

HEALTH CARE REFORM?

President Barack Obama praised the health care industry's promise to cut \$2 trillion in costs over 10 years, but lawmakers questioned how much it really helps in coming up with a solution for the millions of uninsured.

It's "a watershed event in the long and elusive quest for health care reform," Obama said Monday at the White House with representatives of the insurance industry, doctors, hospitals, pharmaceutical companies and a top labor union at his side.

It was a noteworthy sight as leaders of the industry who have killed past attempts at overhauling health care stood behind the president with a proposal to curb their costs.

The proposal, however, was short on specifics. And it appeared to do little to shift positions in Congress as lawmakers attempt to write legislation to implement Obama's goal of extending health care to some 50 million uninsured Americans.

Within moments of Obama's appearance with the industry leaders, lawmakers praised the effort but suggested it didn't go to the heart of the health care debate.

Several lawmakers made clear that the industry proposal would do nothing to stave off the outcome health insurers and others are trying to avoid — a new government insurance plan that would be available to middle-income Americans. Health insurers say such a plan would drive them out of business.

"This commitment to cost-cutting is a good-faith gesture by the health care industry, but it does not mitigate the need for a public plan option in the upcoming reform bill," said Sen. Charles Schumer, D-N.Y., a member of the Senate Finance Committee that's writing a health reform bill.

The industry groups said they would slow the growth of health care costs by 1.5 percent a year by coordinating care, reducing administrative costs and focusing on quality, efficiency and standardization. Health care costs would still grow faster than the economy as a whole, but not as fast as they otherwise would.

The specifics, industry officials said, would come later.

Obama has spoken often of the exorbitant costs in the nation's health care system, but slowing the rate price increases doesn't translate directly to paying the estimated \$1.5 trillion cost of covering the uninsured. Money saved by the private sector doesn't flow directly to the federal treasury.

The top Republican on the Senate Finance Committee, Chuck Grassley of Iowa, called the announcement a "move in the right direction," but said it would be more significant if the Congressional Budget Office, Washington's arbiter of what costs or saves money for the government, determined it saved money.

"When the White House and the industry put concrete proposals on paper and get a score from the Congressional Budget Office, then we'll know if the suggestions really achieve that kind of savings, and it'll be big news," Grassley said. "For health care budgeting purposes, CBO's word is the only one that counts."

Karen Ignagni, president of America's Health Insurance Plans, contended that the voluntary cost-containment effort would help lawmakers who are aiming to craft health overhaul legislation by August.

"They need help from the stakeholder community on cost containment and what you're hearing from all of us is we intend to help and that I think is the story today," Ignagni said.

The groups who signed onto Monday's effort were the American Medical Association, America's Health Insurance Plans, the Pharmaceutical Research and Manufacturers of America, the Service Employees International Union, the American Hospital Association and the Advanced Medical Technology Association.

Officials said they could bring costs down even while continuing to stay profitable — noting that if health care legislation passes they'd be able to tap into a huge pool of currently uninsured people.

HEALTH INSURANCE OPTIONS

President Obama has pledged to find a middle ground in his drive to reshape the nation's troubled healthcare system.

But even before Congress debates a healthcare bill, the president is getting sucked into a fiercely polarized fight over a centerpiece of his agenda: a new government insurance program that patients could choose instead of private coverage.

The battle over the "public option" has mobilized interest groups on both sides of the political spectrum with millions of dollars in their campaign war chests. Television ads promoting and attacking the insurance provision are already hitting airwaves.

The Obama administration and its allies are now scrambling to contain a full-throated ideological debate that some fear could threaten the most ambitious healthcare campaign in nearly a generation.

"Everybody needs to keep their powder dry," Senate Finance Committee Chairman Max Baucus (D-Mont.) said in an interview. "We have a huge opportunity to accomplish very significant health reform. . . . Let's not have any sparks that could light a fire."

The sparks, however, are already flying.

Conservatives have zeroed in on the insurance proposal as a potential Achilles' heel in Obama's healthcare plan, casting it as a move toward Canadian-style government healthcare and contending that federal bureaucrats will dictate personal medical decisions.

Meanwhile on the left, longtime advocates of a single-payer system are also fomenting a showdown with the right to force Obama and Democratic leaders to stand firm behind a new government program.

"This has become a lightning rod," said Maine Sen. Olympia J. Snowe, a Republican who Democrats hope will work with them on healthcare. "There is a lot of suspicion. . . . I'm afraid this could easily be used as an excuse for not moving any further."

Policymakers and politicians have battled for decades over the government's role in a system that relies on both public programs such as Medicare, which serves the elderly, and private insurance, which covers most workers and their families.

Fifteen years ago, the Clinton administration's healthcare campaign was derailed in part by an insurance industry campaign featuring a fictitious couple named Harry and Louise who worried aloud about government making their medical choices.

Now, with the debate flaring anew, Obama and his congressional allies are struggling to head off the conservative assault and tamp down a liberal revolt, even as they work to keep major healthcare groups, including insurers, at the negotiating table and off the political warpath.

At a recent White House meeting, the president assured a group of House Democrats that he was still committed to a government insurance option.

Last week, Health and Human Services Secretary Kathleen Sebelius tried to defuse the issue on the other side of the aisle, telling GOP lawmakers on the House Ways and Means Committee that the administration had no intention of driving private insurers out of business.

Sebelius noted that many state governments offer their employees a choice between public and private health insurance.

Baucus, who plans to introduce sweeping healthcare legislation next month, said he had recommended starting with less controversial elements of healthcare reform. "We don't have to deal with the public [insurance] option on the first day," he said.

Baucus, Obama and others see a new government program as crucial to covering the approximately 46 million people in the United States who have no insurance. They also argue that a public alternative would pressure private insurers to control costs and improve quality.

The federal government already provides health insurance to about 83 million Americans through Medicare, Medicaid and other public programs, including those offered by the military.

Private insurers, meanwhile, face growing criticism for refusing to cover people with preexisting conditions and dropping coverage for sick customers. "This is a benchmark that will set a high standard that private plans have to meet," said Jacob Hacker, a political scientist at UC Berkeley who advocates a public option.

But insurers say more federal regulation could ensure affordable, high-quality insurance for all. In recent months, the industry has offered to guarantee coverage and stop charging more to people with preexisting medical conditions.

A government-run insurance program, industry leaders and many conservatives maintain, would have an unfair advantage and ultimately drive insurers out of business.

That would inevitably mean a single-payer system, said Stuart Butler, vice president for domestic policy at the conservative Heritage Foundation. "The probability that a monopoly would serve customers well is close to nil," he said.

GOP lawmakers are intensifying warnings that a public insurance plan will lead to nationalization of healthcare and new limits on patient choice.

That's a message that will resonate, said veteran GOP pollster Tony Fabrizio. "People don't want government agencies, boards or regulators standing between them and their doctors. . . . They understand that government control inevitably leads to rationing."

Pushing that message is the Conservatives for Patients' Rights Action Fund, a new group founded by former hospital executive Richard L. Scott and assisted by CRC Public Relations, the conservative public affairs firm that worked on the Swift Boat Veterans for Truth campaign against Sen. John F. Kerry (D-Mass.) in the 2004 presidential election.

The fund is in the midst of what the group said would be a monthlong, \$1-million television advertising campaign featuring doctors from Canada and Britain -- both of which have single-payer systems -- discussing waiting lists and limited patient choices. A new ad featuring dissatisfied patients from those countries began airing this weekend.

At the same time, MoveOn.org, the liberal grass-roots powerhouse, has been mobilizing its 5 million members to pressure Congress not to compromise on the creation of a new public plan option.

Last week, the group aired its second healthcare ad of the year, featuring a pair of undertakers bemoaning a public plan that could make people live longer. MoveOn's first ad went after the insurance industry for opposing Obama's public option.

"We're not taking anything for granted," said Nita Chaudhary, MoveOn's national campaigns director. "This is likely to be our biggest fight for the year."

MoveOn has been joined by other liberal advocacy groups such as Health Care for America Now, which aired its own ad last month promoting a public plan. Last week, it aired a second ad highlighting Scott's former work for healthcare giant Columbia/HCA, which a decade ago paid \$1.7 billion to settle fraud charges against the company.

CEOS RICH - KIDS POOR

Katie Hebert, age 4, is a very sick little girl. She gets severe seizure-like attacks that can last 11 hours from an undiagnosed neuro-developmental disorder. She is deaf in one ear, has a feeding disorder and requires daily medication for asthma. In her short life, she has been rushed to the emergency room six times and hospitalized twice. Her health was put at even greater risk when she lost her health coverage -- which meant no more regular doctor's visits, weekly therapy or attention from specialists.

To deal with this crisis, Katie's father tried to buy private insurance, but he couldn't afford the roughly \$1,000 a month, about 30 percent of his salary, to pay for the insurance plan offered by his employer. And even if he could have afforded the insurance, it would not have covered all of Katie's health needs. On top of that, other private insurers would not accept Katie in their programs because of her pre-existing conditions.

The only alternative was the Texas Children's Health Insurance Program (CHIP). But her father made \$260 a month above the limit that would enable Katie and her older brother, Nathan, 7, to qualify for CHIP. Mr. Hebert is a reliable worker who has helped maintain the computers for a banking system in Pasadena, Texas, over the last six years. He requested a voluntary pay cut in an already modest income so his children could get insurance, but his employer didn't respond.

The family eventually spent down its income by paying for unnecessary child care to become financially eligible for CHIP. That wasn't the end of it, however. When Katie's father got an automatic three percent cost of living raise in December, the family's income once again exceeded the CHIP limit, this time by \$20.54 a month. During the period that her father went through the process of having his wages lowered, Katie was without health coverage -- again.

Katie is one of millions of children in working families who face impossible barriers to obtaining health coverage imposed by insurance companies that make enormous profits and pay their CEOs and top managers fat compensation packages. They have the power to decide who gets coverage, what medical treatment they'll pay for, and they set the prices for coverage. The premiums these companies charge and the restrictions they impose are major reasons why 46 million Americans are without health insurance today -- including nine million children.

Insurance companies' massive profits and outsized executive salaries are largely made possible by soaring premiums, high deductibles and rising co-pays that put private health insurance beyond the reach of many moderate- and middle-income families. The average annual family insurance premium in 2008 was more than \$12,500 or above \$1,000 each month.

Since 2001, the cost of family coverage from an employer climbed by almost 80 percent, compared with only a 24 percent rise in workers' earnings. Uninsured and underinsured Americans have had to bear the financial burden of high medical costs. About half the people in the United States with homes in foreclosure and a large portion of those who have filed for bankruptcy have named medical expenses as a cause.

There are a variety of ways insurance companies boost their profits while limiting payouts to cover health care costs for people they insure. Insurance companies routinely deny coverage to people like Katie with pre-existing medical conditions. They also refuse to cover those they think will become ill in the future. In these cases, the cost of treatment may come to tens of thousands of dollars that must be borne by the family as out-of-pocket expenses. Individual health insurance policies bought by people who are self-employed or not covered through their employer are among the most expensive and frequently the most restrictive.

All of these restrictions harm insurance policy holders and increase the bottom line of insurance companies while decreasing the choices of families that work hard and play by the rules but never feel secure that their children will have health coverage from one year to the next. Congress must establish a strong public health insurance plan if we are to give families choices and foster competition in the private health insurance market that will bring escalating health care costs down.

Why should we continue to let children fall between the chasm of profit-driven health insurance companies -- some pay their CEOs between \$10 and \$30 million annually -- and income-restrictive Medicaid and CHIP programs that are different in each of the 50 states?

Children need urgent help and all of us must act now to ensure that all children have access to affordable, comprehensive health coverage, wherever they live in whatever family. Our fragmented system of health coverage for children allows too many of them to go without the critical health services they need. God did not create two classes of children. Our children simply can't wait any longer. Let's make sure Congress hears this from us.

GROUP HEALTH INSURANCE NEWS

Several big health-care interest groups say they're going to slow the rise in health costs over the next decade. Here are stories from this morning's WSJ, Washington Post and New York Times.

Later today, several big players — including the American Medical Association, the Service Employees International Union, and the main trade groups from the drug, hospital, medical-device and health-insurance industries — are expected to meet with President Obama and pledge to slow the growth of health-care costs by 1.5 percentage points per year in each of the next 10 years.

The specifics seem pretty thin. The pledge includes perennial cost-control favorites such as “simplifying administrative costs, making hospitals more efficient, reducing hospitalizations, managing chronic illnesses more effectively and improving health-care information technology,” the WSJ says. All stuff that everybody agrees sounds good, but has been hard to put into practice.

What's more, even if the health establishment slows the growth as promised, the cost of health care will continue to grow faster than the economy as a whole, rising to 18% of GDP by 2019, the WSJ says. (Health spending was 16.6% of GDP last year.)

Still, the fact that such a wide range of players with often conflicting interests (doctors and health insurers, for example) are speaking as a single group is pretty significant. It shows they all want to look like they're on board with health reform, a top priority this year in Washington. That's a big change from the last major health-reform push, in the early 1990s, which failed in part due to fierce industry opposition.

But keeping that broad-based support will become more difficult in the coming weeks and months, as the details of health-reform legislation emerge from Congress. Later today, in fact, the Senate Finance Committee is expected to release several possible options for a public insurance program that would compete with private insurers. That's one of the most contentious elements of the health-reform plans, and one the insurance industry vigorously opposes

FIXING HEALTH CARE

To fix American healthcare, it's important to avoid some common misconceptions.

President Barack Obama has promised to fundamentally change America's healthcare system. But before he and his team get too far down the field, they would do well to read Sally Pipes's new book, *The Top Ten Myths of American Health Care: A Citizen's Guide*. The book clearly and concisely explains even the most esoteric aspects of the healthcare debate.

One of the first myths Pipes demolishes is the oft-cited statistic that some 46 million Americans lack health insurance. Of those, 10 million make more than \$75,000 a year and almost 18 million make more than \$50,000 a year. That means 38 percent of the uninsured likely make enough to afford health insurance but choose not to buy it.

An additional 14 million are, Pipes notes, “fully eligible for generous government assistance programs like Medicare, Medicaid, and SCHIP. The problem is, they’re just not enrolling in these programs.” Pipes wonders, “If 14 million eligibles aren’t availing themselves of taxpayer-funded coverage, then why should we think that a still bigger government healthcare bureaucracy will solve the problem?”

