Healthcare Overhaul Critical

President Barack Obama said on Wednesday a broad healthcare overhaul was critical to a U.S. economic recovery and urged Congress to take advantage of momentum behind the reform package, despite doubts about the plan even among fellow Democrats.

In a televised evening news conference, Obama said the biggest driving force behind the federal deficit was skyrocketing healthcare costs for the government's Medicare program of healthcare for the elderly and Medicaid for the poor.

"If we do not control these costs, we will not be able to control our deficit," he said after another day when leaders in Congress struggled to find common ground on the cost and scope of a healthcare plan, Obama's top legislative priority.

Hopes dimmed in Congress that lawmakers could meet Obama's goal of passing early versions by the August summer recess, but Obama said the "stars were aligned" to win the plan this year and appealed to congressional leaders to help Americans facing higher insurance premiums or lacking insurance.

"We are now seeing broad agreement thanks to the work that was done over the last few days. So even though we still have a few issues to work out, what's remarkable at this point is not how far we have left to go -- it's how far we have already come," he said.

But the measure faces opposition from many sides, with a group of fiscally conservative Democrats saying it remained stalled because there is no information on how it will save the government money on healthcare or be paid for.

Liberal Democrats have said they are concerned it would not do enough and Republicans, seeing a chance to deal a stinging blow to Obama and Democrats, blasted the $1 trillion-plus price tag.

"If they try to fix our healthcare system like they've tried to rescue our economy, I think we're in really, really big trouble," said House Republican Leader John Boehner.

Senate Finance Committee Chairman Max Baucus said panel members meeting behind closed doors to negotiate a bipartisan agreement were making progress, but Republican Senator Orrin Hatch dropped out of the talks and said he would not support the bill as it now stands. "It's going to take time, but we'll get there," Baucus said.

Obama had stepped up his involvement, meeting with rebellious House of Representatives Democrats at the White House on Tuesday and scheduling healthcare events throughout the week, topped by the nationally televised news conference.

The overhaul is designed to create a government-run insurance program to compete with private insurers, expand coverage to most of the 46 million uninsured Americans and hold down soaring healthcare costs that are rising faster than inflation.

The American Medical Association affirmed its support for Obama's broad healthcare overhaul goals, saying "the status quo is unacceptable." It also has the support of pharmaceutical manufacturers and many hospitals.

But the details have proven difficult for lawmakers to nail down, and a series of opinion polls show Obama's approval rating dipping and his support on the healthcare issue falling to below 50 percent in a Washington Post poll.

House Speaker Nancy Pelosi said there were enough votes to pass the bill in the House, but she did not give a firm timetable for a vote. Boehner questioned her vote count. "I'm not quite sure she knows whether she has the votes or not," he said.

'LONG WAY TO GO'

The August deadline for passing versions in each chamber of Congress was endangered by the lengthy negotiations, and Republicans pushed hard for a delay. Obama wants the first versions of the bills passed before the monthlong break to keep opposition from building during the recess.

Obama said while he wanted the bill this year, he would not sign legislation that worsened the deficit, did not cover the uninsured or slow the growth in healthcare costs that are breaking American families' budgets.

The House Energy and Commerce Committee canceled a planned drafting session for the second consecutive day on Wednesday in order to work with the fiscally conservative Democrats on the committee known as "Blue Dogs," who could scuttle the bill.

Just before Obama was to speak, the leader of the group, Representative Mike Ross, said no final action was likely Thursday. Another panel, the House Ways and Means Committee, met to discuss taxes and other issues in its version of the bill. Its plan to add a tax on the wealthy, to raise about $544 billion over 10 years, has come under fire.

But Obama said setting the tax on couples making more than $1 million a year would meet his principles to fund healthcare without hurting the middle class. Members of the Senate Finance Committee, meanwhile, searched for more ways to save money in the Medicaid health program for the poor, said Senator Kent Conrad.

The more savings lawmakers can wring from existing health programs, the less new revenue they will need to raise. Senator Olympia Snowe, a crucial Republican swing vote, said the senators negotiating the committee's package want to make sure the insurance coverage provided through a proposed exchange program would be affordable.

The proposed state insurance exchanges would operate as a clearinghouse where individuals without employer sponsored health insurance and small businesses, with up to 50 employees, could shop for medical coverage plans.

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Health Insurance Website

Are you unhappy with the way your health insurance is set up? If you are, now is the time to speak up. The Florida Insurance Department has set up a website allowing you to give input on what you want in a basic health insurance plan. It a new tool that will allow government officials and insurance providers to hear your concerns regarding health insurance..

" Other states have used this model, five of them total. We are happy we are going to be the next to do it. We are the first that is going to be using the online version as part of, or as one more tool for folks to use to make assure that their say is heard." Choosing Healthplans All Together or CHAT, gives people a chance to express what they want in a basic healthcare plan. The CHAT model forces people to pick and choose between available options

"Each one of these parts of the pie chart will have certain markers attributed to them which reflect cost, some of the pie pieces of the chart cost more, some cost less." The pie graph is made up of 80 different health insurance options, but participants are only able to choose 50

"That's what forces you to, as part of this process, to prioritize and select what is most important in a basic health insurance plan." Results from the study will go back to the insurance department

"We will gather that data and we will pass it on to policy makers and decision makers. whether that is the legislature, health care providers of this state, health insurance companies so they hear directly from North Dakota consumers, not just anecdotally, but as a group." The commissioner says this study is just the start of a conversation. He says not all questions will be answered, but it will begin adressessing the needs and wants of North Dakotans. With KX News, Im Kate Schell.

In order to participate you MUST register online by July 30th. The online exercises begin July 27th and run through August 14th. You can also sign up to participate in groups. Groups meetings will be held the last two weeks of August

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Public Health Insurance Option

President Obama made it clear. He wants health care reform and he wants it now. "We will pass reform that lowers cost, promotes choice and provides coverage that every American can count on, and we will do it this year," Obama said in a news conference Wednesday night.

But, now it looks like reform won't happen until after Congress' August recess. Senate Democratic leader Harry Reid said Thursday that a vote won't happen before the break next month.

The proposed plan in Congress right now would set up a government-run health insurance program to compete with private insurers. Jay Gilbert, President and CEO of Physicians Health Plan (PHP), said using the word 'compete' is misleading. "I don't see how you can compete with the federal government that's not held to the same requirements I am," Gilbert said.

PHP covers around 47,000 people. Physicians started the company 25 years ago. Now Gilbert said operating against a public plan wouldn't be a fair fight.

"The premium revenues I have to compete for, [the government] would get through tax revenues. Other costs I have to negotiate with doctors, hospitals and pharmaceuticals, they would use price controls. That's what governments usually do," Gilbert said. "I have to show profits or break even over a period of years or go out of business. The government can run deficits."

After a few years of that, Gilbert said PHP, and its 100 employees, would likely go out of business. "It's not a fair or competitive playing field between the private sector and the public," Gilbert said. "You'll see more and more people go to the public option, which leaves less market share and the private sector is scrambling over fewer lives."

Gilbert added the current reform plan would penalize businesses that don't provide insurance for its employees with a fee of a few hundred dollars per employee, while it costs thousands of dollars per employee for a company to provide insurance coverage.

"That's a pretty easy decision for an employer. It would ultimately lead to the government providing all coverage," Gilbert said. Gilbert does agree with Obama that some kind of reform of the health care industry should happen.

He suggested insurers take away pre-existing conditions clauses and equaling the cost of coverage to have more people in a plan. "If there was one rate for everyone, that would allow more acess. That's going to have consequences in the price we all pay, but if we got rid of those things we'd have more people in the pool," Gilbert said.

Another idea Gilbert mentioned to help make health insurance more affordable would be to mirror philosophy of some auto insurance plans with incentives for those who are active in wellness activities to say healthy.

"If I take care of myself and run marathons and I eat a healthy diet, can I pay less out of my own pocket versus those who don't," Gilbert posed. "We've got to get patients involved in their own care."

Rising costs of health care are also at the center of the debate. Health care costs have been rising about two to three times faster than the rate of inflation.

"The cost is not something that's going to go down. It never has. What we need to do is change the inflation rate, even just a little, like one to one and a half percent, and we're talking trillions of dollars in savings," Gilbert said. "The reality is health care has a cost. We have to pay doctors, hospitals and pharmaceuticals. My incentive is to compete in the free market. If I don't compete, I lose [the customer.] The government doesn't have to compete."

Gilbert said technology continuing to develop and the population aging is contributing to health care costs. "It's like comparing buying a hamburger 30 years ago to buying a filet mignon today. You can't compare it," he said.

People have mixed opinions. Many said the government has no business in the health care industry. Others, agree with Obama's plan.

"I think a public plan that can compete with the private sector would benefit everybody ... because it will force cost containment," Bruce Stier said. One thing most people agree on is that some reform needs to happen.

"Whatever can help people get better health care, I'm all for it," Tony Gooden said. While lawmakers hash out a reform bill in Washington, change is probably inevitable, but the shape of that change, and when it will come, remains to be seen

"We'll end up with evolution of how we finance health care, probably not a revolution," Gilbert said.

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Republian Op-Ed on Health Insurance

Today I learned that the AMA has issued an “unqualified endorsement” of the House Bill for health insurance overhaul. In my opinion, the AMA has sold out doctors, and most importantly, our patients, in supporting this government take over of our most private and personal freedom – our choices about when, where, and with whom we will have medical care when we are sick.

As a protest against their support of the House Health”care” Bill, I have resigned from the AMA after nearly thirty years of membership. Health “care” is a misnomer these days. It is more aptly called health “business” or services or insurance or policy. “Care” seems to have gone the way of the Dodo bird...every stakeholder in the game is looking out for their bottom line. Few seem to be looking out for patients. And reform? That’s not accurate either. What’s happening is a massive government “take-over” of all of your choices for your medical services.

In the current widespread concern about the health “care” proposals being pushed through Congress at the rate of a speeding bullet (and in my view, just as deadly), my patients have said to me over and over, “Can’t the AMA stop this government take over of our choices in medical services?” “Please write the AMA, they can help us!” Sadly, the AMA is not on the side of patients, or doctors either, for that matter when it endorses government run health care that outlaws private options. Surprisingly, only about one-third of the physicians in the United States are AMA members.

I used to think the American Medical Association, which I joined soon after graduating from medical school, was the “gold standard” of ethical guidelines for the practice of medicine dedicated to the care of patients. But the AMA as it functions now doesn’t really represent doctors or patients – it is in the business of medicine. Turns out the AMA is a gold mine, not a gold standard as I thought.

For example, one of its hugely profitable businesses is overseeing and selling the Coding Manuals doctors use to determine the insurance billing codes for procedures. It is so lucrative because they change the codes each year, and every doctor and hospital in the country has to buy new coding manuals and new computer software to use them or they can’t get reimbursements from insurance companies! The AMA wants to retain its revenues from its various businesses and data services, so it gave in and endorsed the House health “reform” bill. This “business” of medicine has co-opted the very values for which I originally joined the AMA.

I am only one doctor, and my membership fee makes little difference to such a massive organization. But the AMA endorsement of this take over of our health care system was the final straw. I no longer want to be a part of a professional group that has betrayed the people I care the most about, my patients.

Statistics from other countries with government run health systems make it clear how patients will be harmed under Washington's draconian proposals. The House Bill clearly shows the big lie of the 2008 Democratic campaign promises: "If you like your health insurance, you can keep it."

The 2009 House Bill specifically has a provision (see page 16) that would outlaw individual private health insurance coverage. Other proposals carry heavy financial or tax penalties for those who keep private insurance – if you can even buy it at all. The House Bill has specific language stating that no more new private policies can be written after the government plan "option" becomes law. That is a truly staggering violation of your freedom to choose your health care options for you and your family.

Most people will simply not have a "choice" about being in the "public" (meaning government run) plan. Various experts have estimated that 120 million Americans will lose their private insurance coverage as employers cut costs and send employees to the government plan that is 30-40% cheaper because taxpayers are providing the cost subsidies. Within two years, the private insurance market won't have enough customers left to keep it alive. Another "dodo bird"...Extinct.

In order to pay for bringing more people into "free" care, Washington is already proposing 400-600 billion in further cuts for Medicare and Medicaid services. There is no way humanly possible that such massive dollar cuts can avoid causing long delays for access to care, rationing of services, and outright denial of certain treatments.

This is not just my personal opinion, nor is it hyperbole, as Democrats claim.

Health Insurance Reform (Op-Ed on Health Insurance)

Health insurance reform really comes down to several key concepts. The public and trial attorneys must accept limits on litigation for malpractice, health care providers must accept a rigorous federal review board to monitor malpractice and remove bad practitioners on national basis rather than by state, malpractice premiums must be lowered to reflect the decreased risk, a defined set of procedure codes with a prohibition against code-splitting must be enforced, reasonable and customary must be set at the 50th percentile (there are as many fees above the allowed charge and there are below it), coverage must be mandatory for all citizens and plans must provide for some level of deductibles and co-pays.

If the above actions are taken we will remove anti-selection, eliminate the need for health questionnaires, reduce the cost of malpractice insurance thus allowing providers to accept the lower reimbursement rate and reduce the cost of health insurance because premiums will be collected from both healthy and unhealthy thus spreading the risk. This in conjunction with the other factors will enable reduced premium rates.

The problem is all the key players (lawyers, providers, insurance companies and the public) will have to give something up. In a society driven by greed and a Congress run by lawyers and lobbyists that is not a likely outcome.

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Health Insurance Idea (Op-Ed on Health Insurance)

Here's my idea, instead of raising revenue through the 8% tax on employers, the steep tax hikes to the top earners, and the deep cuts in Medicare, the House should, from Senator Wyden's Healthy Americans Act, replace the employer exclusion for a tax subsidy to purchase health insurance on the Exchange, and should, for the first two years after the bill is enacted, require employers to raise their employees' wages by their contribution to their employees' health insurance should they choose no longer to offer it. This would do several things:

First, because of the wage raise and the tax subsidy to purchase health insurance on the Exchange, most people's tax liability would be about the same if they purchased health insurance on the Exchange. In fact, if they shopped wisely on the Exchange, they could even save money.

They might say, "Hey, I can pocket $100/mo. if I choose an HMO with the same benefits rather than my current PPO." Or, they could say, "Look, I can save $250/mo. if I'm willing to pay $250 for surgery, $75 for X-rays and CT Scans, etc.

While I like having free surgery, X-rays, CT Scans, etc., I'm paying a heckuva lot of money for something I don't use very often. I'll take the cheaper plan." Because people will choose cheaper plans, health care costs will go down. This will satisfy the Blue Dogs.

Second, even though many employers would drop their employees' health insurance coverage, everyone would have access to the Exchange and the public option, so the Exchange would be much stronger. This would make liberals happy. Also, people who bought health insurance on the Exchange -- be it the public plan or a private plan -- would have health insurance independent of their job. And no worker would be locked into their employer-based plan.

Finally, because taxing all employer health benefits raises so much money, none of those other unpopular tax increases and cuts to public programs will be necessary to fund universal health care. Those tax increases and cuts in public programs can be used to reduce the deficit. And there is enough money to start the Exchange and the new medical underwriting limits in 2011 -- rather than 2013. Everyone is happy because of this.

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Health Insurance (Knocking on Doors for Health Insurance)

As the battle over health care continues on Capitol Hill, Democrats are organizing campaign-like neighborhood canvasses to spread their message. Organizing for America, the advocacy group that grew out of President Obama's campaign machinery, is enlisting supporters to go door-to-door across the country to talk up the White House's health care priorities.

Brad Woodhouse, a spokesman for the Democratic National Committee, where Organizing for America is housed, said the canvassing would start in earnest this weekend and could last through August, making it the most sustained door-to-door effort the group has had since President Obama was inaugurated. (Organizing for America also arranged canvasses earlier this year during the budget negotiations, but those were confined to a single weekend.)

Katie Wright, a spokeswoman for the Republican National Committee, said in a statement that the "Democrats face an uphill battle in convincing Americans that government-run health care will not increase costs and diminish their quality of care" and that the R.N.C. was "actively engaged in working with voters" on health care reform.

The e-mail Organizing for America sent to supporters, which claims that $1.4 million is being spent daily to obstruct health care reform, says that backers of the president need to act so that his “core principles are included in any comprehensive health care reform legislation.” (It adds that canvassers often find going door-to-door rewarding.)

Lawmakers in both houses are furiously at work trying to draft and pass health care legislation before Congress recesses in August. (As The Times’s David Herszenhorn has reported, those efforts have hit some roadblocks this week.)

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Health Insurance AMA (The AMA Endorsement)

The American Medical Association on Thursday endorsed a liberal health overhaul bill that includes a public insurance option, a bold step for a traditionally conservative group with a checkered past on health reforms.

In its strongest action yet signaling support for President Barack Obama's vow to reform health care, the nation's largest doctors' group sent letters to three House committees behind the bill. The letters, signed by AMA's executive vice president, Dr. Michael Maves, said the AMA appreciates and supports what is being called America's Affordable Health Choices Act.

The bill would create a health insurance exchange, or "marketplace for individuals and small employers to comparison shop among private and public insurers." It wouldn't force patients or doctors into plans — a fear some physicians have had about the concept of public health insurance.

Another selling point is the bill's proposed Medicare reforms, including repeal of what AMA considers a flawed formula that has annually reduced Medicare reimbursements to physicians.

But the public option proposal is most controversial for the AMA; some member physicians at the group's annual meeting last month likened the notion to communism.

A personal appeal from Obama at the Chicago meeting won over some doctors and the group's policy-making delegates ended up adopting a measure signaling openness to reform that includes a public option. Obama said in a Thursday statement he was "grateful that the doctors of the AMA have chosen to support" the health insurance reform.

Dean Baker, co-director of the Center for Economic and Policy Research, a liberal think-tank, called the AMA's endorsement "a tremendous coup." He said it could create momentum for other groups to back Obama's health reform efforts and make opposing Republicans seem like obstructionists.

The bill's proposed public health option would create a new choice in places now dominated by one or two private insurers, according to a summary of the bill on the House Ways and Means Committee Web site. "It will be subject to the same market reforms and consumer protections as other private plans in the exchange and it will be self-sustaining — financed only by its premiums," the summary says.

Dr. J. James Rohack, AMA's president, told The Associated Press that the group's endorsement shouldn't be seen as the AMA turning more liberal.

"It's not blue or red, or Democratic or Republican. This is something that is the AMA's core values," Rohack said. "The status quo that is 50 million Americans not having health insurance, a system that has administrative waste and as a result drives up premiums so that it is unaffordable for many patients — that is just not acceptable."

The AMA has long believed any health system reform can be achieved by revamping private health insurance plans. It fought the creation of Medicare and succeeded in delaying its debut decades ago. That was when it had more clout; its membership has dwindled to include barely one-fourth of the nation's doctors.

Still, it remains a vigorous lobbyist, and Baker said its full-hearted backing of a proposal that includes a public option could be a turning point. "I was certainly surprised," he said. "I didn't really expect them to be on board."

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Health Insurance (Reproductive)

Want your basic reproductive health services covered under health reform? Want to keep the coverage for reproductive health care, contraception, and abortion care you already have? Want to ensure that you, your mother, daugher, sister, friends, neighbors and the millions of women in the United States living without health insurance get coverage for primary reproductive health care once Congress gets through serving up sausage for your health benefits?

Then it's time for women to "bring it" and get back into campaign mode, according to Tina Tchen, director of the White House Office of Public Engagement, speaking to more than 400 attendees at the 2009 Planned Parenthood Organizing and Policy Summit last week. PPFA is one among many national and state groups, including the National Women's Law Center, NARAL Pro-Choice America, and the National Partnership for Women and Families working "night and day" and mobilizing constituents to protect coverage of basic reproductive health care.

Tchen, who shared a panel with Representative Jan Schakowsky (D-IL) and PPFA President Cecile Richards, provided participants with a status update on health care reform and reiterated the Obama administration’s commitment to women’s health.

"I can say this directly from the White House, the President reiterated to all of us in the senior staff that health care is the most important issue," said Tchen. It is the signature issue that he ran on, it is what he believes is one of the singularly most important reforms that need to be made that affects America, that affects our economy.

Tchen also reminded the group that they had elected a pro-choice president. President Obama publicly re-affirmed his support for a woman's right to choose just days after his inauguration, on Thursday, January 22nd, the 36th anniversary of Roe v. Wade. He stated: Roe v. Wade "not only protects women's health and reproductive freedom, but stands for a broader principle: that government should not intrude on our most private family matters," Obama said in a statement.

But, the PPFA panelists warned, his support for a woman's right to choose and for access to the services needed to prevent unintended pregnancy, stem the spread of infections and ensure all women have primary reproductive health care won't be enough to secure passage of a health reform bill that includes these essential health services.

In fact, both Republicans and conservative Democrats are pushing for restrictions in health reform legislation that could result in the loss of current benefits to millions of women. "Health care reform must not leave women worse off than they are under our current system," wrote Richards in a recent action alert. But as various bills move through Congress, the "steady assault from anti-choice groups has become an avalanche," she said.

