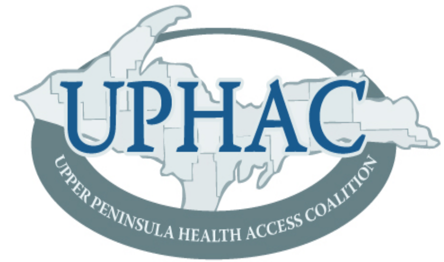

Access to Health Care News Update – 9.13.07

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)

UAW stance on health care worries workers

Free Press – 9.5.07

A growing belief that the UAW will allow Detroit's automakers to offload health care costs onto the union is elevating anxiety levels among automotive factory workers, with at least one opposing a deal that hasn't been reached yet.

Some autoworkers are concerned that the automakers' push to create a special retiree health care trust -- known as a Voluntary Employee Beneficiary Association, or VEBA -- is too risky and could leave them without coverage once they retire.

Others see it as a way to protect benefits even if an automaker goes bankrupt.

The Detroit automakers have asked the UAW to agree to a VEBA that would take on responsibility for a significant portion, if not all, of the companies' hourly retiree health care liability. People close to the negotiations have said General Motors Corp. would not want to pay more than 65% of its liability into the trust. GM's full health care liability is about $64 billion. If a VEBA were established, the automakers would pay a lump sum to a trust that the union would likely be responsible for managing to cover retired autoworkers' health costs.

"They're talking about starting out underfunding it, and that means the costs will shift to us," said Greg Shotwell, a GM hourly worker and union activist who runs the Web site www.soldiersofsolidarity.com. Some union workers at other companies have ended up without private health benefits in their retirement plans because the VEBAs ran out earlier than planned, Shotwell said.

If the union agrees to a partially funded VEBA, Shotwell fears it may try to rush the ratification of a contract so that workers won't have time to understand it.

Act now to solve budget crisis, Milliken and Blanchard urge

Free Press – 9.5.07

Former Govs. William Milliken and James Blanchard urged immediate action Wednesday on moves to address state government's looming budget crisis, calling for tax hikes, spending reform, government consolidation and cuts in spending on health care and prisons.

Milliken and Blanchard, who headed up a financial crisis review team for Gov. Jennifer Granholm in January, said in a statement "some important first steps have been taken," but much remains to be done.
The former governors urged "immediate integrated action on all fronts."

The state Legislature and Granholm remain at loggerheads over how to resolve a potential $1.7-billion to $1.8-billion deficit in the 2007-08 budget year that begins Oct. 1. Senate Majority Leader Mike Bishop, R-

Rochester, said Wednesday morning he would like to see action this week, in part because the deadline for placing ballot proposals before state voters for the Nov. 6 election is Thursday.

OPINION: New SCHIP Guidelines

Source: Cover the Uninsured, from New York Times, 9.2.07

The Bush administration's new guidelines for the State Children's Health Insurance Program (SCHIP) which make it difficult to expand eligibility above 250 percent of the federal poverty level seem "too stringent" because a "compelling case can be made for raising the limit to at least 300 percent, and there are plausible reasons in some states for going higher," a *New York Times* editorial states.

Critics of the current eligibility levels for programs such as New Jersey's that cover families up to 350 percent of the federal poverty level are "apoplectic" that New York has proposed raising the threshold to 400 percent ($82,600 for a family of four). Proponents of raising income eligibility levels argue that, "alarming deterioration in private insurance coverage," coupled with soaring premiums means that "even middle-income families are feeling the pinch." The Times concludes: "What used to be a problem for low-income families has become a problem for the middle class as well. SCHIP needs to reflect that."

Health Insurance Goes Dutch

Wall Street Journal Health Blog 9.6.07 (Posted by Joseph Mantone)

The Dutch are taking a novel approach to health care, and it has nothing to do with providing herbal remedies in Amsterdam's coffee shops. Starting in 2006, the Netherlands has required all adults to buy their own health insurance, or pay a penalty. And insurers must offer policy to all comers, no matter how sick or old they are, WSJ's Gautam Naik reports.

The government subsidizes policies for adults who can't afford to pay premiums and makes "risk-equalization" payments to insurers that cover the elderly and those with some chronic conditions such as diabetes. The current Dutch program differs from plans in other parts of Europe, which mostly offer national health care, and the U.S., which largely relies on employers paying for the bulk of coverage.

The idea behind the Dutch is that individuals will enroll in health plans that provide the coverage they need instead of a one-size-fits-all plan chosen by an employer. And individuals will pay more attention to health costs, which are largely ignored when the government picks up the tab. The Dutch want the "risk-equalization" incentive payments to motivate insurers to cover more than just healthy customers.