Of course, there are many Americans who legitimately cannot afford insurance and others are paying too much for the coverage they have. President Obama believes the answer is government-provided healthcare. “If I were designing a system from scratch, I would probably go ahead with a single-payer system,” he has said.

Many people think that is the only humane alternative, but Pipes disagrees. “It is government monopoly healthcare that is heartless and uncaring. And the inferior treatments it provides come with a very steep price tag—rationed care, lack of access to tests, with the latest technological equipment, and long waiting lists.”

38 percent of the uninsured likely make enough to afford health insurance but choose not to buy it. Pipes knows whereof she speaks. She is a Canadian citizen (now living in California) and recounts her experiences under a single-payer system. She illustrates Canada’s cost-cutting measures that deny access to new drugs with a personal anecdote. Her uncle was diagnosed with non-Hodgkin’s lymphoma five years ago. “If he’d lived in America, the miracle drug Rituxan might have saved him,” she writes. “But Rituxan wasn’t approved for use in Canada, and he lost his battle with cancer.”

As Pipes learned firsthand, “To save funds, Canadian health officials routinely delay the approval of new and more expensive drugs.” Of the 100 new drugs launched in the United States from 1997 through 1999, only 43 made it to Canada during that time.

Canada's waiting lists are infamous—over 800,000 Canadians are on lists for surgery and other necessary treatments. The average wait between a referral from a primary care doctor and treatment by a specialist is 18 weeks. “That’s almost double what doctors consider clinically reasonable,” Pipes points out.

In other government-managed systems, things are not any better. “Sweden’s waiting lists have led some patients to visit veterinarians,” Pipes reveals.

Of the 100 new drugs launched in the United States from 1997 through 1999, only 43 made it to Canada during that time. Part of the problem is a physician shortage. One out of ten Canadians is seeking a primary care doctor. According to Pipes, “Over the last decade, about 11 percent of physicians trained in Canadian medical schools have moved to the United States.” This is in large part due to a massive pay discrepancy. “The average Canadian doctor earns only 42 percent of what a doctor earns in the United States,” says Pipes.

Pipes concludes her book with potential solutions for our healthcare problems. She points out that most regulations governing healthcare are designed to protect a system with a “disconnect between provider and consumer.” She proposes that individuals be free to shop for insurance across state lines, thus injecting a hefty dose of competition into the insurance market.

Pipes also argues that the tax breaks on healthcare enjoyed by corporations should be extended to individual consumers. As she notes, the current system guarantees that “people wind up with coverage that’s in their employer’s best interest, not theirs.”

The U.S. healthcare system is broken. President Obama promises to fix it. With her new book, Pipes has provided his administration with an admirable toolkit.

HEALTH INSURANCE STORY

Emily Morley got some very bad news in March 2006. Her cancer had spread, the doctor informed the 67-year-old Canadian. She would need to see an oncologist. Then Morley got some really bad news: She'd have to wait several months to get an appointment. Only after her family raised a ruckus, calling the local paper and starting a petition to demand she get care, did the government get her a specialist. Then, it was more bad news: Morley had only three months to live.

At least she had time to put her affairs in order. "Had her family not intervened," noted provincial lawmaker Don McMorris, "it is quite likely that Emily Morley may have died before even seeing an oncologist for the first time."

But that's how a single-payer, or "universal," health-care system works (so to speak). Even the very ill routinely hurry up and wait.

Alarmingly, Congress is gearing up to "reform" American health care along Canadian lines — and proponents are trying to take a shortcut to get there. According to former Medicaid director Dennis Smith, proponents of a government-run health system are hoping to enact a bill by bypassing the usual, lengthy bipartisan review process. The goal of any reform, supposedly, would be to trigger "competition" between government-run health care and currently existing private health insurance plans.

Yet, Smith warns, the government will inevitably tilt the playing field to favor its own plan, running private coverage out of business. At the end of the day, Americans w could be left with a single, government-run health plan é la Canada's. So let's take a look at what such a system means for our northern neighbors. As Sally Pipes, president of the Pacific Research Institute and a former Canadian citizen, recently told Congress, today some 750,000 Canadians are on a wait-list for medical procedures.

Further, 3.2 million (out of a population of 32 million) are waiting for a chance to see their primary-care physician. Once a PCP diagnoses a problem, Canadians must keep on waiting — 17.3 weeks on average — before they can see a specialist. Why? "The Canadian government controls costs by rationing care," Pipes explained.

Long wait times and lack of equipment force many to seek care in the United States. Take Member of Parliament Belinda Stronach. She supports Canada's health-care system. But where did she go when she was diagnosed with cancer in 2007? To California, where she paid for treatment out-of-pocket.

Then there was a mother in Calgary, Alberta, who had to be flown to Great Falls, Mont., to deliver her quadruplets. This relatively small American city had better facilities than any hospital in the wealthy province of Alberta. Our current system is far from perfect, of course. Millions of Americans lack health insurance, prompting many to put off seeing a doctor until a small, treatable problem has become a larger, more threatening condition.

But the answer isn't to try and cover everyone through a single-payer system. We'd be better off changing how the federal tax code treats health insurance (which, illogically enough in our economy, ties it to our jobs). Such a change would foster genuine competition among insurers by allowing Americans to shop for the coverage that suits them best in an open market. Current policy provides unlimited tax breaks for health coverage provided through employers.

Meanwhile, Americans who want to buy their own insurance must do so with after-tax dollars. Few can afford to do that, especially since insurers are more interested in competing for big group coverage (more lives, more money) rather than individual or family-based coverage.

Lawmakers could change this, and provide vouchers or other forms of direct assistance to help poorer Americans buy private plans they would own and control. This would make insurance portable when people change jobs.

Maintaining our standard of care is critical. There's a reason Canadians "fly south" for treatment: Our system, for all its flaws, provides superior quality and access to care. Let's ensure that policymakers, in their understandable zeal to reform health care, don't make changes that weaken the entire system.

HEALTH INSURANCE COVERAGE

By all appearances, Jamie Peet is an insurer's dream demographic. She's young. She wants health coverage. And she's healthy.

Well, she thought she was healthy. Aetna didn't agree. After the 22-year-old Middletown resident was laid off from her job in December, she applied for an individual health insurance plan through Aetna, her employer's small group health plan insurer. A company rep told her she should have no problem getting a plan since she had been an Aetna customer.

What happened? Aetna looked into her previous health history, and rejected her application, citing "pre-existing conditions," she said.

Surprising for Peet, since, as far as she knew, she was fine. "In the best health of my life," she said. "What I don't understand is since nothing had changed in my health history from when I was accepted before, how could they just decide not to cover me."

The simple answer is that individual health insurance is not treated the same as group health insurance under the federal Health Insurance Portability and Accountability Act known as HIPAA.

But that answer is the only simple one as more unemployed U.S. workers are learning in their attempt to secure or keep health coverage in the individual market. Last year an estimated 18 million Americans bought health insurance through the individual market, up from 17 million in 2005, according to the National Conference of State Legislatures.

Studies suggest that some insurers reject at least 10 percent of applicants for individual coverage because of pre-existing medical conditions. Under HIPAA, employers cannot exclude you or family from a group health plan because of a pre-existing condition. They must offer you coverage and pay the same percentage of your premium as they do for healthy employees.

But what Aetna didn't tell Peet - until apparently it was too late - is that she could have continued her coverage under options that allow workers to convert a group health policy into an individual one - regardless of pre-existing conditions. Never heard of a conversion plan? It's not surprising since insurers are not required to notify policy holders about the option. Also, not all employer group health plans are required to offer conversion plan policies under the Pennsylvania Conversion Rights law. The Philadelphia region's two major insurers - Aetna and Independence Blue Cross - offer them.

If you don't qualify for a conversion plan under Pennsylvania law, a second option is available under HIPAA called the conversion/alternative mechanism policy. In Pennsylvania, Blue Cross Blue Shield is the lone insurer that provides these plans and it currently has 1,373 members enrolled.

While conversion plans prevent private insurers from denying coverage or imposing exclusions for pre-existing medical conditions on individual plans, there is a tradeoff: These policies are usually more expensive and they don't provide as comprehensive coverage as the individual plans, insurance experts say.

As for Peet's rejection-worthy medical conditions, she says she was told there were two: acne and temporomandibular joint disorder (TMJ), which causes tenderness and pain on the joint where your jawbone meets your skull. Yes, she was treated for acne in high school, but Peet says she never heard of TMJ before she got the rejection notice.

She did see a doctor for jaw pain last October. He wrote her a prescription for extra-strength ibuprofen and recommended she see a dentist, she said. After two weeks, the pain disappeared and she hasn't had a problem since, she said. -- Other than she couldn't buy health insurance.

Area insurance spokespeople say various factors are considered when evaluating an individual's insurability. They include the severity of an illness, whether the condition or medical history is temporary or chronic, the treatment prescribed or recommended, the presence of complications risk and the overall experience of others with the same or similar medical conditions or history.

In Aetna's case, "severe" acne is a medical condition that is factored into the underwriting process, which determines if individual coverage will be offered.

"This includes cases where an individual is receiving treatment for scarring or is using more than three prescription medications," Aetna spokesman Walt Cherniak said. "In these cases, individuals may also need treatments such as chemical peels, derma-abrasion, saline injections, antibiotics, or steroids."

Aetna also includes prescription drugs in its underwriting process, Cherniak said, so with acne diagnosis the insurer also factors in the use of Accutane within the previous six months.

"Accutane has serious side effects: It can lead to high triglyceride levels and liver damage," Cherniak said. "The use of Accutane always requires close medical management and ongoing monitoring."

Peet says she took Accutane for five months ending in February; she last saw her dermatologist in March since part of the drug's protocol is seeing the dermatologist one month after completing treatment.

She appealed the rejection, but Aetna upheld it. Peet has filed a complaint with the Pennsylvania Insurance Commission, which is pending.

Then recently, Peet said she received paperwork from Aetna offering her a conversion plan. But the letter stated that her application had to be sent no later than 31 days after termination of her group coverage, which is the deadline under the state conversion rights law.

The Aetna letter was dated April 30. She lost her group coverage Dec. 31. Not that she could have afforded the conversion plan premiums, which she said were double the price she was quoted for Aetna's individual plan.

Finally, after going uninsured for a month, Peet found health coverage that started Feb. 1. The high-deductible plan she has costs \$180 a month - \$30 more than the Aetna individual plan would have cost. Also the copays are a lot higher than Aetna's plan. "I do know a lot of people my age don't think they need insurance, but I'd rather have it in case of something catastrophic," she said. "I feel bad for those who have more problems applying for medical insurance. I can't imagine."

PROPAGANDA VIA REPUBLICANS

President Obama and U.S. Senate health care reform leaders must not override state consumer protection laws as suggested by health insurers last week, a move long-supported by insurers and the Bush Administration, said Consumer Watchdog in a letter to the president and senators. The hard-fought state laws enacted in nearly every state over the last 10 years were made necessary because Congress failed to enact Patients' Bill of Rights legislation.

Download Consumer Watchdog's letter here:

<http://www.ConsumerWatchdog.org/resources/ltrObamaKennedyBaucus.pdf>

In the letter, Consumer Watchdog wrote:

"Federal regulation would be a boon to the industry, and has long been on the insurer's wish list because over the last decade almost every state has developed comprehensive patient protection laws that the insurers loathe.

"Insurers would like to take advantage of the moment of reform to eviscerate HMO Patients' Bill of Rights laws enacted in nearly every state and replace them with window-dressing federal rules that clear the way for the worst of the industry's practices."

The insurers' proposal was floated last Tuesday during the U.S. Senate Finance Committee by Karen Ignagni, CEO of the HMO and health insurer lobbying organization, America's Health Insurance Plans.

Consumer Watchdog called the insurers' proposal to kill the "public option" to private insurance coverage -- the reform that the industry hates most because of its value to consumers -- in exchange for new federal regulation of the industry a "false compromise."

In the letter, Consumer Watchdog wrote:

"Insurers are not conceding a thing. They are trying to turn the squelching of a beneficial public option into a double victory. They need all of you to play along with the charade in order to succeed in killing state patient protections as well as any government competitor. If you allow the insurance industry to prevail in this deception, the worst public fears about insurers' lobbying power in Washington will be proven correct."

A similar window-dressing federal regulation scheme was last brought forward in Senator Mike Enzi's (R-WY) bill, S. 1955, in 2006 which would have gutted HMO Patients' Bill of Rights laws and state common law access to courts by enacting President Bush's promised "Association Health Plans" expansion.

In the letter, Consumer Watchdog wrote:

"The Enzi bill was described in terms similar to those used by Ignagni ... to describe the federal 'standards' the insurers are willing to accept if the public option is taken off the table. Such 'harmonization' at the federal level of 'inconsistent' state laws will result in lowest common denominator regulations enforced from an impossible distance. Done the industry's desired way, an individual's state common law right to sue an insurer for even the most egregious misbehavior would also be erased."

Ignagni has also promised the industry's agreement to cover all Americans regardless of health, and not to charge more based on characteristics like health status or gender. Even these apparent concessions are far from hardships for the insurance industry, said Consumer Watchdog, in the context of their demand that all Americans be required to purchase their product.

FAQ - HEALTH INSURANCE

Joseph Antos, a health economist at the conservative think-tank American Enterprise Institute for Public Policy Research, tells msnbc.com what he sees as the main problem with U.S. healthcare, what he thinks of universal coverage, and what President Obama should do.

Q: What is the main problem with the health care system in the United States?

A: The principle problem is the high and rising cost of health care and the likelihood that much of that money is spent on low- or no-value services.

Q: Is the current U.S. system sustainable? In other words, what will happen down the road if nothing is changed?

A: Absolutely not. What we're seeing in the United States are substantial increases every year in the share of GDP going into the health sector. What that means is that we're slowly but surely squeezing out all other forms of consumption, and clearly that's not sustainable. That's the path we're on and we need to get on a path in which the increase in health care spending slows down. It's completely reasonable for an aging society, which the United States is, to spend more of its GDP on health care, however, we have to find a way to recognize that there are resource constraints. Our system is really designed as if there were no resource constraints whatsoever — and that's what's behind this seemingly inexorable increase.

Q: How should the United States alter its system and is universal health care feasible?

A: I think we should start by looking at cost and value. The fact is that increasing health care cost is the principle reason why people don't have insurance. If you can't afford it you can't buy it. So, dealing with cost first is the most important step that we could take. I don't think we're going to take that step because politicians would rather look like they're giving you something for nothing. Ultimately, however, the resources come out of the system somehow — in the form of higher taxes, or higher out of pocket payments for health care — so there's not only no free lunch but also no free health care.