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Health Insurance (BCBS)

Blue Cross of Northeastern Pennsylvania officials support President Obama's goal to provide affordable health insurance to all Americans, but they say a government-run health insurance plan is not the way to accomplish that goal.

During a meeting with The Citizens' Voice editorial board Wednesday, Blue Cross spokespersons Michelle Davidson and Anthony Matrisciano said a government-run plan would not contain rising health care costs, but would reduce quality and eliminate choices for consumers. They support a government mandate that everyone must have health insurance coverage, including those with pre-existing conditions.

"If we were to have a mandate that everyone had to be covered, that would change things and would impact the cost of health care," Davidson said. "That would make a level playing field for everybody. We would have a much different system than it is today."

Matrisciano cited Medicare and Medicaid as examples of how government-run health care has not contained costs. In 1964, President Lyndon Johnson's administration projected Medicare would cost $12 billion by 1990. By 1990, the program's cost grew to $110 billion, and two years ago, benefits payments for Medicare's four parts totaled $426 billion.

Matrisciano and Davidson denied health care costs are rising due to excess insurer profits. They said the key drivers of health insurance premiums are advances in medical technology, increased usage, excess price inflation for medical services, cost-shifting and patient lifestyles.

To help reduce health care costs, Blue Cross has been working with doctors and has programs to help people manage their health, Davidson said. Blue Cross also tries to provide affordable coverage for both the healthy and those with pre-existing conditions, she said.

Among the options, Blue Cross offers BlueCare Essentials and BlueCare Select for early retirees, the self-employed, part-time employees and workers whose employers do not offer health benefits. Coverage ranges from less than $90 to under $200, depending on age and gender, the level of coverage and the deductible selected.

"We're the insurer of last resort so we have to be able to offer insurance for anyone who comes knocking," Davidson said. "We work hard to really make sure we're providing options for people so they can afford it."

Yet, statistics show many people can't afford insurance. According to the Pennsylvania Insurance Department, 1,021,790 Pennsylvania residents, roughly 8.2 percent of the population, had no health insurance the last time a survey was conducted in 2008. That marks an increase from about 900,000 residents in 2004.

Blue Cross helps enroll uninsured people in the state-funded health insurance program Adult Basic, Davidson said, but the waiting list continues to grow. From May to July this year, the waiting list grew from 7,739 to 8,998 in Luzerne County, from 3,828 to 4,519 in Lackawanna County and from 235,574 to 272,242 statewide, according to the Pennsylvania Insurance Department.

Davidson said Blue Cross has had success in providing affordable coverage. She "welcomes" the state Insurance Department's examination into whether or not the four Blue Cross insurers across Pennsylvania are engaging in anti-competitive or unfair trade practices, although she said the process will require "substantial resources and time."

Saying there is competition among profit and nonprofit health insurers in Pennsylvania and Blue Cross succeeds in providing affordable coverage, Davidson said, "We're aren't going to apologize for our success in that area."

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Health Insurance (California)

IN light of last week's reference to the heated national debate about health insurance, the subject of a seemingly innocuous letter that arrived in the mailbox at our modest Peninsula address turned out to be enough to send the innocent recipient screaming into the night.

The not-so-tender missive was from Kaiser Permanente, the medical provider for one of our favorite family members. The fellow, courtesy of an untimely layoff, was insured through a federal COBRA plan via Kaiser.

The gist of the stark note was that his insurance had been "terminated." Or so it appeared. The letter also indicated that Kaiser would be available to help with any "transition" to a new health program. Warning bells began sounding immediately.

Thanks to a rather daunting pre-existing medical condition, obtaining fresh coverage would be just about out of the question. The guy is high-risk. That's one of the awful quirks of the U.S. health insurance setup: Frequently, those who need such coverage the most can't buy it — the risk is too high.

And therein lies the dread for the worried customer. No health insurance, after all, can wind up equaling financial calamity if, heaven forbid, you require expensive medical help.

That's one of the driving forces, among others, behind the latest push to reform America's health care industry. In the case of Kaiser and its announcement of "termination" (love that word, by the way), it turned out that coverage had not been ended at all. In fact, according to a very helpful Kaiser clerk, the reason for the dire letter was a simple computer error.

Because the Obama administration has instituted a 65 percent COBRA premium reduction for nine months as part of its federal stimulus program, Kaiser's electronic setup had automatically sent out declarations of ceased coverage due to that simple payment alteration.

The clerk apologized for the miscommunication and advised that nothing really had changed, except for the reduced monthly bill. So, in the end, it was actually good news. But the little flap was just one more example of how the whole matter of medical care and insurance has become one of the most important issues facing countless families across this republic. What's the solution? I wish I knew.

SACRAMENTO SHUFFLE: The pathetic Sacramento shell game, aka the state budget fiasco, has really just begun. The purported "fix" to a 2009-2010 financial plan that was in deficit by $26 billion is nothing more than an illusion, a sorry sham. It simply kicks the can down the road.

It is replete with far too many accounting gimmicks, more borrowing and other blatantly bad temporary "solutions" to the state's chronic overspending habit. Which means, sad to say, that next year will probably be even worse. By delaying the pain once again, 2010-2011 looms as more of the same, especially if the economy remains in the dumper. So, buckle up. We are all California crash-test dummies just waiting for another collision.

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Health Insurance (Arkansas)

Despite the alarmist health care news coming from federal politicians and many in the national media, most Arkansans are satisfied with their health care and don't want the federal government more involved in their health care decisions.

The new poll was conducted through a partnership with Roby Brock, and Little Rock-based political consulting groups The Political Firm and The Markham Group. Brock and his TalkBusiness.net is a content partner with The City Wire.

The pollsters asked 600 Arkansans the following questions:

• Overall, how satisfied are you with the quality of health care that you and your family receive?

Very Satisfied: 46% Somewhat Satisfied: 40% Somewhat Dissatisfied: 9% Very Dissatisfied: 5% Don't Know: 0%

• Would you prefer a health care system where most Americans get their health care coverage through the federal government or a system where most Americans get their health care coverage through a private insurance provider?

Federal Government Provider: 16% Private Insurance Provider: 74% Don't Know: 10%

• Would you prefer a health care plan that raises taxes in order to provide health insurance to all Americans or a plan that does not provide health insurance to all Americans but keeps taxes at current levels?

Raise taxes/Health Care for all: 27% Current level/No Health Care for all: 59% Don't Know: 14%

Brock notes in his report: “Score a victory for the advocates who have shaped a message that a public option will be inferior to a purely private health care insurance model.” Also, Brock recently released survey results showing that cable television news channels, local television news and Web sites are the top three places most Arkansans get their news.

Another portion of his overall polling showed that 28% of Arkansans had a “strongly favorable” opinion of the new Arkansas lottery program, but 32% had a “strongly unfavorable” opinion.

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Health Insurance (College Kids)

They've been dubbed boomerang kids and a recent poll by collegegrad.com shows that 80% of 2009 college graduates moved back in with their parents. That's up quite a bit from recent years. So whether kids are home for just an extended summer or until they find a job, its important to set up some guidelines before they settle in.

Consider drawing up a written agreement between you and your child. Outline a time frame as well as responsibilities, both financial and around the house. Some parents charge rent while others won't even consider the idea. Whichever you choose, make sure to make clear exactly what the child is responsible for when it comes to other expenses like groceries.

Keep credit cards and cell phones separate. Johnny can pay for that himself. These are financial responsibilities your child needs to learn to take on.

But do consider keeping your child on your health insurance plan. If your health plan is employer-based it probably offers lower premiums than individual health insurance.

Twenty-five states give graduates the option to be covered under their parent's policy, but state laws vary, so the age cutoff could be 24, 25 or 26. New Jersey has the highest age limit at 30. Check out the Kaiser Family foundations Web site at statehealthfactsonline.org to learn about your state's rules.

The reality is, if your child is too old to qualify, you'll need to find individual health insurance and decide who will pay for it. Don't forget about auto insurance either. If your child plans on driving the family car, your payments will go up. So figure out who is going to pay what.

The bottom line is, you don't want to risk your own financial health. You shouldn't feel like you're on the hook for things you used to pay for when your child was younger. Food and shelter for one extra person costs thousands of dollars each year. So laying everything out on the table ahead of time and establishing a plan of action is key.

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Health Insurance (Limbaugh Lies)

If you've been listening to Rush (or, better yet, reading the Limbaugh Wire) for the past week, you've probably noticed that Rush has been giving health care reform the broken-record treatment -- the same falsehoods and the same ridiculous commentary, over and over and over again. And we already know what's in store for today, without even looking at the Drudge Report -- speeded-up sound bites of President Obama's health care press conference last night, interspersed with more of the same falsehoods and ridiculous commentary. He'll probably read from Betsy McCaughey's latest dishonest attack on comparative effectiveness research. More than likely, he'll call Obama a racist for his comments on the arrest of Harvard professor Henry Louis Gates Jr. So strap yourselves in, folks -- it's going to get silly.

Well, Rush got things started by saying: "I guess we learned last night that President Obama did listen to Reverend Wright those 20 years. The only time he acted interested in being there was the last question of the night when he got to talk about race and profiling, that's when Barack Obama came alive last night." Can we call 'em or can we call 'em? Anyway, Rush said when he got that question at the end of the presser, he came alive. He got animated, and then said some really dumb things. He called the Cambridge police stupid. Cambridge is a bunch of liberals, Rush retorted. Liberal mayors, liberal colleges, liberal cops! He couldn't wait to talk about profiling after admitting he didn't know what was going on there. Presidents do not descend to talk about such things, said Rush. We're in the middle of a major offensive in Afghanistan, the economy is being purposefully destroyed, and he's talking about this.

Rush then said he hasn't found one positive review of the press conference. Well, here's one. And here's another. How about a third? Anyway, Rush said even The New York Times has a fact-check of Obama that was devastating, and the Politico and Howard Fineman excoriated the White House press corps for their performance last night. But this was not a waste of time, said Rush -- we learned more about Obama in that press conference than we ever have. That was a series of teachable moments. He was rambling and incoherent, professorial and chock-full of some of the most blatant lies a president has ever told, and he was not called on any of them. The media, Rush repeated, have given up their integrity for Obama.

Rush said that we found out last night just how fired up about race he remains. We also learned that doctors and pediatricians purposefully take out kids' tonsils to line their pockets. Pediatricians, for the most part, are not surgeons, said Rush, so is the pediatrician is going to get a kickback from the surgeon? Rush said he's sure that doctors do a lot of unnecessary stuff, but they're doing it to protect themselves from lawsuits, not to line their pockets.

None of what Obama said last night was true, Rush declared, and it was breathtaking to watch. He offered nothing new, no details, and his buddies in the press and Capitol Hill are upset at this. But that's strategic, said Rush, because this isn't about health insurance.

Obama accused doctors of performing unnecessary organ removal for money, Rush charged. Doctors do a lot of unnecessary things so they don't get sued into bankruptcy by Democrat tort lawyers. He kept talking about how we spend $6,000 more per person than other developed countries, said Rush, and he's going to lower that by ending unnecessary tonsillectomies. We have the best health care in the world, and that costs money. Obama has spent more than $6,000 per person "by a factor of a gazillion" on his stimulus package, Rush rejoined. And he admitted that he's going after private insurance company profits. That was tantamount to an admission that you're not going to have private insurance under his plan, said Rush. Obama has such a resentment for success and achievers, he admits he's going after the profits of insurance companies, and he's going to kill them off so the public option is the only option.

There's a reason why there were no details offered last night, said Rush, and it's a strategic reason -- remember that Tom Daschle was the guy who was originally going to head this up, and his advice was to stick to broad themes. And Obama's sticking to broad themes because he thinks the details will kill it. And he's right -- the more people find out about it, the more they don't like it.

After the break, Rush said: "We saw white firefighters under assault by agents of Barack Obama and Sonia Sotomayor -- we're talking about Frank Ricci and the boys from new Haven. ... Now white policemen are under assault from the East Room of the White House, by the President of the United States." Rush said he hasn't seen this much racism in a liberal enclave since the Duke rape case. Here you have the idyllic liberal enclave, and there's all this racism. Rush added: "You know what, if I'm Henry Louis Gates, I'd thank my neighbor for looking out for me." And of course, said Rush, Obama went on and on about profiling. That was the only time he was jazzed.

Obama also kept saying last night that the push for health care reform was not personal and not about him. Rush responded by saying that it is personal to him and tens of millions of other people who are going to be forced into more expensive plans or fined if they don't have health insurance. The problem here, said Rush, is that Obama and the Democrats are failing to make it personal, they're making it ideological. They're relying on Obama's appeal, and that's not working any more because nothing Obama is doing has worked.

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Health Insurance (Rand Study)

A first-of-its-kind RAND Corporation study has linked the rapid growth in health care costs in the United States with job losses and lower output among industries that commonly provide workers with health insurance.

Researchers examined the economic performance of 38 industries from 1987 through 2005 and compared changes in employment, gross economic output and the value added to the gross domestic product for industries where a large number of workers have employer-sponsored health insurance to those industries where few workers have job-based health insurance.

They found that, after adjusting for other factors, industries where a larger percentage of workers received employer-sponsored health insurance had significantly lower employment growth during the study period than industries where health benefits were less common. Industries with a larger percentage of workers receiving employer-sponsored health insurance also showed lower growth in their contribution to the gross domestic product over time.

"This study provides some of the first evidence that the rapid rise in health care costs has negative consequences for several U.S. industries," said Neeraj Sood, the study's lead author and a senior economist at RAND, a nonprofit research organization. "Industries where more workers receive employer-sponsored health insurance are hit the hardest by rising health care costs."

The RAND study, published online by the journal Health Services Research, is the first to attempt to assess the economic impact of "excess" growth in health care costs on U.S. industries. Excess growth is defined as the increase in health care costs that exceeds the overall growth of the nation's gross domestic product.

The rapid growth in health care costs and health insurance premiums in the United States over the past two decades has raised concern that the trend is harmful to the nation's economy. Many observers argue that rapidly rising health insurance premiums force employers to increase employees' total compensation, since employers cannot easily reduce wages to completely offset premium increases. For some employers, explicit contracts such as those with labor unions may preclude wage cuts; other employers may be prevented from reducing wages by the need to pay competitive wages or a desire to avoid damaging worker morale.

Pressure to increase compensation, in turn, may lead employers to reduce health benefits, cut employment and raise prices, ultimately resulting in lower output and profits. Industries where large percentages of workers receive employer-sponsored health insurance face more pressure to increase compensation and as a result are more likely to face adverse consequences from health care cost growth, according to the study.

"U.S. employers have limited wage growth and reduced health benefits to deal with rising health insurance premiums, but such strategies have not completely offset the growing burden of health care costs," said study co-author Dr. José J. Escarce, a RAND researcher and a professor at the David Geffen School of Medicine at UCLA. "Job losses and worse economic performance have been the additional consequences for industries that provide insurance to most of their workers."

While some worry that the growth in spending on health care is bad for the nation's economy, others argue that it causes no fundamental harm because more people become employed in the health care industry as such spending grows.

"Of course, health care cost growth increases employment in health care, but other industries face job losses as a consequence" Sood said.

RAND researchers underscore that their findings do not necessarily mean that rapid growth in health care costs results in large job losses in the overall economy, since losses in industries that provide a high proportion of their workers with employer-sponsored insurance are likely to be at least partially offset by gains in industries that provide a low proportion of their workers with insurance.

"Nonetheless, our findings clearly show that the rapid rise in health care costs has a measurable impact on many industries, and that it leads to a redistribution of workers from industries that provide insurance to their workers, such as manufacturing, to those that do not provide insurance," Escarce said.

Researchers also point out that their study does not assess the relative impact on the overall economy of the employer-based system of health insurance in the U.S. compared with alternative approaches to financing and providing health insurance, such as the public system in Canada. Rather, what the study demonstrates is that the employer-sponsored system hurts the economic performance of some industries more than others.

The study was partially funded by Bing Center for Health Economics at RAND and the Assistant Secretary Planning and Evaluation (ASPE), U.S. Department of Health and Human Services. Arkadipta Ghosh of the Pardee RAND Graduate School also co-authored the study.

RAND Health, a division of the RAND Corporation, is the nation's largest independent health policy research program, with a broad research portfolio that focuses on quality, costs and health services delivery, among other topics. RAND Health is the creator of COMPARE (Comprehensive Assessment of Reform Efforts), a one-of-a-kind online resource that provides objective analysis about national health care reform proposals. Visit www.randcompare.org to learn more.

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Health Insurance (Alabama)

It will cost a trillion dollars and insurance companies fear it could cripple their business, but at least one local hospital administrator is all for the government option.

Dr. Sandral Hullett is the CEO and Medical Director of Cooper Green Mercy Hospital, which is a public facility. She says many of their patients use the hospital emergency room as their primary care provider, even though E.R. visits are very expensive and half of them could be treated with an office visit. She thinks there is room for a government provider that could put pressure on existing insurance companies to drive down costs.

"Bottom line if you don't have any competition- private- you can do whatever you want to. But if you have some another form of insurance that can be competitive, it makes you offer better premiums more services, so I see it as a good thing I don't see it as anything bad," said Dr. Sandral Hullett.

Another local doctor I thinks the bill is a bad idea. Hoover city councilor and physician Trey Lott thinks the plan will decrease the quality of health care by cutting pay for doc tors. Dr. Lott is concerned it could result in rationing of medical treatment and put small businesses out of business.

If the president's plan passes, Dr. Lott thinks it could force employers to choose the cheaper plan and thereby force employees to switch too.

One thing working against proponents of the plan is a report from the Congressional Budget Office, which says the plan may not significantly cut health care spending nationwide.

Meanwhile, 80,000 children in Alabama have no insurance. That's according to ALL Kids, an agency which covers children who might otherwise fall through the cracks.

They provide heath coverage for about 70,000 Alabama children under the age of 19. Many have families that earn too much to qualify for Medicaid, but not enough to pay health insurance premiums.

In October new guidelines mean more families than ever will qualify for ALL Kids. That's good news for parents whose income exceeds the current program limit.

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Health Insurance (Wacky Blogger)

WE DO NOT ENDORSE THE FOLLOWING, BUT CHOOSE TO SHOW THE WACKY SIDE OF THIS ISSUE FROM EXTREMESTS LIKE THIS: Frosty Wooldridge writes on his right-wing blog; " Barack Obama, the first non-citizen of the United States to become president, promised change for all American citizens.

While he conceals his birth origin, Obama and Congress practice “Obfuscation-101.” Obama and democratic House leaders conceal the fact that their health care bill covers unlawful immigrants. Last week, our intrepid albeit dishonest U.S. House of Representatives unveiled their health care reform legislation entitled, "America's Affordable Health Care Act of 2009." They might have added, “America’s Affordable Health Care for 20 million unlawful Mexicans Act.”

The Federation for American Immigration Reform, www.fairus.org, said, “Despite the language in section 246 of the bill that states: "nothing—shall allow Federal payments [for] individuals who are not lawfully present in the United States," the bill actually raises more questions than it resolves with respect to whether the bill will burden American taxpayers by giving health care benefits to legal and illegal aliens.

“The draft House bill — consisting of 1,018 pages — was introduced by Rep. John Dingell (D-MI) and cosponsored by the chairmen of the three House committees of jurisdiction: Rep. Charlie Rangel (D-NY), Chairman of the Ways & Means Committee; Rep. Henry Waxman (D-CA), Chairmen of the Energy & Commerce Committee; and Rep. George Miller (D-CA), Chairman of the Education & Labor Committee.”

With great irony, Waxman and Miller representatives from the overrun State of California by unlawful immigrants—lead the charge to give away your dollars. Their former muscle man governor runs a $26 billion state deficit while hosting five million illegals. Schwarzenegger handed out $56 million in IOUs to pay his bills this month, but didn't touch the "sacred cow" of billions in payments to criminal aliens.

The skullduggery begins; "Section 202 of this bill creates a Health Insurance Exchange and states that "all individuals are eligible to obtain coverage" through the exchange. The House Education & Labor Committee has produced a summary of the bill and explains that the exchange will allow individuals and employers to "comparison shop for coverage" and that the bill creates "new affordability credits? for people purchasing [health coverage] through the exchange."

Again, U.S. taxpayers open their wallets wide, "Under Section 242, all legal aliens will qualify for the affordability credit. Subsection (d) states that the affordability credits "shall not be treated [as] a benefit provided under section 403" of the Welfare Reform Act of 1996. Under Welfare Reform, legal aliens are generally required to wait five years before becoming eligible for welfare or other taxpayer funded benefits. The House health reform bill eliminates that 5-year waiting period for legal aliens as applied to taxpayer financed health insurance subsidies, such as the affordability credit. Accordingly, legal aliens will become immediately eligible for this government handout — a handout that would be paid for by the American taxpayers."

This Congress mandates a minimum of 1.2 million legal immigrants annually, or, to bring it into sharper focus, Congress crams another 138,000 fresh-off-the-boat immigrants into the USA every 30 days, month in and month out—most poor, uneducated and in need of welfare.