It's too early to tell if the Dutch treatment to manage costs and improve quality will become a model for the rest of the world. But anecdotal reports show things are moving in the right direction. Insurer Rival UVIT offered to pay the gym membership fee for Rianne Boel, who was overweight and diabetic, if she lost 7.5% of her weight in 15 months. Boel cut back on french fries and pizza and started walking, cycling and rowing. The changes helped her reach the goal. "I don't like exercising," Boel says, "but at least I can now walk without a stick."

Besides the benefit of walking upright without support, customers such as Boel have also benefited from a price war that saw insurers offer premiums lower than what the government estimates. The government predicted insurers in 2006 would offer annual premium averages of €1,106, or about $1,500, but the average was set at €1,028, 7.6% lower. This year, it has risen to €1,103, which is still less than the €1,134 the government predicted for 2007.

Alain Enthoven, a Stanford professor whose ideas about "managed competition" were influential in the Dutch approach, believes the U.S. should replicate the plan. "The lesson for America is that this is what we ought to do," Enthoven says.

Historic deal aims to shift retiree health costs to UAW

Free Press Column (Tom Walsh) – 9.7.07

UAW contract talks with Detroit's three automakers are shaping up as a high-stakes trade-off of historic proportions.

The union is willing to bargain toward a landmark deal to shift more than $100 billion in retiree health care costs from Detroit's auto companies to a union-run trust fund, but *only if* General Motors Corp., Ford Motor Co. and Chrysler LLC lay a lot of money on the table and make very specific promises about what products will be built by UAW workers in U.S. factories during the term of the next labor contract.

All three companies and the UAW are actively engaged in detailed talks about how to structure and run a voluntary employee beneficiary association (VEBA) to pay for the health care of retired hourly workers in the future, according to people involved in the talks. This is a daunting task because the union has never tackled a financial management project of this scale, and company and union negotiators are working to ensure that the expertise is available and the right governance system safeguards obligations to retirees.

Exactly how many billions of dollars the three companies must ante up to get the VEBA started -- estimates range from a combined $60 billion to $90 billion -- won't likely be hammered out until the last few days of negotiations. The current contract expires Sept. 14….

…Current negotiations over the VEBA…are so complex that one bargainer said it's "impossible to handicap" whether a comprehensive deal could be forged before next week's expiration of the current contract. GM's future obligations for retiree health care have been pegged at about $64 million, Ford's at more than $30 million and Chrysler's at $17.5 million. To make lump-sum payments to finance future obligations, the companies will want a discount of 30% to 40% off the total liability. The union will push for a smaller discount. Successful shifting of those obligations into a union-run VEBA would take a big load off the company balance sheets and help upgrade their debt ratings, which are stuck in "junk" status, well-below investment grade.

Wall Street financial analysts love the notion of a health care VEBA for the auto industry and already have built it into their expectations for company performance. If the UAW and the automakers fail to come up with a solution on this issue, it undoubtedly would hurt their stock values and credit standing at a time of general turmoil in the credit markets.

That's why there's such a strong belief that a health care VEBA deal would get done -- because it has to. But that doesn't mean it would be easy.

Jobs fall in August; payrolls much weaker than expected, first drop in 4 years

CNN Money – 9.7.07

NEW YORK -- The number of Americans with jobs fell for the first time in four years in August, as Friday's closely watched government jobs report came in much weaker than Wall Street forecasts. There was a net loss of 4,000 jobs in the month, down from the 68,000 increase in July, which was also revised lower. Economists surveyed by Briefing.com had forecast an increase of 110,000.
The unemployment rate stayed at 4.6 percent in August, despite the drop in payrolls, in line with economists' forecasts. The rise in those who are unemployed was balanced by a bigger drop in those counted as in the nation's labor force.

The August jobs report was being particularly closely watched by investors and economists for clues as to what the Federal Reserve will do with interest rates when it meets Sept. 18. There is greater uncertainty than normal as to what the Fed will do with its benchmark rate in the face of turmoil in the nation's credit and financial markets.

Feds Nix NY Plan to Expand Kids' Health Care

Wall Street Journal Health Blog – 9.7.07 (Posted by Heather Won Tesoriero)

The Bush administration rejected an application from New York to offer subsidized health insurance originally developed to help poor children to many middle-income families.

New York wanted to loosen eligibility for the so-called SCHIP program to families with incomes as much as 400% of the federal poverty level, or $82,600, Newsday reports. Gov. Eliot Spitzer estimated that some 70,000 kids in New York would have been eligible for the insurance, if the feds had approved the plan.

Under the SCHIP program, the government subsidize the cost of health coverage, but it's generally limited to those families at not more than 250% of the poverty level, or $51,625, for a family of four.

