization and expansion of the State Children's Health Insurance Program (SCHIP) argued that "Democrats are trying to make ever-larger percentages of the American middle class dependent on government for their health care," writes the McClatchy newspaper group in a commentary published in the *Buffalo News*.

The editorial board calls the bill the "belated realization of the simple fact that millions of Americans, mostly children, simply will not have health insurance unless the government steps in to provide it." The editorial says the current private health care system does not serve Americans who are too rich to qualify for Medicaid but too poor to buy private insurance. This system "simply does not view sick children as clients to be served. It sees them as costs to be minimized." The commentary notes, "the fact is that it is the nation as a whole that benefits when more children get the health care they need, so they can stay in school, avoid expensive and debilitating illnesses later on, and receive care in an orderly manner instead of clogging up emergency rooms or leaving the few doctors and hospitals that will treat them holding the bag for unpaid bills, costs that get passed along to the insured."

Web Link:

This basic BC-BS health insurance plan is available in 6 states (not Michigan): www.tonik.com It was described on the AmeriCorps listserv as: "Although the annual deductible is higher, all of the plans offer 4 office visits with a much smaller co-pay (\$20-40) for illness AND preventative care. Meds come with a co-pay, too. Monthly premiums are comparable, if not cheaper (depending on the plan). After the deductible is met, I believe, coverage is 100%."

Medicare Won't Pay Hospitals to Remedy Flubs

Wall Street Journal Health Blog 8.8.07 (posted by Theo Francis)

In one of the darker ironies in American health care, hospitals are often paid extra to treat the problems that arise when they make mistakes. Starting late next year, [Medicare won't pay for treatment for some conditions associated with screw-ups.](#)

Under a little-noticed new [rulebook](#) that came down last week, Medicare will return the bill unpaid for care to solve these problems: bed-sores; two kinds of catheter-associated infections; air embolism, or bubbles of air

or gas entering the bloodstream during medical procedures; Mediastinitis (infection of the area between the lungs) after coronary bypass surgery; giving patients the wrong blood type; leaving objects inside surgery patients, and In-hospital falls

The government estimates its direct savings at about \$20 million a year, and **Medicare has said hospitals can't turn around and stick patients with the tab**. Other insurers are likely to follow suit, and hospitals may well do a better job for all patients, not just those on Medicare, say some advocates of the new rules.

The American Hospital Association had proposed a narrower list, saying some bedsores and hospital-acquired infections occur even with top-notch care. The trade group wanted only "never events" — such as air embolism, blood incompatibility and leaving objects inside patients — unreimbursed.

Consumers Union, which has been campaigning for better control of hospital infections, generally applauded the new rules. "We think it's going to be a very powerful incentive for hospitals to improve care, and also a way to contain costs," spokesman Michael McCauley told the Health Blog.

SCHIP Report – The Commonwealth Fund

A new report from The Commonwealth Fund, [Reauthorizing SCHIP: Opportunities for Promoting Effective Health Coverage and High-Quality Care for Children and Adolescents](#), says that Congress and the nation have a historic opportunity to build on these gains. The report, written by a team of noted child health policy experts, presents a framework for promoting effective health coverage and achieving high quality in both SCHIP and Medicaid, the other major public program that covers low-income children.

Centers Claim Big Savings from Delivering Primary Care

The Commonwealth Fund newsletter – 8.6.07

The lobby that represents community health centers made a pitch Monday for legislation sharply increasing federal funding for those facilities, saying they offer a brand of health care far less costly than what's given in traditional doctors' offices. Primary care services provided by the centers result in per-patient medical expenses 41 percent lower than for patients seen in other settings, said a study released by the National Association of Community Health Centers.

"These savings occur despite the fact that health center patients are more likely to be poor and uninsured or publicly insured than patients relying on other health care providers," said the authors of the study, which included the Robert Graham Center, a research arm of the American Academy of Family Physicians, and Capital Link, a Washington, D.C. consulting firm.