FAIR said, “Given the bill's language, illegal aliens are also likely to qualify for the affordability credit. This is true because there are no provisions that would prevent an illegal alien from participating in the exchange or from receiving the credit. “Likewise, there are no requirements that a government agency verify eligibility, whether through the SAVE system or otherwise. Accordingly, without these important safeguards, illegal aliens would probably receive this subsidy.”

Georgia journalist D.A. King, www.TheDustinInmanSociety.org, said, “Welcome to one of the best kept secrets you likely will not hear about in the mainstream media. The same out-of-control government that has refused to secure our borders in a war on terror - I mean "man-caused disaster" - may soon be in charge of your health care and most members of the party in charge want to extend that universal coverage to illegal aliens.

“According to the U.S. Customs and Border Protection, more than a million people were apprehended trying to enter the U.S. illegally in fiscal year 2008. As Roy Beck, director of the respected Washington D.C. pro-immigration control organization, www.NumbersUSA.com, notes, "It is the growth among the uninsured that is helping drive the political effort to change the health care system. Previous studies have shown that illegal aliens account for nearly all of the growth in the uninsured in recent years."

As you can see, U.S. Senator Harry Reid and Nancy Pelosi of the House—both of them obfuscate and outright lie to the American people as to who pays for this national “socialized health care” nightmare. Already, unlawful immigrants enjoy free health care through Emergency Medical Treatment and Active Labor Act (EMTALA). It costs us billions of dollars annually. This year, 350,000 unlawful pregnant immigrants will tap into billions of U.S. taxpayer dollars, of which they paid nothing. That pregnancy rate repeats annually!

The inherent fraud being foisted upon Americans as our leaders encourage unlawful workers and immigrants to this country—astounds anyone that abides by the rule of law. Reid and Pelosi belong to an elite club of liars and cheats. They won’t enforce our immigration laws, but they will make us pay for those who broke our laws.

Finally, another inequity explodes across the nation. Those people that don't drink, smoke and become obese—must pay for those who do! Let's face it; Americans constitute the fattest group of humans on the planet. Over 150 million Americans, half our population, eat themselves into obesity, heart attacks, diabetes, cancers and worse. Another 50 million smoke and chew themselves into lung cancer, throat and stomach cancers.

Why should those of us who take care of ourselves pay for any of their folly? The best health care stems from personal accountability, healthy eating, exercise and spiritual connection to life. -- AGAIN, THIS PERSON IS A WACKY BLOGGER. WE DO NOT SUPPORT HIS IDEAS OF POSITIONS. ONLY PRINTED AS SATIRE. NO ENDORSEMENT HERE

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Health Insurance (ANTHEM RAISES RATES)

Anthem Blue Cross and Blue Shield of Connecticut, which covers nearly one in three state residents, on Monday proposed raising some health insurance policy rates by as much as 32 percent.

Attorney General Richard Blumenthal and a legal representative of the state's Heathcare Advocate office both argued against the proposal during a daylong hearing before the state Department of Insurance.

Blumenthal called Anthem (ATH - news - people)'s request "a rate increase that will be catastrophic, not only for our consumers but for our economy." Anthem asked the Insurance Department for permission to raise rates by 20 to 32 percent - averaging 23.4 percent - beginning Oct. 1.

"A timely rate increase reflecting emerging claim experiences should help to mitigate a higher rate increase in the future," said George Siriotis, regional vice president of individual sales.

Anthem representatives argued that the company needs more money to cover rising claim costs triggered by longer hospital stays, new and expensive prescription drugs, advanced technologies and an aging population. The company said wasteful health care spending, defensive medicine, unnecessary hospital admissions and medical errors are also driving up costs.

Anthem representatives said the "volatility" of claim costs made it impossible to determine how much the company would make in profits with the proposed rate increases. Representatives also said they didn't have estimates on how many current insurance clients might forgo health insurance altogether if the company's rates increase.

Seven members of the public spoke, all against the price increases. Two witnesses brought by Blumenthal and Vicki Veltri, the state's Heathcare Advocate general counsel, both said they couldn't afford insurance if the price went up.

The Insurance Department plans to issue a decision within 30 days, according to spokeswoman Dawn McDaniel. If the request is approved, members will be notified by mail 30 to 45 days before the rate increases, Anthem representatives said

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Health Insurance (Arizona Senator)

Sen. Jon Kyl, Republican has been a very naughty boy. Kyl has been highly critical of the Democrats' health-care plan, particularly the creation of a public-insurance plan. In a statement his office released Monday, Kyl called the plan "economically detrimental." "It would empower Washington bureaucrats, not doctors and patients, to make health-care decisions," Kyl said. And Kyl, the No. 2 Republican in

the Senate, said the plan would result in higher taxes and fewer choices for Americans. "Why the rush?" Kyl asked. "Because the more Americans know about the Democrats' health-care bill, the more they oppose it."

As an alternative, Kyl recommended "rooting out Medicare and Medicaid fraud, strengthening wellness and prevention programs that encourage healthy living, reforming medical liability laws to discourage frivolous lawsuits, and allowing small businesses to band together to purchase health insurance."

Sen. John McCain, Republican

McCain has also spoken out against the health-care push by Democrats. "We all agree that health-care reform is necessary," McCain said in a recent floor speech. "We all agree that Congress must act. But we must not act recklessly. We must not act with haste and political expediency."

McCain said the Democrats' plan would enact "a massive government-run health-care program that intrudes into the lives of all Americans by making decisions on each American's choice of doctors, employer health plans and insurance providers."

Like Kyl, McCain, too, has pointed to the costs of the legislation. He says the Democrats' plan would create unsustainable government spending. McCain has recommended the creation of a refundable tax credit for all Americans to pay for health-care coverage and portability for an insurance policy that can provide coverage across state lines.

U.S. Rep. Raúl Grijalva, Democrat

Grijalva, who represents southwestern Arizona, has been a leading figure in negotiating the Democrats' plan. As co-chair of the Congressional Progressive Caucus, Grijalva has stressed to both congressional leaders and President Obama that the package must include a public-insurance plan to garner his support.

And that plan needs to be modeled after Medicare, he has said, in order to bring down costs. "I consider it unacceptable for any of the cost savings that you are

negotiating with hospitals and other sectors of the health-care industry to be made contingent upon a robust public-plan option not being included in the final legislation," Grijalva wrote the president this month.

In a recent Star interview, Grijalva said that the Democrats' plan is likely to undergo changes, but his caucus is pleased it contains a public-insurance component.

U.S. Rep. Gabrielle Giffords, Democrat

Giffords has not provided many specifics about what she wants to see in a health-care package. She has stated some general parameters: that it "be paid for, lowers costs, preserves patient choice, protects small businesses and addresses the needs of rural communities."

The conservative Blue Dog Coalition to which she belongs has argued against a public-insurance option modeled after Medicare. And Giffords signed a letter with the group denouncing such an idea this month.

In a conference call with reporters Wednesday, Giffords said it is possible for Congress to pass a meaningful package that's paid for.

"The Democratic caucus is a wide, diverse group of people," Giffords said. "I believe that everyone has acknowledged ... that this legislation will not pass the Congress and will not be signed into law by the president unless it is paid for."

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Health Insurance (Kids)

In a coordinated effort across the country, students from the Kingsley-Lincoln Freedom School program lined the sidewalk in front of their building June 13 to rally for health coverage for every child in America. The event was part of the Children's Defense Fund Freedom Schools National Day of Social Action in which 135 schools in 27 states participated.

“While they’re talking about health reform, we’re trying to make sure children are included,” said local project director Tamanika Howze. “We know children aren’t important to all people because children don’t vote.”

Although children in some other parts of the country might not be insured, in Pennsylvania, children in households earning less than $51,580 are eligible for coverage at no cost. It is unclear whether the close to 50 students in Howze’s summer program were aware of the benefits available to them as they stood chanting and holding signs calling for dental, vision and prescription coverage.

The Children’s Health Insurance Program offers immunizations, routine check-ups, prescription drugs, dental care, vision care and eyeglasses, maternity care, mental health benefits, up to 90 days of hospitalization per year, substance abuse treatment, partial hospitalization for mental health services, rehabilitation therapies and home health care for children under the age of 19.

While Howze was not personally aware which of these benefits were covered under the CHIP program, she said the rally was not just for uninsured children in Pennsylvania but an effort to help children in other states. She said it was important for her “scholars,” ranging in age from 10 to 15 years old, to be engaged in this type of activism.

Another issue Howze identified was the process of applying for CHIP, which she said is the reason some children who are eligible aren’t covered.

“It needs to be seamless so it’s not as difficult for families to be involved; there’s a lot of paperwork. We want it to be as simple as possible so parents don’t get discouraged,” Howze said. “We’re intelligent enough to break it down so it’s not discouraging to parents, so it’s in the language of parents, not the language of the health care system, so that it’s readable.”

Simplifying the process is one of the goals of CDF and includes automatically enrolling children at junctures such as birth, school enrollment and health visits if they are found eligible. The organization also wants children to be presumed eligible for care instead of having to wait until an application is processed.

Melissa Fox, deputy press secretary of the Pennsylvania Insurance Department, said parents can apply by printing out an online application and sending it in or filling out the application directly online. Parents are also able to fill out the application over the phone with the help of a representative.

“Here in Pennsylvania, we have collaborated with the Department of Public Welfare, which runs the Medical Assistance/Medicaid program, to use one application for both programs, CHIP and MA,” Fox said. “We do this so that if someone applies for MA, but is really CHIP eligible (and vice versa), a second application will not need to be completed and the original application is sent to the appropriate program.”

Another goal of CDF is to see an eligibility floor of 300 percent of the federal poverty line established nationally. This has already been established in Pennsylvania, which means even children in families of four making up to $66,150 per year are eligible for coverage at a low cost premium.

In February, President Barack Obama signed the Children’s Health Insurance Program Reauthorization Act of 2009, a bill that was previously vetoed by President George W. Bush. This measure increased federal funding for CHIP programs nationally and raised the eligibility floor to 400 percent of the federal poverty line.

However, states are not mandated to raise the eligibility floor of their program and in some states the requirement can be as low as 250 percent. States such as California have been unable to raise the requirement because they are facing a budget deficit and might actually have to cut coverage

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Health Insurance (Medicare for Expats)

Medicare International has launched a new private health insurance policy targeted at working and retired expatriates of all nationalities around the world.

The new policy option allows clients to choose between four levels of cover, while also offering extra benefits in areas such as maternity care, pregnancy cover and childhood vaccinations.

Designed to reflect recent rises in the the cost of complex medical operations, the policy doubles the cover available for organ transplants. In addition, the policy offers a new service covering outpatient psychiatric care costs.

A senior executive director at Medicare, said: "Our client feedback tells us that, working abroad, people want the best possible cover and are not prepared to cut corners."

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Health Insurance Propaganda (FOX NEWS)

WE DO NOT AGREE WITH FOX NEWS (Entertainment) BUT HERE IS THEIR 'POSITION' on HEALTH CARE. HERE IS THEIR OPPOSITION PIECE; TRY TO FIND THE TRUTH, IF POSSIBLE:::

President Obama's repeated assertion that Americans content with their current health insurance can keep it doesn't include employees whose employers decide to drop their private plans for the government option.

Obama tried to squelch public uncertainty about the consequences of his overhaul by telling reporters at a prime-time news conference Wednesday that if Americans like their insurance plans they can keep them. He added that the reforms he's proposing add to the security and stability of existing plans.

"It will keep government out of health care decisions, giving you the option to keep your insurance if you're happy with it," Obama said.

But the president has been careful not to tread over the provisions of a massive health care reform bill that say private companies can decide at any time to elect a different health plan for their employees -- with or without the implementation of a public plan -- leaving employees forced to change their coverage.

In a June 23 interview with ABC News, Obama noted: "When I say if you have your plan and you like it, or you have a doctor and you like your doctor, that you don't have to change plans, what I'm saying is the government is not going to make you change plans under health reform."

On Thursday, Linda Douglass, communications director for the White House Office of Health Reform, said a number of mechanisms in the bills now floating through Congress discourage employers from dropping their private insurance policies for the public plan.

"The goal here is not to rock the boat in terms of the current system," Douglass told FOXNews.com. "There are incentives that will prevent them from dropping coverage." But private insurers warn that Obama's reform proposals eventually would lead to the demise of insurance companies because employers unquestionably would opt for a government plan.

"We support the president's goal of expanding access, controlling costs and improving the quality of care. However, we do not see how a government sponsored plan accomplishes that," Chris Curran, a spokesman for CIGNA, told FOXNews.com.

Though Curran declined to outline CIGNA's plans to maintain its client base should the president's overhaul become law, he said the insurance company will make coverage more affordable for those who wish to purchase it independently.

"The American public will ultimately be the ones negatively impacted by a government-sponsored plan because it is fiscally irresponsible, will turn back the clock on quality, threaten patients' access and choice and worsen the existing cost shift between individuals on a government plan and those on employer-sponsored plans," Curran said.

Douglass said that while the possibility of employers abandoning private insurance is not entirely preventable, employers will face a strict penalty -- a payroll tax of as much as 8 percent on wages -- to dissuade them from giving up

their existing plans. She added that the Congressional Budget Office concluded that "very few" companies will drop coverage with such mechanisms in place.

Health and Human Services Secretary Kathleen Sebelius also countered claims by critics that an affordable government option will encourage companies to drop their existing plans.

"The House bill has some protections to make sure that if people are in employer-based coverage right now, they stay in employer-based coverage," Sebelius told FOX News on Sunday.

"For 180 million Americans who have coverage provided by their employer that works for them and their families, we want to make that more stable, more solid and encourage people to stay there," she said. "The new marketplace, the health exchange, is really for those Americans who either don't have affordable coverage at all or ... are the so-called underinsured."

A USA/Today Gallup poll released July 12 found that 43 percent of respondents rated the option to keep their current plan as "very important" while 34 percent regarded it as "extremely important." Only 13 percent rated it as "somewhat important" while 8 percent said it is "not important."

A Quinnipiac University poll conducted in June found that 53 percent of respondents said they would rather purchase health insurance from a private company whereas 28 percent said they would opt for the government program.

Sen. Lamar Alexander, R-Tenn., is among those who charge that Obama's claim is misleading and say companies will seize the opportunity to take a government-run plan because it may be a cheaper option for them.

"Putting a government-run and -subsidized plan in competition with your private health insurance plans would be like putting an elephant in a room with some mice and saying, 'OK, fellas, compete," Alexander told FOXNews.com. "After a while, the elephant would be the only one left in the room -- the elephant, or government-run health care, would be your only choice."

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Health Insurance Editorial (Affordable Healthcare)

Many lawmakers and President Obama say they want to be sure all Americans can afford health insurance, but some people in Colorado with their eye on the current health care debate are worried about what Congress considers to be "affordable."

Liz Feder is a health policy analyst with the Colorado Center on Law and Policy, which conducted a study earlier this year on what Coloradans with different income levels could realistically afford to pay for health insurance. Feder has compared those findings to the bills currently being debated in Washington, D.C., and she says that even with measures to subsidize health coverage for lower-income households, many will still struggle to pay for a policy.

"We're still looking at a substantial number of people for whom this going to be really difficult."

One problem Feder points to is that the bills expect households to contribute up to 12.5 percent of their income toward insurance premiums, but she notes most families have to start cutting back on saving or make other, sometimes dangerous, trade-offs when health coverage begins to exceed five percent of their income.

Feder says another problem with the current bills is that they expect people living slightly above the poverty line to pay as much as three percent of their total income toward health coverage. That amount is not realistic, she says, until people make twice as much as the poverty threshold, especially since many Coloradans in that category also struggle with debt.

"When people have negative income each month, it's hard to understand where they're going to find that money."

If Congress opts to require all Americans to have health coverage, Feder warns, it should make sure not to hurt any households in the process.

"If there's a mandate, we think it needs to be implemented in a very slow and cautious way, because people are going to have to make some pretty substantial adjustments."

Feder says she also would like to see plans and subsidies that take into account the full out-of-pocket costs for health care, not just insurance premiums.

Some opponents of the bills say that expanding subsidies is unfair competition for private insurance companies. President Obama says the details are still being worked out, but he anticipates passage of a comprehensive plan this year.

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Health Insurance (Rx)

The following is a health insurance story, from real people, like you.

Many years ago when I was in the Marine Corps, I knew a gunnery sergeant who liked to say, "We operate on the KISS system — Keep it simple, Stupid."

Congress should keep that system in mind when it works on health care reform.

Consider the case of Gregg Neely, who was the subject of Sunday's column. He is a 42-year-old accountant, and the father of three. His wife, Stacy, is also a professional. She works in Human Resources for the Rockwood School District.

In October of 2006, Gregg was diagnosed with amyotrophic lateral sclerosis, better known as Lou Gehrig's disease. He started having trouble swallowing and eating and he began to lose weight. In March of this year, he contracted pneumonia and spent 16 days in the hospital. While in the hospital, doctors installed a feeding tube. His health insurance paid for the hospital stay and the installation of the feeding tube, but then refused to pay for the formulated food that goes into the feeding tube.

Gregg was fortunate to have a pulmonologist who cared. Dr. Neil Ettinger spoke to the medical director of the insurance company, and then to an appeals

committee. He made two arguments. First, tube feedings were necessary. They were not optional. Second, it was less expensive for the insurance company to allow Gregg to remain in his home, where his care was provided by his wife, than to have him go to a nursing home. Less expensive for the insurance company and better for the patient.

Still, the insurance company denied the appeal. Last week, the insurance company reconsidered and decided to pay for the foodstuff and the supplies. The case made me think about the debate over health care reform.

Buried deep in Gregg's policy — in Section 8, Item 27 — was an exclusion for outpatient tube feedings or formula.

Who reads their policies? Nobody. The cover page of Gregg's policy says the document is 162 pages long. Even if a person did read it, what good would it do? Most of us don't understand the language. "The cost of outpatient enteral tube feedings or formula and supplies except when used for Phenylketonuria (PKU) or any other amino and organic acid inherited disease is not Covered, except as defined as a Covered Service."

What health care reform should be about is simplifying things. If you have insurance and you get sick, your care will be provided. Period. Of course, there will be levels of care. If you have a gold-plated policy, maybe you get a private room. Maybe you can go to any doctor. If you need a wheelchair, maybe you get a new one. Perhaps a cheaper policy will require you to share a hospital room. Maybe you have to go a doctor who is "in-network." Maybe your wheelchair will be of the used variety. But still, you're covered. You need tube feedings to live, you get the food for those feedings.

I would argue that a health insurance policy ought to be no longer than five pages.

It's like tax reform. The first step in tax reform ought to be simplifying the tax code. Right now, it is thousands and thousands of pages, and most people figure that all of those pages were put there to benefit somebody. That's why some type of flat tax sounds so attractive to so many of us.

When Congress talks about health care reform, they ought to keep in mind Gregg and Stacy Neely, two well educated people with jobs and health insurance. They were as prepared as anybody can be for this kind of disaster.

And what happened? In the midst of trying to deal with a horrific disease, they had to fight the insurance company. Stacy had to go in front of a committee and plead for something as basic as food for a feeding tube. That's ridiculous.

A basic health insurance policy might well exclude certain kinds of therapies, or elective surgeries, or experimental procedures. But if you have the misfortune to contract some kind of dreaded disease, you ought to have the peace of mind of knowing that you will get the necessary treatment. After all, you have health insurance.

So that's the first thing I'd tell Congress. We want to simplify things. We want to know that if we have health insurance and we get sick, we'll get care.

Unfortunately, I am not sure Congress understands simplicity. I read that the final health care reform bill will probably be about 1,000 pages. In other words, it will be like our health insurance policies — unread and unreadable.

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Health Insurance Editorial (Public Option)

Guess we know who's in charge over at the White House while the president is out of town.

In an interview with The Wall Street Journal published today, Rahm Emanuel, the White House chief of staff, suggested the administration is open to negotiations on one of President Obama's central goals for a health care bill: a government-sponsored insurance plan – a "public option," in Washington argot – that would compete with the private sector.

“The goal is to have a means and a mechanism to keep the private insurers honest. The goal is non-negotiable; the path is” negotiable, the newspaper quoted Mr. Emanuel as saying.

But Mr. Emanuel did not get the last word. Within hours, the chief of staff was big-footed – all the way from Moscow — by his boss, Mr. Obama, who is in Russia prior to the meeting of the “Group of Eight” economic powers. The White House issued an official statement declaring that Mr. Obama remains committed to the public option.

“I am pleased by the progress we’re making on health care reform and still believe, as I’ve said before, that one of the best ways to bring down costs, provide more choices, and assure quality is a public option that will force the insurance companies to compete and keep them honest,” the statement said. “I look forward to a final product that achieves these very important goals.”

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Health Insurance (Idaho Residents)

Heather Cody, an Idaho Falls mental health therapist, had to travel more than 7,000 miles across the Pacific Ocean to get medical treatment.

As a newly minted mental health therapist in her early 40s, Medicaid recipients were the bulk of Cody’s business. When the agency she worked for decided to stop accepting Medicaid, she took a part-time hospital job where she worked toward getting benefits and her clinical licensure. When patient loads declined, she was put on-call and her hours drastically reduced.