Indeed, recent guidelines on eligibility require that a state demonstrate to the feds that it has already signed up at least 95% of poor children in public health programs before expanding the subsidized coverage to children from more prosperous families. The Empire State didn't show it had met that threshold. "New York has not demonstrated that its program operates in an effective and efficient manner with respect to the core population of targeted low-income children," said Kerry Weems, just named acting administrator for the Centers for Medicare and Medicaid Services. Rep. Charles Rangel, D-N.Y., called the Bush administration's decision "unconscionable," the AP reported.

Health Insurers Invoke Law of Unintended Consequences

Wall Street Journal Health Blog – 9/7.07 (Posted by Vanessa Fuhrmans)

The health insurance industry's main trade group is blasting some initiatives taken by states a decade ago to improve coverage.

America's Health Insurance Plans, a trade group, put out an analysis of what happened over 10 years in eight states that enacted a couple of reforms the industry opposed in the 1990s.

No. 1 on the list: "guaranteed issue," a requirement that insurers sell health insurance policies to all comers, regardless of their health. The requirement removed the ability of insurers to deny people coverage because they're too sick and costly. The other bugaboo: "community rating," which requires insurers to charge all consumers the same or very similar premiums without regard to such factors as age, gender or health status.

Among the states examined in the report are Massachusetts, New York and Washington. Milliman, an actuarial firm, crunched the numbers. The report concludes that health coverage mandates usually had unintended consequences: a rise in insurance premiums, a decrease in enrollment and an exodus of health insurers from the state that introduced some combination of the two.

After state legislators enacted guaranteed issue and a modified form of community rating in Kentucky in 1994, for instance, more than 40 insurers fled the market and the percentage of working age adults purchasing insurance on their own fell faster than the national average. Like a number of the states reviewed in the report, Kentucky did away with most of the reforms by the late 1990s.

"It demonstrates that insurance reforms without universal access drives up health care costs for consumers and encourages individuals who have health insurance to drop insurance and take the financial risk of being uninsured," AHIP's president and chief executive, Karen Ignani said in a statement.

These days, in fact, states are looking more at mandating individual and employer coverage to ensure universal access, though that hasn't stopped health insurers from continuing to lobby against guaranteed issue and community rating.

Democrats Look Outside Traditional Conference Process to Move SCHIP Bill

The Commonwealth Fund Newsletter – 9.6.07

Leading House Democrats said Thursday that they will negotiate compromise children's health insurance legislation informally with their Senate counterparts if Senate Republicans continue to block a formal conference committee on the bill.

House Democrats held a rally with labor union activists on Thursday intended to pressure both President Bush and the Senate to act quickly on a renewal of the State Children's Health Insurance Program (SCHIP), which covers more than 6 million low-income children.

Both chambers have passed bills to renew the program, which expires Sept. 30. But Senate Republicans have blocked the appointment of senators to a conference committee that would negotiate a final bill, saying they want an agreement to limit the bill's scope and expense before a conference convenes. The House bill (HR 3162) is broader and more expensive than the Senate version (HR 976).

"If they're going to block it," said Rep. Pete Stark, D-Calif., chairman of the Ways and Means Health Subcommittee, "I think we get together and we get a plan."

"It won't stop us from coming to an agreement on our own in the next few weeks," said Rep. Frank Pallone Jr., D-N.J., chairman of the Energy and Commerce Health Subcommittee.

Both men, who helped write the House bill, said after Thursday's rally that they would prefer a formal conference. But one alternative, they said, is for House and Senate Democrats to agree informally on a compromise bill on their own, then approve it in a brief conference at the end of the month if Senate Republican opposition can be overcome.

Another alternative is a short-term extension of SCHIP, perhaps to Nov. 15, Stark said. He said Congress has only nine legislative days before the end of the fiscal year, when the program expires, to clear a conference report for President Bush—who has threatened to veto either the Senate or House versions of the legislation.

The Senate version is much more bipartisan than the House bill; it passed 68–31 on Aug. 2, enough to override a veto. The House bill passed 225–204 on Aug. 1, far short of the two-thirds necessary to overcome a veto.

But each bill has provisions that are objectionable to many members in the opposite chamber. The House bill includes a nearly $50 billion expansion of SCHIP, to $75 billion over the next five years—about $15 billion more than the expansion the Senate approved. The House bill also would cut payments to insurers who participate in Medicare Advantage, a Republican-championed program in which insurers provide benefits to seniors in place of the government. Medicare Advantage has greater support in the Senate.

The Senate bill, however, includes a larger tobacco tax increase than the House bill. The Senate bill would raise the cigarette tax by 61 cents, to $1 per pack, 16 cents more than the increase the House approved. Some House Democrats voted against the House bill because of its tobacco tax increase.

Health Risks Costing Workers

Associated Press – 9.11.07

First they tried nudging. Now companies are penalizing workers who have high health risks such as obesity and high blood pressure or cholesterol as insurance costs climb.