We will eventually get the point where everyone will have access to health insurance. It's not clear to me that we'll require everyone to buy insurance or participate in a government program. We're clearly moving in that direction, but we won't get there next year. It won't happen in five years. This takes a lot of work, major changes in institutions. We do need to get on with it, but people shouldn't be misled into thinking they'll wake up next year with full insurance and no extra costs.

Q: How would universal health care impact the taxpayer?

A: Some estimates say that over the next 10 years that the Obama plan, if it were implemented next year, would cost one-and-a-half trillion dollars. Since his promise is that the average person would not see their health care costs increase, that means that most of the additional cost would come from taxes, and he said that only high-income people would bear that cost.

Now, there's another way to pay for this, and that is to find ways to eliminate unnecessary health spending. But, that's not popular with politicians. While you or I might agree that something is not necessary, the physicians and the hospitals would see that as a reduction in their pay. Furthermore, it is rarely clear in medicine what is or isn't necessary for a specific patient.

Q: Is there another country's system, or combination of elements of other systems, that the United States should adopt to improve its coverage?

A: Holland and Switzerland are the two countries mentioned by many people across political lines. But I never point to any other country and say that's the way we should go because it's far more complicated. As admirable as (those countries' health care systems) may be, they came about because of the historical and cultural developments of their populations over the last 40, 50, 60 years. We're not talking about something as simple as changing health institutions — it's about how citizens view the role of their government and their relationship with their doctor. So, there may well be some elements that one might think of as elements of management, but when you get to the question of can you simply transplant a system the answer is clearly no. We don't have to look at Europe to know we could do better. All we have to look at is Florida, being one of the highest cost systems, and Minnesota, being one of the lowest cost, to know we could do better. But we need to work through the problems ourselves.

Q: Do you think President Obama will lead the country in the right direction regarding health care coverage? What advice would you have for him?

A: I think he's trying to lead in the right direction and I think if it were just up to him that we would be moving in a better direction than if we left it up to the Democrats in Congress, many of whom take an extreme view of what they can accomplish politically when this problem is only a political problem to a small extent.

I think the main advice would be to reduce his promises, reduce the political rhetoric, concentrate on trying to reduce spending, embrace bipartisanship, which he is more inclined to do than his colleagues in Congress, and focus in two areas that I think don't get enough attention. The first is the Medicare program, our program for the elderly and disabled which has serious structural problems and has been largely ignored in health care debate. The second is the tax treatment of health insurance which has been discussed but primarily as a political talking point raised favorably by Republicans and dismissed by Democrats.

HEALTH INSURANCE PLANS BY OBAMA

Economic crises come and go, but entitlements are forever. The Great Depression eventually dissipated, but Franklin Roosevelt's crown jewel — the Social Security system — is still with us. And so it will be with the Obama Administration. The early headlines have been all about the President's efforts to repair the financial system and jump-start the economy. If he succeeds, he probably will be re-elected. But Barack Obama's place in history will be determined by the long-term structural changes he initiates, and his most important legacy battle is just beginning as Congress tackles the holy grail of modern liberalism, a universal health-care system.

The President has been clever about this. He hasn't made it the centerpiece of his Administration — and a fat target for his opponents — as Bill Clinton did. He hasn't proposed a specific plan, allowing, instead, a proposal to percolate through the Congress. "Everything about this process seems the polar opposite of 15 years ago," says John Rother of AARP. "The Administration seems determined not to make the same mistakes as Clinton did." (See the five truths about health care in America.)

Indeed, Democrats have a history of strategic idiocy when it comes to health care. Nearly 40 years ago, Richard Nixon proposed a universal system in which employers would be required to pay for their employees' coverage, but Democrats blocked it because they favored a government-run single-payer system.

Twenty years later, Bill and Hillary Clinton proposed a system similar to Nixon's — but failed to bring aboard moderate Republicans, who favored a universal system based on requiring individuals rather than employers to participate. In the 2008 campaign, Obama and Hillary Clinton proposed plans that looked very much like the 1993 Republican scheme — do you detect a pattern here? — and the congressional debate, which will take place this summer, begins there.

This time, with significant Democratic majorities in both houses of Congress, there is real optimism that a universal plan will be passed and enacted. But Clinton also had Democratic majorities — and strong public approval, at first. This time, because of the rules agreed on in the arcane budget process, Democrats will need only a simple majority vote in the Senate. But the process could run into the same two roadblocks that caused universal health insurance to fail in the past: the specter of "socialized medicine" and the fear that the cost of the program will, like that of other entitlements, spiral out of control.

In the 2008 campaign, Obama and Clinton worked overtime to assure voters that if they liked their current health-care coverage, they could keep it — that is, the system would remain a private one, presided over by a more strictly regulated insurance industry. And in the months since the election, the insurers have indicated that they will play ball: they've said they will cover everyone, at the same rate, regardless of pre-existing condition. (There are caveats: the details of health insurance are devilish, and pitched battles are fought over arcana too obscure to cover in this space.) But more-liberal Democrats have decided to press the issue.

They have proposed a "public" health-insurance option, similar to Medicare. They argue, correctly, that the profits made by insurance companies are a good part of what makes health care so expensive in the U.S. and that a public option is needed to keep the insurers honest. Needless to say, the insurers are vehemently opposed to this and will unleash a torrent of negative advertising and lobbying power if the final bill includes it.

The President recently told a remarkable story about his grandmother. In the last months of her life — she was dying of cancer — she broke her hip and received a hip replacement from Medicare. "I don't know how much that hip replacement cost," Obama told the New York Times, and he questioned whether giving people "a hip replacement when they're terminally ill is a sustainable model." This is the most sensitive health-care issue imaginable. But the question of whether the government can decide which health-care treatments are appropriate is central to whether an affordable universal system can be devised.

Part of the answer is implicit in the electronic medical-records system that Obama has proposed: it will be easier to determine which treatments are cheaper and more effective. The other part of the answer involves an essential change in Medicare, from fee-for-service to a managed-care system that decides whether a hip replacement is necessary for a terminal cancer patient. Since most of the baby boomers about to enter the Medicare system have been living with managed care for the past 20 years, a gradual transition may not be impossible.

My guess is that the public option is a bargaining chip that will be cashed in to gain support from moderate Republicans and Democrats as crunch time approaches. The real battle, and the fate of this liberal dream, will be fought over what gets covered and who decides.

SENATE AND HEALTH INSURANCE PLANS

In an effort to defuse the most explosive issue in the debate over comprehensive health care legislation, a top Senate Democrat has proposed that any new government-run insurance program comply with all the rules and standards that apply to private insurance.

The proposal was made Monday by Senator Charles E. Schumer of New York, the third-ranking member of the Senate Democratic leadership, in a bid to address fears that a public program would drive private insurers from the market.

Calls for a new public plan have provoked more political passion than any other issue in discussions of how to revamp the nation's \$2.5 trillion health care system. The Senate Finance Committee begins to wrestle with the idea at a meeting on Tuesday, where it will examine ways to expand coverage.

President Obama campaigned on a promise to create a public plan, in an effort to compete with private insurers and keep them honest. But insurance companies and Republican lawmakers say a government-run plan could drive private insurers out of business and eventually lead to a single-payer system run by the government.

Scorched by Republican opposition to the idea of a new public program like Medicare, Senate Democrats are looking for a middle ground that would address the concerns of political moderates. One way they propose to do that is by requiring the public plan to resemble private insurance as much as possible.

“The public plan,” Mr. Schumer said Monday, “must be subject to the same regulations and requirements as all other plans” in the insurance market.

Democrats in Congress hope to shift the debate from the question of whether to create a public health insurance plan to the question of how it would work.

In so doing, they look for the support of influential moderates. But in the last few days, three moderate senators — Ben Nelson, Democrat of Nebraska; Olympia J. Snowe, Republican of Maine; and Arlen Specter of Pennsylvania, who switched parties to become a Democrat — have expressed reservations about a public plan.

Insurers also remain skeptical. Karen M. Ignagni, president of America’s Health Insurance Plans, a trade group, said, “We are very, very grateful that members of Congress have been thoughtfully looking at our concerns.” But she said she still saw no need for a public plan “if you have much more aggressive regulation of insurance,” which the industry has agreed to support.

Linda Douglass, a White House spokeswoman, said that Mr. Obama was for a public plan but that he realized it could be defined in different ways.

Mr. Schumer said his goal was “a level playing field for competition” between public and private insurers. But Ms. Ignagni said, “It’s almost impossible to accomplish that objective.”

The chairman of the Senate Finance Committee, Max Baucus, Democrat of Montana, asked Mr. Schumer to seek a solution. In his response, Mr. Schumer set forth these principles:

¶The public plan must be self-sustaining. It should pay claims with money raised from premiums and co-payments. It should not receive tax revenue or appropriations from the government.

¶¶The public plan should pay doctors and hospitals more than what Medicare pays. Medicare rates, set by law and regulation, are often lower than what private insurers pay.

¶¶The government should not compel doctors and hospitals to participate in a public plan just because they participate in Medicare.

¶¶To prevent the government from serving as both “player and umpire,” the officials who manage a public plan should be different from those who regulate the insurance market.

In addition, Mr. Schumer said, the public plan should be required to establish a reserve fund, just as private insurers must maintain reserves for the payment of anticipated claims. And he said the public plan should be required to provide the same minimum benefits as private insurers.

But some thorny questions remain. Could states tax the premiums of a public plan, as they tax private insurance premiums? Would the public plan have to comply with state laws, as private insurers do? Would the government ever allow the public plan to become insolvent?

In the pursuit of universal coverage, liberal Democrats say, it would be a mistake to rely entirely on the same insurance companies that have profited by selecting healthier customers, avoiding sick people and refusing to pay many legitimate claims.

“Private insurance plans are often just one step ahead of the sheriff,” said Senator Sherrod Brown, Democrat of Ohio.

On Monday, some insurers and Republican lawmakers circulated a video clip of a recent speech by Representative Jan Schakowsky, Democrat of Illinois, in which she said insurers were right to fear that a public plan option could “put the private insurance industry out of business.” Ms. Schakowsky said that might happen because of “the superiority of the public health care option.”

IS AMERICA TOO BIG TO INSURE

The U.S. health-care system is the world's largest. It accounts for nearly 16 percent of the economy. Today one in eight workers is employed in the health-care industry compared to one in 100 in 1950. The industry has been nearly recession proof. In the nine downturns we have experienced since 1985, the industry lost jobs only in the 1980 and 1984. Despite horrendous job losses in the current recession, jobs in the health-care industry are still growing, but at slower rate.

The industry is also a world leader in research and innovation. In last 10 years nearly two-thirds of Nobel prizes in medicine have been awarded to scientists working in U.S. research laboratories. The industry has also been a magnet for venture capital money, the life blood of innovation in an economy. U.S. health-care companies remain open to innovations in most phases of their businesses.

There are other positive features in the U.S. health-care system relative to what is available in the rest of the world.

First, health care services and technologies are easily available to those who are insured. Second, the waiting time for surgeries, such as hip replacements, is much shorter than in most countries in the world. Although we now frequently hear dramatic stories about medical tourism in Thailand and India for elective surgeries, nearly 40 percent of the world's medical tourists seeking acute elective treatments come to the U.S.

But there is the proverbial fly in the ointment and it is a big fly. Despite its excellence in many areas, it also happens to be the most expensive system in the world.

On a per-capita basis, we spend more money on health care than any of the rich countries of the world. A recent study of health care spending by rich nations concludes that the U.S. spends nearly \$650 billion more than its closest rival Switzerland, according to The McKinsey Quarterly.

The billion-dollar question is: what extra value are we getting for the additional hundreds of billions we spend relative to the other rich nations of the world? Undoubtedly our best hospitals are world class; many of our patients with insurance receive state-of-the-art medicine and have to wait less to see a doctor. But the U.S. lags behind the rich countries and even many not so rich countries in terms of two well accepted broad measures of well being of a nation — life expectancy and infant mortality.

The 2008 data on life expectancy at birth shows that for the U.S. it is 78 years. We rank 46th in the world and lag behind countries such as South Korea, Finland, U.K., Germany, Belgium, Austria, Norway, Spain, Israel, Sweden, Canada, France, Singapore, Hong Kong, Australia, and Japan. As far as infant mortality is concerned, we do not do well either. Latest data show that at 6.26 deaths per one thousand live births, we are behind Cuba, Italy, Taiwan, Greece, Ireland, Canada, the UK, Australia, Denmark, South Korea, France, Japan, and Sweden, according to the CIA — The World Fact Book.

Although important, the macro performance of our health care system mentioned above is not an urgent concern at this point. The pre-eminent concern is that our health-care system is fast becoming economically unsustainable.

In the last several years, the growth of health care cost has outstripped the growth of the economy as well as the per-capita income of workers.

The premiums of commercial health insurance policies, mostly paid by employers, have skyrocketed. In the last 20 years the cost of a health-care policy for a family of four has more than doubled. This is a huge financial burden for households who are self-insured as well as businesses that provide health care insurance benefits for their employees. It is also a huge burden for large government programs such as Medicare and Medicaid.

Today the unfunded liability for Medicare stands at an astronomical \$36 trillion. The financial burden for Medicaid for the states is such that it will need nearly 75 percent of new state tax revenues to stay afloat, according to the U.S. Centers for Medicare and Medicaid Services.

To compound our health care problems, more than 46 million Americans, or 18 percent of the population under the age of 65, are now uninsured. Millions face premiums they may not be able to pay.

In 2007, nearly one-third of our businesses did not offer health insurance and that number is expected to rise in the foreseeable future as insurance policies continue to become unaffordable for small businesses.

The system is in a crisis and undoubtedly needs reform. What makes sense will be the focus of my next two columns.

STATE HEALTH INSURANCE

While the city contemplates changing its health insurance carrier for the first time in decades, officials say a comparison with the state's Group Insurance Commission plan should be analyzed and could save even more money than the recent bids received from private firms.

City Councilor Cathy Ann Viveiros asked the city to use a cost-analysis tool by the Massachusetts Municipal Association's private nonprofit Interlocal Insurance Association to compare city health insurance bids from longtime provider Blue Cross and competitor United Healthcare of New England.

“My preliminary discussions with MIIA suggest that the city would likely see a decrease in premium costs with the GIC,” Viveiros wrote Human Resources Director Madeline Coelho. City Administrator Adam Chapdelaine said the Correia administration supports seeking more insurance comparisons.