Knowing the risk, she’d paid for medical coverage for her children, but not herself. About two years ago, she was diagnosed with osteoarthritis in her right hip which required a $60,000 hip replacement.

“I got pretty depressed, really. ... I didn’t feel very helpful to my tribe,” she said. “I reached out to friends and it was hard. It’s hard to admit you’re not doing well and need help.”

Desperate, she discovered “medical tourism” – an industry that helps those with medical problems travel to foreign countries for cheaper care. She signed up for Medtral, a medical travel firm based in Auckland, New Zealand.

Cost of the hip replacement would be around $23,000, including air travel from San Francisco to New Zealand, lodging, physiotherapy, anesthetic and an apartment. All she’d have to cover was food and activities.

Cody took the chance and is expected to return from New Zealand this week.

“I don’t understand why it is so expensive [in the U.S.],” she said. “When I went in to see the doctors they didn’t spend much time with me and then I’m out the door. I just felt ripped off. … The prices are so extreme there’s just no way you can consider having [treatment]. I would have had to sell everything I had… then what kind of life do we have? It’s just so out of the ballpark of what’s possible.”

Cody’s frustration is shared by business owners around the country. About four weeks ago a small delegation from the Idaho Main Street Alliance showed up in Washington D.C. to talk about health care reform and changes in the health insurance system.

The alliance is made up of more than 300 small business owners from around the state who view health care as a primary concern. They support a public health insurance option because they think it will give them more choices and increase transparency in the system.

“According to a recent survey by the Kaiser Family Foundation, insurance premiums increased six times faster than wages over the last nine years,” said alliance executive director Nancy Snodgrass. “…The choice of a public health insurance plan as part of comprehensive reform will force private health insurance companies to compete and guarantee affordable coverage will be there for everyone.”

As the debate continues in Congress and the White House, Idaho officials are entering the fray. Last week Idaho House Minority Leader John Rusche of

Lewiston, a physician, told reporters it is imperative to fix the nation's health care system. "It's too costly, it's unavailable to lots of people and it's the leading cause of individual bankruptcies," he said during a phone interview.

Idaho U.S. Rep. Walt Minnick, a Democrat, has taken aim at the public option measure, saying it would make "'big government' the nation's dominant insurance company." He and other Blue Dog Democrats have also been critical of what they see as the current Democrat-backed proposal's emphasis on expanding coverage rather than reducing costs.

"And the bill does nothing to train more doctors, while at the same time raising taxes and adding billions to our national debt, something Idahoans rightly will not stand for in these tough times," Minnick stated.

Idaho U.S. Rep. Mike Simpson, a Republican, has also issued statements critical of the public option, calling it "another absurdly expensive government bureaucracy" that will do little to solve the crises of cost of and access. Like Minnick, Simpson emphasized the need for more doctors and the sense that adding a "massive new tax burden" will hinder rather than help small businesses.

Representatives from the Idaho Main Street Alliance, however, said failing to pass reform this year would be costlier to their businesses than a public option insurance measure.

"As a small business owner, I need health care reform and I need it as soon as possible," said Jerry Simonson, owner of the Talk Shop in Rigby. "Right now, we have no good choices for health care. This proposal will give us new choices and new bargaining power. As small businesses, we need that. The cost we really can't afford is the cost of doing nothing." Comment on this story::

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Health Insurance (Wal-mart)

Even as the national business lobby ramps up its opposition to health-care reform, there are signs that employers around the country are divided on the issue, reducing the force of an opposition push.

The U.S. Chamber of Commerce launched an ad campaign this week, with its lobbyist R. Bruce Josten warning that Democratic bills would "take us to a government takeover of the health-care system."

Wal-Mart, on the other hand, recently came out in support of a mandate on employers to provide health insurance, and the temp firm Kelly Services, which employs thousands, followed with a similar statement.

Less noted has been the diversity of opinion among small and medium-size businesses. Many agree with the Chamber that a public insurance option would undermine the private insurance market and that requiring companies to provide coverage would impair job growth. Others say the current system is so broken that they are assessing whether to support the reform plans.

The wait-and-see approach that many businesses are taking -- alternately skeptical and hopeful -- is a further sign that the alliances that previously scuttled health-care reform may be scrambled this time around, not just in the health-care industry but also in the business world at large. President Obama and congressional Democrats face formidable obstacles to their reform efforts, but one factor in their favor is businesspeople who may not be as inclined as they were in the past to bring grass-roots pressure against reform.

While the business lobby warns of the devastation of the employer-based insurance system that now covers 177 million Americans, some businesspeople say it would not be so bad if insurance became less tied to the workplace. Others envision a system in which health premiums increase at a more reasonable pace.

Take the board of directors of the state Chamber of Commerce in Maine, a state whose moderate Republican senators are key to the health reform outcome, and one of five states where the U.S. Chamber is running print ads; the others are Arkansas, North Carolina, Colorado and Louisiana. Board members expressed

varying degrees of support for the reform proposals and said there has been no effort by the Maine Chamber to lobby in opposition.

Mitchell Sammons, an executive at Sheridan Corp., a Maine building contractor, said that health premiums for the company's 90 employees have been rising and that a public option would bring needed competition to Maine, where the private insurance market is dominated by one or two companies.

Sammons, a Republican, dismissed worries that a public option would drive private insurers out of business. "They always find a way to make a buck," he said.

Jim Conlon, president of Bangor Savings Bank, said premiums are becoming harder to afford for the lower-salaried people in his 650-person workforce, such as "the teller whose husband's a fisherman." He likes the idea of a new insurance exchange that would draw more insurers into the market.

"If there's a bigger playing field with more competition . . . then that's a home run," he said.

John Oliver, vice president of public affairs for L.L. Bean, based in Freeport, Maine, said that the employer mandate is a "concept we do have openness to" and that a well-structured public option is a "reasonable goal."

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Health Insurance Advice (Consultation)

The bickering over who will pay for what kind of health care continues.

But until then, most of us are wondering how much we personally should plan to spend for own health care. Whether you're insured, or looking for insurance, the out-of-pocket bill can be more than you anticipate: Medical expenses, in fact, are the No. 1 cause of personal bankruptcy in the U.S.

There are several calculators for medical budgeting online, from Money-Zine, PayFlex and Health-Alliance. Or, you can go the old-fashioned way: sit down with a

pen and paper and jot down the estimated cost of doctor visits, prescriptions, health-insurance copays, deductibles and premiums, etc. And budget some money for the unexpected.

Intuit, the keepers of TurboTax and Quicken budgeting software, even offer a health expense tracker for free. The tool boils down medical jargon, funnels bill paying and organizes medical expenses for tax season. It also calculates how much you should plan to pay on your own. We haven't given it a full test drive yet, but if you have, let us know how it went.

Keeping tabs on health care costs not only helps ease budgeting woes, but can help you trim your tax bills, as nonreimbursed health care costs are tax-deductible. Set aside receipts and records for things like copays for doctor visits, prescription costs or any other expenses that your insurance carrier doesn't pick up. Bankrate.com points out that the deduction is applicable only if your costs exceed 7.5 percent of your adjusted gross income. At first blush, that seems like a high bar, but throw in expenses for a spouse and dependents, and you may well qualify. Talk to an accountant about what medical expenses you have and if they count toward the deduction.

Bankrate also has a nifty chart detailing some of the other overlooked health-related deductions. Among them: travel expenses to and from medical treatments, uninsured treatments (glasses, fir example) and dental expenses.

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Health Insurance (Unemployment)

The United States jobless rate jumped to 9.5%, the highest since August 1983. Today, 46 million Americans are without health insurance. With health insurance often tied to one's job, the number of uninsured people is sure to rise along with the unemployment rate. We offer solutions to people who are looking for temporary health insurance, short term health insurance or Cobra insurance alternatives.

There are many reasons people are in need of temporary health insurance, short term health insurance or Cobra insurance alternatives. They could be recently unemployed, between jobs, laid off, on strike or hold temporary or seasonal employment. Many others are recent college graduates, early retirees, or are waiting for their group health insurance benefits to begin after starting a new job. Some are simply looking for an alternative to Cobra insurance alternatives because this option does not meet their needs.

We work with Assurant Health and other leading insurance companies nationwide to provide people with affordable quotes on complete coverage. These plans offer coverage between 30 and 365 days with next day coverage available. The coverage is affordable and backed by the largest provider of short term health insurance policies.

This information is gaining importance as the nation's unemployment numbers look increasingly grim. In May, the payroll decline was more than forecasted and followed a 322,000 drop. The following month of June brought 467,000 job cuts. Companies from General Motors Corp. to Kimberly-Clark Corp. are expected to continue cutting costs. Unemployment is projected to keep rising for the rest of the year.

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Health Insurance (Benefits)

Employers have a delicate balancing act to achieve with their benefits package. On one hand, they need to be able to attract and retain excellent staff, while on the other hand, ever-increasing costs of key benefits such as medical insurance are forcing them to make tough and often unpopular benefit choices.

In many companies, particularly small- to medium-sized businesses, this scenario has resulted in the reduction or elimination of important insurance benefits such as life, disability, dental, vision and health. When the employer simply cannot carry the financial burden of providing a comprehensive suite of insurance benefits, employees have been left to their own devices to either secure coverage on an

individual basis, often at higher rates, or to go without insurance coverage and hope for the best.

Not only is this a risky proposition for the employee, it puts the employer at a serious competitive disadvantage.

Voluntary benefits bridge the gap

Fortunately, the popularity of voluntary benefits has continued to grow helping to bridge the gap between employees' needs and employers' budgets.

Voluntary benefits are made available by the employer but paid for by the employees who choose the benefits. This can be a great option for employers who understand employees' need for protection and who want to continue to offer employees the benefit of group insurance coverage without further stretching their benefit dollars. In addition, voluntary products are offered at group rates and premiums are paid through convenient payroll deduction. Here's a look at potential voluntary benefits:

Life insurance. A 2004 LIMRA International study found that 53 percent of U.S. households do not have enough – or any – life insurance. Employers who offer a low group life benefit (e.g. $15,000) may want to consider voluntary term life, which is an easy and affordable coverage to add to the organization's benefit package. An employee can purchase coverage on his/her life and the lives of his/her spouse and children as well.

Dental insurance. Employers may not feel able to offer dental insurance on top of medical benefits, but a study by Greenwald & Associates in 2000 found that more than 75 percent of employees rated dental insurance as "extremely important or important" for themselves and their dependents. Providing dental insurance as a voluntary benefit gives employees affordable access to comprehensive dental benefits without expense to the employer. In fact, offering voluntary dental benefits may reduce the company's medical costs through early detection of health concerns such as oral cancer or pre-term pregnancy complications due to periodontal disease with preventive care.

Disability insurance. Disability is a very real threat that most of us don't want to think about. The Health Insurance Association of America reports that one in three American workers over age 30 will become disabled for at least three months at some point in their career. Yet less than half of U.S. employers with fewer than 100 employees offer disability insurance. Both short-term and long-term coverage is essential to protecting employees' futures, and one or both can be offered on a voluntary basis.

Vision insurance. According to the Vision Council of America, one in four kids has an undetected vision problem that can lead to difficulties in school. Vision coverage is less commonly offered as an employer-paid benefit, but voluntary vision insurance can give employees and their families access to affordable vision care benefits.

Health insurance. Ask the average employee what benefit they value most, and overwhelmingly, they will say health insurance. Employers know they need to offer health insurance to attract and keep good people, but it's difficult to cope with the rising costs of providing this benefit – up to 40 percent for some companies in the last year. Business owners want to provide quality health insurance at a price their company can afford. To do that in today's environment, it's necessary to think creatively and beyond traditional medical benefit designs.

Employee education is key

Introducing voluntary benefits into a benefits package is most successful when employees have a clear understanding of the options available to them. Many employees do not realize there are gaps in their insurance and financial protection, and few seek advice from a financial professional. The 2006 Financial Well-Being IndexSM reports 73 percent of employees surveyed have not had a financial analysis of life insurance, disability income protection, retirement savings, savings goals, estate planning or education funding within the last three years.

Fear of intimidation or pressure sales seems to be the main reason for the lack of planning, as employees say they would welcome non-intimidating help. In fact, 83 percent of employees at small and medium-sized businesses reported interest in

having access to financial planning as a benefit available through the workplace, and 61 percent said they expect it to be available to them at no cost.

Some voluntary programs, address this need by providing the services of a team of salaried insurance and financial professionals as part of the worksite enrollment process. When the employer chooses to offer these programs, employees meet one-on-one with a salaried insurance professional at the workplace. This professional provides an overview of the employer-sponsored benefits available, and then can also provide needs analysis tools to help the employee identify potential gaps in his or her coverage. Through the team of insurance and financial professionals, employees also have access to retail products such as individual disability, mutual funds, banking and more.

The result of this additional hands-on assistance is higher employee participation. Employees get the protection they need and employers gain the competitive advantage of offering a complete benefits package.

Managing benefits in today's environment isn't easy—it requires the flexibility to consider new approaches and a new employee/employer relationship. With the right tools, education, and team, the process can be relatively painless.

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Health Insurance (Propaganda)

San Francisco Mayor Gavin Newsom recently wrote a column for the Huffington Post promoting his Healthy San Francisco plan as a model for the federal "public option" touted by President Obama. Healthy San Francisco could be a model, but not in the way Mayor Newsom imagines.

Currently under negotiation between federal politicians and lobbyists, the "public option" refers to a new complex of bureaucracies that would provide health insurance to any American who prefers to have his health insurance paid for by taxpayers rather than receive it as a benefit of employment or acquire it himself. Former U.S. Secretary of Health and Human Services Michael O. Leavitt describes

this as a “Trojan horse” that would crowd out health insurance chosen by employers or individuals and metastasize into a government monopoly.

The public option aims to tax privately purchased health benefits to subsidize these new bureaucracies which, like Medicaid, will likely be scattered across federal, state, and local governments. That is a key reason why an estimated 119 million Americans will lose their private health benefits and become dependent on the “public option,” according to economists at The Lewin Group.

Democratic leaders insist that the “public option” will not cause people to drop their private coverage. Unfortunately, President Obama and HHS Secretary Kathleen Sebelius have previously made no secret of their preference for single-payer, government-monopoly health insurance, as in Canada. So, it’s difficult to avoid the conclusion that they would actually prefer maximum crowd-out.

Voters who prefer choice in health care have become skittish, and they have other reasons for concern. Every time Democratic leaders roll out a federal health reform proposal, the Congressional Budget Office issues a report concluding that the costs will be much higher than the politicians suggest. To buck the tide, the White House has called upon Mayor Newsom to trumpet the success of Healthy San Francisco, which is the “public option” writ small.

Mayor Newsom insists that his Healthy San Francisco, which hikes taxes on employers to pay for the city’s public-health bureaucracy, has increased choice and competition while lowering costs. In recent interviews, the mayor claims that patients dependent on Healthy San Francisco enjoy access to a wide selection of private doctors and services through the plan’s “Care Network.” That sounds good but it isn’t true.

Until June, the “network” was limited to branches of the Department of Public Health and the Community Clinic Consortium, alongside two private providers. However, one private provider is the Sr. Mary Philippa Health Center, the charity wing of St. Mary's Medical Center, a small part of the mega-system Catholic Healthcare West. This is doubtless a fine center for poor people but non-profit

hospitals affiliated with communities of faith have been doing this long before Mayor Newsom got involved.

The second private provider is the Chinese Community Health Association, undoubtedly a similarly motivated organization. These two private providers served less than three percent of Healthy San Francisco's dependents, according to a January, 2009, report. Noticeably absent from The Care Network were any mainstream hospitals or physician practices.

On June 3, after two years of operations, Healthy San Francisco finally added Kaiser Permanente to its network – but this move bears all the signs of political pressure. Kaiser Permanente is an HMO, a model which integrates payer and provider. It makes no sense for Kaiser Permanente to "join" Healthy San Francisco's network. Even Blue Cross, Blue Shield, CIGNA, or Aetna can't get Kaiser Permanente to join their networks, because they are competitors.

The only part of Healthy San Francisco that's "real" are the taxes, of which $28 million were levied on San Francisco's small businesses in 2008. Despite this excess taxation, there are signs that lack of access to care – a classic side-effect of government programs – is a significant problem. According to a report in the San Francisco Chronicle in March, pregnant women with appointments were waiting five hours to be seen, and women seeking mammograms experienced severe backups at San Francisco General Hospital.

LOOK AT THIS PROPAGANDA:: "High taxes, high costs, limited choice, and long waits under a "public option." Is this the future of health care in the United States?"

John R. Graham is Director of Health Care Studies at the Pacific Research Institute and is the author of the "U.S. Index of Health Ownership," the only project to rank all 50 states' health laws and regulations according to free-market principles.

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Health Insurance (Costs Rising)

Many small businesses are worried that rising health insurance costs are choking their growth and hindering the creation of new companies, and they fear health care reform plans being debated in Congress and by the Obama administration could end up costing them even more in taxes, according to business advocates.

A survey of views on those costs released yesterday by the U.S. Public Interest Research Group, which includes its counterpart Maryland PIRG, found that 29 percent of the 343 small businesses they interviewed were able to offer insurance. Of the 21 businesses surveyed in Maryland, nine provided health coverage and nearly all said their insurance costs rose over the past year.

A dozen Maryland small-business employers said difficulties with health care would prevent others from starting their own businesses in the future. Nicholas Green, a field organizer with Maryland PIRG, said the report was not scientific but intended to be a "real human snapshot" of the struggles that owners of small businesses and their employees face. "Rising health care costs are choking American small businesses just when we need them the most," Green said.

Carma Halterman, a coffee shop owner in Charles Village, said the costs - around $300 a month per employee - are too prohibitive for her to offer insurance.

"We go for days and weeks sometimes with a nagging medical condition, avoiding the cost of treatment, and that really affects my bottom line and productivity," said Halterman, 46, owner of Carma's Cafe, while joining Maryland PIRG officials in the report's release Tuesday outside her shop.

The U.S. PIRG report comes as the debate on health care reform ramps up in Washington, with the Obama administration and congressional Democrats facing criticism from Republicans that their plans would be more costly to taxpayers.

A Senate bill would put the cost of health care reform at about $600 billion. A House bill, which passed through the Ways and Means Committee on Friday, would allow the uninsured to get a public or private insurance plan, or keep the plan they currently use. An estimated 47 million people in the U.S. lack health insurance.

About half of the House bill's $1 trillion price tag would come from Medicaid and Medicare changes, while the other half would come from a variable surcharge on 1.2 percent of the wealthiest Americans, those making $350,000 or more.

Businesses with fewer than 25 employees would get a tax credit, but employers and individuals could face tax penalties if they don't offer and buy insurance under the House plan.

In Maryland, the U.S. Small Business Administration's Office of Advocacy estimates that businesses with fewer than 500 employees - which they defined as a small business - numbered more than 112,000 in 2006, the most recently available data. Most of the businesses surveyed by U.S. PIRG were even smaller, with 50 employees or less.

According to the U.S. PIRG survey, more than three-quarters of the small-business owners they surveyed who don't offer health care felt stymied in doing so due to high costs, complications and red tape.Of those businesses that could afford coverage, 55 percent indicated that they did so for business reasons - to attract competitive employees - and not altruistic ones, the survey found.

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Health Insurance (Public Option)

Gary Zuckett is making forays across West Virginia to sell a national health care plan while attempting to shatter the “myths” generated by the nation’s private insurance network.

“There’s a lot of misinformation out there, a lot of scare tactics being used by the opposition,” says Zuckett, executive director of West Virginia-Citizen Action Group.

“We’re going to have a good fight on our hands. This is a once-in-a-generation chance to really make significant reforms that I think would benefit everybody in this country and everybody here in West Virginia.”

Zuckett is taking his message to town hall-style meetings arranged by labor groups that a national plan, now in limbo in Congress, would fill in the cracks through which many low-income workers are falling while exposing no senior to risk, nor threatening anyone satisfied with a private carrier.

“The insurance industry is doing an excellent job of confusing and scaring people, and the Rush Limbaugh crowd is saying it’s going to be a death sentence for seniors,” the WV-CAG leader said in a Register-Herald interview.

“I don’t know how to figure that one out. One of the reasons we’re doing editorial meetings is just to sort of clear the air and get the facts out there.”

One common criticism leveled at the plan is that government simply cannot run a business, period.

“If you look at Medicare, that system uses around 3 percent of its income in administration, and the rest goes toward health care services,” Zuckett said.

“If you look at the private insurance market, they’re up in the 20 to 30 percent range that they eat up in administration, advertising, multimillion-dollar CEO salaries — all the stuff that isn’t providing health care to people. So, that argument falls flat.”

As for seniors left in the lurch, Zuckett considers this another myth that can be shattered easily.

“You try to take Medicare away from seniors, and you’re in for a fight,” he said.

“That’s not going to happen. They’re not going to cut Medicare. There are going to be some changes in Medicare to take back some of the basically insurance industry subsidies passed during the Bush years.”