Lee Morrison, 51, doesn't mind the push, which came in the form of added insurance charges from his employer, Western & Southern Financial Group. "I knew if I wanted to be healthier and pay less, it was up to me to do something about it," said Morrison, who has lost 54 pounds and lowered his body mass index enough to earn refunds the past two years.

A small number of companies have linked health factors to what employees pay for benefits, but the practice is expected to grow now that some federal rules have been finalized, spelling out what's allowed by law. Employee advocates worry that other anti-discrimination laws such as the Americans with Disabilities Act won't cover the person who is 20 or 30 pounds overweight.

The businesses are deducting from employees' paychecks, adding insurance surcharges or offering insurance discounts or rebates only to low-risk workers.

"Employers know they have to do something," said Garry Mathiason, a senior partner at the national employment and labor law firm Littler Mendelson, based in Boston. "I believe that in just the next two years more employers will turn to penalties to change employee behavior."

Mathiason said more than 300 companies have sought advice on creating more aggressive wellness programs since the firm released a study in April on legal issues and trends associated with requiring healthy practices.

Health care spending in the United States is estimated to reach $2.2 trillion this year, with at least 54 percent of spending in the private sector, and is expected to nearly double by 2016, according to the National Coalition on Health Care.

A 2003-2004 National Health and Nutrition Examination Survey showed about two-thirds of adults in the United States were overweight and almost one-third were obese. A U.S. surgeon general's report said health care costs of obesity totaled more than $117 billion in 2000.

More employers have charged higher insurance premiums the past few years for tobacco-using employees. Otherwise, wellness programs had been primarily voluntary, offering in-house fitness centers and free health screenings, for instance.

But many employees of Indianapolis-based Clarian Health didn't use the programs, hospital spokesman James Wide said. In 2009 the company will start reducing pay for employees in its health plan by $10 per paycheck if their BMI -- a measurement of body fat through a height and weight ratio -- is in the obese range of more than 29.9. The deduction will be $5 per check if they don't meet required cholesterol, blood pressure or blood glucose measurements. Workers will be required to complete an annual health risk assessment and can appeal to have their fees dropped if they show improvement.

"We want more people to participate so that they can take control of their health," Wide said.

Some workers and employee advocates say companies are intruding in workers' private lives.The National Workrights Institute says employers adopting the charges are trying to control private behavior and amassing huge amounts of personal health information. "It's a backdoor approach to weeding out expensive employees," legal director Jeremy Gruber said.

Employers wary of risking legal problems feel more confident after federal regulations were finalized July 1 covering how wellness programs can comply with nondiscrimination requirements under the Health Insurance Portability and Accountability Act. Rewards (and therefore penalties) based on health factors cannot exceed 20 percent of the total cost of employee health coverage.Employers also are warned that they must consider other federal and state laws, including the ADA.

Businesses acknowledge they are trying to cut health care costs but say they also want to help employees get healthier. Each company determines what qualifies as high risk, but they generally follow traditional health standards.

Cincinnati-based Western & Southern Financial Group adds between $15 and $75 monthly to the insurance cost of health plan participants according to their BMI scores. A fitness center, weight loss programs and health screenings are provided, and employees reducing their BMI receive refunds, said Noreen Hayes, senior vice president of human resources.

Fifteen percent of employees who paid surcharges in 2006 received refunds this year, and about 40 percent of employees in the company's health plan pay the charges. The surcharges help cover some of the costs the company incurs as a result of those employees' conditions, Hayes said.

Roselyn Bryant, 61, of Cincinnati, doesn't face any of the health risks but still is glad that the bank where she works in the mail department doesn't charge for them. "I think it's too harsh to charge people for things they can't always control" she said.

Helen Darling, president of the National Business Group on Health, representing more than 200 of the nation's largest employers, thinks most employers prefer positive incentives. "I think it's a mistake to use penalties for something as complicated as maintaining weight in a society that does everything to make you inactive," she said. "It can make people mad, and we are in a war for talent."

Scott's Miracle-Gro Co., a lawn and garden company based in Marysville, Ohio, charges $40 more per month in health premiums for employees who don't complete annual risk assessments. The company charges $65 more for workers who don't try to reduce any high health risks that show up.

"We think that personal accountability is a big part of driving overall wellness, but we also provide our associates with the tools they need," spokesman Jim King said. "We think our program is a good balance of the carrot and the stick." King said participation rose from 70 percent to 95 percent after the charge was added. Scott's earlier stopped hiring tobacco users in states where that is allowed and reserves the right to fire employees who use tobacco.