The MIIA represents 115 of the 351 cities and towns, and formed a health benefits trust plan with Blue Cross Blue Shield of Massachusetts separate from the state plan.

Viveiros said the MIIA spreadsheet tool offered to all municipalities allows evaluations of current and prospective health insurance plans with the GIC plan. “If we’re going to make a decision on whether to make any changes in health insurance,” said Viveiros, “we should have all the options.”

With state cutbacks in local aid, the city also could be required to make this comparison and choose a different option, Viveiros said.

That’s because Gov. Deval Patrick’s proposed that municipalities demonstrate their health insurance coverage is at least as cost-effective as a GIC plan. Patrick’s filing of the second Municipal Partnership Act in January includes an option that allows the state to cut nonrestrictive local aid to a city or town if it doesn’t join the state insurance plan or have at least an “equitable rate,” said Cindy Roy, spokeswoman for the state Department of Administration and Finance.

If passed by the Legislature, local aid would be lowered by the difference between the GIC and the community’s cost.

The city’s 75 percent share for nearly 5,000 employees is about \$38 million, while members’ share puts the total cost to roughly \$50 million.

Rationale for the GIC option, Roy said, “is some municipalities are spending entirely too much on their health care costs. And there are options to lower their costs and there are incentives to do just that.”

Twenty-six municipalities will participate in the recent GIC offering as of July 1, Roy said.

The legislature’s Joint Committee on Municipalities hearing Tuesday will include the MPA. Rep. David Sullivan, a committee member, concurred the GIC option might be a way to “leverage some efficient cost savings.” A challenge, he said, is reaching collective bargaining agreements with multiple unions.

The MPA proposal this year reduces the 70 percent threshold approval by unions to 50 percent for GIC participation, Roy said.

The state’s GIC offers a half-dozen carriers, but does not include Blue Cross.

Chapdelaine said about a year ago, under his predecessor Alan Silva, the city sought help via an online tool to compute individual health insurance costs through the private, nonprofit Pioneer Institute. “That’s what we’re beginning to do,” he said, saying the administration will also “look at what the MIIA has to offer” to cut costs.

According to Viveiros, the institute is not set up to do “a complete plan analysis” to compare each carrier’s plans.

Chapdelaine called the Pioneer Institute a “research institute” and the MIIA “an advocacy group.” He said the two groups could provide complementary information. He did not know when the city would have it.

Chapdelaine said he understood the city's Insurance Advisory Committee had not shown interest in the GIC. An issue city unions would want to address is different co-payments and out-of-pocket expenses.

"The unions are not saying we won't change," said fire Lt. Michael Coogan, chairman of the Insurance Advisory Committee representing city unions. Speaking of any change from Blue Cross, he said, "We want to assure members we're not exploring a lesser plan." Viveiros suggested the city could negotiate a different share of the premiums to offset workers' expenses.

The GIC, Roy said, "is one of the ways to reduce the costs that municipalities are facing."

SOCIALIZED MEDICINE

With another "national conversation" about health reform upon us — as it is every decade or so — we will hear a lot of derisive talk about the evils of "socialized medicine."

The term is regularly confused with "social health insurance," which is not at all the same concept. Socialized medicine refers to health system in which the government owns and operates both the financing of health care and its delivery.

Social health insurance, on the other hand, refers to systems in which individuals transfer their financial risk of medical bills to a risk pool to which, as individuals, they contribute taxes or premiums based primarily on ability to pay, rather than on how healthy or sick they are.

Socialized medicine is one form of social insurance. More typically, however, social insurance is coupled on the health-care delivery side with a mixture of government-owned facilities (e.g., municipal hospitals), private nonprofit hospitals (roughly 90 percent of all American hospital beds) or private for-profit facilities (investor-owned hospitals, private medical practices, pharmacies and so on). It follows that one cannot simply treat social insurance as socialized medicine. In principle, one could have social insurance with 100 percent private for-profit delivery facilities.

Under private commercial insurance, individuals also transfer the financial risk of bills for health care to a risk pool, but the premium the individual contributes to the risk pool reflects that individual's health status. These premiums are, as actuaries put it, "medically underwritten" and "actuarially fair." The risk pools under private insurance can be operated by not-for-profit or for-profit insurers. And like social insurance, private insurance typically is coupled with a mixed private and public delivery system.

Large employers typically self-insure and use private insurers only to procure health care on behalf of employees (e.g., negotiate fees with the providers of health care) and administer claims. Other employers do not self-insure and instead purchase so-called group health insurance policies for all their employees jointly, as if they were one large family. The premium for a group policy is "experience rated" over the covered group of employees, which means that they reflect the average actuarial cost of all of one company's employees.

The individual employee's own contribution toward his or her employment-based insurance, however, is divorced from the individual's (or the attached family's) health status. In this sense, then, employment-based insurance could be described as "private social insurance," as distinct from "government-run social insurance."

Former Mayor Rudolph Giuliani of New York has exemplified the perennial confusion in this country over socialized medicine. In his ill-fated presidential bid, and subsequently as a supporter of Senator John McCain's bid for the presidency, Mr. Giuliani routinely decried as socialized medicine (or "socialist") any proposal presented by Democratic candidates, because typically the latter advocated tax-financed subsidies toward the purchase of health private insurance or expansions of public insurance programs. But technically none of them advocated socialized medicine.

Perhaps Mr. Giuliani was unaware that Americans all along the ideological spectrum reserve the purest form of socialized medicine — the V.A. health system — for the nation's veterans. I find this cognitive dissonance amusing. Indeed, if socialized medicine is so evil, why didn't Republicans privatize the V.A. health system when they controlled both the White House and the Congress during 2001-06?

Mr. Giuliani also seems to forget that, in 1996, he found social health insurance a perfect solution to the financial problems faced by former Mayor John V. Lindsay, who fell on financially hard times during the 1990s as a result of chronic illness.

In a fit of compassion, then Mayor Giuliani rushed to his friend's assistance with — you guessed it — taxpayers' money, rather than with a private sector solution. He did so by appointing Mr. Lindsay to two no-show city jobs that came with tax-financed municipal health insurance and a tax-financed pension.

It seems fair, then, to ask Mr. Giuliani why it was perfectly fine to bail out a financially distressed man who had been wealthy enough in his younger years to provide adequately for his old age, when proposals to extend the same kind of assistance to hard-working, uninsured members of lower-income families are decried by him as "socialism."

One can only hope that our members of Congress and the typical American voter can make the right distinctions.

HEALTH INSURANCE CODE NEEDED

Managed care companies are the only sector of the health care industry lacking a code of conduct. It is time for that to change (see also Health Insurance).

Recently, the American Medical Association (AMA) drafted language for a National Health Insurer Code of Conduct. The code's four key principles are: clinical autonomy, transparency, corporate integrity and patient safety and welfare. I commend the AMA for drafting this code. Unfortunately, the health insurance industry has been silent on it.

Why is this code of conduct so important? Financial incentives -- not patient welfare -- are the driving force behind insurance operations.

A survey by the Medical Society of the State of New York showed that more than 90 percent of physicians indicated they had to change a patient's treatment -- or medication -- based on restrictions from insurance companies. A survey by The Toledo Blade of members of the Ohio State Medical Association and the AMA revealed that 95 percent of respondents said insurers interfered with decisions about prescriptions, 91 percent with testing, 74 percent with referrals and 69 percent with hospitalization decisions.

Every day insurance companies challenge physicians' authority and expertise. Studies and my personal experience reinforce that. This problem is particularly acute as insurance companies and pharmacy benefit managers seek to dictate a particular medication to prescribe. Insurance formularies and other barriers to specific medications make it difficult for doctors to prescribe the medication they deem the most appropriate.

In the worst cases, unauthorized drug switching occurs. That's when a medication is switched to another drug that is supposed to be its equivalent but might have different active ingredients -- often by a pharmacist and without the doctor's knowledge. This seemingly harmless switch can be detrimental to the patient, sometimes increasing risks and decreasing care.

We doctors prescribe the medication that's best per individual patient. Although in some instances a generic alternative might work, it is not always appropriate. The patient's doctor should make that determination, not an insurance company concerned with its bottom line.

The time has come for the health insurance industry to adopt a National Health Insurer Code of Conduct. The health and welfare of every patient is at stake.

PERSONALIZED HEALTH INSURANCE

Thanks to patients who still value their health in hard times, the recession has barely slowed the growth of concierge medical practices, which charge hefty membership fees for highly personalized care and around-the-clock access.

From Seattle, where the movement began in 1996, to South Florida, where its largest concern is now based, physicians with boutique practices say they are losing far fewer patients for financial reasons than they had expected. While some new practices are not filling as quickly as they might, they continue to attract a steady flow of patients willing to pay thousands of dollars for the privilege.

The practices typically charge at least \$1,500 a year, with the most elite services asking \$25,000 or more per family. The fees cover a thorough physical exam and enable physicians to limit the number of patients they see so they can provide premier service.

Doctors give patients their cellphone numbers and schedule leisurely same-day appointments with no waiting. Some make house calls, though patients still need health insurance to pay for hospitalizations and specialists.

Most of the 20 physicians and executives interviewed said that a small number of patients had decided not to re-enroll in recent months, citing lost jobs or devalued portfolios. They tend to be like Susan Schwartzman, a book publicist from Yonkers who said she had given up her concierge doctor because of declining income, but only after first canceling her gym membership and swearing off restaurants.

For the most part, however, boutique practices have shown resiliency. Doctors said the recession seemed to have reaffirmed the importance of health care to their patients. With jobs scarce and stress at a peak, many may see a link between continued health and continued employment. And with savings depleted, they recognize that assiduous preventive care may help them avoid costly chronic conditions and hospitalizations.

“It’s the old penny-wise, pound-foolish thing,” said Dr. C. Scott Molden, who practices internal medicine in St. Louis with MDVIP, the largest consortium of fee-based doctors. “I tell people, ‘You cannot afford to not be in my practice. You cannot afford to be sick, even with insurance.’ What I’m offering is to keep people out of hospitals.”

Ted McCallum of Newtown, Conn., said that after losing his job as a hotel manager in June, he decided to stick with his MDVIP doctor, Robert L. Ruxin of Ridgefield, because their 20-year relationship provided stability in unsettling times.

“It did involve forgoing some of the luxuries I’ve gotten used to,” Mr. McCallum, 57, said about losing his job. “But I wasn’t willing to forgo this one.”

“As the saying goes, If you have your health, you’re a rich man,” he added.

Similarly, Janet K. Yerta, an 82-year-old retiree in Atlanta, has remained with her MDVIP physician, Dr. T. Kirkland Garner, despite watching her investment income wither. “I’m not one of those people that’s running over with money,” she said. “But there are two things I value: my salvation and my health.”

Critics of concierge medicine consider it elitist and say it has widened the already significant class disparities in American medicine. They also say it has exacerbated the shortage of primary care physicians by leaving more patients to be treated by a shrinking pool of doctors.

But advocates counter that the concierge movement reflects deep exasperation with the two-hour waits and 10-minute appointments of conventional primary care. Given the burnout among physicians who must see more than two dozen patients a day, they say the concierge model may sustain doctors who would otherwise hang up their stethoscopes.

Dr. Thomas W. LaGrelus of Torrance, Calif., who leads the Society for Innovative Medical Practice Design, a professional association of concierge physicians, estimated that there were 5,000 such doctors in the United States, out of an estimated 240,000 internal medicine physicians and related subspecialists.

MDVIP, which started in Boca Raton, Fla., in 2000, expects to add more than 80 doctors to its network of 300 this year, said Darin Engelhardt, the firm's president. The company is privately held and does not release detailed membership data, but Mr. Engelhardt said that renewal rates among its 100,000 patients had remained at its usual level of 93 percent a year during the recession. Each MDVIP doctor is limited to 600 patients, who each pay \$1,500 to \$1,800 a year.

"I'm happily able to report that we have not seen any adverse impact from the economy," Mr. Engelhardt said. "What we've been told by patients is that during difficult times like this, they are reassessing their priorities and that their health care needs come to the forefront."

Dr. Dragan Djordjevic, a Chicago physician who affiliated with MDVIP two years ago, said he had expected a lot of dropouts. "Every day, patients would come in and talk about how the economy was killing them," he said. "So naturally, I'd go home thinking they were going to cancel."

But Dr. Djordjevic said that he had lost perhaps only five patients from 600 since the beginning of the year, and that they had been easily replaced from a waiting list of more than 100.

Peter W. Hoedemaker, the chief executive of MD², a concierge medical provider based near Seattle, said the company had been pleasantly surprised by patient enrollments at its new office in Chicago. The five MD² practices, each with two doctors, charge \$25,000 per family and limit each doctor to 50 families. About a dozen openings remain in Chicago, Mr. Hoedemaker said, far fewer than projected, and the group is looking to expand to New York City.

As the economy crumbled last fall, Dr. Cynthia L. Williams of Torrance worried about the unfortunate timing when she sent letters in November informing her 2,200 patients that she would be converting to a \$2,000-a-year concierge practice. Nonetheless, she said, she had signed up 315 patients and was adding one a week. “On my busiest day I’m seeing 14 patients, but on a lot it’s eight,” she said. “In the old practice, I was booked about one patient every 12 minutes, about 25 to 30 a day. I love it, and I think my patients love it.”

Many of the doctors boasted of their ability to keep patients out of emergency rooms by intervening by phone for conditions like diverticulitis or an abnormal heart rhythm. They said their deep knowledge of their patients helped them detect subtle changes and danger signs.

“A close personal relationship with a physician is not something that’s easy to find anymore,” said Dr. David L. Elliott, an MDVIP physician in Phoenix. “People find it valuable.”

COBRA OPTIONS

Q. I am a 64-year-old male who is currently covered on my wife's health insurance plan. She is retiring at the end of June, and I will need to find health insurance until I turn 65 on March 17. I've checked a couple of insurers locally and the monthly rates they quoted \$705 and \$1,045 are enough to take your breath away. Are you aware of any other options I can pursue?

A. COBRA is probably your best bet. COBRA is the federally mandated temporary continuation health insurance coverage. When your wife retires, you should be eligible to buy COBRA coverage from her former employer. That will allow you to stay on that employer's group plan. The employer will not contribute toward the cost of this coverage, but you will get insurance at a group rate instead of a much more costly individual rate. Your monthly COBRA premiums might be about half the cost of those quotes you got when you called around to insurance companies. "COBRA is going to give him the best coverage at a premium he can afford," said Andy Marshall, president of Falcone Associates, a Syracuse employee benefits firm. There are a few state insurance programs, but your income has to be low to qualify. Ask your wife's employer about COBRA.