One glaring deficiency is in the prescription plan that forces seniors to pay 100 percent out of their pockets for medicine, and forbids the program from negotiating with the drug industry to lower prices, although the Veterans Administration is allowed to do so, he said.

Another misconception is that choice is abandoned. Not so, says Zuckett, because anyone happy with a private carrier may remain in that coverage plan.

Three means of financing the plan are on the table. One would impose a surcharge of about 1 percent of the federal income tax on those earning $300,000, affecting about one-half of 1 percent of all West Virginia taxpayers, he said.

“That would cost those people an extra $4 a week — a couple of cups of coffee, or a pack of cigarettes a week,” Zuckett said.

“They want to spread out the costs among people that can most afford to pay it. It doesn’t make sense to tax people in the low income or the middle income scale to pay for health care to give them because they can’t afford health care already.”

A second approach, advanced by President Obama, would scale back itemized deductions for those in higher income brackets, say from the existing 40 cents on the dollar to 28 cents.

A third payment method would impose taxes beyond earned income, since some people are living off various sources of income without paying into Medicare, even though they will use it once eligible, Zuckett said.

“These are three not very painful ways to pay for this program,” he said.

Critics also are misleading Americans into thinking the plan eliminates a patient’s choice of doctors, he said. “That’s not going to change,” he said. “We’re not picking doctors. We’re talking about health insurance, the way it’s paid for.”

In fact, he said, the medical community should applaud the idea because they no longer would be battling for every reimbursement as they now do with private carriers. “Another plus for the public plan — and I think this is a big plus for a lot of people — it will be portable,” he said. “You can take it from job to job. If you lose your job, you wouldn’t lose your insurance.”

From 2000 to 2007, one report Zuckett displayed shows, health insurance premiums for working families in West Virginia soared by 75 percent. The annual

combined premium for employers and workers shot from $6,844 to $11,970. The cost shared by employers and workers for insurance equals nearly 30 percent of the state's median family income.

Some 140,000 nonseniors work at jobs without health plans, or 61 percent of that segment of the work force.

Included in the health care package are some reforms that would bar insurance firms from dropping policyholders if they are stricken or eliminating people with pre-existing conditions. "We're letting the insurance industry basically kill people here because they refuse treatments, pre-existing conditions, that sort of thing," Zuckett said.

"You can't blame insurance companies because they're in business to make money for their stockholders. And the more treatment they withhold, the more money they make. It's a bottom line decision. It's pretty heartless. You can talk about the ethics of it."

A "Turn Around America" rally is planned at 1 p.m. Sunday at the state Capitol, not only to focus on health care, but to draw attention to the proposed Employee Free Choice Act, aimed at compelling employers to recognize a union if a majority of workers sign authorization cards; raising penalties on firms that coerce, intimidate or fire workers trying to organize; and ushering in a neutral third party to resolve labor disputes.

"We have a problem," Zuckett said of the health care status in America. "There is not enough competition in the market. That's another reason we need this public plan — put a little competition in there. That's the way it should be."

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Health Insurance (Republican Opinion)

I'm one of the nearly 50 million Americans who don't have health insurance. I don't want it, either.

But the bill the House of Representatives is debating would force me to buy it. How good can any product be if Congress compels me to purchase it?

Politicians and interest groups have been trying virtually all my life to foist medical insurance on me. But their proposals rest on mistaken and even insulting assumptions.

First, they presume that everyone wants, needs, and should have abundant medical attention. But I come from a long-lived and healthy family, I've been a vegetarian since childhood because I've never liked the way meat tastes, I don't smoke, and I love to hike – the more miles the better.

I am disgustingly healthy, so much so that the only doctors I see – or try to: I'm near-sighted – are ophthalmologists. Could I be hit by a bus tomorrow when I head out for my daily walk? Possibly. But that's such an unlikely disaster that I've chosen to spend my money on more personally pressing needs than medical insurance.

On the other hand, unlikely disasters do happen. So I might purchase catastrophic coverage if it were reasonably priced – just as I might visit doctors for lesser complaints if their care were reasonably priced.

But the government's meddling is what helped mess-up the medical market to begin with.

The federal government perverts costs with its Medicare and Medicaid programs: Recipients of this largess have no incentive to save money since someone else pays their bills.

In fact, the incentives run the opposite way as patients demand more procedures and tests while magnifying problems I resolve out of my medicine cabinet into emergency-room runs. Doctors who get away with charging Medicare hundreds for diagnosing Grandpa's indigestion would charge me the same.

Meanwhile, state governments shackle the insurance industry, mandating that policies cover everything from chiropractic care to hormone replacement. These

launch premiums into the stratosphere. I'd much rather pick and choose the coverage I want at a price I'm willing to pay than buy the plan bureaucrats and special interests decree.

But the universal-healthcare crowd thinks it knows better than I do how to spend my money. Why can't they leave me alone? I'm not forcing them to eat flaxseed and bike to meetings instead of hopping into their limousines. It's time for them to return the favor.

Besides, if that bus does hit me tomorrow, I want – and will pay for – top-notch care. And that's not what government-run medical systems dispense. Delays, expedient rather than proper treatment, and double standards of care depending on who you are and whom you know characterize universal-healthcare systems.

Which makes sense. We live in a world of finite resources and infinite desires, where medical care must be "rationed" like all other products and services.

Though we can't choose whether goods are rationed, we can choose how they are. Either the politicians and bureaucrats who bring us long lines at DMVs, failing public schools, and the endless war in Iraq will decide who gets what kind of treatment, or the free market will.

Fans of universal healthcare deride the market: They say it's cold and cruel because we each have to pay for the care we demand. But government healthcare can be far colder and crueler. Its care is inferior: Contrast an inferior, run-down veteran's hospital with a general one. And it's expensive. Dr. Jeffrey Anderson recently wrote in Investor's Business Daily, "Since 1970 – even without the prescription drug benefit – Medicare's costs have risen 34 percent more, per patient, than the combined costs of all health care in America apart from Medicare and Medicaid...."

Absent such meddling, the price of medical care would return to reasonable levels. It benefits no provider of any service to charge such astronomical fees that customers can't afford to patronize him.

Then, too, in a market free of the state's stranglehold, doctors and hospitals would compete with one another to lower prices and attract the ill or injured.

That doesn't mean everyone could finally buy all the procedures they wanted or even needed – but that's where private charity would come in. Humanitarians who send inner-city kids to summer camp and volunteer their time or money at soup kitchens would strive to ensure that needy Americans received medical care.

President Obama says, "We have no choice but to fix the healthcare system because right now it's broken for too many Americans." But the only fix we need is for government to get out of medicine.

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Health Insurance (Kids)

It is common for young adults who are blessed with good health to believe that they do not need to carry health insurance. Some young adults believe in health myths such as: Only old people get sick; my parents are in good health, so I don't have to worry about my health for a long time.

For others, their parents have always had employer sponsored health insurance, so they believe they should wait until they have a job that provides health insurance. These beliefs lead them to put health insurance on a back burner. For some, they know they should own it and have the funds to pay monthly premiums, but it's not a high priority. Other young adults have no concept of how health insurance works, how to buy it, or why they should own it. Perhaps they have not had a discussion with an older adult of influence who shared with them the importance of having health insurance, regardless of age.

In 2007, of the young adults in our country (ages 18-24), 28.1 percent of this group did not have health insurance coverage. This statistic made this group the least likely of any age group to have health insurance. This information was in the 2007 U. S. Census Bureau report, published in August of 2008.

The reality is that young adults do get sick. And it's not just strep throat or the flu. They can develop life-threatening illnesses that require sophisticated and costly tests, long hospitalizations, and long-term courses of treatment and/or therapy. An average of once a month, I am informed of a young adult who has experienced a major illness. Some of these individuals have health insurance, some don't. Those who don't are saddled with enormous debt for their care. They know they will be making payments for several years to the providers, or they will have to borrow money from family or a bank to get the bills paid within months.

Buying health insurance for a young adult is relatively inexpensive. They can purchase a plan of short term insurance which will cover them for up to six months. This is the ideal solution when between graduation and the first job or between jobs for short periods of time. Plans of permanent health insurance can be purchased, to be held for an indefinite period of time. These cost more, but are the ideal choice if it is unlikely that the individual will be seeking or finding employment with an employer who will likely offer health insurance to employees.

There are many options available spanning a wide range of cost, and I will be the first to admit that the plans are not easy to understand and sort through. Talk to an insurance advisor about the various options. When purchasing, be sure that you are buying genuine health insurance and not just a discount program. These discount plans are like having a band aid when a tourniquet is needed at the time of a major health care issue.

Parents, talk to your young adult children. Encourage them to buy health insurance and assist them with the process, if necessary. You might give some thought to helping them pay for this coverage while they are looking for a job that will enable them to keep it in the future. These times are tough for most. Don't let them become tougher for your young adult children by their being burdened with avoidable health care debt.

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Health Insurance (NC)

President Obama's trip to Raleigh on Wednesday is the latest indication of an intense and unusual political battle in the middle of summer in North Carolina – the fight over the president's plan to overhaul the nation's health care system.

It's July in a nonelection year, but the state's political machinery is fully engaged, complete with letter-writing campaigns and bus tours. Rallies, phone banks and door-to-door canvassing are under way, TV commercials fill airwaves, and petitions appear beside ripe tomatoes at farmers markets.

The flurry of activity comes as Obama tries to persuade Congress to pass a plan to revamp the health care system by the end of the year.

Though the health care debate is national, it is particularly loud in North Carolina, a state with a concentration of moderate Democrats that both sides see as persuadable, particularly Sen. Kay Hagan.

The state is also the home of some major players in the health care industry, including GlaxoSmithKline, one of the nation's largest pharmaceutical manufacturers. North Carolina, too, is seen as one of the nation's newest battleground states, having gone for Obama in November after voting Republican in the previous seven elections.

One recent night at Raleigh's RBC Center, critics of Obama's efforts were trying to fan opposition, literally.

The 350 people packed into the arena's club room were given fans with a drawing of a hand and the slogan: “Hands Off My Health Care.”

They heard speeches and watched videos comparing health care proposals by Obama and congressional Democrats to national health care plans in England and Canada. They were told to expect long waits to see doctors or undergo surgery. One video featured a news report from an Oregon TV station: A patient with advanced cancer was denied an experimental $4,000-per- month cancer drug but was told about the state's assisted suicide option law.

“Politicians want to control who lives and who dies,” said Dallas Woodhouse, head of the state chapter of Americans for Prosperity, a Raleigh-based conservative advocacy group.

Americans for Prosperity sponsored Tuesday's event and a similar one Wednesday at the Jesse Helms Center in Wingate. It has also planned a bus tour across the state in August to generate opposition to Obama's plan.

Participants were asked to focus their lobbying on Hagan and Democratic congressmen Bob Etheridge and Larry Kissell – whose 8th District stretches from central Charlotte to Fayetteville. All are seen as being on the fence.

The star of the event was Charlotte Mayor Pat McCrory, a Republican who lost the governor's race in 2008 and who might run again in 2012.

The health care system is in crisis, McCrory said. But, he stressed, a government-run system is not the answer.

“Have you ever gone to a DMV office lately?” he said of the motor-vehicle agency run by the state. “Can you imagine if that is how we distribute our medical needs in the future? It would be a disaster.”

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Health Insurance (TN)

Critics elsewhere may be questioning how many jobs the stimulus program has created, but here in central Tennessee, hundreds of workers are again drawing paychecks after many months out of work, thanks to a novel use of federal stimulus money by state officials.

Here in one of Tennessee’s hardest-hit areas, some workers were cutting down pine trees with chainsaws and clearing undergrowth on a recent morning, just past the auto parts factory that laid them off last year when it moved to Mexico. Others were taking applications for unemployment benefits at the very center

where they themselves had applied not long ago. A few were making turnovers at the Armstrong Pie Company ("The South's Finest Since 1946").

The state decided to spend some of its money to try to reduce unemployment by up to 40 percent here in Perry County, a small, rural county 90 miles southwest of Nashville where the unemployment rate had risen to above 25 percent after its biggest plant, the auto parts factory, closed.

Rather than waiting for big projects to be planned and awarded to construction companies, or for tax cuts to trickle through the economy, state officials hit upon a New Deal model of trying to put people directly to work as quickly as possible.

They are using welfare money from the stimulus package to subsidize 300 new jobs across Perry County, with employers ranging from the state Transportation Department to the milkshake place near the high school.

As a result, the June unemployment rate, which does not yet include all the new jobs, dropped to 22.1 percent.

"If I could have done a W.P.A. out there, I would have done a W.P.A. out there," said Gov. Phil Bredesen of Tennessee, a Democrat, referring to the Works Progress Administration, which employed millions during the Great Depression.

"I really think the president is trying to do the right thing with the stimulus," Mr. Bredesen said, "but so much of that stuff is kind of stratospheric. When you've got 27 percent unemployment, that is a full-fledged depression down in Perry County, and let's just see if we can't figure out how to do something that's just much more on the ground and direct, that actually gets people jobs."

Tennessee is planning to pay for most of the new jobs, which it expects will cost $3 million to $5 million, with part of its share of $5 billion that was included in the stimulus for the Temporary Assistance for Needy Families program, the main cash welfare program for families with children. The state did not wait for the federal paperwork to clear before putting residents of Perry County back to work.

Other states are still drawing up plans for how they will spend the welfare money, which is typically used for items like cash grants for families and job training. Some are likely to use part of it to subsidize employment, as Tennessee is doing, but it is hard to imagine many other places where the creation of so few jobs could have such an immediate and outsize impact as it did in this bucolic county of 7,600 people.

A stimulus job came just in time for Frank Smith, 41, whose family was facing eviction after he lost his job as a long-haul truck driver. Then he landed a job with the Transportation Department.

“The day I came from my interview here, I was sitting in the court up here where I was being evicted,” Mr. Smith said after a sweaty morning clearing trees under a hot sun to make room for new electric poles. “Luckily I’m still in the same place. There’s a lot of people that were totally displaced.”

Scott and Allison Kimble married after meeting on the assembly line at the Fisher & Company auto parts plant. When the factory closed last year and reluctantly relocated to Mexico, the Kimbles, along with many of their friends and neighbors, found themselves out of work. Now Mr. Kimble has a stimulus job working for the Transportation Department, and Ms. Kimble has one in what has become a growth industry, taking telephone applications for unemployment benefits.

“I know what they feel like,” she said between calls. “I’ve been in their position.”

Michael B. Smith, 53, who drove a forklift at the plant for 31 years, now drives a Caterpillar to clear land for a developer. Robert Mackin, 55, who lost his job, his health insurance and his home, now has a job with the Transportation Department, a rental home, health insurance and an added benefit: the state employee discount when his daughter goes to a state college.

“With a degree, she can always go somewhere,” Mr. Mackin said.

The impact has been enormous, all across the county. Even the look of the place is changing, following the old W.P.A. model. In addition to the jobs for adults, there

are 150 summer jobs for young people, some of whom have been working with resident artists to paint murals depicting local history on the buildings along Main Street in Linden, the county seat.

Over all, two-thirds of the new jobs are in private sector businesses that requested the money. Some, in retail, might be hard to sustain when the stimulus money runs out in September 2010. Other businesses say the free labor will help them expand, hopefully enough to keep a bigger work force.

The Commodore Hotel Linden, a newly restored 1939 hotel that has brought new life to downtown, has seen an increase in its bookings since it has expanded its staff thanks to the stimulus. And the Armstrong Pie Company expects to be able to keep on the new bakery assistants and drivers it hired with stimulus money, saying the new workers have helped the company triple its pie production and expand its reach through central Tennessee.

The county mayor, John Carroll, has been working to lure new industry to the area. Walking through the cavernous, empty Fisher plant, Mr. Carroll pointed to a forgotten display case filled with dozens of awards for safety and manufacturing excellence. “What we can offer,” he said, “is a great work force.”

Mr. Kimble said the new jobs had given him and his wife paychecks, health insurance and a reason to get up each morning. But he said he hoped that a big, long-term employer would move in soon.

“This job here is not a permanent fix,” he said. “We still need some kind of industry to look and come into Perry County. But for right now we’ve got hope, and when you’ve got hope, you’ve got a way.”

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Health Insurance (ME)

As you are reading this, Sen. Olympia Snowe is crystallizing forever the legacy she will leave behind when she retires after decades of public service. That’s because

right now, Sen. Snowe is the linchpin of the process to move forward genuine health insurance reform in the U.S. Congress.

If she continues to dawdle, stall and waiver, she will go down in history as the person most responsible for killing — perhaps once and for all — the possibility that Americans will finally be guaranteed high quality health care they can afford. For Sen. Snowe, as for health insurance reform overall, the time to make it happen is now. The clock is ticking, the insurance companies are mobilizing to protect their profits and, with enough time to do it and their seemingly endless supply of cash, they very well could twist and twist and twist the debate until it snaps.

Of course, it is hardly fair to put all the responsibility on Sen. Snowe alone. Genuine health insurance reform has been something of a Holy Grail for American politicians since Harry Truman was president. But we really are as close as we ever have been. Closer even.

The Senate Health, Education, Labor and Pensions Committee (known as HELP) has reported out legislation that get us there. The HELP committee bill would dramatically improve the current system, ensuring that those people who have and like their current insurance would get to keep it and while driving down costs by finally giving health insurers a real competitor in the form of a public health insurance plan. It's worth noting that in Maine competition between for-profit health insurance companies remains a talking point not a reality and Mainers are paying the price and then some.

The bill took on and conquered the things about the system today that no one but an insurance company executive could love. It barred companies from denying insurance to someone because of a pre-existing condition and stopped the common and truly vile practice of charging women more than men for the same policy because women are more likely to spend time in the hospital — having children.

Not a single Republican on the committee voted for it. The same holds true for a bill in the U.S. House of Representatives that was put together — turf wars miraculously shunted aside — by the three committees that have jurisdiction over

health issues. Sen. Snowe's fellow Republicans have, virtually to a person, done nothing more productive than spout talking points about "rationing" and "socialism" that are so trite as to be embarrassing.

So really, if health insurance reform is killed, Sen. Snowe should by all rights get no more of the blame — in fact, less — than her fellow Republicans. But Sen. Snowe bears the extreme burden of knowing better. A moderate awash in a sea of extremists, she is negotiating in the Senate Finance Committee with Democrats to put forth a bill that is not only positive but bipartisan. The problem is, for whatever reason, she is not finishing the job. We are hearing nothing about moving closer to a good, solid plan that will lower the astronomical costs of our health insurance.

Stalling serves no purpose other than to kill the bill. The facts will stubbornly remain the facts; the insurance industry will not suddenly stop its desperate lobbying to kill reform, nor will it quit raising our premiums again, and again and again. In fact, the Republican leadership and the insurance industry have as much as said that they are hoping to kill it by letting it die on the vine. It's time for Sen. Snowe to get to work — for real.

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Health Insurance (Kaiser)

Scrambling for additional money to pay for a health care overhaul, Senate Democrats are eyeing the insurance industry for as much as $100 billion over 10 years.

But the ideas they're exploring, including taxing companies that sell costly policies and imposing a "windfall" tax on profits, all have drawbacks and could have unintended consequences. "The biggest problem is, at the end of the day, these taxes will be passed on to consumers in form of higher premiums," said Dan Mendelson, president of the consulting firm Avalere Health in Washington.

The debate over taxing insurers comes amid increasingly harsh rhetoric from Democratic lawmakers and the White House about insurance premiums and

industry profits. They question whether the insurance industry, which is likely to gain millions of new customers from a health overhaul, has contributed enough to help pay for it.

Insurers say they are doing their share by promising to stop rejecting applicants with medical conditions if health reform legislation also includes a requirement that almost every American carry insurance.

Here are some of the ideas under consideration:

- Taxing insurers for selling policies with high premiums:

In theory, proponents say, taxing high-cost "Cadillac" policies should dissuade sales of plans with overly generous benefits, which some economists say encourages overuse of medical services.

But not all premiums are high because the plans offer overly rich benefits, said Paul Fronstin of the Employee Benefit Research Institute. Sometimes they reflect that employers have disproportionately more older or sicker workers, or are in a more expensive part of the country.

In addition, lawmakers haven't yet defined a "Cadillac" plan. One idea calls for taxing insurers that sell policies costing 30 percent to 60 percent more than a popular policy offered to federal workers. Such premiums would be nearly $19,000 and $23,000, respectively. Another possibility is using $25,000 as the threshold.

About nine percent of workers have family coverage premiums of $17,000 or more, according to the nonpartisan Kaiser Family Foundation. (KHN is a program of the foundation.) Less than one percent have premiums of $25,000 or more.

To avoid taxation, employers or insurers might tinker with the benefits to drive the premium down just low enough to miss the threshold. That would achieve one goal — reducing premium costs — but would reduce the tax take, Fronstin said.

Unions oppose the idea. "A tax on insurers is going to be passed on to workers, either by increased premiums or some other way," John Sweeney, president of the AFL-CIO, said Friday.

But others say that some insurers won't pass the increased cost along to consumers, but will instead tout their lower premiums as a way to pick up new customers.