Per-patient costs averaged \$2,569 in 2004 compared with \$4,379 for patients treated elsewhere—a difference of \$1,810. The figures included expenditures for office visits, drugs, emergency care, other hospital care, and out-of-pocket health care spending, said the authors of the study.

Community health centers are typically located in poor areas and take patients regardless of their ability to pay. They treat a mix of uninsured patients, Medicaid patients, and other patients who have coverage, which is often meager.

In a telephone press briefing, Virgilio Licon, a physician with a community health center in Colorado, gave an example of the type of care delivered by the facilities. He described an obese patient he began treating last week who has diabetes, high blood pressure, high cholesterol, and who "is somewhat depressed." It's likely that over the next six to nine months, because of the diabetes education program, behavioral health services, and medications provided by the facility, the patient will lose weight, have her blood pressure under control, and have lower cholesterol levels, Licon said. The mix of primary care services heads off costly complications leading to emergency room and other expensive hospital-based treatment, according to the study.

Americans often are without such a "family-centered medical home," which if applied widely, would save tens of billions of dollars annually, the association said. **The federal government now spends some \$2 billion a year on community health centers that treat about 16 million people; if funding were increased to \$5 billion**

a year by 2015, the health care system would save between \$23 billion and \$40 billion annually, said Dan Hawkins, senior vice president for policy at that association.

According to the study, the number of jobs produced by community health centers would increase from 143,000 now to 460,000 in 2015 if annual funding were boosted to \$5 billion. The figures take into account direct employment as well as indirect economic effects, such as goods and services purchased by centers from local businesses and the jobs those acquisitions help to fund.

Cover the Uninsured Offers Promotional Materials for SCHIP Reauthorization

See: <http://covertheuninsured.org/materials/promotional/>

Lessons from Local Access Initiatives: Contributions and Challenges

The Commonwealth Fund – publication, 8.14.07

Overview: Community health initiatives—locally crafted responses to health care access problems—have been steadfast in their efforts to connect uninsured and medically indigent people to health care services and health insurance. These programs assist in outreach, coordinate and integrate care, and help clients use limited resources efficiently. This report offers five case studies of community health initiatives. All five local community initiatives seek to improve access and coverage for those most likely to be uninsured: low-income, nonelderly adults. Some, like Community Health Works in Forsyth, Ga., offer coverage for a limited period of time, often for individuals who seek care after contracting an illness, while others, like Choice Regional Health Network, in Olympia, Wash., manage care for clients with complex needs, chaperoning them through systems they characteristically have trouble navigating.

OPINION: U.S. Lags Behind in Quality of Medical Care

Cover the Uninsured – from New York Times, 8.12.07

An editorial in the New York Times states that compared to other industrialized nations the United States is a "laggard" in terms of several important areas of health care, particularly insurance coverage.

The editorial notes that "All other major industrialized nations provide universal health coverage"--most with "comprehensive benefit packages with no cost sharing by the patients"--but the United States "to its shame" has 45 million people without health insurance and millions more with poor coverage. The editorial highlights research that shows people without health insurance postpone treatment "until a minor illness becomes worse, harming their own health and imposing greater costs."

"With health care emerging as a major issue in the presidential campaign and in Congress, it will be important to get beyond empty boasts that this country has 'the best health care system in the world,'" adds the *Times*.

OPINION: SCHIP Bill Will Provide Case Study for 2008

Cover the Uninsured, from New York Times, 8.11.07

In the week leading up to the August recess, Democrats celebrated passage of legislation expanding the State Children's Health Insurance Program (SCHIP), while Republicans saw it as "a boneheaded blunder that would cost them control of the House next year," says the *New York Times* in a commentary.