A Brookfield, Wisconsin-based financial information services and technology company uses rebates. Fiserv Inc. offers a $35 monthly rebate to full-time employees in its health plan who complete health assessments and $25 rebates for spouses. Those at high risk for a chronic disease such as diabetes must participate in a disease management program to get the rebate, company spokeswoman Lori Stafford said.

Linda Cushman, health care strategist with the human resources consulting firm Hewitt Associates, said that whatever methods employers use, more employers are focusing on health risks such as obesity. "Employers are paying the lion's share of health care costs and feel that they have the right to call the shots," Cushman said.

A Country Doc Hatches a Retail Clinic

Wall Street Journal Health Blog – 9.11.07 (Posted by Jacob Goldstein)

The doctors in a rural Illinois town where Ben Brewer runs a family practice are “fighting mad” at the prospect of a retail clinic opening in the town’s only grocery store. And their aggressive opposition has so far kept a big, out-of-town multi-specialty group from opening a nurse-staffed clinic there to treat simple maladies, on the model being used around the country by big players like CVS and Walgreens.

But Brewer’s frustrated when he sees his patients head to the ER for simple weekend earaches that wind up costing them $600. On a recent day, he figures that 12 of the patients who came to his office could have been treated in a clinic. “I think it’s time to beat the clinics or join them,” he writes in his WSJ column. So he’s opening his own clinic in a nearby town where he practices one day a week.

It’ll be a one-room office staffed by nurse practitioners and open from 8 a.m. to 8 p.m. weekdays and 10 a.m. to 4 p.m. on weekends. The rent will be $250 a month, and there are a couple of pharmacies close by where patients can fill prescriptions. He figures 15 patients a day let him break even.

“I think a retail clinic will have better operating margins than our office, especially with financial pressure mounting on traditional primary care practices,” Brewer writes. “And I think it will help meet the needs of patients in the area. A storefront clinic won’t solve all the problems facing our practice or the health-care system, but it could help prevent $600 earaches.”

Wall Street Health Blog Brief: *9.11.07*

As auto workers leave the industry in droves, many are choosing new careers in health care, Jeffrey McCracken reports from Detroit. Car makers are encouraging younger workers to leave by offering buyouts that feature money for education to help with career changes. Ford says 40% of its former workers who are going to school are studying in medical fields — more than half specializing in nursing, followed by radiology, dental hygiene and pharmacology. “Health care is where the jobs are,” says Marty Mulloy, Ford’s head of labor relations.

Automakers, union yet to agree on health care

Free Press – 9.11.07

With less than 72 hours to go before the national contract between the UAW and the Detroit automakers expires, those close to the talks say the parties have made progress but still have substantial financial issues to negotiate, not the least of which is whether the union will agree to take management responsibility for future retiree health care costs.

General Motors Corp. and Ford Motor Co. must transfer their future retiree health care costs to the union, many analysts and people familiar with the company strategies say, while Chrysler LLC also would benefit, though to a lesser degree, from such an agreement.

In their initial proposals to the UAW, the automakers proposed the creation of a special retiree health care trust -- known as a Voluntary Employee Beneficiary Association, or VEBA -- in which they would pay some portion of their retiree health care liability into an account to be managed by the union to cover future UAW retiree health care costs.

"Obviously, the VEBA is the big thing and everything falls in place after that," said auto industry analyst Kevin Tynan. "I imagine the rest of the stuff gets done based on the VEBA."

And from the union's perspective, analysts say, UAW President Ron Gettelfinger likely faces two options. "If Gettelfinger doesn't give the companies what they want on retiree health care, he'll get nothing in terms of wages, benefits or job security in the rest of the contract," Sean McAlinden, an economist at the Center for Automotive Research in Ann Arbor, told Bloomberg News. "If he does, he'll be able to make some gains."

Gettelfinger, 63, needs to push for an agreement by or within a few days after the midnight Sept. 14 contract deadline to show management he is in control of the union and the bargaining process, McAlinden told Bloomberg.

Dow Jones reports that the union has not provided a definitive response to the companies on whether it will negotiate to create a VEBA. But people familiar with the talks told the Free Press that a VEBA is under consideration at the UAW and that informal talks between members of negotiating teams have occurred.

Rise in Insurance Rates Slows, Kaiser Survey Says

NPR, All Things Considered, 9.11.*07 · Listen:*
http://www.npr.org/templates/story/story.php?storyId=14324358

A new survey shows that an increase in health insurance rates this year is less than the increase last year. But, that's not necessarily good news to the employers or employees who pay the premiums.
Every year, the Kaiser Family Foundation asks 2,000 small, medium and large businesses what they're doing about health insurance and how much they're paying.

This year, businesses reported facing a 6 percent increase in health insurance premiums. That's lower than last year's 8 percent increase and much lower than the 14 percent increase in 2003. But that hides another key number: Health insurance rates have gone up faster than inflation every year for the past decade. And the cumulative effect hurts, says Kaiser's Drew Altman.