Another complication involves companies that don't buy insurance coverage for their employees but instead pay the medical bills directly _ these are deemed "self-insured."

Just over half of workers with insurance are covered by policies that are partially or fully self-funded by employers. If such employers are taxed on their coverage, or can't fully deduct the cost of providing benefits as a business expense, "they are done" providing the benefit, Fronstin predicted.

- Taxing insurers' profits:

Sen. Charles Schumer, D. -N.Y., last week decried growth in health insurance industry profits over the past decade and suggested a tax on profits that could garner as much as $100 billion over 10 years. Profits for the 10 largest companies grew fivefold since 2000, said Schumer, who said the industry need to pay its "fair share" toward reform.

Robert Zirkelbach, spokesman for industry trade group America's Health Insurance Plans, said the focus on industry profits is misplaced, and that for every dollar spent on health care nationally, about a penny goes to insurers' profits.

Insurers' profit margins - or the amount left over after companies pay for medical services, taxes, salaries and other expenses - averaged 7.1 percent in 2005; 5.8 percent in 2006 and 6.2 percent in 2007, but fell last year to an average of 2.2 percent, according to Fortune magazine.

- Taxing each new policy sold:

Dubbed 'pay-for-volume,' the idea is to "ensure that those who are actually benefitting from reform would also be funding it," said Mendelson of Avalere Health.

In theory, if everyone in the U.S. were required to have insurance, the industry might pick up more than 47 million new customers.

But imposing such a fee could prove be tricky. Mendelson said it would be hard to know which new customers signed up as a result of the health overhaul legislation, thus triggering a fee on the insurer.

- Ending some tax-free coverage:

This idea would set a threshold for premium increases, said Robert Laszewski, an industry consultant who has promoted such an approach. Insurers whose premiums rise faster than a specific rate would no longer be able to sell products that are tax-free for workers. For example, if the economy grows by 3 percent a year, the premiums could grow no more than 6 percent to retain the policies' tax-exempt status.

That could prompt workers and employers to switch to less expensive policies and would encourage doctors and hospitals to work with insurers to keep costs down, Laszewski said. But others are skeptical that the change would give insurers much leverage over providers.

- End or cap the tax exemption for employment based insurance.

While President Obama and leading congressional Democrats have said they don't like this idea, it's still in the mix, according to some lawmakers.

Currently, workers with such job-based insurance don't pay taxes on the value of those benefits, a loophole that costs the U.S. Treasury about $226 billion a year. Sen. Kent Conrad, D-N.D., said this week that one of the options still being debated is taxing workers on the value of any policy worth more than $25,000 a year.

Such a tax is strongly opposed by unions, who often have negotiated policies with generous coverage and higher premiums. Obama also has said he prefers other ways to raise money to pay for health reform, saying it's not the time to burden the middle class with a new tax.

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Health Insurance (Use Terror Tactics)

WE DO NOT AGREE WITH THIS EXTREMIST VIEW AGAINST HEALTH REFORM:

Democrats want to ration health care for everyone in America -- except those who break our immigration laws. The House Ways and Means Committee defeated an amendment that would have prevented illegal aliens from using the so-called "public health insurance option."

Every Democrat on the panel voted against the measure.

Nevada GOP Rep. Dean Heller's measure would have enforced income, eligibility and immigration verification screening on all ObamaCare patients. Heller proposed using existing state and federal databases created years ago to root out entitlement fraud.

If congressional Democrats are truly committed to President Obama's quest to wring cost savings from the system, why won't they adopt the same anti-fraud checks imposed on other government health and welfare beneficiaries?

The Democrat leadership denies that an estimated 12 million to 20 million illegal aliens will receive taxpayer-subsidized health insurance coverage. Senate Finance Committee Chair Sen. Max Baucus, D-Mont., calls the proposition "too politically explosive."

But Obama lit the fuse in February when he signed the massive expansion of the State Children's Health Insurance Program. That law loosened eligibility requirements for legal immigrants and their children by watering down document

and evidentiary standards -- making it easy for individuals to use fake Social Security cards to apply for benefits with little to no chance of getting caught.

Immigration analyst James R. Edwards Jr. reported in National Review that "no health legislation on the table requires federal, state or local agencies -- or private institutions receiving federal funds -- to check the immigration status of health-program applicants, so some of the money distributed via Medicaid and tax credits inevitably would go to illegal aliens." Moreover, the Senate Finance Committee plan creates a new preference for illegal aliens by exempting them from the mandate to buy insurance.

That's right. Law-abiding, uninsured Americans would be fined if they didn't submit to the ObamaCare prescription. Law-breaking border-crossers, visa-overstayers and deportation fugitives would be spared.

The solution is not to give them health insurance but to turn off the magnets that draw them to enter illegally in the first place.

For years, advocates of uncontrolled immigration have argued that illegal aliens are not getting free health care, and that even if they were, they would not be draining government budgets. The fiscal crisis in California gives lie to those talking points. In March, the Associated Press reported that Sacramento and Contra Costa counties were slashing staff and closing clinics because of the prohibitive costs of providing non-emergency health services for illegal aliens.

At a time when Democrat leaders are pushing rationed care in a world of limited resources, Americans might wonder where the call for shared sacrifice is from illegal alien patients like those in Los Angeles getting free liver and kidney transplants at UCLA Medical Center.

"I'm just mad," illegal alien Jose Lopez told the Los Angeles Times last year after receiving two taxpayer-subsidized liver transplants while impatiently awaiting approval for state health insurance.

Now, multiply that sense of entitlement by 12 million to 20 million illegal aliens. Welcome to the open-borders ObamaCare nightmare -- AGAIN WE THINK THIS STORY IS ANOTHER EXAMPLE OF THE REPUBLICAN HEALTH CARE POSITION...

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Health Insurance (Legislation)

Working day and night, House Democrats advanced major health care legislation through two committees on Friday and struggled to line up the votes necessary to prevail in a third.

But the sense of urgency diminished in the Senate, where bipartisan negotiators ended talks for the week with no indication a deal was imminent and a different group of six Democrats and Republicans announced its opposition to "timelines which prevent us from achieving the best result."

The White House and Senate Majority Leader Harry Reid are pushing for legislation to clear both houses by August, but the letter said, "we believe that taking additional time to achieve a bipartisan result is critical."

The letter was signed by Democratic Sens. Ben Nelson of Nebraska; Ron Wyden of Oregon and Mary Landrieu of Louisiana; as well as Maine Republican Sens. Susan Collins and Olympia Snowe and independent Sen. Joe Lieberman of Connecticut.

Separately, the White House urged Speaker Nancy Pelosi to toughen the emerging bill so it will hold down the future increases in Medicare payments to doctors, hospitals and other providers. The request, in a letter from Budget Director Peter Orszag, came one day after Congress' top budget official warned that as drafted, the legislation fails to slow the growth in health care costs nationally.

The Ways and Means Committee was the first panel to act in the House, voting after midnight to slap a new 10-year tax increase of $544 billion on the wealthy to help finance legislation.

The committee vote was 23 to 18, with three Democrats joining all Republicans in opposition.

In a nearby committee room, the Education and Labor Committee met throughout the night, then took a brief break around dawn before returning to work and approving its portion of the bill on a vote of 26-22.

Republicans failed in numerous attempts in both committees to knock out central portions of the bill, including the tax increases and a requirement for the government to sell insurance in competition with private companies.

Separately, the Energy and Commerce Committee met to consider its part of the bill.

There, Rep. Henry Waxman, D-Calif., confronted a pivotal group of moderate to conservative members of the rank-and-file demanding changes, and claiming the votes to block the measure unless they get them.

Speaker Nancy Pelosi, D-Calif., has vowed to pass health care legislation in the House by the end of the month.

That task grew more demanding on Thursday, though, when the director of the Congressional Budget Office, Douglas Elmendorf, said of the legislation so far, "We do not see the sort of fundamental changes that would be necessary to reduce the trajectory of federal health spending by a significant amount. And on the contrary, the legislation significantly expands the federal responsibility for health care costs."

Slowing the rate of growth for health care spending is one of Obama's twin goals for health care, alongside expanding health care to the millions who now lack it.

At its core, the effort involves a requirement for insurance companies to offer policies to all willing buyers, and bars them from charging higher premiums on the basis of pre-existing medical conditions. Legislation would rely on government subsidies to make insurance more available for lower-income individuals and

families, and use tax increases as well as cuts in Medicare and Medicaid to pick up the cost.

"I will not defend the status quo," the president said Thursday in New Jersey, where he used a political fundraising appearance for Gov. Jon Corzine to make his latest plea for congressional action.

The Senate Health, Education, Labor and Pensions Committee approved its portion of the legislation on a party-line vote earlier in the week.

But Baucus' Senate Finance Committee is days overdue for a promised public drafting session, with no date set to begin.

Baucus has been negotiating for days with Republicans in hopes of achieving a bipartisan compromise. But time clearly is running short, given Obama's personal request for him to deliver a bill by the end of the week.

Baucus and other negotiators ended talks for the week without agreement. "I think it would be prudent for the president to be patient," said Sen. Olympia Snowe, R-Maine, urging Obama to abandon his call for legislation to pass both houses by early August.

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Health Insurance (Single-Payer)

Opinion Piece from Blogger:

Imagine for a moment that our public fire departments were privatized.

Imagine that you needed a special insurance policy before calling the fire department in an emergency, or you'd have to pay thousands of dollars out-of-pocket for the firefighters to put out the fire.

Instead of calling 911 for the nearest neighborhood fire department, you'd call whichever fire department is in your insurance plan, even if it's across town or

miles away. You might have to call your 'Fire Protection Insurance Company' or 'Fire Protection Management Organization' for approval.

Depending on your fire protection insurance plan, the fire department might tell you they can put out the fire in your living room and bedroom, but not the kitchen or the garage... unless you pay an additional out-of-pocket fee.

An insurance company agent might tell you that they won't pay for a fire department to put out a fire, because your house has a 'prior condition' or is too old or in a high-risk area.

If you don't have coverage and don't want to pay an expensive out-of-pocket fee, you might try to put out the blaze yourself, or just let your house burn. The fire might spread to other houses in your neighborhood. An uninsured neighbor's housefire might spread to your own house.

Imagine that you complained to your US Senators and Representatives that the system doesn't work, that over 45 million Americans can't afford 'fire department coverage' and millions more have inadequate plans, that thousands are losing their homes every year, and maybe your own home has been damaged. And your Senators and Representatives replied that we can't have fire departments that are publicly owned and paid for with our tax dollars because that would be socialism. Even though public fire departments would be far cheaper and save lives and property, moving to a public plan would cause insurance companies to lose lots of money, and we can't have that.

Insurance companies would spend millions of dollars in political contributions to make sure that fire departments remain under their control. They'd hire PR firms and place ads on TV and in newspapers to convince you of the wonderful job they're doing, telling you how public fire protection is a radical idea, un-American, too expensive, inferior in the services they'd provide, etc.

The whole scenario is absurd, you might say. (In fact, it's close to what many Americans experienced before public fire departments were established in the mid 1800s, when homeowners without insurance often watched their houses burn

while negotiating fees with fire companies.) Why have a bureaucracy of insurance company middlemen, demanding high fees as gatekeepers for fire protection without actually providing the service itself, when we can have a far less expensive public system that guarantees firefighters will show up in an emergency regardless of who you are, where you live, or what's in your bank account? Any reasonably intelligent human would recognize privatized fire departments as a disaster, a menace to public safety and utterly irrational.

So why do we tolerate a health care system that's run the same way?

Private health insurance companies and HMOs don't provide medical treatment. Instead, they act as gatekeeping bureaucracies that make an enormous profit based on the likelihood that at some time in your life you'll suffer illness or injury and will need medical treatment. They provide cost but no value.

Physicians for a National Health Program notes that "[o]ver 31% of every health care dollar goes to paperwork, overhead, CEO salaries, profits, etc." The overhead for Medicare, based on administrative costs but without the demand for profit, is about 3%. Why not convert to a public system, expanding Medicare to cover all Americans, perhaps saving us a third of the cost by eliminating the insurance and HMO middlemen — a system comparable to our public fire departments?

That's what a Single-Payer national health care system would do. It would guarantee health care and medical prescriptions for everyone regardless of ability to pay, employment, age, or prior medical condition (criteria currently used by private insurance firms and HMOs to limit or deny coverage). Single-Payer would allow everyone to choose their health care provider — you could visit the physician or hospital of your choice, rather than select from a limited list of those approved by an insurance company or HMO.

We'd pay for Single-Payer with a progressive tax plan. Tax sounds like a bad word, until one realizes that the amount most middle- and low-income working Americans would pay would be far less than we currently shell out for private insurance and HMO plans, and any additional fees when you go to the hospital or clinic or doctor's office would be zero or minimal. That's because HMO-insurance

company profits, big CEO salaries and bonuses, and administrative waste would be eliminated. Just as public fire departments have created an incentive for public education and measures to prevent fires, Single-Payer would create an incentive for encouragement of good habits, like a healthy diet, exercise, and quitting cigarettes.

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Health Insurance (Overhaul)

Despite an apparent bump in the road in President Barack Obama's sweeping health care overhaul, many local residents expect that Congress will eventually pass a health reform package. In the meantime, local folks are paying attention. "It will affect absolutely everybody," said Al Cummings of Marietta. "It will affect not only the people who have good (health) insurance now, but those who have none."

Senate Democrats told Obama Thursday to slow down in his push for an August vote, but spoke optimistically of wrapping up the bipartisan bill in two weeks. An August vote is not likely to happen, the president was told. "We wasted a lot of time over several administrations and something should have been done about health care a long time ago," Cummings, 78, said. "They've dragged their feet for years."

With a combination of Medicare, a government plan for seniors, and a supplemental private insurance, Cummings feels secure now, but wonders what Obama's plan will contain. "I have been following it right along, but sometimes it's all too deep for the average person to understand," he said. "They talk in riddles sometimes."

He would like to know exactly what the new proposal will cover and what it will mean to him.

Overall, many are questioning the engineering of House and Senate committee bills on health care that have emerged in recent weeks. Doubts revolve around

costs to taxpayers and the reach of government. In the House, moderate and conservative Democrats bucked against legislation written with a liberal tilt by party elders. In the Senate, moderate Democrats are insisting on trying to work out a deal with a handful of Republicans willing to talk.

Cummings has concerns. "At this point, we don't need to join a government plan, we have a good one with my retirement plan, but what if my company decides they don't have to pay out what we've paid into the plan?" he said. "I'm not quite sure how all this will work out."

Shelley Elliott of Devola thinks she knows what the future holds and she is deeply concerned. Elliott, 55, fears that the Obama health plan will go the same way as health coverage in England, where many close relatives live. "I am watching it closely and I am worried," she said. "My family is from England and I've lost several very close relatives to heart disease and cancer because their treatment was delayed. They were on a list and it takes forever to get in. That is fact."

Elliott, who has dual citizenship (she was born in the U.S.), said she has relatives who have been told by the system, "You are older and you can wait." "A necessary drug might be too expensive or certain tests people need are not allowed because of age - you are either too young or too old," she said. "My relatives cannot believe that Americans would let this happen."

Elliott wants fellow Americans to pay more attention to the Obama health care plan - look at the facts, and read information about it, before making a decision. "We've got to stop it," she said. "For some reason, nobody is believing what they are told by people from England and Canada about their health care system. Nobody is paying attention."

When you are 20 years old and never sick a day in your life, you might not think health insurance applies to you. Tyler West, 20, of Little Hocking was of that mindset until he was admitted to the hospital recently. "I don't have health insurance," West said. "It's too expensive for me with all my other bills to pay. I did go to the hospital because I was sick and it's pretty pricey."

He ended up with a payment plan to the hospital to meet his obligation. West expects a government health care plan would work for him. "It all depends on the price," he said.

Retired physician Russell Schreiber of Marietta said America needs to look at what's worked and what has not worked in other countries to craft a comprehensive health care plan here. "We should follow the lead of other industrialized nations," said Schreiber, an Obama supporter. "We should take a world view." His daughter recently gave birth in a New Zealand hospital, a country with full government health care. Attention to both mother and child was excellent, Schreiber said. "It did not cost her a penny," he said.

Maureen Olander, 54, of Devola, is an ardent supporter of the president's health care initiative and the legislation can't come soon enough for her. "The state of health care in this country is a national and international disgrace," Olander said. "It doesn't cover the people who need it. I hope it does go through this summer - if not in August, then in September."

Olander said her two adult children, 22 and 25 years old, are currently not covered by health insurance. "Once they graduate from college, they can no longer be on our health insurance and even with their jobs, they can't afford the premiums," she said.

Olander said sometimes she feels guilty that she and her husband have good health insurance when so many others, including their children, do not. "I encounter this every day in my office," she said. "I want a public alternative. It's important. If this doesn't go through, there will be a huge price to pay." She doesn't know the details of the Obama health plan, but she supports it, regardless. "I trust President Obama," Olander said.

In the midst of a family health care issue now, Robert Davis, a retired engineer and teacher, let his supplemental health insurance go. He and his wife have Medicare coverage, but the added coverage is too expensive, he said. "My supplemental skyrocketed in the past two years," Davis said. "I dropped it and I am paying out of pocket for my wife's health care needs." He is paying close attention to Obama's

health proposals. "I voted against him, but I decided to let him have a chance to prove his point," he said. "Now, I don't think that he has the depth of experience and knowledge someone should have to be president."

Davis is concerned about the price tag of the current legislation - trillions of dollars, he said. "I agree that everybody ought to be entitled to health care, but I don't think that this country can support it," he said. "It will be a matter of raising taxes on everyone." This former International Telephone & Telegraph engineer, who returned to Marietta from California for retirement, does not believe the health plan in its current form stands much chance. "I don't think it will fly at this point in time," Davis said. "There may be some compromise as time goes on. I certainly hope so."

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Health Insurance (For Needy)

If Congress passes health reform law similar to Massachussetts' universal health care system, currently uninsured families on Guam could become insured, and those below a certain income level would be able to get assistance for premium payments, said John Carlos, regulatory administrator at the Department of Revenue and Taxation last week.

The Affordable Health Choices Act grants health insurance credits to low- and moderate-income families, while requiring all individuals to obtain health insurance coverage, according to a summary released by the House Committees on Ways and Means, Energy and Commerce, and Education and Labor. The bill also penalizes non-insured individuals, the summary said.

The measures are similar to those in Massachusetts health reform law, passed three years ago, which required that all residents to become insured, and included subsidized insurance programs and fines for the uninsured in its health care plan.

The health care reform bill mandates employers to either provide insurance coverage to their workers or contribute funds on their behalf, in an amount based

on 2 to 8 percent of their payroll. Businesses with payrolls that do not exceed $250,000 will be exempt from the requirement, according to the legislative summary.

Carlos said businesses on Guam, particularly those with 20 or more employees, are already providing assistance to their employees in terms of health insurance premium payments.

Citing Massachussetts state law, Carlos said that with an increase in the number of people insured on Guam, insurance companies may earn more compared to the number of claims paid. Consequently, Carlos said, insurance premiums may become stable, and premiums may not increase as much every year.

Frank Campillo, health plan administrator for Calvo's Select Care, disagreed. "It could be argued that more people insured will translate into lower premiums," Campillo said. "However, there are other parts of this bill that negate those possible savings, including the fact that a public plan will compete with private enterprise."

Carlos said the cost of health insurance is rising yearly on Guam.

"At some time in the future, if this trend continues, the premiums would become not affordable for both Government of Guam or for the employees of the government," Carlos said.

In a Wednesday news conference, President Obama called attention to the 47 million Americans who are uninsured, the rising costs of premiums and out-of-pocket costs for those who are insured, and Americans' fears of the loss of health care coverage, should they change or lose their jobs.

In both the House of Representatives and the Senate, versions of the bill are being heavily debated. Senate leaders recently stated they could not meet President Obama's August deadline for health care reform before their monthlong recess.

On July 16, the American Medical Association endorsed the House version of the bill, citing these provisions: coverage to all Americans through health insurance

market reforms, an end to coverage denials based on pre-existing conditions, and individual responsibility for health insurance, including premium assistance for those who need it.

Vincent Tyquiengco, 22, of Baza Gardens hopes the legislation will pass. He's been searching for a job that includes health insurance, because he is no longer covered under his family's health insurance plan.

"It's scary, because if something happens, I might not have the money," Tyquiengco said. "Not a lot of people have the money to pay for health insurance, or have jobs that come with health insurance."

He said some of his friends are in a similar situation. "They said if something happens to them, they just can't afford it," Tyquiengco said."We're trying our best not to get hurt or sick." Because they are uninsured, he and his friends hold back from going to the doctor if they can help it, Tyquiengco said. "Only if it's serious, we go," he said. Jacqueline Dayrit of Yigo supports health insurance reform, including the bill's provision to prevent coverage denials based on pre-existing conditions.

Dayrit said she knows people who have switched jobs after developing a medical condition, such as cancer, and who have then found out that treatments for their pre-existing condition are excluded from their new health care coverage. "We have health insurance to take care of us," Dayrit said, "not to give us stress."