A new bill that would make permanent "Timothy's Law," which requires insurers issuing group or school blanket health insurance policies in New York to provide a minimum of 30 inpatient days and 20 outpatient days for the treatment of mental health conditions. The law, which took effect Jan. 1, 2007, is set to expire at the end of this year.

Timothy's Law also requires large group health plans with more than 50 members to provide mental health coverage at the same level provided for other health conditions.

New York Governor "Paterson" introduced the legislation after receiving a report from the state Insurance Department that the law has been successful. That report found the law increased monthly costs by one half of 1 percent.

The law is named after Timothy O'Clair of Schenectady County, who committed suicide in 2001 at age 12 after struggling with mental illness. His parents had to give up custody of the boy to the state so he could get care because their insurance would not cover all the treatment.

Women are more likely than men to feel the pinch of rising health costs and eroding health benefits, with about half of working-age women reporting problems accessing needed care because of costs, compared to 39 percent of men, according to a study by the Commonwealth Fund

Layed Off?

I hope this helps some people who are being laid off. Obviously, continuation of health insurance is of importance. Most people will have the option of continuing their insurance through COBRA, though usually at a substantial price. However (and many people still aren't aware of this), there is a 65 percent government subsidy to a person's COBRA premium that will last nine months.

With that said, many people don't realize that individual health insurance policies are an option that may be less expensive than COBRA, even the subsidized COBRA. Many people think COBRA is the only option, when in fact, depending upon their age and health condition, they may be able to buy an individual health insurance policy for less. This is something that won't expire, unlike COBRA.

There are many considerations a person who has been laid off may make when considering continuation of health insurance benefits such as: How much financial risk are they willing to bear? How soon do they realistically think it may be before they're able to land another job? What is their financial condition during this period of unemployment?

If they're covering a family, buying individual policies allows more flexibility of benefits and pricing than COBRA. You could conceivably buy one type of policy for a husband (perhaps one that just covers hospitalization, but nothing else) or a wife (one that provides two covered doctor visits in a year and then hospitalization), and another type for children (that covers everything). People can mix and match based on their finances and need.

Often, people put off making any decisions until the deadline for COBRA enrollment is close. Because it can sometimes take a few weeks to be accepted into an individual health insurance plan, there may be no time to shop around if a person has waited until the deadline. An important message is that if people want to consider options, they should start looking as soon as they are laid off. Please consider your options and protect yourself financially.

COBRA PREMIUM BAILOUT

When you're laid off, the loss of health insurance can be almost as devastating as the loss of income. But what many don't know is that the federal government will pay most of the insurance tab for nine months.

Under the recently enacted economic stimulus plan, the federal government is offering reduced premiums on Cobra coverage, which allows former employees to retain their group health insurance for 18 months. Workers who are terminated between Sept. 1, 2008, and Dec. 31, 2009, will be required to pay only 35 percent of the premium to continue their insurance plan. The discount is available for nine months; after that you'll have to pay the full premium.

Chris Zweidinger, vice president of employee benefits at Crissie Insurance Group, said many recently laid-off workers are being overcharged for Cobra because they are not aware of the discount.

"It's not being communicated. I'm seeing tons of people who are overpaying," Zweidinger said. "It's tough to be unemployed, but it's even tougher when you're paying a rate that should be reduced by 65 percent."

Zweidinger said that if you are being overcharged, you should contact your employer about getting the rate reduced.

If you're unemployed longer than 18 months or start your own business, that's the time to shop for individual health insurance plans, experts said.

An insurance broker can help you determine which plan best suits your needs. Robert Zirkelbach, a spokesman for industry group America's Health Insurance Plans, cautions consumers not to choose a plan based on price alone.

"They should look not just at the premium but at a variety of other factors: Do they have a particular physician they go to regularly? They need to make sure they're in the network," Zirkelbach said. "Do they want the variety of choice of a PPO, or are they fine in a more managed network like an HMO?"

Zirkelbach also recommended paying close attention to the amounts of deductibles and co-payments so that you are fully aware of the costs of coverage beyond the premiums. Don't skimp on your health coverage due to a job loss, said Dieter Freer, divisional senior vice president for local and consumer markets at Blue Cross and Blue Shield of Illinois.

"Health care is very, very expensive, and if you get exposed to a critical situation when you are not covered, it could be financially ruinous," said Freer. "If you owned a house, you wouldn't let your fire insurance go. The chances of your house burning are not as great as something going wrong with your health."

COBRA CAN HELP UNEMPLOYED

Virginians who have lost their jobs in a wave of layoffs since September have a new lifeline for health insurance, but only if their former employers still have health plans and know about the obligation to offer continuing coverage.

The federal stimulus package adopted in February will pay 65 percent of health insurance premiums for laid-off workers for up to nine months, while a newly adopted state law will offer the same opportunity for people cut by small businesses since the beginning of September through the end of this year.

However, the federal subsidy applies only to businesses that still offer operating group health plans at a time when corporate bankruptcies, plant closures and liquidations have prompted some big employers to drop health insurance completely.

In the Richmond area, for example, more than 1,900 employees of Circuit City Stores Inc. lost their jobs and any chance of continued health coverage when the retailer went bankrupt and closed all its operations. LandAmerica Financial Group is still providing health coverage for its nearly 300 remaining employees in the area, but eventually will cease health-plan coverage as it sells off its assets in bankruptcy.

"The intent is good, but there's a disconnect," said George T. Drumwright Jr., a deputy county manager in Henrico County who helped establish a regional center for laid-off workers. "If you're bankrupt, or going to go bankrupt, you're only keeping that until the last person turns the light out."

The problem already has begun to show, first in local social-services departments and now at the Capital Region Employment Transition Center at Innsbrook in western Henrico, Drumwright said. "We're hearing people having difficulty with it. It's just beginning to bubble up to the surface."

At the same time, Virginia insurance carriers are taking the lead in letting an estimated 168,000 small businesses know about a new state law that requires them to offer continuing health coverage, using the same 65 percent stimulus subsidy, to workers laid off by companies with fewer than 20 employees.

The law, adopted by the General Assembly at its veto session last month, does not have a mechanism to enforce the notice requirement, so insurance regulators are working with carriers and health plans to notify affected businesses. The Virginia Employment Commission plans to take out advertisements as a low-cost way to get out the word.

"The real deal here is we have a lot of small business out there who know nothing about this at all," said S. Owen Hunt, associate general counsel at Anthem Blue Cross Blue Shield, which is mailing notices to about 24,000 small businesses with group health accounts. "Their only source of information is us. . . . We're going to go out and give them information about it. That's just good business."

The vehicle for the insurance subsidy is COBRA, a long-standing federal law that allows employees who lose their jobs an opportunity to continue coverage under group health plans at their own expense. The cost can be enormous, more than \$1,200 a month in some instances, which prompts many of the unemployed to look elsewhere for help.

COBRA coverage also is no guarantee for employees of companies in the throes of bankruptcy, such as Qimonda North America Corp., which cut 2,000 jobs when it closed two semiconductor chip factories in eastern Henrico. The company is maintaining its group health plan for a skeleton staff, so COBRA coverage is still an option for former workers, such as Jack and Sandra Hicks.

The New Kent County couple lost their jobs at the two factories in mid-March. "They said COBRA was there as long as the company didn't go completely bankrupt," said Sandra Hicks, who was a materials buyer for one of the Qimonda factories.

Continuing their coverage would have cost the couple more than \$800 a month, without any subsidy, so they took out an individual policy for \$558 a month.

"We're both over 50. If something happens to us, it could bankrupt us," she said. "We have to have insurance."

The stimulus subsidy gives the Hickses a second chance at continuing coverage while paying 35 percent of the cost, but they have an even better option with the Health Coverage Tax Credit. The credit is linked to the federal Trade Adjustment Assistance program, which provides enhanced benefits for workers who lost their jobs because the work was outsourced to overseas operations or affected by increased imports.

Qimonda applied for coverage for workers laid off in Virginia and North Carolina. The program offers to pay 80 percent of health-insurance premiums for eligible workers for up to two years. Moreover, coverage would continue even if the company disappears because Anthem is the insurer of last resort for the program, which the VEC is administering for the federal government. The Department of Labor said last week that it is distributing nearly \$6.2 million under the program in Virginia in the federal fiscal year that ends Sept. 30.

"Qimonda has been actively working with both the Virginia and North Carolina unemployment offices, as well as our external health-care providers, to ensure individuals understand these benefits," said Don O'Grady, vice president of human resources.

Advocates for the unemployed are intensifying their efforts to let laid-off workers know their options under COBRA and, for small businesses, Virginia's so-called "mini-COBRA" program.

"It's huge -- it's really important for people," said Jill A. Hanken, staff attorney at the Virginia Poverty Law Center and a member of a state working group on health-care coverage for people in the economic crisis.

Hanken and other advocates know the COBRA coverage isn't perfect, even with a hefty premium subsidy. It depends on a company with a viable health plan, and thousands of the newly unemployed worked for companies in deep, sometimes irreversible trouble.

"It's a narrow, targeted subsidy for a subset of those folks who are losing their jobs," she said. But the gaps in eligibility worry Cheryl Fish-Parcham, deputy director for health policy at Families USA. "The lack of help for people whose companies have gone completely out of business is an enormous problem," she said.

The biggest example here is Circuit City, a Henrico-based retailer that cut off health coverage for 34,000 employees nationwide after it was unable to emerge from Chapter 11 bankruptcy.

LandAmerica will close its headquarters by the end of the year and lay off the 291 employees remaining from a work force that numbered 930 at the beginning of last year. The company sold its two largest subsidiaries in December to a Florida-based rival, Fidelity National Financial Inc., which then laid off 1,500 of the 5,500 people the companies employed nationwide. Fidelity will not say how many people were laid off in the Richmond area or return calls for information about continued group-insurance coverage under COBRA.

What's left of LandAmerica is still maintaining the health plan and offering the chance for continued coverage, said spokeswoman Cheryl Gentry. "Whoever's eligible and signs up qualifies for the subsidy."

But Gentry added, "At some point, the plan will likely go away. When the plan goes away, the COBRA will go away, too."

HEALTH INSURANCE HELPER

Messages come in many forms. This one just happens to be in the form of an aggrieved mom from Atlanta driving a purple school bus across the country to grab attention for the national debate swirling around health care.

Kathie McClure can testify that in every corner of the United States, the ranks of the uninsured are swelling. People who do have health insurance are more concerned than before they will not be able to afford to keep it.

The Purple Bus Lady is touring the country and encouraging people interested in health care reform to visit her Web site at www.votehealthcare.org. It does not matter whether it is employer-sponsored insurance or purchased on the individual market, insurance is becoming unaffordable for more and more people every day, McClure said.

Over Mother's Day weekend, she traveled alone through the San Joaquin Valley, making only one public appearance in Fresno but stopping long enough in the north Valley to chat with a reporter about her mission.

"I realized this was a problem we couldn't solve on our own. No individual could fix this alone. I decided to act up and demand change, so I formed the nonprofit VoteHealthcare.org that is working with groups around the country," including Health Access California, said McClure, an attorney who "joined the fight" in November 2007 after years of unsuccessfully battling insurance companies on behalf of her children.

When McClure's children were diagnosed with serious health conditions in their early teen years - her son, Chris, with Type 1 diabetes and her daughter, Caitlin, with epilepsy - the family insurance covered them. But when they finished college and lost family eligibility, that is when McClure said her wake-up call came.

"My son can't buy insurance in Georgia because of pre-existing conditions, and my daughter can't buy anything for less than \$250 a month, and that doesn't include drug coverage. Her medications cost at least \$350 a month to control her seizures," McClure said.

She has committed herself to traveling to all 50 states in her purple painted mini-school bus, attending public events, speaking at churches and other gatherings, being interviewed on radio and television, all for the purpose of educating and inspiring as many people as she can to get involved in changing the way health care works in the United States.

"I think it's dawning on people that this is a problem beyond their control. I think people are finally seeing that just because you work hard and pay your bills and that was always enough to take care of your family, that may not be true any more," McClure said.

In two legs of her journey, she has traveled 20 states so far and will hit 10 more on her way back to Georgia. She has met hundreds of people and learned much, especially that many people have had similar experiences and are just as frustrated as she with the way things are today.

She encourages them to go to her Web site, use the resources there and get involved by contacting members of Congress.

"This isn't an issue of Republicans against Democrats or rich against poor. Purple represents a mixture of the red and blue factions that are too often seen as dividing our country. The bus is painted purple because affordable, quality health care is something all Americans need," McClure said.

The one thing that has stood out for McClure during her travels thus far does not bode well for the future. "There is a lot more poverty in this country than I ever realized," she said.

HEALTH INSURANCE FUNDRAISER

It seems like people are making a difference in each other's lives now more than ever. Kind of like this next story we bring you. They all attend church together and they're all now working towards the same goal. The only difference between the three women you're about to meet is that one of them has cancer and no way to pay for her treatments.

Cancer is not prejudice but insurance companies can be, not offering a reasonable rate if say, you have a pre-existing condition. Christy Kelshaw, Co-Founder of Portneuf Gap Project: "They've worked hard all of these years, they're ready to relax and enjoy their life and they're going to lose everything if someone doesn't step in and help."

Tawna and Christy are not wasting any time getting the word out about their new organization that does just that. If you don't qualify for governmental assistance or work a part-time job without insurance benefits, they want to help.

Tawna Brockett, Co-Founder of Portneuf Gap Project: "It's kind of a last ditch effort to try and help somebody. It's a very reactive approach right now, in the future we have many ideas on how we can be more proactive." Every Saturday they man a booth at the Farmer's Market in Pocatello. The Portneuf Gap Project has already raised \$2,000 for Carol Fraire who's fighting cancer for the second time.

Vern Fraire, Carol's Husband: "I told her she was free from it, I always had faith and believed that she was free from it and yet she came up with it again. That does something to a man when you're supposed to providing and you can't." Vern says worrying about his wife is stressful enough, add to that they could lose their home and words can't describe the couples reaction when Tawna, Christy and Ramona broke the good news to them.