"Nobody is celebrating, and a moderating rate of increase doesn't feel like moderation to employers or working people," Altman says. "All they know is that it's going up this year again and it's going up more than anything else around."

It's going up much more than wages and much more than the costs of goods and services. Still, the percentage of small- and medium-sized firms offering some type of health insurance held steady from last year to this year at about 60 percent, and virtually all large firms continue to offer insurance to their employees.

The survey shows no big increase in the number of workers enrolling in the new high-deductible health plans, but it does show that in the past couple of years, some companies are moving to higher premiums for higher-wage employees. Altman says it's a scramble.

"Employers are trying to do everything they can but they have no single, magic solution, so they're trying lots of things," Altman says.

Even experts in health insurance are getting hit and have to be creative. "This year we got hit by a 33 percent increase by one of our two major insurers," says Altman of the Kaiser Family Foundation. "We had no recourse so we switched plans and got a better rate."

In the survey, employers said they are very, or somewhat likely to increase what employees pay for their health insurance and prescription drugs. But they have said that even in years that they haven't made major changes.

Altman suspects that what will really happen is that businesses will play a more active role this year in making sure health care reform is an issue in state and national elections.

Health Insurance Gaps Keep Would-Be Retirees Working

Wall Street Journal Health Blog – 9.12.07 (Posted by Jacob Goldstein)

The number of Americans between 65 and 74 who are still working has jumped sharply, from 19.6% in 2000 to 23.2% last year, the Census Bureau said today. This morning's Washington Post suggests several reasons for the jump, but one caught the Health Blog's eye: Cuts in retiree health benefits have pushed employees to work longer to save on health care costs.

"People are simply hanging on to their job as a way to hang on to their income and to their health insurance so they can supplement their Medicare coverage," Christian Weller, a University of Massachusetts professor and a senior fellow at the liberal Center for American Progress, told the paper.

Ron Crouch, director of the Kentucky State Data Center, told the Louisville Courier-Journal:
"We're living a lot longer and I'm afraid we're going to see people run out of money before they run out of life."

Of course, some people work past 65 because they like working. And as the percentage of private-sector workers eligible for an employer-sponsored retirement plan continues to fall, plenty of people are forced to keep working because of financial needs that go beyond health care. For many, it's a combination of factors.

"I purchased a townhouse pretty recently, so the payments are still high," a 70-year-old assistant principal told the Post. "Also, I worry a lot because my son [who is too ill to work] doesn't have health insurance. If I didn't have these situations, I'd have retired by now."

Hashing Out Kids' Health Insurance on The Hill

Wall Street Journal Health Blog – 9.11.07 (Posted by Jacob Goldstein)

Lawmakers from the House and Senate are meeting today to work out their differences on increasing funding for the State Children's Health Insurance Program before the current program expires at the end of the month. WSJ's Washington Wire reports:

The House is widely expected to shift in the Senate's direction in the final agreement — by agreeing to a higher tobacco-tax increase and dropping Medicare provisions until a later time. But the House, which passed an additional $50 billion in funds for SCHIP, may insist that the Senate agree to more spending than the $35 billion it passed.
"We're not going to accept $35 (billion)," House Ways and Means Chairman Charles Rangel (D., N.Y.) said in a briefing with reporters on Friday.

President Bush has vowed to veto the bills passed by both houses, arguing that they are an unwise expansion of the government's role in health care. The Senate version passed with 68 votes, just over the

two-thirds required to override a veto. But the more expansive House version passed by a non-veto-proof 225 to 204 vote.

So if Rangel (pictured) and his House colleagues are intent on passing a bill into law, they'll be considering compromises that could win the backing of some House Republicans, to give the House a shot at overriding the promised veto.

Health Savings Accounts Aren't Catching On

Wall Street Journal Health Blog – 9.11.07 (Posted by Jacob Goldstein)

A closely watched survey of employer-sponsored health insurance released today is getting attention for finding a 6% rise in premiums this year.

That headline number is climbing faster than inflation, though still below the double-digit increases of a few years back.

But the Health Blog was interested in a nugget buried inside the results. High-deductible insurance plans tied to special savings accounts continue to lag behind expectations, despite being praised high and low as a tool to slow the rise in health-care costs.

Only 5% of all covered workers are enrolled in them this year — a change that's not statistically different from the 4% who were covered last year, according to the survey. The plans come in a few flavors but are widely known for their association with tax-advantaged health savings accounts, or HSAs. They're sometimes known as "consumer-driven" plans because employees pay directly for more of their care.

Supporters say the plans can use market forces to cure the health care system, transforming passive patients into active consumers who seek out the best care at the best price. But, as we noted earlier this year, the plans have proved unpopular with the public.