The bill is facing considerable opposition from legislators in Congress who say the plan is too expensive.

Opponents of the bill cite the bill assessment by Congressional Budget Office Director Douglas Elmendorf, who has said the current legislation significantly expands federal responsibility for health care costs, according to the Associated Press. "Changes ... made to health care have all resulted in higher costs," Campillo said, citing health care-related laws such as ERISA, COBRA, OBRA, HIPAA and most recently, the American Recovery and Reinvestment Act, more commonly known as the economic stimulus act.

"Consequently, I am doubtful that a new bill that completely changes the entire health care system will be able to contain costs, which is the main objective of this administration's bill," Campillo said.

He is concerned in particular with the public health insurance plan included in the House bill. "We know that private plans on Guam and throughout the nation pay higher amounts for health services than Medicare to medical providers and the hospitals," Campillo said.

If the bill becomes law, then health insurance companies will be competing with a public plan, and the medical loss ratios (the portion of a plan's premiums that pay for medical services) may be even higher for private plans, Campillo said. He added, "My opinion is that if the bill is passed in its current form, it will increase costs again to the nation and to individual citizens. We will watch the development of the bill and see what the U.S. Senate will do with their version."

The Senate committee on Health, Education, Labor and Pensions passed its version of the bill on July 15, and the bill is now before the Senate Finance committee. The committee's version, which requires that all individuals become insured, provides health insurance subsidies for Americans with low to moderate incomes. Small business tax credits also will be available to companies with fewer than 50 employees, who pay 60 percent or more of their employees' health insurance premiums.

At the same time, the committee's bill penalizes companies with 25 workers or more who do not provide health insurance for their employees. If the bill becomes law, annual penalties will be $750 per uninsured full time worker and $375 per uninsured part-time worker, though companies are exempted from paying penalties on its first 25 worker. Businesses with 25 workers or fewer would not pay a penalty.

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Health Insurance (Reform)

Harry and Louise, the ad couple who helped derail Bill Clinton's push for health-care reform in the early '90s, are back, and this time they're playing for the other team. They're perhaps symbolic of the mid-summer muddle in which a number of players who were openly hostile to the Clinton push are claiming to be for reform -- of some sort.

And though some observers doubt that the fictitious duo will be nearly as effective this time around, their re-entry has left patient-advocate groups and private insurance companies scrambling to counteract the message as President Barack Obama is pressing legislators to agree on the estimated $1 trillion health-care reform before Congress recesses next month.

Harry and Louise entered advertising lore in the early 1990s as the married couple who opposed President Bill Clinton's health-care reform package -- and ultimately proved to be one of the catalysts that doomed the plan. Now they're supporting Mr. Obama's health-care initiative -- as vague as that may be at the moment -- as part of a three-week, $4 million "Harry and Louise" campaign running on cable and broadcast networks. The effort is being co-sponsored by the consumer health-care advocacy group Families USA and the Pharmaceutical Research and Manufacturers of America (PhRMA), the pharma industry's chief lobby group. Both are based in Washington.

Ironically, the two groups have long been adversaries when it comes to health care, but PhRMA President-CEO Billy Tauzin said it's time to recognize the common goal of reform.

"This is a historic opportunity for change," Mr. Tauzin said in a statement, "and working together we can achieve our goal, which will benefit both patients and the U.S. economy."

The quandary remains, however, the philosophical difference between those who believe the government should run health care, and those who believe the system should be fixed so that those without access to care have it whether they can pay for it or not.

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Health Insurance (NM)

Today, the country's health-care system has become the subject of major debate in Washington. One important consideration is the creation of a public option to increase access and competition and drive down rates. In this debate, the federal government should consider how New Mexico solved part of its problem with workers' compensation insurance 20 years ago by creating a nonprofit private insurance company run by a board of directors, the majority of which are publicly appointed.

The New Mexico State Legislature enacted sweeping workers' compensation reform during a special session in 1990. Among the changes was the creation of the Employers Mutual Company (now known as New Mexico Mutual) to offer competitively priced workers' compensation insurance. The company was set up as an independent public corporation to operate like any other insurance company, subject to the same rules, regulations and assessments.

At the center of the national debate over a public option is the question of cost, who will pay for it and is this a move toward the socialization of health insurance and the delivery of health-care services.

Those in opposition to the creation of a public option are the same groups who opposed the creation of New Mexico Mutual, most notably the insurance industry who would have to compete with the newly formed company and almost every segment of the health-care industry who fear their payments would be leveraged downward through the bargaining power of a large pool of consumers. It can be argued that such opposition alone lends credence to the formation of this option.

Start-up funding for New Mexico Mutual was a $1 million appropriation from the state that was paid back in less than two years with interest. The company was also authorized to issue revenue bonds, and $10 million in revenue bonds were issued to capitalize the company to be repaid over an 8-year period. The bonds

were repaid two years ahead of schedule. In all, the company paid the state more than $5 million in interest and has been debt-free ever since.

The company is not a state agency and does not receive a state appropriation. Very simply stated, New Mexico Mutual was created by the government, at no cost to the government or the taxpayer, to help solve a social and economic problem and has been a tremendous success.

Through similar action, Congress should enact legislation to create a national health insurance company as a nonprofit, independent public corporation. The company should be a stand-alone company, not a federal agency, under the management of a board of directors appointed by the president with the advice and consent of the Senate to assure public accountability. There are a number of highly qualified professional men and women who could serve on such a board with vast experience in the field of insurance and investment from whom to choose. The company would have to be licensed in each state and would be subject to the same rules, regulations and assessments and would operate like any other insurance company in each jurisdiction.

The purpose of this private/public partnership would be to increase competition and reduce the growth of health insurance cost over the long term through providing a variety of health insurance products for groups and individuals and negotiating fair and reasonable payment for health-care services. Products would be available through any properly licensed insurance agent or other employer purchasing group. The company would guarantee choice of doctors, invest in prevention and wellness, encourage patient involvement and end barriers to coverage for people with pre-existing medical conditions, thus ensuring that every American has an option available to insure them and their families and receive the health care they need and deserve.

Start-up funding, and start-up funding only, would have to be provided through seed money from the federal government to be paid back in two years with interest. Initial capitalization to meet insurance industry regulatory requirements should come through an authorization from the federal government to issue revenue bonds with a definite timeframe to be repaid from premiums raised

through the issuance of health insurance policies and from other revenues of the company. Through this mechanism, the company would have to survive on its own based on good business judgment, actuarially sound underwriting and pricing practices and aggressive case management and utilization review of medical costs.

In New Mexico, as a result of the 1990 work comp reform, work comp rates are still 50 percent less than what they were at the time the legislation was passed while maintaining excellent benefits to injured workers. And New Mexico Mutual has played an important role in controlling rates by providing competitively priced products and establishing industry standards for sound loss control programs, safety incentives, utilization review of medical costs and total claims case management. The creation of New Mexico Mutual was truly a win-win for employers and workers. Other insurance carriers who compete with New Mexico Mutual for market share undoubtedly do not share this belief - but so much more to the point.

The creation of a public option as described above is essentially a mirror image of New Mexico Mutual. And, like New Mexico Mutual, at the end of the day such a company would have the effect of reducing rates, reducing health-care costs, and being available to businesses and individuals through the market of their choice, all at no cost to the taxpayer. Nothing is being socialized, private business and the importance of private business as the economic driver of our economy would not be threatened. In fact to the contrary, such a public/private partnership would become part of the business community and in fact serve a valuable purpose to both businesses and individuals by offering an alternative to the purchase of health insurance in an open competitive marketplace.

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Health Insurance (Op-ed)

Our private health insurance industry hires armies to both find healthy people to insure and then combs through records to terminate those people when their medical costs become too large of a "business expense." Terminations for

preexisting conditions or illnesses not covered are euphemized as "rescissions" by the companies.

Terminations are one way the companies meet Wall Street's expectation for higher profit margins year after year. Terminations also help support excessive executive pay for CEOs and their platoons of senior executives aka senior VPs, executive VPs, VPs, Regional VPs, etc.

On June 16, Bart Stupak (D-MI), Chair of the House Commerce Subcommittee held a three-hour hearing, “Termination of Individual Health Insurance Policies.” To clarify, the hearing was concerned with individual policy market, not with employer-sponsored group health care.

Among the discoveries was that the total compensation for one of the insurance CEOs (identity not revealed in the hearing) was $1.2 BILLION That rescission of policies had netted companies savings of $300 million.

Claims department performance is graded according to how much is saved by rescinding policies. One employee was heralded for saving $10,000,000 by canceling policies when claims were posted.

Insurance companies have flags based on potential costs that trigger an investigation (WellPoint has 1,400 of them), the sole purpose of which is to not only deny the immediate claim, but of rescinding the entire policy-- usually all the way back to the original date of issue. In addition to now having zero health insurance coverage, the insured must also reimburse the company for any and all paid claims under the policy.

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Health Insurance (Reform Rally)

Hundreds of people, including those who told personal stories of hardship, rallied Sunday in Milwaukee to support efforts to reform health care.

During a rally at American Serb Hall, one person told the crowd about a sister who died last month from lupus and was forced to leave the hospital against a doctor's recommendation because her insurance company wouldn't pay for additional days. Another told of losing health insurance when the company her husband worked for closed and how she had difficulties getting coverage because she previously had suffered a heart attack.

"This is about figuring out how to pay for a right in this country, a right to life," Patricia McManus, president and CEO of Black Health Coalition of Wisconsin told the crowd.

Organizing for America, the group that grew out of President Barack Obama's campaign, sponsored the gathering. Volunteers wearing red "I Am a Reformer" T-shirts handed out leaflets and encouraged people to write to their representatives.

U.S. Rep. Gwen Moore (D-Milwaukee) said 14,000 people are losing their jobs in the United States each day, which is boosting the numbers of uninsured people who no longer have access to health insurance or can't afford to pay premiums. "My colleagues who are holding this up," Moore said of lawmakers who are deeply divided over health care reform, "they say you really don't get it. You really don't understand."

Moore said profits are the reason insurance companies are against a public insurance option that would pay a little more than Medicare rates to providers. With a public insurance option, "We won't need to advertise Viagra every day," said Moore.

Jennifer MacGaffey, an internist at Aurora Advanced Healthcare, told the group that she has seen patients younger than 65 who don't qualify for Medicare. Some did not seek help for ailments or refused to have their cholesterol or blood pressure checked because of concerns about paying high deductibles or worries that their health insurers would drop them because of pre-existing conditions.

However, Republican Party of Wisconsin Chairman Reince Priebus said the proposed changes won't mean lower health care costs for Americans. "Giving

more power to the federal government is not the answer to finding affordable health care for families," Priebus said in a statement. "In fact, the public plan President Obama and congressional Democrats have proposed and are poised to rush through is the first step to a government takeover which will take decisions away from doctors and patients."

Because many Americans are not aware of the public insurance option, Robert Kraig, program director for Citizen Action of Wisconsin, advised the crowd to spread the word to their friends and families. "The issue is the special interests who don't want to compete with a public health insurance option," said Kraig.

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Health Insurance (Blogger Speaks Out)

United Insurance just announced a 155 percent increase in profits in the second quarter. We must stop such profits by health insurance companies. Not that I am against making a profit, I just think we don't need a profit based on the health or sickness of people.

The health insurance industry is spending millions of dollars lobbying Congress. Many of the opponents to health-care reform are the very ones taking all the money. The minority leader of the Senate, Mitch McConnell, is the largest taker of the insurance money.

Let's stop the insanity of having heath-care insurance based on the profit of sickness and diseases

Another blogger said:

As somebody who now has pretty good insurance for the first time in years, I can attest to how important it is. I can now choose the doctors I need to see, whether or not they are "in network." We can finally afford to get daughter, who is bipolar, the treatment she needs. It has been such a blessing to finally have decent insurance, but we really struggled for years when we had insurance that wasn't very good. I can't even imagine what it must be like for families with no insurance.

It is a basic human right to have access to decent, affordable medical care. If Europe and Canada can provide excellent insurance for their citizens, why can't the United States? The answer is that we can. The time to do so is now

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Health Insurance (Limbaugh)

HEALTH INSURANCE FROM A FAT DRUG ADDICT:

Conservative commentator Rush Limbaugh has waded further into the nation's universal health-care policy debate by offering his own health-care reform proposal.

In an interview with FoxNews's (NWS) Greta Van Susteren, host of On The Record, Limbaugh challenged the claim that 47 million Americans are without health insurance, arguing that the figure is much lower than that, so a comprehensive social-policy revision is not needed.

Limbaugh argued the 47 million figure contains "millions of illegal aliens" who should not be covered. And he disagreed than tens of millions of uninsured Americans are going without medical care, contending that they do receive medical care when they're treated at hospital emergency rooms. Those who cannot pay are not billed, Limbaugh said, and those who can pay or have assets are subject to hospital collection-agency efforts to recover some or all of the medical care expense.

That's the system Limbaugh would like to keep in place: those who don't have health insurance must visit the emergency room, and the hospitals that treat them must determine who to seek repayment from. People who can't pay but have assets, he said, "have their car repossessed," he said.

Limbaugh said the major issue in health-care insurance concerns major medical/catastrophic coverage -- a citizen's risk of incurring an enormous medical bill from a surgery, accident, or serious illness: a $60,000 knee operation, a $100,000 cancer treatment, a $200,000 bill to remove a brain tumor.

Limbaugh said the above can be addressed by passing an insurance program targeted to catastrophic coverage, and he estimated the U.S. Congress could cover 12 million Americans for $30 billion per year. So there's no need for "a comprehensive, trillion-dollar health care reform bill," he said.

Economic Analysis: One up, one down, regarding Limbaugh's health-care reform proposal. I'm giving Limbaugh credit where credit is due: his concept for a federal major medical/catastrophic coverage policy for those currently don't have/can't afford it is consistent with measures in current House and Senate reform bills seeking the same. However, Limbaugh's estimate that only 12 million Americans would need to be covered by a federal major medical policy undoubtedly is low, so his forecast of a $30 billion annual cost also is probably low.

David H. Wang, an economic modeler, will run a major medical cost forecast using different assumptions; I'll publish his results when they're complete in a couple of weeks. But Limbaugh's idea to have the uninsured continue show up at hospital emergency rooms for primary care and other medical services just does not represent a credible, feasible, or financially savvy policy.

To have tens of millions of citizens continue to impose $1,000 and more per visit to the emergency room costs on the U.S. taxpayer for primary care, when so many more efficient policy options exist, simply makes no sense financially and does not represent the most effective allocation of federal taxpayer dollars.

Any federal health-care reform bill must include an affordable insurance plan that covers and enables regular, sustained, preventive health care services by primary care physicians.

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Health Insurance (Affordable?)

Most people in the United States who try to buy an individual health insurance policy on their own never end up getting coverage, often because the premiums are just too expensive, according to a new study.

A report by the Commonwealth Fund, a private foundation that supports independent research on health policy reform, found that roughly three of every four people who tried to buy a policy from the individual health insurance market in the past three years didn't get one. The main reason cited was premium cost. About 57 percent said it was very hard or even impossible to find coverage they could afford.

About 47 percent of the people surveyed said it was difficult or impossible to find a plan with the coverage they needed, and 36 percent reported being charged more or denied coverage because of a pre-existing condition or had the condition excluded from their coverage.

Called "Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families," the report compared the experiences of working-age adults with individual- and employer-based private health insurance.

It also found that people who bought health insurance in the individual market spend a lot more on premiums and deductibles than those with employer-based coverage.

The survey found that among U.S. adults with individual insurance, 64 percent spend $3,000 or more annually on premiums, whereas just 20 percent of those with employer-based insurance spend that much. Out-of-pocket expenses, including premiums, averaged $6,750 for people with individual market insurance, compared with $2,250 for those with employer-based plans.

"In our current system, millions of people without access to employer coverage have no affordable option for health insurance," said Karen Davis, president of the Commonwealth Fund. "To achieve a health-care system that works for all Americans, we need health-care reform that offers comprehensive, affordable health insurance to everyone regardless of their health status, premium subsidies to help families with low and moderate incomes afford health insurance, and requirements to ensure that no one is denied health insurance because of a health problem."

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Health Insurance (Affordable)

For most people, being solely responsible for their own health insurance just isn't feasible. And healthcare costs are no picnic for those with employer-based insurance either. Such are the findings in a new report from the Commonwealth Fund, a private healthcare-research foundation.

It says: "Over the last three years, nearly three-quarters of people who tried to buy coverage in this market never actually purchased a plan, either because they could not find one that fit their needs or that they could afford, or because they were turned down due to a preexisting condition."

To be exact, among adults ages 19 to 64 with individual coverage or who tried to buy individual coverage in the past three years: -- 47% found it very difficult or impossible to find coverage they needed. -- 57% found it very difficult or impossible to find affordable coverage. -- 36% were turned down, charged a higher price, or excluded because of a preexisting condition.

Ultimately, 73% never bought a plan.

The report also found that: "Even people enrolled in employer-based plans are spending larger amounts of their income on health care and curtailing their use of needed services to save money."

Here's the full issue brief, released Tuesday:

Among its conclusions: "The individual insurance market is clearly inadequate as a source of affordable health coverage for those Americans who do not have access to employer-based insurance.... Enrollment in the market has remained low over time, even as more people have lost their coverage: only about 16 million people, or 6 percent of the under-65 population, have individual coverage."

And here's a recent column from The Times' David Lazarus on a family shut out from the private insurance market. They resorted to the state's Major Risk Medical

Insurance Program. He writes: "Susan, 62, a freelance writer, was diagnosed with ulcerative colitis, a digestive disorder, four years ago. Stephen, 58, a part-time teacher and a poet, has Type 2 diabetes. 'We're spending all our retirement cash,' Susan told me. 'But this is the only insurance we could get.' "

Still hoping the individual insurance market is an option? It might be. But Kathy Kristof writes: "Choose the wrong policy and you could wind up without enough coverage to pay for a lengthy hospital stay or an expensive medicine. We offer tips on navigating this tangled system and, in related stories, alternatives for those who don't qualify for private insurance or can't afford it."

The Commonwealth Fund, by the way, describes itself as aiming "to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults."

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Health Insurance (High Cost)

The individual insurance market is too expensive and out-of-reach of most Americans seeking coverage, according to a report from the Commonwealth Fund. Some 73% of those who tried to buy insurance through the individual market in the past three years ended up not getting a policy, mainly because of the high cost. And 36% said that they were denied coverage because of a pre-existing condition or a medical problem excluded from coverage, according to the report.

Half of those with individual policies spent more than 10% of their income on premiums and out-of-pocket costs, and faced problems such as lack of drug coverage or strict limits on treatment coverage. The findings were from the Commonwealth Fund's Biennial Health Insurance Survey of about 3,500 adults conducted by telephone in 2007.

The report follows others critical of the individual market, which covers about 6% of adult Americans under age 65. As part of comprehensive health reform, insurers have agreed to end exclusions for pre-existing conditions in this market, and ratings based on gender and health status.

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Health Insurance (Increases)

As President Barack Obama prepared to take to the airwaves to defend his health care overhaul last week, Hernando school officials got a little insurance sticker shock of their own. The district's insurance carrier, Blue Cross Blue Shield of Florida, is seeking a 21.5 percent rate increase.

"We expected increases in health insurance, but you don't really expect 21 percent increases," said Heather Martin, the district's executive director of business services. "It's very disappointing in these economic times."

The actual increase will likely come in at least a few percentage points below that, Martin said. Last year, for example, Blue Cross started with an 18 percent increase. By tweaking plans and raising deductibles and co-pays, the two sides brought that down to 12 percent.

Martin said she's hopeful this year's increase will be closer to 15 percent and that the district's insurance committee — composed of staffers and members of both unions — had made progress toward that number during talks with Blue Cross on Wednesday.

Blue Cross declined to comment beyond a written statement issued through spokesman Mark Wright.

"The specifics of our negotiations with any client are confidential. However, I can say that for groups such as this, projected claims experience for the upcoming plan year is the determining factor for premium rate calculations."

In other words, the company uses the district's claims history and estimates for what next year's claims will be to justify the rate increase.

The district's history isn't exactly pretty, Martin acknowledged. Claims have been "relatively high" in recent years, she said. Last year, Blue Cross paid more than $14 million in claims. "We are not an extremely healthy district," Martin said. "We have not improved it."

Martin noted, though, that the district is "punished" for the lack of urgent care facilities in the county. That forces employees to go to hospital emergency rooms, an expensive way to get urgent care that drives up the district's clams, she said.

The School Board has agreed in past years to have the district absorb most or all of insurance premium increases and should try to do the same again this year, said board member Sandra Nicholson.

"If there's any possibility of us being able to eat the increase, I think we probably will," Nicholson said. That could be a tall order, considering this year's proposed budget has only $1 million in reserves that aren't set aside for some purpose.

But it would help employees who have seen out-of-pocket costs rise, said Colin Davies, president of the Hernando United School Workers.