Carol Fraire, Battling Cancer for a Second Time: "God had a plan and these friends have decided it needed to be more than just me. It needed to be the community, it needed to be reaching out to others. There's a lot of people in my boat."

Christy Kelshaw, Co-Founder of Portneuf Gap Project: "This is a way for people to do something that makes them feel hopeful about our country, our community, our economy about just the power that they have because sometimes you feel powerless."

The women will host their first official fundraiser on Friday June 5th, from 7 p.m. to 10 p.m. at the Westside Players Warehouse, 1009 S. 2nd Avenue. You can buy tickets at The Popcorn Shop, Portneuf River Outfitters and Scrappin Essentials. They will also be set up at the Farmer's Market, Revive at Five and the Chariot Races until June 3rd. It's a night set aside for Arts and Entertainment with a raffle, a silent auction and a dessert bar.

NEW HEALTH PLANS

The latest proposal to change how health care coverage is provided in Michigan attempts to extend consumer protections and create a new fund to help cover those facing catastrophic illness.

Democrats who control the Michigan House are scheduled to detail their plan Monday at events across the state. The plan would expand MICHild, the state's health care program for children. All health insurers in the Michigan market would be called upon to contribute to a catastrophic protection plan to aid patients whose medical claims top \$25,000 a year.

Supporters of the House Democrats' plan say it would improve access to health care coverage by requiring insurance companies to cover people who have pre-existing conditions such as cancer or diabetes. Insurers would be banned from raising rates on individuals who become sick.

The Democratic plan will compete with Republican legislation due to be introduced within the next week in the state Senate. Sponsors of the Republican proposal say it will focus on helping the more than 1.2 million people in Michigan who don't have health insurance.

Both proposals expand upon the individual health insurance market debate in the Legislature for the past few years. The Democrat-led House and Republican-led Senate could not reach a compromise on the individual market changes in 2008 so they are revamping their plans this year.

The individual market offers policies for people who don't have insurance coverage through employers or the government. That number is growing in Michigan as the economy worsens. But the price of individual market policies has soared, making it unaffordable for some.

Rep. Marc Corriveau, D-Northville and chairman of the House Health Policy Committee, said changes are needed in Michigan beyond the individual market. Corriveau also said Michigan should not wait for whatever policies are adopted by President Barack Obama's administration and the Democrat-led Congress before addressing its own problems.

"This is attempting to fix a broken system," Corriveau said. "We need to stabilize the market in our state."

Sen. Tom George, a Republican from Texas Township in Kalamazoo County and chairman of the Senate Health Policy Committee, already has had several meetings across the state to develop health care proposals that should be introduced within the next week.

George noted that the ranks of Michigan's uninsured, estimated at 1.2 million just a few years ago, likely has grown in recent months with the deterioration of the economy. The upcoming Senate bills would aim to make basic individual health policies more affordable, possibly by subsidizing the cost. The resulting lower prices could entice some who now go uninsured to buy coverage.

Both George and Corriveau said they hope their proposals will have some overlap and soon lead to a consensus in the Legislature.

HEALTH INSURANCE SURVEY

Emergency medical, travel, and security assistance provider, On Call International, today, launched an interactive survey to U.S. health insurance professionals in an effort to gauge the industry's overall readiness to face and manage unforeseen medical emergencies during members' international travel, as well as planned efforts within the medical tourism phenomenon.

On Call International seeks observations and opinions from health insurance professionals to complete this online survey. Upon close of the survey, On Call will summarize and publish the findings in a comprehensive report to interested respondents. Health insurance professionals interested in the findings can be among the first recipients of the report by taking the survey today.

“As a 24/7 emergency responder to individuals traveling the world, we know that accidents happen more than you think,” said Mike Kelly, On Call International President & CEO. “Through this survey and subsequent report of industry feedback and best practices, we hope to alert the health insurance industry of the potential risk traveling outside a home network can bring, and how to help ensure its members are prepared and protected should the unexpected occur.”

On Call will ensure the privacy and anonymity of the respondents and responses will be collected in the aggregate, not to be traced back to individual respondents.

On Call International is a leading provider of customized medical, security and travel assistance for international business and leisure travelers, as well as expatriates, students and others away from home. Operating 24/7/365, On Call International specializes in emergency evacuations from any point on the globe, assisting more than seven million travelers. The U.S.-owned and trained assistance company serves the travel, insurance and maritime industries. On Call is a member and the U.S. representative of the 26-partner International Assistance Group, a global network of independent assistance companies.

INSURANCE TRANSPARANCY NEEDED

“There is no question that ‘meaningful health insurance’ is at the heart of the effort to get affordable, quality coverage for all Americans,” said CAP Senior Fellow Judy Feder at “Truth in Labeling: Transparency and Health Insurance,” an event CAP hosted last Friday. A group of experts joined Feder for the discussion, including Georgetown University Research Professor Karen Pollitz, American Cancer Society Action Network’s Senior Program Editor Steve Finan, and Senior Program Editor at Consumer Reports/Consumer Reports on Health Nancy Metcalf.

In order for health insurance to be meaningful it must “comply with the three A’s,” said Feder. “It must be adequate, available to all, and affordable.” This is unfortunately not the case with most plans; they often have coverage gaps, deny people insurance, or are too expensive for most consumers.

Being underinsured is nearly as dangerous as being uninsured. Even with insurance, “you can lose everything if you have a heart attack,” explained Pollitz. Millions of insured Americans accrue staggering medical bills each year due to inadequate coverage.

It can be difficult to tell what benefits a health insurance plan provides, and consumers are generally not even allowed to read a policy before purchasing it. These practices also make it difficult to avoid hidden costs. “For almost anything we buy these days people can get consumer information, except for health insurance,” said Finan. Despite the wide variety of plans available, consumers have almost no tools to effectively compare them and make an informed decision.

Even after purchasing coverage, it is nearly impossible for the average consumer to understand their plan and judge whether it will cover costs. “The policy language is in legal and health jargon making it difficult for people to understand,” said Pollitz. In one study three out of four people didn’t understand their policy and 53 percent didn’t know whether there was a limit on their out-of-pocket spending.

The fundamental lack of coverage transparency can lead to insurmountable debt. “We are trained as consumers [to] buy bargains,” said Metcalf, but plans that seem cheap often have costly loopholes. Pollitz and her team compared three hypothetical patients with serious health conditions under 10 different insurance plans offered in Massachusetts and 10 others in California. The discrepancy in out-of-pocket payments for their breast cancer patient ranged from \$4,039 to \$55,250, as detailed in their report, “Coverage When It Counts.”

Often patients don't know about the limits in their coverage until they receive their bill. Even if consumers know they have an out-of-pocket limit, and know what it is, sometimes this limit isn't comprehensive and it is difficult to determine what is covered and what isn't. "It is important to make the out-of-pocket limit real," said Pollitz. Otherwise patients can incur staggering debts, even under a seemingly comprehensive policy.

"We all agree that everyone should have basic coverage, but the question is what does this mean? What do you leave out?" asked Metcalf. This will be a central issue in the process of health care reform and creating a system that doesn't leave people without coverage.

Vital steps toward health insurance reform and transparency will be standardization, comparability, disclosure, and honesty of language. "The most important step is to make health insurance less variable," said Pollitz. "What we have now aren't choices. They're traps." Consumers should also have access to comparative information the same way they do for other products through services such as Consumer Reports. One way to do this would be through a Coverage Facts label, modeled after the FDA's Nutrition Facts labels.

Health insurance must undergo significant reform, and transparency needs to be at the heart of it. Patients should not have to face a lifetime of debt because of dense, complex legal language. As Feder said, "If health insurance doesn't work for sick people it doesn't work."

WELLCARE REPORT

WellCare Health Plans Inc. swung to a first-quarter loss due to legal costs from a Medicaid-fraud case and increased costs at its Medicare Advantage private fee-for-service plans, a market WellCare is getting out of. Still, results topped analysts' expectations.

Last week, the company agreed to pay \$80 million to settle a Florida Medicaid fraud investigation that had already led to a management shake-up and the restatement of more than three years of its earnings.

WellCare administers medical benefits for about 2.5 million enrollees in Medicare and Medicaid health plans. While such programs are expected to see rising enrollments as the population ages and following the government's expansion of State Children's Health Insurance Program, they also are more vulnerable to shifts in government health policies.

WellCare reported a loss of \$36.9 million, or 89 cents a share, compared with prior-year earnings of \$1.3 million, or 3 cents a share, a year earlier. Excluding items such as legal costs, earnings fell to 29 cents from 52 cents. Revenue increased 13% to \$1.8 billion. Analysts polled by Thomson Reuters most recently were looking for adjusted earnings of 18 cents on revenue of \$1.77 billion. The latest period included a 79% decline in investment and other income, which WellCare said lowered earnings by 19 cents.

WellCare's medical-benefits expense ratio, or the amount of premiums used to cover medical costs, rose to 86.7% from 86.2% amid lower premium rate growth at its Medicaid programs. Total membership rose 60,000 from a year earlier to 2.46 million. Medicaid membership was up 10%, however, while total Medicare Advantage membership rose 32%. Its prescription drug plan membership was down 18%.

WellCare plans to exit fee-for-service Medicare Advantage contracts amid woes in that segment. The move next year is expected to affect some 110,000 individuals, or more than 40% of members in those plans.

HEALTH INSURANCE REVIEW

With cases of the H1N1 flu virus now being reported in Blount County and across the state, the Tennessee Department of Commerce and Insurance is urging Tennesseans to review the details of their health insurance policies. Take a few minutes and answer these questions:

What is your out-of-network co-payment? If your area is affected by the spread of the H1N1 flu outbreak and your regular healthcare provider is not be able to see you in a timely manner, you may need to visit an out-of-network provider. If you have to go out-of-network, be aware you will have to pay a higher co-payment for your office visit and possibly any tests run during the visit.

What is your co-payment for the most common H1N1 treatments? The two drugs that doctors are encouraged to prescribe to treat H1N1 flu are Tamiflu and Relenza. Also find out if there are any coverage limitations that apply to the distribution of the medication. Some policies will restrict coverage on the number of doses per prescription or per year.

ASK YOURSELF: Does your policy have a preauthorization requirement for hospital admission, laboratory testing or other services?

Get prepared for any eventuality with the following checklist: Have your health insurance I.D. card handy. Review your health insurance policy provisions. Know which doctors and hospitals are in your network. Make note of your co-payments. Know how much a doctor's office visit will cost. Check to see if your co-payments go up if you go out of network. Find the list of pharmacies covered by your health insurance policy. If you have plans to travel, make sure you check to see if there are any in-network doctors or medical facilities where you will be visiting. Make sure you have contact details for your health insurance company available in case you have questions.

Your employer may be gathering all pertinent health insurance information together for you in one simple-to-reference form. If they do, post the information where it can easily be accessed by you and your family.

WHAT THEY KNOW ABOUT YOU

Ohio health insurance consumers may be unaware that there are insurance-related businesses, or insurance support organizations, that collect and provide information to health (and life) insurers about an individual's medical conditions and prescription drug usage, Ohio Department of Insurance Director Mary Jo Hudson said.

As more people look to individual health insurance after losing their jobs and with some small businesses dropping coverage because it's too expensive, consumers may be wise to confirm the accuracy of any health information collected by these companies.

Often, insurance companies become members or customers of insurance support organizations, also referred to as data-collection or data-mining companies. Some of these organizations offer many services, including claims and billing data that helps insurers determine the "usual and customary" (UCR) charge for services within a given area. Others offer information similar to a clearinghouse.

For example, when an insurer takes an application for health insurance, the insurer may submit certain personal identifying information to one of these insurance support organizations to find out if any other insurer has had the same applicant. If the insurance support organization does have a "match," the information is sent to the insurer, using certain codes. The insurer receiving the coded information can then question the applicant further about any undisclosed health information.

Consumers consent to the insurer making inquiries of any person or organization that has health information about them when they sign the application form. These consents uniformly list insurance support organizations as entities from which information may be obtained.

If you would like to determine what information, if any, has been collected about you by one of the insurance support organizations, you can contact the insurance support organization directly. Each company's web site has information about how consumers can obtain such information. If there is misinformation, you have a right to correct it, similar to credit reports from credit reporting agencies.

Sections 3904.08 to 3904.09 of the Ohio Revised Code govern the insurance information practices of insurers and insurance support organizations that collect consumer information. Under Ohio law, you have a right to know what information has been collected. Any company collecting insurance health information about consumers is also required to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and must safeguard the confidentiality, including limiting access to, any information collected.

How to get your personal information under Ohio law

If an individual provides proper identification and submits a written request for information, the organization within 30 business days of receiving request must:

- Inform the individual of the nature and substance of such recorded personal information in writing, by telephone or by oral communication, whichever the organization prefers.
- Permit the individual to see and copy such recorded personal information in person or have it mailed, whichever the individual prefers.

- Disclose to the individual the identity, if recorded, of entities the organization has disclosed such personal information to within two years prior to such request. If the identity is not recorded, provide to the individual the organizations to which such information is normally disclosed.
- Provide the individual with a summary of procedures by which to request a correction, amendment, or deletion of recorded personal information.
- Except under certain circumstances, the organization may charge a reasonable fee to cover the costs in providing the information.

How to correct your personal information

Within 30 business days from the date of a written request from an individual to correct, amend or delete any recorded personal information about the individual within its possession, the insurance support organizations must:

- Correct, amend or delete the portion of the recorded personal information in dispute.
- Notify the individual in writing that a correction has been made and furnish the correction to other organizations, as described in Ohio Revised Code section 3904.09.
- Notify the individual of its refusal to make such a change, the reasons why and inform the individual of their right to file a concise statement with the organization that stays with the disputed information, explaining what the individual thinks is the correct, relevant or fair information and why the individual disagrees with the organization's refusal.

HEALTH INSURANCE PROBLEMS

Many people who believe they have adequate health insurance actually have coverage so riddled with loopholes, limits, exclusions and gotchas that it won't come close to covering their expenses if they fall seriously ill, a Consumer Reports investigation found.

At issue are so-called individual plans that consumers get on their own when, say, they've been laid off from a job but are too young for Medicare or too "affluent" for Medicaid. An estimated 14,000 Americans a day lose their job-based coverage, and many might be considering individual insurance for the first time in their lives.

But increasingly, individual insurance is a nightmare for consumers: more costly than the equivalent job-based coverage, and for those in less-than-perfect health, unaffordable at best and unavailable at worst. Moreover, the lack of effective consumer protections in most states allows insurers to sell plans with "affordable" premiums whose skimpy coverage can leave people who get very sick with the added burden of ruinous medical debt.