The fight over SCHIP provides a glimpse into the 2008 campaign strategies of both parties and also gives parties a chance to prove their credibility on a major issue facing the nation. House Speaker Nancy Pelosi (D-Calif.) said, "Health care is really the biggest issue outside of the war." Because the Democrats' proposal partially pays for the program's expansion by reducing payments to private insurance companies that offer comprehensive health plans to Medicare beneficiaries, Republicans see this as "an irresistible opening to go after Democrats."

Google & Microsoft: Health Care Giants?

Wall Street Journal Health Blog – 8.14.07 (Posted by Jacob Goldstein)

Google and Microsoft are angling to get into the health care business. And while the companies are still rather cagey about their plans, **both seem on the verge of offering patients products to store and transport their personal health information** — information that is now often buried in paper files in doctors' offices.

Microsoft is likely to announce its health plans later this year, with Google to follow next year, this morning's New York Times [reports](#). The article describes a Google Health prototype that includes a "health profile" for medications, conditions and allergies; a personalized guide for diet, exercise, treatments and drug interactions; reminders for doctor visits and prescription refills; and a doctor directory.

Citing unnamed sources, the Times says **Microsoft is looking at "online offerings as well as software to find, retrieve and store personal health information on personal computers, cellphones and other kinds of digital devices — perhaps even a wristwatch with wireless Internet links some day."**

These rumblings have been going on for a while. Google recently put together a [much-remarked-upon](#) cadre of health experts to advise it in its quest. And, as the WSJ [reported](#) last month, Microsoft is in the midst of hiring dozens of people to staff a new health group, and recently bought a company that makes databases for patient records.

Value-Driven Health Care Purchasing: Four States that Are Ahead of the Curve

Studies from The Commonwealth Fund – 8.15.07

Overview: Health care purchasers, suppliers, and consumers are rallying for better-quality health care. In response, several states are pursuing value-based purchasing (VBP) initiatives that emphasize collection of quality-of-care data, transparency of quality and cost information, and incentives. In this overview of public-private VBP efforts in Massachusetts, Minnesota, Washington, and Wisconsin, the authors find that tiered premiums, pay-for-performance measures, and the designation of high-performance providers as "centers of excellence" are paying off. Minnesota, for example, has used incentives to achieve about \$20 million in savings in 2006. Similarly, Wisconsin's Department of Employee Trust Funds has announced premium rate increases in the single digits for the third straight year. More research is necessary to determine the true impact of VBP, but health plans and providers are paying attention to and learning from these current efforts. (Note: Accompanying the overview report are four separate state case studies.)

See: http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=515778&#doc515778

The Commonwealth Fund's State Scorecard How Will States Translate the Findings into Action?

The Commonwealth Fund newsletter – 8.16.07

The Commonwealth Fund's Commission on a High Performance Health System recently published [Aiming Higher: Results from a State Scorecard on Health System Performance](#). The State Scorecard is designed to examine variation across the states on 32 indicators of health system performance related to access, quality, avoidable hospital use and costs, equity, and healthy lives. It reveals an unfortunate truth: **where you live has a direct impact on your access to, and quality of, health care**. By identifying the correlations between health care access and quality, and by illustrating areas in which states have room to improve, the Fund hopes to catalyze discussions at the state and federal levels on what steps are needed to improve health system performance and contain costs across the nation.

The State Scorecard estimates the cost savings and improved health outcomes that could be achieved if middle- and low-performing states implemented policies and strategies similar to those executed by the highest performers. The *State Scorecard* was developed, in part, to uncover strategies leading to high performance, and to identify states that have undertaken these strategies.

Across the board, higher performance is associated with state policies that improve access and quality. For example, Hawaii—the first state to require employers to provide health insurance to full-time employees—ranks first in terms of providing access to care. Ten years ago, Rhode Island implemented pay-for-performance incentives for Medicaid managed care plans, and the state now ranks first on several measures of health care quality.