Davies said some employees have decided to go without insurance because they can no longer afford it, and he predicted that number could rise. "You choose whether to eat or have insurance," Davies said.

The unions accepted smaller pay raises last year in exchange for the district covering more insurance premium costs. Insurance will likely dominate negotiations again this year, said Joe Vitalo, president of the Hernando Classroom Teachers Association.

Vitalo expressed the kind of sentiment voiced by many Americans and that Obama says is motivating him to get health care reform done sooner rather than later. "It's probably the most legalized form of extortion there is," Vitalo said.

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Health Insurance (Altertive Medicine)

There is a concerted move to make alternative medicine too eligible for health insurance coverage in the US. Sen. Tom Harkin of Iowa has co-sponsored a measure that would prohibit health insurers from discriminating against practitioners of nontraditional medicine, “It’s time to end the discrimination against alternative healthcare practices,” Harkin said at a congressional hearing.

Backers of the amendment say it could save tens of billions of dollars in the long run by providing less expensive and better alternatives to drugs and surgery in a variety of cases. The amendment was adopted by a Senate committee writing health legislation, but details are still being negotiated.

More than a third of American adults and 12% of children use these treatments, according to an NIH and CDC survey that included meditation, yoga and deep breathing exercises in addition to types we mentioned earlier, Shirley S. Wang writes in Washington Post.

With hundreds of disciplines falling under the general category of alternative medicine, and with a variety of sometimes-conflicting studies about their effectiveness, there is much disagreement about the value of including such providers in a national health insurance program.

State by state, there is a wide disparity of coverage of alternative medicine. For example, Massachusetts licenses acupuncturists, and many health insurance plans cover the service, but most do so only on a limited basis, by restricting the number of visits or the dollar amount of coverage.

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Health Insurance (Kennedy)

Ted Kennedy wakes up in his house on Cape Cod to a packet of news clippings put together by his wife. If there's a hearing in Washington, D.C., he watches on his computer.

Five hundred miles away, Congress is wrestling with legislation to give every American access to quality health care. It is the moment the Massachusetts Democrat has worked toward for 46 years. But instead of marshaling the crowning achievement of his career, he is sidelined, battling brain cancer.

"He has lived for this day when America would finally extend this right to every citizen. There's no doubt if he could, he would be here in the thick of this," Kennedy's son Patrick, a Democratic congressman from Rhode Island, said in an interview, sitting on a bench on the Capitol grounds with tears in his eyes.

But history's third-longest-serving senator isn't out of the game. Exerting what influence he can from his sickbed, he advises his aides in Washington over the phone. He has made himself the poster child of what he calls "my life's cause," and is using his illness in a final press for universal health care.

Kennedy, 77, seems determined not to miss this. He has outlasted medical expectations since doctors diagnosed a malignant tumor in spring 2008 and is not above expending every last bit of his political capital to deliver the bill. Democratic leaders are making plans to bring him to the Senate floor later this year in a wheelchair, a bed if necessary, to cast his vote.

"I have enjoyed the best medical care money (and a good insurance policy) can buy. ... Every American should be able to get the same treatment that U.S. senators are entitled to," Kennedy wrote in an essay in Newsweek last week, adding: "We're almost there."

He cited his sophisticated course of treatment — risky surgery at Duke University Medical Center to remove part of the tumor, proton-beam radiation at Massachusetts General Hospital and multiple rounds of chemotherapy — as a privilege of the rich.

"My wife, Vicki, and I have worried about many things, but not whether we could afford my care and treatment." Kennedy's aggressive cancer is bringing a sense of urgency to a famously slow-moving Congress, with friends on both sides of the aisle mindful of passing a bill in time for him to see it signed.

The last time he came to the Capitol was April. In June, he missed passage of his own groundbreaking measure to regulate tobacco. This month, Kennedy, who heads the Senate Health committee, could not participate in the drafting of his legislation.

People close to him say he has his good days and bad. Sen. Christopher Dodd, D-Conn., who has taken over duties as chairman, has had dinner with him twice. Former aides recalled hundreds of meals at Kennedy's home in McLean, Va., or later on in Washington's elegant Kalorama, where experts on all manner of subjects gathered for lively exchanges. His well-informed staff is respected on Capitol Hill and in Kennedy's absence enjoys unusually direct access to some lawmakers.

But Kennedy's aides have not been in a position to broker compromises and have caused tension at times, trying to carry on in Kennedy's stead while lacking his stature. Few senators possess the friendships that have brought Republicans to the table or the gravitas that holds the party rank and file in line.

"He's the only Democrat who really has the sway with the unions, the trial lawyers, gays and lesbians, environmentalists, feminists," said Sen. Orrin Hatch of Utah, a Republican who has teamed with Kennedy on health-care legislation for three decades

The tragedies in Kennedy's life — his brothers' deaths, his son Ted Jr.'s partial leg amputation from bone cancer, his daughter Kara's lung cancer — shaped a commitment to universal health care that spans nearly a half-century.

Patrick Kennedy recalled traveling with his father in the 1970s to some of the poorest corners of America to highlight people without health insurance. He said his father walked the halls while hospitalized for treatment in Massachusetts and

North Carolina this year, asking other cancer patients and their families how they were managing the bills. "It still breaks his heart," the younger Kennedy said.

Ted Kennedy's record on health-care reform is hardly flawless. Critics say his refusal to compromise with Presidents Nixon and Carter missed promising windows of opportunity. During President Reagan's years, he bowed to labor unions and declined to back a plan for catastrophic health insurance, a move he later regretted.

Now an overhaul seems more possible than it has in years, and Kennedy's absence is keenly felt. Some wondered privately if Kennedy could have headed off some of the contentious debates and the staggering number of amendments his health committee's bill carried.

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Health Insurance (Real Life Story)

Doctors at the Maple City Health Care Center, a neighborhood clinic where a toddler's family receives most care, couldn't diagnose a problem. Their child needed to see a specialist, but no local dermatologist would agree to accept Medicaid, the government's safety net plan. Instead, Antonia Mejorado, 33, has to drive nearly two hours to see a dermatologist willing to treat her daughter's potentially serious illness.

"There is not a doctor around here that takes Medicaid," said Mejorado, whose husband, Osvaldo Soto, 33, has recently seen his hours cut to almost nothing at a local mechanic shop.

When workers get laid off and lose their health insurance, the medical insurance plan that covers some 60 million poor, elderly and disabled people, is a critical safety net. At no time is Medicaid more needed than during an economic downturn. Yet it's also precisely during a recession that Medicaid's shortcomings are clearest.

Medicaid, the second-largest item in most state budgets, after education, is funded jointly by the states and the federal government, with the federal government matching state dollars by as much as 76 cents to every 24 cents of state money. Wealthier states bear a bigger share of their Medicaid costs than poorer states do.

But in a recession, state revenues sink at the very time that more unemployed people sign up for Medicaid.

Over the past year, enrollment in Arizona, for example, has increased by 13 percent. It has jumped by 100,000 in the last four months alone. Medicaid enrollment in Alabama has been increasing at 5,000 per month for the last six months. In Indiana, enrollment rose by more than 17,000 between January and April, up about 9 percent from the previous year. In the stimulus bill passed last January, Congress rushed $30 billion to the states to keep Medicaid afloat, with an increase in the normal federal matching fund formula.

The Recovery Act's additional Medicaid money accounts for nearly two-thirds of all the stimulus funds going to the states in the current fiscal year, according to the Government Accountability Office.

But even as states get their Medicaid windfall, some needy people complain that they're not getting care under the program, because they are not eligible due to their states' restrictive rules, or because they can't get to see a doctor even though they are signed up for Medicaid.

About one in five physicians say they are not accepting any new Medicaid patients, largely because of low payments or delays in reimbursements, according to the Center for Studying Health System Change in Washington, D.C.

Ashley Soto, the 2-year-old with unexplained hair loss, is eligible for Medicaid because she was born in this country. The child's parents, who are from Mexico, are not. Her mother worries that a serious diagnosis could mean more long days traveling the 75 miles between Goshen and Michigan City, Ind.

“A lot of things are scary — not having a doctor nearby in case something happens to her,” said Mejorado, who is also the mother of three other children ages 17, 14 and 14 months.

The problem is that low reimbursements and complicated, time-consuming paperwork have left many physicians wary of the program, noted Cindy Hayes, director of physician services for Elkhart General Hospital in nearby Elkhart, Ind. Some clinics in the region have stopped accepting Medicaid completely, while others have waiting lists for appointments. At Elkhart General, hospital officials have worked hard to reopen Medicaid access to pregnant women who need prenatal care, plus labor and delivery services, she said.

“We rely on reimbursements from other payers to compensate for Medicaid,” said Hayes. “We’re taking our fair share.” Some doctors who have stopped accepting Medicaid patients say that it’s not that they don’t want to see them, it’s that they can’t afford to anymore.

Medicaid reimbursement rates can be as much as 40 percent lower than those for private insurance, according to John Holohan, the director of the Health Policy Research Center at The Urban Institute, a Washington think tank.

Michigan, for example, recently announced a 4 percent cut in payments to doctors, dentists and hospitals who treat Medicaid patients. The move prompted a new exodus of doctors who’ve decided to limit care. "I love what I do, but I can't keep getting cuts from Medicaid," Dr. John Pfenninger, a family physician in Midland, Mich., said. "It's time to say no. "

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Health Insurance (Questions)

From a blogger:

There is so much talk about the cost of universal health care, why is it that so many questions are not being addressed?

1.There is a frequent Republican dismissal of uninsurance as "most of those are illegal immigrants". I would like to posit the most unworthy uninsured possible, say an illegal immigrant who is a drug dealer, child rapist, terrorist sympathizer. Now assume that this evil person has TB, or AIDS or Swine Flu, or any of a long list of communicable diseases.

At some point this terrible person is going to prison where he will receive medical treatment. But how much damage will he do to others along the way? And in cold economic terms, how much will the spread disease cost the economy in lost productivity, insurance expenditures on the infected, on emergency room visits by the infected uninsured, on lost jobs by those whose companies must lay them off because of health insurance surcharges? Can anyone direct me to a sensible discussion of this?

2.The CBO has spoken about the cost of Obama's health care plan. (Does this mean the public option?) Does this report compare the cost in Emergency room visits and lost economic productivity to the un ensured, under insured, or those whose health care insurance disappears upon serious disease?

3.How I lost my health insurance at the hairstylist's Talks about loosing her insurance once she got sick. Has anyone heard a discussion of the prevalence of this problem? I have not. Again, in economic terms, which seems to be the only ones that Republicans care about, what is the cost to our economy of forcing such people off of the roles of the productively employed and onto the roles of those whose substenance and health care is paid for by tax dollars?

4.Actuarially, an older employee is more likely to incure health care costs. How much of a part do health care costs pay in the difficulty laid off older workers are having in the economic downturn? What is the cost to the economy of the loss of experienced workforce to actuarial realities? Since this involves the prohibited ageism, it has become the elephant in the room that no one will discuss. Has anyone seen a decent discussion of this?

5.It is accepted axiomatically that a well educated populace is a more productive populace, and leads to a better economic life for the entire country. There is no

discussion that schools do not earn a direct profit. The situation is similar with highways. National highways and freeways do not return a direct profit in tolls, yet they are considered of benefit economically to the nation. Why is the health of the worker population different?

6.Almost any other industrialized nation pays less of their economy for health care, insures a larger percent of the population, and has better outcomes. Has anyone seen comparisons with our system? This discussion has been so zenophobic. The feeling has been, if it is not American there is nothing to learn from it. Regarding health care in other countries, all I have seen is poor Canadians who had to wait for Cancer tests because of rationing.

There is no discussion of Americans who have had to wait for Cancer tests because of economic rationing, (they don't have/can't get health insurance). The Republican stance seems to be that they took a chance by not having health insurance, and this is the payback. There is no discussion of the percent of their income, that health insurance would have cost.

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Health Insurance (President Speech)

PRESIDENT OBAMA: I'm pleased to be joined today by representatives from the American Nurses Association on behalf of the 2.9 million registered nurses in America - men and women who know as well as anyone the urgent need for health reform.

I should disclose right off the bat that I have a long-standing bias towards nurses. When Sasha, our younger daughter, contracted a dangerous case of meningitis when she was just three months old, we were terrified. But it was the nurses who were there with us, explaining what was going on, telling us it would all be okay.

So I know how important nurses are, and the nation does too. Nurses aren't in health care to get rich; they're in it to care for us from the time they bring new life into this world to the moment they ease the pain of those who pass from it. If it

weren't for nurses, many Americans in underserved and rural areas would have no access to health care at all.

That's why it's safe to say few understand why we have to pass reform as intimately as our nation's nurses. They see firsthand the heartbreaking cost of our health care crisis. They hear the same stories I've heard across this country - of treatment deferred or coverage denied by insurance companies; of insurance premiums and prescriptions that are so expensive they consume a family's entire budget; of Americans forced to use the emergency room for something as simple as a sore throat just because they can't afford to see a doctor.

This is a problem we can no longer wait to fix. Deferring reform is nothing more than defending the status quo - and those who would oppose our efforts should take a hard look at just what it is they're defending. Over the last decade, health insurance premiums have risen three times faster than wages. Deductibles and out-of-pocket costs are skyrocketing. And every single day we wait to act, thousands of Americans lose their insurance, some turning to nurses in the emergency room as their only recourse.

So make no mistake: The status quo on health care is not an option for the United States of America. It is threatening the financial stability of our families, our businesses, and government itself. It is unsustainable.

I know a lot of Americans who are satisfied with their health care right now are wondering what reform would mean for them. Let me be clear: If you like your doctor or health care provider, you can keep them. If you like your health care plan, you can keep that too.

But here's what else reform will mean for you: you'll save money. If you lose your job, change your job, or start a new business, you'll still be able to find quality health insurance you can afford. If you have a preexisting medical condition, no insurance company will be able to deny you coverage. You won't have to worry about being priced out of the market. You won't have to worry about one illness leading your family into financial ruin. That's what reform means.

The naysayers and the cynics still doubt we can do this. But it wasn't too long ago that those same naysayers doubted that we'd be able to make real progress on health care reform. And thanks to the work of key committees in Congress, we are now closer to the goal of health reform than we have ever been. Yesterday, the House introduced its health reform proposal. And today, thanks to the unyielding passion and inspiration provided by Senator Edward M. Kennedy, and the bold leadership of Senator Chris Dodd, the Senate HELP Committee reached a major milestone by passing a similarly strong proposal for health reform. It's a plan that was debated for more than 50 hours and includes more than 160 Republican amendments - a hopeful sign of bipartisan support for the final product.

Both proposals will take what's best about our system today and make it the basis of our system tomorrow - reducing costs, raising quality, and ensuring fair treatment of consumers by the insurance industry. Both include a health insurance exchange, a marketplace that will allow families and small businesses to compare prices, services and quality so they can choose the plan that best suits their needs; and among the choices available would be a public health insurance option that would make health care more affordable by increasing competition, providing more choices, and keeping insurance companies honest. Both proposals will offer stability and security to Americans who have coverage today, and affordable options for Americans who don't.

This progress should make us hopeful - but it shouldn't make us complacent. It should instead provide the urgency for both the House and the Senate to finish their critical work on health reform before the August recess.

America's nurses need us to succeed, and not just on behalf of all the patients they sometimes have to speak up for. If we invest in prevention, nurses won't have to treat diseases or complications that could've been avoided. If we modernize health records, we'll streamline the paperwork that can take up more than one-third of a nurse's day, freeing them to spend more time with their patients. If we make their jobs just a little bit easier, we can attract and train the young nurses we need to make up a nursing shortage that's only getting worse. Nurses do their part

every time they check another healthy patient out of the hospital. It's time for us to do ours.

We're going to get this done. These nurses are on board. The American people are on board. It's up to us now. We can do what we've done for so long and defer tough decisions for another day - or we can step up and meet our responsibility as leaders. We can look beyond the next news cycle and the next election to the next generation, and come together to build a system that works not just for these nurses, but for the patients they care for; for doctors and hospitals; for families and businesses - and for our very future as a nation. -- PRESIDENT OBAMA

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Health Insurance (Editorial)

I spent Sunday reading T.R. Reid's "The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care". It's very, very good. I'll probably base a couple of posts on it. For now, however, I want to point out something he says about the successful efforts in Sweden and Taiwan to overcome the political opposition and rebuild their patchwork health care sector's into national health-care systems:

Both countries decided that society has an ethical obligation -- as a matter of justice, of fairness, of solidarity -- to assure everybody has access to medical care when it's needed. The advocates of reform in both countries clarified and emphasized that moral issue much more than the nuts and bolts of the proposed reform plans. As a result, the national debate was waged around ideals like "equal treatment for everybody," "we're all in this together," and "fundamental rights" rather than on the commercial implications for the health care industry.

Elsewhere, Reid quotes Princeton health economist Uwe Reinhardt saying that "the opponents of universal health insurance cloak their sentiments in actuarial technicalities or in the mellifluous language of the standard economic theory of markets, thereby avoiding a debate on ideology that truly might engage the American public."

This year, however, it's not just been the opponents of the policy who have relied on the "mellifluous language of the standard economic theory of markets." It's been the advocates of reform. Ask yourself what the administration's one-line goal is on health-care reform. Is it "equal treatment for everybody?" Is it "if every American is guaranteed a lawyer, why not a doctor?" Is it even "guaranteed health care for everyone?"

No. It's "bend the curve." And the problem with "bending the curve" is that it's a broadly testable proposition. This is, in part, why the Congressional Budget Office's skeptical assessments pose such a threat to health-care reform. If the White House's primary objective was health care for every American, or guaranteed care that you could keep even if you lost your job, or choice of insurance plans for every American, you could spend a bit more on health care and say you were achieving your goal. But if you say that the point of health-care reform is to save money, and then the outfit charged with estimating such things says it won't, that strikes at the heart of the project.

The economic case for health-care reform requires a really radical version of reform. Single-payer, say, or the Wyden-Bennett Healthy Americans Act. The consensus Democratic health-care plan -- the basic approach that the Obama campaign committed itself to and that Democrats in Congress are pushing -- is primarily a coverage plan. It has some cost-saving features on the margins, but it's primarily a way of getting to universal coverage. You can argue for that plan in primarily moral terms, with some economic arguments around the margins. But the administration has been pushing it in primarily economic terms, with some moral arguments around the margins. And now they're caught in that dissonance.

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Health Insurance (Opinion)

In response to my earlier post on declining trends in rates of entrepreneurship in the United States, a lot of people commented that the cost of health insurance was a big part of the problem. So this week I am taking a look at the effects of health care on small business and entrepreneurship.

Clearly, health care costs have reached levels that are adversely impacting entrepreneurial activity. One result of the spiraling expenses is the inability of new companies to offer health insurance to their employees. The Kauffman Firm Survey, which tracks a sample of new businesses drawn from the 2004 cohort of U.S. start-ups, reports that only 29.5 percent of new employer firms and only 12 percent of all start-ups provide health insurance to their full-time employees.

A second effect has been to lead many older small firms to reduce health care coverage. According to the Kaiser Family Foundation, which conducts an annual survey of health care costs, the majority of businesses with three to nine employees do not offer employee health insurance; only 49 percent of these businesses did so in 2008. Moreover, the foundation data indicates that the provision of health care is much lower among small businesses than large ones. Only 62 percent of companies with three to 199 employees offer health insurance, as compared to 99 percent of businesses with more than 200 employees. According to the U.S. Small Business Administration's Small Business Economy 2009, 25 percent of the 15.7 million workers in small businesses do not offer health insurance.

Self-employed people are much less likely than other people to have health insurance. The 2009 Small Business Economy reports that only 49.3 percent of self-employed workers have employment-based health coverage, as compared to 70.5 percent of wage and salary workers. Moreover, the S.B.A. publication also shows that approximately 3.7 million self-employed people aged 18 to 64, or 26 percent of the total, are uninsured.

Small businesses also pay more for health insurance than large companies. According to the Commonwealth Fund, small businesses now pay 18 percent more than large businesses pay to obtain comparable insurance.

A third effect of the tremendous rise in health insurance costs over the last decade has been to impose a huge financial burden on new companies. The cost for the average new company to provide its employees with family health insurance at the average cost for firms of its size (as reported by the Kaiser Family Foundation) is now $68,611 a year, more than double what it was 10 years ago. Granted, some

of those costs aren't paid by the employers, and some employees have individual coverage, making the actual numbers paid by employers lower, but it's still a huge figure in comparison to new-firm revenue. According to the Kauffman Firm Survey, the average three-year old surviving firm generates only $152,000 in revenue annually.

Finally, because leaving a job to start a business causes one to give up employer health insurance, the employer-based health insurance system in this country is keeping some people from becoming entrepreneurs. A recent working paper by Rob Fairlie of University of California Santa Cruz estimates that workers with employer-provided health insurance have 2.5 to 3.9 percent lower odds of becoming self-employed than those without health insurance, suggesting that health insurance affects the start-up decision.

To all the readers who commented on my earlier posts and got me to look at health care costs and entrepreneurship, you've got me worried. The health care mess is clearly weighing down entrepreneurship in this country.