For its investigation, CR hired a national expert to help evaluate a range of health plan policies from many states and interviewed consumers who bought those policies. CR also talked to insurance experts and regulators to learn more. Among their findings:

- > Health insurance policies with gaping holes are offered by insurers ranging from small companies to brand-name carriers such as Aetna and United Healthcare. And in most states, regulators are not tasked with evaluating overall coverage.

- > Disclosure requirements about coverage gaps are weak or nonexistent. So it's difficult for consumers to figure out in advance what a policy does or doesn't cover, compare plans or estimate their out-of-pocket liability for a medical catastrophe. It doesn't help that many people who have never been seriously ill might have no idea how expensive medical care can be.

> People of modest means in many states might have no good options for individual coverage. Plans with affordable premiums can leave them with crushing medical debt if they fall seriously ill, and plans with adequate coverage may have huge premiums.

> Even as policy makers debate a major overhaul of the health-care system, government officials can take steps now to improve the current market.

HEALTH FUND EFFORTS

The White House on Monday proposed an additional \$59 billion in changes to the tax code that would help pay for the cost of efforts to cover the more than 40 million Americans without health insurance, including a substantial tightening of estate and gift tax rules.

Other new revenue raisers would affect life insurance products, limit certain accounting methods, and bar the paper industry from reaping a tax credit for a recycled fuel known as "black liquor."

Budget documents released Monday reiterate President Barack Obama's plans to create a \$630 billion "health reform reserve fund" to help pay for the health-care efforts, which are expected to cost at least \$1.2 trillion over 10 years. Tax provisions in the plan should cover \$325.6 billion of the reserve fund, with the rest coming from savings to the federal government's health-related costs.

The centerpiece of the tax proposals -- a limit on charitable deductions for taxpayers in the top two income brackets -- was rolled out earlier this year and remains in the proposal.

But the White House dropped its estimate of how much that proposal would raise, from \$317.8 billion to \$266.7 billion over 10 years. The charitable deductions proposal has drawn opposition from congressional Democrats.

On Monday, the White House added several other tax-generating proposals to supplement that plan, including proposed changes to estate and gift tax laws. The plan would require "consistent valuation [of property] for transfer and income tax purposes." According to the White House, the estate and gift tax provisions would raise \$24.2 billion over 10 years.

Another proposal would end the paper industry's practice of combining liquid byproducts from the production of paper -- or so-called "black liquor" -- with diesel fuel to receive alternative fuel tax credits.

The alternative fuel mixture credit is slated to expire at the end of this year, and lawmakers, including Sen. Max Baucus (D., Mont.), had vowed to shut down paper companies' use of the credit either by not renewing the credit with respect to "black liquor" or passing legislation earlier to block it.

The White House is proposing to deny paper companies access to the credit immediately when legislation to block the tax benefit is signed by the president.

The budget also seeks to take away some tax breaks for the life insurance industry, raising \$12.7 billion over 10 years, according to the White House estimate.

Life insurers follow special rules when determining how much to deduct for dividends received on investments in common stock. The White House is proposing to further restrict those deductions.

In addition, the Obama administration wants to modify rules governing deductibility of expenses related to the sale of life insurance contracts, including sales commissions.

Another proposal in the bill seeks to improve the enforcement of current tax laws, including a requirement that some business file their tax returns electronically. The White House would seek greater penalties for companies required to file electronically that didn't do so.

The tax enforcement changes would raise an estimated \$10.4 billion over 10 years.

The administration in February outlined other provisions that would raise revenues for the health reserve fund, but through changes to Medicare payments.

The most significant Medicare provision would put in place vast reductions in payments to private insurers through the Medicare Advantage program, creating a competitive bidding system to make Medicare Advantage payments more comparable to payments through the government's traditional Medicare fee-for-service program. That provision is slated to save \$175 billion over 10 years.

INSURANCE TERMS DEFINED

"I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick." — Modern Hippocratic Oath as written in 1964 by Dr. Louis Lasagna

In my last column, we reviewed the parties involved in the business of medicine. The common thread for uniting all of these entities is health insurance.

Hardly any preventative or restorative health services are paid for directly by the health consumer. Most cosmetic surgery, elective vision correction surgery, significant amounts of dental or orthodontic services, some chiropractic services and most veterinary services still follow a fee-for-service model.

Regardless of the evolution over the last 50 years, our health care system now looks to third-party payers to exchange consumer dollars for professional or facility services.

The most important thing a health consumer can do when reviewing an individual or work-related group health insurance policy is to read through that potential policy's definitions, schedule of benefits and subsequent covered and non-covered services. It is also important to assess the network facilities and provider panel. This is paramount if you hope to maintain certain provider or facility relationships.

If your goal for insurance coverage is to maintain the most choice to see any provider at any facility, ensure your non-network deductibles and coinsurances are not outrageously cost prohibitive. Let us then review some basic but important health insurance definitions:

Premium: The charges that must be paid by an insured to maintain coverage

Schedule of benefits: A summary of deductibles, coinsurance, copayments, out-of-pocket maximums and other limits. Details the payment difference between in-network and out-of-network services

Explanation of benefits (EOB): The statement sent to an insured listing services provided, amount billed, eligible expenses and payment made by their insurance

Deductible: The amount of eligible expenses insured must pay each year from his/her own pocket before the plan will make payment for eligible benefits

Copayment: A cost-sharing arrangement in which an insured pays a specified charge for a specified service, such as \$10 for an office visit. The insured is usually responsible for payment at the time the service is rendered. (In addition to coinsurance and deductible payments)

Coinsurance: The portion of covered health care costs for which the insured has a financial responsibility, usually a fixed percentage. Coinsurance usually applies after the insured meets his/her deductible

Out-of-pocket maximum: The total payments that must be paid by an insured (i.e., deductibles and coinsurance) as defined by the contract. Once this limit is reached, covered health services are paid at 100 percent during the rest of that calendar year

Network provider: A medical provider who has contracted with an individual insurance carrier to render medical services to insureds at a pre-negotiated fee. Providers include hospitals, physicians, and other medical facilities

Non-network provider: A medical provider who has not contracted to render medical services or supplies to insureds at a pre-negotiated fee.

Maximum allowable amount: The maximum amount paid by an insurance carrier for a covered service. This is usually the contracted rate for full payment to a Network provider

Usual and customary (U&C): A term used to refer to the commonly charged or prevailing fees for health services within a geographic area. A fee is considered to be reasonable if it falls within the parameters of the average fee for the service within the community. Often, an insurance carrier will list any balance above their maximum allowable amount as the U&C. This balance will then be owed by the patient to a non-network provider.

MICHIGAN HEALTH INSURANCE

With health insurance costs and the number of uninsured people rising, Michigan House Democrats are to introduce proposals today that aim to make health coverage more affordable and to expand government programs for lower-income children and adults.

Rep. Marc Corriveau, D-Northville, a chief sponsor of the legislation, told the Free Press on Friday that the legislation would:

- Prohibit insurers from rejecting applicants with chronic health problems or raising rates excessively on renewal.
- Create a Michigan Catastrophic Protection Plan that would collect fees from insurers, based on their market share, which would pay health claims of more than \$25,000 for any insured Michigander. It would be managed by Michigan's Office of Financial and Insurance Regulation.
- Expand government programs for children and adults by requiring the state's nonprofit insurers -- Blue Cross Blue Shield of Michigan and all HMOs -- to pay money equal to their tax breaks. That's \$80 million for Blue Cross alone.
- Prohibit higher rates for women, as now occurs, often charged to cover the possibility of pregnancy-related care.
- Give discounts for healthy behavior, including not smoking.

Republicans are to introduce their own proposals Wednesday, Sen. Thomas George, R-Kalamazoo, said Friday. Those bills center on expanding public insurance plans to cover more people, he said.

The bills come after the Legislature failed to reach an agreement last year after more than two years of hearings about how to change Michigan's health insurance market.

Michigan's uninsured rate is growing, as more people lose jobs or workplace coverage, as is the cost of insurance. About 1.2 million Michiganders have no insurance. The average individual plan in Michigan cost \$4,118 in 2008, according to America's Health Insurance Plans, an industry group.

PATIENTS FLEE TO AVOID PAYMENTS

In hindsight, maybe Jesse Ashlock shouldn't have walked out of the New York emergency room last summer, only a couple hours after being knocked unconscious in a Brooklyn bicycle crash.

Medical crews told him he needed a blood test, chest X-rays and probably a CT scan to check for head injuries. And he certainly should have had treatment for major road rash, including raw scrapes on his face, neck and hands.

But the 31-year-old editor for a design magazine was between jobs, briefly without health insurance and afraid of being stuck with a sky-high hospital bill. The doctor on duty dismissed Ashlock's questions about cost, telling him she was "a physician, not an accountant," he said.

So Ashlock stalked out of Woodhull Hospital without treatment, becoming part of a small but growing number of patients turning down emergency care because they fear they can't afford it.

“I’ve heard all kinds of horror stories ... I could easily imagine it being \$5,000,” said Ashlock. “I was worried about having a concussion and worried about going to sleep, but I was fine.”

Even as rising unemployment strips people of health insurance, sending many to emergency departments for care, doctors on the front lines say the lingering recession is also prompting an unexpected outcome.

More patients, they say, are refusing potentially costly procedures ranging from tests to confirm heart attacks to overnight stays to monitor dangerous infections.

“I have definitely seen an increase in this problem,” said Dr. Sara L. Laskey, who works in the emergency department of MetroHealth Medical Center in Cleveland, Ohio. “They’re really making conscious decisions about what they do and don’t want done.”

Just last month, Laskey saw a woman with bronchitis and pneumonia with life-threatening oxygen levels who refused hospital admission because she had no insurance. Even when Laskey arranged for her to have an oxygen kit to take home, the woman turned it down because of the cost.

“She refused, saying she would share her husband’s oxygen,” Laskey said. “Ultimately she left without the oxygen or an admission.”

Discharged ‘against medical advice’

Increasingly, such cases are raising ethical dilemmas for doctors, forcing them either to persuade patients to agree to treatment or else to discharge them “against medical advice.” That’s a formal designation that signifies a patient is knowingly disregarding a doctor’s guidelines.

About 119.2 million visits were logged in U.S. emergency departments in 2006, according to a report last year by the federal Centers for Disease Control and Prevention. Of those, about 1.5 million, or 1.3 percent, ended with discharges against medical advice, or AMA. Doctors believe those numbers are both underreported and growing.

“Even without the recession it goes on all the time, but it probably goes on more now,” Dr. Neal K. Chawla, who works at a stand-alone emergency clinic run by Inova Fairfax Hospital in Falls Church, Va.

“It’s like, ‘OK, I’m not dying of a heart attack, let me go home,’ ” he said. “I have similar conversations two or three times a day.”

Just this month, Chawla, a spokesperson for the American College of Emergency Physicians, said he argued with a man who refused hospitalization to drain a large abscess on his buttocks; another man who declined admission for an infected kidney stone; a woman with low-risk chest pain who didn’t want to pay for further cardiac exams; and a patient with acute appendicitis who needed emergency surgery but didn’t want to pay for an ambulance.

“He called his mother to drive him over,” Chawla said.

Some patients can be convinced to submit to care, but others can’t, said Dr. David J. Alfandre, a researcher with the National Center for Ethics in Health Care run by the U.S. Department of Veterans Affairs.

“Everyone has a right to decide what’s done with their body,” said Alfandre, who reviewed studies of discharges against medical advice in a report for the Mayo Clinic Proceedings in March. “The hard part is ensuring that the patient understands the risks and benefits.”

Rates of hospital discharges against medical advice are about the same as for emergency rooms: between 1 percent and 2 percent, Alfandre found. Of some 39.4 million hospital discharges in 2006, about 390,000 were classified as AMA, according to statistics from the federal Agency for Healthcare Research and Quality.

Overall discharges grew by 14 percent between 1997 and 2006, but AMA discharges, the smallest category, jumped by 48 percent in that period.

“Early leavers,” as they’re sometimes known, are most often men on state-sponsored Medicaid or with no health insurance who have serious social and financial concerns, research shows. About 21 percent of people discharged against advice had no insurance, compared to about 7 percent of routine discharges, according to AHRQ.

Have you ever refused medical care because of the price tag?

‘If they leave the ER now, they’re likely to go back’ People who leave against advice are at higher risk for ending up back in the hospital, or for becoming seriously ill or dying, Alfandre said. Asthma patients who leave AMA are about four times more likely to be readmitted, his review showed. General medical patients are about seven times more likely to wind up again in the hospital.

“Patients should be told, ‘If they leave the ER now, they’re likely to go back,’ ” Alfandre said.

Several emergency department doctors said they see many more reluctant patients than they ever sign out against medical advice.

“If it’s a really dumb decision, I’ll sign them out AMA,” Chawla said. “Cardiac is one of the big ones. We’re very cautious about the heart.”

Other doctors said even when they don't sign patients out against advice, they do have detailed conversations about the value of certain tests and procedures.

"In my mind, that's not necessarily a bad thing. Testing is out of control," said Dr. Jeffrey Sankoff, who works in the emergency department at the Denver Health Medical Center in Colorado. "I think it's good we're having those conversations about risks and benefits."

Those talks can help direct patients to solutions less dire than refusing treatment. Most hospitals provide charity care, though the amounts and conditions vary widely. Many also offer help connecting patients with services such as Medicaid. And most hospitals will set up payment plans, if nothing else, to allow patients to manage the bills.

No care, but billed anyway?

Not every doctor is so proactive, however. In Jesse Ashlock's case, no one stopped him as he stripped off an X-ray vest, put on his shirt and strode out of the emergency room, still bleeding from the scrapes on his face and hands.

"I think the frustration is that they didn't want to discuss the cost," he said of his decision to leave.

Adding what he regards as insult to injury, Ashlock later received a bill for \$618.67, which he still hasn't paid. He called Woodhull Hospital officials to ask why he was being charged for services he didn't receive, but the bill still stands.

It covered the cost of his evaluation, according to a spokeswoman for the New York City Health and Hospitals Corp., which operates the hospital. After being contacted by msnbc.com, hospital officials contacted Ashlock to resolve his bill, said Pamela McDonnell, HHC's director of media relations.

In the end, Ashlock said he'll probably pay the bill in installments so it won't damage his credit. And he's grateful overall that his injuries from the bicycle accident have healed, leaving only small scars.