The *State Scorecard* results can motivate and focus states as they work to improve their health systems. Toward that end, [the Fund is facilitating a series of forums through which states can disseminate the information provided through the *Scorecard* and begin a dialogue on opportunities for creating systems and models that meet their residents' needs.](#)

2008-09 PACKER POLICY FELLOWSHIPS

Australian-American Health Policy Fellowship Program

On behalf of the Australian Government Department of Health and Ageing, The Commonwealth Fund invites applications for the 2008-09 Packer Policy Fellowships. (8.17.07)

[Deadline for receipt of applications for the 2008-09 fellowships has been extended to 10.1.07.](#)

The Packer Policy Fellowships offer a unique opportunity for outstanding, mid-career U.S. professionals--academics, clinicians, decisionmakers in managed care and other private health care organizations, federal and state health officials, and journalists--to spend up to 10 months in Australia conducting research and working with leading Australian health policy experts on issues relevant to both countries. In addition to undertaking original policy research, fellows will participate in seminars and policy briefings, which include meetings with senior officials at the Commonwealth and State levels, Ministerial officers, service providers, academics, and other stakeholders in the public and private sectors. At the end of their tenure, fellows produce a report and present project findings to senior government officials and policy experts at a final reporting seminar.

Kaiser CEO Says Big Business Should Buy Better Health

Wall Street Journal Health Blog – 8.15.07 (Posted by Jacob Goldstein)

[Kaiser Permanente CEO George Halvorson says big corporations should demand a new kind of health-care for their employees — a package that includes personal health records, intensive case management for chronically ill employees, and performance profiles and cost data for doctors.](#)

That sounds like the Kaiser mantra. And the new product — which he describes in his new book [Health Care Reform Now!](#) — could create “virtual Kaisers” around the country, Halvorson says. But if corporations heed his call and start trying to buy these services, Kaiser may not be the one to sell it to them, he adds.

Other big insurers could step in. They already have lots of doctor and hospital data in their claims databases, and some have started rating doctors. Technology companies might also be attracted by the heavy-duty information systems needed to put such a system in place, Halvorson writes. And as we [noted](#) yesterday, Microsoft and Google are both scrambling to get into consumer health care.

Report: States Take Initiative to Provide Health Care

The Commonwealth Fund newsletter – 8.15.07

With health care costs on the rise and almost 45 million Americans lacking insurance, many states have proposed initiatives to increase health care coverage for their residents and lower premiums, according to a report released Wednesday from the National Governors Association (NGA).

In 2005, the United States spent more on health care than any other industrialized nation—nearly \$6,700 per person—but ranked lowest in the quality of care provided, the report said. States are taking broad approaches to overhauling health care, including increasing coverage through expanding public programs such as Medicaid and the State Children's Health Insurance Program (SCHIP), creating small business incentives and premium incentive programs to aid workers in purchasing employer-sponsored health insurance, and establishing participation requirements to encourage employers and individuals to obtain health insurance. States also are attempting to improve quality of care and increase prevention and wellness programs, the report states.

The NGA report points to [several state programs already in progress that address these issues](#). For instance, Illinois' All Kids program expands [public health programs to include all children](#) in the state who have been without health insurance for at least 12 months, while a similar program in Wisconsin provides enhanced benefits for pregnant women.

Several states have instituted [programs to aid small businesses](#), which often are unable to offer affordable health insurance due to prohibitive costs. Oklahoma and New York offer subsidized plans that require businesses with 50 or fewer workers to contribute a percentage of employee premiums, according to the report.

In Utah, [low-income individuals who are eligible for insurance through their employer but cannot afford the premiums](#) can receive up to \$150 a month and an additional \$100 per child. Texas also has instituted a similar program. Massachusetts and Vermont both require employers to offer insurance or pay a portion of their employees' premiums. Businesses in Vermont also are assessed a \$365 annual fee per full-time employee if any employees remain uninsured.

Another tactic some New England states have employed to lower costs is [requiring individuals to obtain health insurance if they can afford it](#), thereby spreading risk for insurance companies across a larger group.