One possible reason is that roughly half of the workers enrolled in the plans don't receive any company contributions to the savings plans, leaving the employees to pay higher out-of-pocket costs themselves, according to the survey.

SCHIP Expansion Stalls Over Dispute in Congress

Source: Cover the Uninsured, Washington Times, 9.10.07

Discussions in Congress to reach a compromise on State Health Children's Insurance Program (SCHIP) legislation "have stalled over a dispute on whether to pay for the program with cuts to Medicare," reports the *Washington Times.*

Senator Charles Grassley (R-Iowa) said, "The House bill is more expensive by billions of dollars and contains cuts to Medicare Advantage--both of those items are poison pills for some Senate Republicans." However, House Democrats said they have little incentive to compromise because House Republicans have not said that they would support a bill that does not include Medicare Advantage plan cuts. "This is a complete red herring for House Republicans to talk about wanting Medicare cuts taken out of the bill," a House Democratic aide said. Democratic House leaders plan to send a comprehensive bill to President Bush before funding for the program expires at the end of the month. Senate Republicans have expressed "less urgency" to put together a deal by month's end, stating: "If we don't get it done by the end of the month, we'll just pass an extension and deal with it later in the year," a Senate Republican aide said. "It's no big deal--it's done all the time."

The House bill calls for a spending increase of about $50 billion, with the Senate version spending an additional $35 billion over five years.

OPINION: New York's Denial Will Make it Harder for States to Expand Coverage

Source: Cover the Uninsured, from New York Times, 9/8/07

The Bush administration reached a "deplorable, preordained" verdict when it denied the state of New York permission to expand its Children's Health Insurance Program (CHIP) to cover middle-class children, states a *New York Times* editorial.

New York was aiming to raise its income level for CHIP eligibility from the current $51,000 a year for a family of four to more than $82,000 -- four times the federal poverty level. The administration imposed new "excessively stringent" requirements last month that denied New York expansion of its program and made a similar expansion in other states "nearly impossible." The administration based its rejection of New York's proposal on the grounds that the state was not meeting the new requirements. According to the *Times*, "The administration seemed more intent on blocking the program than finding a reasonable compromise." New York can petition the administration for reconsideration, although the likelihood the administration will change its mind is "vanishingly small."

OPINION: Senate Plan to Fund SCHIP May Stand Up to a Bush Veto

Source: Cover the Uninsured, Los Angeles Times, 9.7.07

The State Children's Health Insurance Program (SCHIP) must be renewed by September 30 or the 6.6 million children in the program will face the threat of losing enrollment. According to an editorial in the *Los Angeles Times*, "It's clear that any bill that reaches the president's desk would have to garner sufficient bipartisan support to stand up to Bush's threatened veto. The more modest Senate version could."

President Bush has pledged $5 billion more to the program, while the Senate plan would increase funding by $35 billion. Although the Senate bill has been described as "limited," it passed 68 to 31, which is enough to override a presidential veto. The *Times* editorial states that Republicans and Democrats are "losing perspective," and rather than House Democrats using cuts to Medicare Advantage payments to fund the program, Congress needs to refocus its efforts on the Senate bill. "It's SCHIP that needs the attention. Use the Senate's higher tobacco tax, and only that tax, to fund the program." The editorial concludes, "A smaller, more realistic SCHIP bill is better than a late bill, or no bill at all."

Americans' life expectancy up to 78, study finds

Associated Press – 9.12.07

ATLANTA — The life expectancy for Americans is nearly 78 years, the longest in U.S. history, according to new government figures from 2005 released Thursday. That age, based on the latest data available, was still lower than the life span in more than three dozen other countries, however.

More bad news: The annual number of U.S. deaths rose from 2004 to 2005, a depressing uptick after the figure had dropped by 50,000 from 2003 to 2004. In 2005, the number of deaths increased by about that same amount.

U.S. life expectancy at birth inched up to 77.9 from the previous record, 77.8, recorded for 2004. The increase was more dramatic in contrast with 1995, when life expectancy was 75.8, and 1955, when it was 69.6. The improvement was led by a drop in deaths from heart disease and stroke — two of the nation's leading killers, according to the National Center for Health Statistics, which released the new life expectancy report Wednesday.

'Marketplace' Report: Gas Prices Up, Obesity Down

NPR, *Day to Day, 9.12*.07 · Listen: http://www.npr.org/templates/story/story.php?storyId=14348271

Higher gasoline prices may not be all bad. According to a new study, higher gas prices could help reduce obesity levels by encouraging people to drive less and walk or ride bikes more. The study found that an additional $1 per gallon would reduce U.S. obesity 15 percent after five years. *Marketplace's* Amy Scott spoke with Robert Smith about the study.