Ensuring quality of care has been a priority for several states. Washington State has [implemented health records banks to aid caregivers](#) across the state and has sought to [give patients more information about treatment options, with the goal being to drive down health care costs](#).

Changes in Store for Industry-Funded Doctors' Education

Wall Street Journal Health Blog – 8.15.07 (Posted by Jacob Goldstein)

Now that the feds are picking up the tab for many Medicare patients' prescription drugs, some senators are [prying into](#) doctors' continuing medical education, or CME. Their questions could lead to changes in how CME, which most states require for doctors to renew their licenses, is funded and monitored.

The senators want to know [whether the billion dollars a year the drug and device industries are pouring into CME winds up making doctors prescribe too many expensive, brand-name medicines and devices](#). One of the guys they're asking is Murray Kopelow, the M.D. who runs the [Accreditation Council for Continuing Medical Education](#), which watches over more than 700 CME providers.

In a recent conversation with the Health Blog, Kopelow said ACCME will likely start sending auditors to CME lectures. "We could have trained monitors observing CME presentations and reporting their findings to us," to see whether the presentations are straying from the rules, he said. The group hasn't yet decided whether the monitors would work undercover.

CME providers that step out of line might find themselves facing sanction more quickly and more often. Providers now have several years to clean up their act, and only one provider or so a year loses its accreditation. "The Senate and others have said we don't ... have as heavy a hand as we could. The ACCME is going to talk about that," Kopelow said.

The way money passes from drug and device companies to CME providers could also change, Kopelow said. Now, a provider applies to a company for funding, and the company decides whether to grant the request. This can lead to what Kopelow calls "curriculum bias." What gets taught in industry-funded CME tends to be the subjects companies want doctors to learn about. So CME on new diabetes drugs might find industry funding more easily than CME on ways to help diabetics lose weight and change their diet to stay off drugs altogether.

[One idea Kopelow's group is considering would put industry money in a central pot that is then allocated by medical professional societies. "That would mean that the patients' needs and the profession's needs would be driving the curriculum," he said.](#)

States Could Use SCHIP to Cover Young Adults Through Broader Medicaid Coverage

The Commonwealth Fund newsletter – 8.15.07

States should be allowed to use the State Children's Health Insurance Program (SCHIP) to cover young, childless adults if they extend their regular Medicaid programs to cover low-to-moderate-income children, according to Sara Rosenbaum, a health law professor at George Washington University's School of Public Health and Health Services.

Young adults who have grown out of child health insurance programs are the most uninsured group, according to the Commonwealth Fund. In 2006, more than 10 million young adults ages 19–26 were uninsured, according to Rosenbaum, whose paper, "SCHIP Reconsidered," was published in *Health Affairs* on Tuesday.

According to Rosenbaum, SCHIP's reauthorization is an opportunity for policymakers to reassess and alter SCHIP to address the "staggering" number of young adults who are uninsured, while also taking into account developments in Medicaid policy that have changed the interaction between Medicaid and SCHIP.

"Despite Medicaid's broad coverage, financing medical assistance for children is so inexpensive—even with comprehensive coverage, children cost Medicaid \$719 each, on average, in 2001—that many states might respond to this opportunity to secure funding for older children, pregnant women, and parents," Rosenbaum said.

Because Medicaid is an entitlement program, it would give child health financing a "more secure financial base," Rosenbaum said. In addition, covering children through Medicaid and young adults through SCHIP would make sense, partly because Medicaid coverage includes Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits, she said. These benefits are essential to monitoring children's health and not necessary for young adults, or available through SCHIP.

Children covered through Medicaid could also take advantage of the 100 percent federal funding contribution rate for vaccines through Medicaid's Vaccines for Children program, as well as the 90 percent federal funding rate for family planning services and supplies, Rosenbaum said.