Google's Health Guy Logs Off

Wall Street Journal Health Blog – 9.12.07 (Posted by Jacob Goldstein)

Latest twist in the tech-giants-want-to-be-health-giants saga: Google's health-care point man is leaving the company for points unknown. Adam Bosworth, who was the company's VP of engineering, is on vacation at the moment and "has decided to pursue other opportunities after that," a company spokesman told the WSJ. The Web site Search Engine Land reported the story yesterday.

Last year, Bosworth wrote a post on Google's blog, discussing the company's big-picture thoughts on health care and information. And at a health-care conference this spring, he did a little more big-picture expounding, leading at least one listener to conclude that Google was going to get into the electronic medical records business.

The company has also convened a panel of big-name advisors, and reportedly worked up a Google Health prototype that includes that includes a "health profile" for medications, conditions and allergies; a personalized guide for diet, exercise, treatments and drug interactions; and reminders for doctor visits and prescription refills.

Medical Care Often Inaccessible to Disabled Patients

NPR, Morning Edition, 9.13.07

Take a moment to consider a basic part of a doctor's office: the exam table. What if you weren't able to climb up on that hard, plastic table with the crinkly, white paper? Frail elderly people often can't, and they need the most medical care. Younger people with disabilities often can't climb onto the exam table, either.

There is a lot of medical equipment that requires patients to stand or climb, and the inability to use that equipment can keep people from getting the medical care they need.

Federal civil rights laws require medical offices be accessible. But few are, and those rare offices are hard to find. There is no one "clearinghouse of information," says Dr. Kristi Kirschner of the Rehabilitation Institute of Chicago. But people need sources of information to find doctors and hospitals that have accessible equipment, such as exam tables that go up and down. Instead, Kirschner says, patients are left to figure it out on their own.

Listen to full radio feature, with first-person stories, at:
http://www.npr.org/templates/story/story.php?storyId=14362338#14370443#14370443

A Breast Cancer Death, Tangled in Bureaucracy

Wall Street Journal Health Blog – 9.13.07 (Posted by Jacob Goldstein)

Shirley Loewe died of breast cancer in June. In the four years after she was diagnosed, she was "denied assistance or care at least six times, for reasons that ranged from not being poor enough to not being sick enough," the WSJ reports.

Loewe was a hairdresser in Longview, Texas. She didn't have health insurance and her $15,000-a-year income was too high to qualify for Medicaid in the state. A little known federal law, the Breast and Cervical Cancer Prevention and Treatment Act, allows women to be covered by Medicaid even if they don't otherwise meet all of its eligibility criteria.

But in 2003, when Loewe was diagnosed, Texas was one of more than 20 states where the law only applied to women initially diagnosed at clinics that get funding from a federal cancer-detection program. Because she was diagnosed at a medical center that didn't qualify, rather than a different clinic less than a half mile away that did, Loewe was ineligible. She wound up cutting back her work hours, which allowed her to qualify for Medicaid but forced her to move out of her house. Texas has since changed its rules so that it doesn't matter where a woman is diagnosed. But similar rules still apply in 21 states.

Her odds of surviving wouldn't have been good even if she had qualified for coverage under the law. She had inflammatory breast cancer, a rare and often fatal form of the disease, and her tumor had grown to four inches in diameter by the time she was diagnosed. But, the story suggests, if she had been covered by Medicaid from the time she was diagnosed, she might have received care more promptly, and her life might have been less fraught with worries over money and bureaucracy.

"People die every day waiting for the system to catch up," a social worker told Loewe's daughter. "Why should your mother be any different?"

MDCH Recognizes Take A Loved One For A Checkup Day Sept. 18

Michigan News Wire – 9.12.07

The Michigan Department of Community Health (MDCH) is pleased to help recognize Tuesday, September 18, 2007 as *Take a Loved One for a Checkup Day*. This observance is part of a national campaign sponsored by the U.S. Department of Health and Human Services, Office of Minority Health which focuses on educating African American, Hispanic/Latino, Asian American/Pacific Islander, American Indian and Alaska Native communities, and others about the health gap between these groups and the general population of the United States.

The focus of the day is to encourage individuals to take charge of their health by visiting a health professional (doctor, nurse, dentist, nurse practitioner or other health provider), by making an appointment for a visit, by attending a health event in the community, or helping a friend, neighbor, or family member do the same. Many people wait until there is an emergency before they go for a checkup. *Take a Loved One for a Checkup Day* is an excellent way to screen individuals, and when necessary, refer them for follow-up care.

"Family members and friends can help each other by encouraging their loved ones to get regular checkups or other preventive health screenings," said Janet Olszewski, MDCH Director. "If they do not already have a doctor or have health insurance, they should contact their local community health center or local health department to ask about free or low-cost care."