Too Young for Medicare, Too Old for Cheap Insurance

Wall Street Journal Health Blog – 8.17.07 (Posted by Sarah Rubenstein)

As Massachusetts moves to make health coverage universal, the state is running into a familiar problem: [The high cost of insurance for older adults who don't yet qualify for Medicare.](#)

In many states, the 50-to-64 set struggles to afford health insurance, especially if they don't get coverage through an employer. Because they tend to use more health care than younger adults, insurers often charge them a lot for coverage — or [reject them altogether](#).

And in Massachusetts, 78,000 people in this age group didn't have insurance last year, the Boston Globe [reports](#). About 42,000 of those people have incomes low enough to qualify for free or subsidized coverage from the state. But for the remaining 36,000, paying for coverage may still be a struggle, because Massachusetts law allows insurers to charge older people twice as much as younger people, the Globe says.

Evelyn Hartrey, 60, found that the least-expensive plan would cost her \$352 a month, while a 27-year-old would pay \$176 for the same coverage. "That is discrimination," she told the Globe.

The state agency overseeing the near-universal insurance law sees it differently. Nationally, average health care spending from all sources for people aged 50 to 64 was more than triple spending for people aged 20 to 29. So even if older adults pay twice as much as younger ones, they're getting a break, the agency told the Globe. "Is insurance expensive? Absolutely," spokesman Dick Powers said. "Have we made it less expensive? Absolutely."

Indeed, to folks whose stories appear in [this WSJ.com article](#), \$352 a month may seem relatively cheap. Check it out for tips on planning for health costs as you age.

Analysis: Pain medicine use has risen by 90 percent

Associated Press – 8.20.07

MYRTLE BEACH, S.C. -- People in the United States are living in a world of pain and they are popping pills at an alarming rate to cope with it. **The amount of five major painkillers sold at retail establishments rose 90 percent between 1997 and 2005**, according to an Associated Press analysis of statistics from the Drug Enforcement Administration.

More than 200,000 pounds of codeine, morphine, oxycodone, hydrocodone and meperidine were purchased at retail stores during the most recent year represented in the data. That total is enough to give more than 300 milligrams of painkillers to every person in the country.

Oxycodone, the chemical used in OxyContin, is responsible for most of the increase. Oxycodone use jumped nearly six-fold between 1997 and 2005. The drug gained notoriety as "hillbilly heroin," often bought and sold illegally in Appalachia. But its highest rates of sale now occur in places such as suburban St. Louis, Columbus, Ohio, and Fort Lauderdale, Fla.

The world of pain extends beyond big cities and involves more than oxycodone. In Appalachia, retail sales of hydrocodone _ sold mostly as Vicodin _ are the highest in the nation. Nine of the 10 areas with the highest per-capita sales are in mostly rural parts of West Virginia, Kentucky or Tennessee. Suburbs are not immune to the explosion. While retail sales of codeine have fallen by one-quarter since 1997, some of the highest rates of sales are in communities around Kansas City, Mo., and Nashville, Tenn., and on New York's Long Island.

The DEA figures analyzed by the AP include nationwide sales and distribution of drugs by hospitals, retail pharmacies, doctors and teaching institutions. Federal investigators study the same data trying to identify illegal prescription patterns.

An AP investigation found these reasons for the increase:

- **The population is getting older.** As age increases, so does the need for pain medications. In 2000, there were 35 million people older than 65. By 2020, the Census Bureau estimates the number of elderly in the U.S. will reach 54 million.
- **Drugmakers have embarked on unprecedented marketing campaigns.** Spending on drug marketing has gone from \$11 billion in 1997 to nearly \$30 billion in 2005, congressional investigators found. Profit margins among the leading companies routinely have been three and four times higher than in other Fortune 500 industries.
- **A major change in pain management philosophy is now in its third decade.** Doctors who once advised patients that pain is part of the healing process began reversing course in the early 1980s; most now see pain management as an important ingredient in overcoming illness.