"You just have to look on the bright side. I'm walking around and talking to you," he said. "Still, \$600 is a lot of money."

HEALTH INSURANCE DISCRIMINATION?

Insurance companies offered Tuesday to end the practice of charging higher premiums to women than to men for the same coverage.

Karen M. Ignagni, president of America's Health Insurance Plans, a trade group, made the offer in testifying before the Senate Finance Committee.

It was the latest concession by insurers as Congress drafts legislation to overhaul the \$2.5 trillion health care industry.

In November, insurers said they would accept all customers, regardless of illness or disability, if Congress required all Americans to have coverage. In March, insurers offered to stop charging higher premiums to sick people.

Ms. Ignagni said the industry would accept aggressive federal regulation, but would resist creation of a government-run insurance program of the type proposed by President Obama and many Democrats in Congress. The government-sponsored program would compete with private insurers.

Senator John Kerry, Democrat of Massachusetts, told Ms. Ignagni, "The disparity between women and men in the individual insurance market is just plain wrong, and it has to change."

She said she agreed the disparities “should be eliminated.”

Mr. Kerry introduced a bill on Tuesday to prohibit insurers from considering sex as a factor in setting premiums for policies in the individual insurance market.

Women are often charged 25 percent to 50 percent more than men for insurance providing identical coverage.

In interviews last fall, insurance executives said they had a sound reason for the different premiums: Women ages 19 to 55 tend to cost more than men of the same age because they typically use more health care, especially in the childbearing years. Moreover, insurers said women were more likely to visit doctors, to get regular checkups, to take prescription medications and to have certain chronic illnesses.

Congress is considering proposals to provide tax credits or subsidies to millions of people with low or moderate incomes to help them buy insurance. Without substantial changes in the insurance market, such assistance would be worth less to women because of the higher premiums.

KAISER HEALTH NEWS

Kaiser Health News/Philadelphia Inquirer examined health insurance for young adults, many of whom lose coverage after they graduate from high school or college or reach a certain age. According to the not-for-profit group Commonwealth Fund, adults between ages 19 and 29 are among the largest and fastest-growing groups of uninsured people in the U.S.

In addition, the unemployment rate among people ages 20 to 24 reached 14.7% in April, an increase from 9% in 2008, Sara Collins, assistant vice president of the Commonwealth Fund, said, adding that "young people may now be even more vulnerable" to a loss of health coverage because of the economic downturn.

Some states have enacted regulations requiring insurers to extend coverage to young adults under their parents' health plans, even if the adult children do not remain in school, Kaiser Health News/Inquirer reports. According to Laura Tobler, health policy analyst at the National Conference of State Legislatures, state laws typically allow parents to continue to cover unmarried dependents up to age 25 under their plans, although some states have extended the age limit to 30. These regulations generally apply to group plans subject to state regulation and individual policies in some states.

In addition, insurers such as Independence Blue Cross and Aetna are reaching out to young people with low-cost insurance plans. However, experts say these plans often come with high deductibles and provide mainly catastrophic coverage.

GROUP INSURANCE FOR ALL

The Day Spa Association and the International Medical Spa Association are proud to remind the industry that members of both organizations can now be covered by a single group policy at affordable rates with more than adequate coverage, especially in emergencies.

Today, more than 14% of Americans -- 41.2 million are uninsured, many of them working in small businesses like day spas, medical spas and the many suppliers of professional goods and services. With insurance premiums at an all-time high and ever-rising, most small day spa businesses cannot afford to cover their owners or staff.

“With most insurance laws being governed by their State Boards, the task of obtaining a group health policy outside the states’ borders for our DSA members was an impossible undertaking”, says Hannelore Leavy, Founder and Executive Director of The Day Spa Association and The International Medical Spa Association. After over a decade of searching, we are finally able to offer our members a group health insurance plan that is fit for the day spa and medical spa industries”.

AIM Health Max is the DSA/IMSA members’ Major Medical Alternative option. The premiums are a fraction of the cost of a comprehensive major medical plan and the plan is highly rated by industry “watchdog” organizations. Best of all, this plan is available at an affordable price and applicable in all 50 states.

This is a high benefit program available to both salon and day spa businesses as well as for individuals. This program has no deductibles, there is no lifetime maximum benefit limit and offers up front defined benefits. Coverage includes insurance for doctor, hospital, X-ray, lab, surgical, \$5 prescription drug card and extra benefits such as advance lump sum payment upon diagnosis of a critical illness.

If you and/or your employees are on a high deductible plan, uninsured or on a plan that just costs too much, you need to check this out.

* No Medical Questions, this plan will accept everyone regardless of their personal health history.

* No APS or Exam. This plan will not check your medical background or require you to have a paramed or doctor examination.

* No Rate Up. You will not be rated up on this plan due to age, location or medical history.

Monthly Premiums start for as little as \$127 for singles, \$211 for single parents and \$274 for a family plan.

Day Spas, medical spas and other businesses belonging to the associations can enroll as an employer group. Employer groups can include coverage for their full time and part time employees as well as their independent contractors. The monthly premium structure allows the employer group the options to offer the health insurance fully subsidized by the employer or on a cost sharing basis with the members of the group or as a full pass on cost to the group members. This flexibility provides several attractive options for cost conscious employers. AIM also offers the option of billing the insured directly, thus there is no additional payroll deduction/accounting necessary by the employer.

EXTENTION FOR OHIO

On their third stint without health insurance, the Wirebaughs worry that they are one accident away from financial ruin.

Barb Wirebaugh's husband worked for the same company for more than 28 years until his job disappeared like so many others in the manufacturing industry. Then more jobs were found and lost, and the couple from Bucyrus in north-central Ohio have nearly given up on finding health coverage.

"I am just so, so tired," said Wirebaugh, who is running her own mental health counseling service. "I worry about so much. I am grateful to have my children on the coverage they have. I'm just worried that one disaster would wipe us out."

Their three children are on Medicaid, but Wirebaugh and her husband are like roughly 1 million other adults in Ohio's downtrodden economy — jobless or employed, and without coverage. Not only have workers lost their jobs in the onslaught of the recession, many small businesses are no longer able to afford insurance policies for their employees.

Gov. Ted Strickland faced a quandary as he tried to address the plight of the uninsured in his proposed budget: The number of Ohioans without health coverage is growing when the state can least afford to do anything about it.

The percentage of uninsured adults between ages 18 and 64 went from 15 percent in 2004 to 17 percent in 2008, according to the 2008 Ohio Family Health Survey.

Strickland developed plans he said would give an additional 110,000 uninsured Ohioans access to health coverage with an impact of only a few million dollars on state revenue. The state could not afford to pursue more aggressive measures that could help more than just a fraction of the uninsured population.

And what the state can do to help the uninsured will likely have an impact elsewhere.

"Someone's cost is someone else's revenue," said Bill Hayes, president of the Health Policy Institute of Ohio, a nonpartisan organization that conducts research on health care trends and policies.

Small businesses already straining in the recession believe that cost will fall on them. The friction between expanding health coverage and protecting the interests of small businesses will be a key component in the debate over the roughly \$54 billion budget now in the hands of the Republican-controlled Ohio Senate.

TRANSFORMING HEALTH INSURANCE

The reforms include medical insurance for Americans not currently insured. America's Health Insurance Plans, the American Medical Association, the American Hospital Association, the Service Employees International Union and the Pharmaceutical Research and Manufacturers of America have all agreed to cut spending increases, as interested parties realize that there is a growing anger among the public about costs.

In my country, the UK, I think it is resentment, rather than anger, that is growing. For many treatments it depends on where you live in the UK as to whether you receive the treatment, even though we all pay for it. This is called the 'postcode lottery'. And although mainly funded from taxation, our health service is very expensive, with our doctors the highest paid in Europe. There is a widespread fear of going into hospital as so many hospitals are dirty, with geriatric care particularly criticised for many failings. There are rising numbers of avoidable deaths in hospital, as the Telegraph reported in January.

What is urgently necessary for healthcare on both sides of the Atlantic is a greater emphasis on prevention of avoidable illness, rather than on treatment. New York has set a good example to follow, by its talks with the food industry and restaurants to cut the amount of salt in the food they sell. When people reduce their intake of sodium it is the simplest and most effective boost to their health possible, and the best way to avoid chronic disabling illnesses like stroke, type 2 diabetes, arthritis, high cholesterol, high blood pressure, heart disease, heart attack, cancer, depression and many more, including obesity.

For too long the food industry has been able to coast along doing nothing very effective about reducing salt levels in its highly-salted convenience foods and lobbying to curb the efforts of enlightened campaigners. And for too long, the drug companies have been allowed to provide 'sweeteners' of one sort or another to interested parties so that prescription medications have more and more been partrayed as a rational solution to health problems that are actually dietary or lifestyle in origin, rather than medical.

A change of heart and a change of philosophy would reap rich rewards in health and financial cost savings, in my opinion. If you, Dear Reader, feel in need of a tonic and have not already reduced your salt intake, why not try doing so? Sodium reduction brings a host of health benefits in its train.

COLLEGE INSURANCE RATES

The acceptance letters are in, decisions are being made and another horde of parents is getting ready to send children to college in the fall.

If you're part of that wave, here's an important item for the to-do list: make sure your child has the right kind of health insurance.

The task used to be fairly straightforward. Most group health plans have traditionally allowed dependent children to stay on a parent's policy until the age of 23 or, in some cases, 25, if the child is a full-time student.

That's still typically the case. But with so many people losing jobs and, in turn, health benefits, counting on employer-sponsored health insurance isn't the automatic default it once was -- as Rich Costigan knows all too well.

Costigan, a construction worker in Royal Oak, Mich., and his wife, Karen, have a son in college and a daughter who will start in the fall. The construction company Costigan worked for recently went out of business. He still has six months' worth of health benefits banked with his union, and he will be eligible for coverage for up to 18 months through Cobra after that.

But on the chance that Costigan might be out of work for an extended period, the couple is looking for alternatives for both children, including individual policies and the college-sponsored health plans at the students' colleges. Their son, Greg, goes to Wayne State University in Detroit. Their daughter, Kristin, plans to attend Grand Valley State University near Grand Rapids, Mich.

"We have a lot of research to do yet," Costigan said. "We're still trying to get our minds around the situation."

As the Costigans and countless other parents research their options, the main goal should be making sure a student has enough coverage to pay for a serious injury or sudden illness, according to Dr. James C. Turner, director of the University of Virginia's department of student health and president-elect of the American College Health Association.

"You don't want your child to run out of coverage, rack up medical debt and risk becoming uninsurable just when he or she is starting out in life," Turner said.

Because college-age people are young and most often healthy, they're likely to be tempted to fly without a medical safety net. That may be why 20 percent of traditional-age college students don't have health insurance, according to the Government Accountability Office. "The reality is, accidents and illnesses do happen, even to young people," said Denny Ebersole, an insurance broker in New Orleans and board member of the National Association of Health Underwriters.

So make sure your college student is protected from that youthful sense of immortality.

RECHECK BENEFITS: "Employers have been steadily scaling back dependent benefits to cut health care costs," said Steven DeRaleau, chief operating officer of HumanaOne, the division of Humana offering coverage for students and recent college graduates.

If you're lucky enough to have employer-sponsored insurance, your first step is to make sure you can keep a full-time student on your policy. Even some people who could last year might not be able to this year.

VERIFY COVERAGE: If you are covered under a network-style plan like a health maintenance organization or preferred provider organization, and if your child is attending school away from home, you'll need to ask some questions. This applies whether you have employer insurance or an individual policy.

Call the insurer to learn whether there are network-affiliated doctors and other health care providers close to your child's school. If not, ask whether out-of-network providers are at least partly covered by your plan and what percentage of their fees you'll be expected to pay. Finally, if your child needs specialized care while away, will he or she need to get a referral from a hometown physician, or can the student receive a referral from a physician near campus?

Because most plans cover out-of-network care in full in emergencies, parents can usually work out these details, especially because most colleges offer student health services that can help take care of routine medical needs. For students with a chronic illness, though, attending a college beyond the network coverage area may pose challenges.

THE BIG LOOPHOLE: Group health care policies that cover full-time students often come with a huge loophole, warns Sandy Praeger, the insurance commissioner of Kansas and chairwoman of the National Association of Insurance Commissioners' health insurance committee. If an injury or illness forces the student to take a leave from school or cut back on classes, some policies consider that student no longer full time and thus no longer eligible for coverage.

Starting this October, when the federal Michelle's Law goes into effect, all group insurance plans must cover students on medical leave for up to one year. The law is named for Michelle Morse, a student in New Hampshire who died of colon cancer in 2005. She had continued her full college course load throughout her treatment, so she could keep her health insurance.

Despite the new layer of protection, many insurance brokers and agents may still be unaware of Michelle's Law -- or pretend to be -- and may encourage you to buy additional coverage to protect against this loophole. This is something you probably will no longer need to do, Praeger said.

But you do want to ask exactly how your insurer defines "full-time student." You don't want your child to lose coverage because he or she happens to take a light load one term.

INDIVIDUAL POLICIES: If you don't have a group insurance option, you'll need to shop for an individual policy for your child. Because college students are usually young and healthy, premiums for fairly comprehensive coverage are relatively low.

And this is one actuarial category, according to Ebersole, in which plans with high annual deductibles are not significantly cheaper than traditional coverage. But there is at least one situation in which a high-deductible plan may be a good option for a student: if the family is already covered under a high-deductible policy that is linked to a tax-advantaged health savings account to pay out-of-pocket health expenses.

The Internal Revenue Service allows parents to use such accounts for a dependent full-time student. The extra tax break can make insuring your child under a high-deductible plan worthwhile, Ebersole said.

One place to look for such an individual policy is a Web site like eHealthInsurance.com.

COLLEGES' PLANS: More than half of all colleges offer their own health policies for students. But the provisions vary widely, so be cautious.

Some limit the number of doctor visits, prescription drug coverage and length of hospital stays. The maximum benefits on these plans can also be extremely low, like \$2,500 per condition per year to \$1 million per lifetime, according to the G.A.O.

"It varies from state to state and college to college," Praeger said. "Limited coverage is still better than no coverage, but it's important for parents to understand these limitations before they sign up."

OUT OF COVERAGE

Maggie Walmsley was heading home from class at Cabrini College recently when her stepmother called with some graduation advice.

"She told me, 'You can't mess with your future, because our insurance company has your information, and once you graduate, you're off,' " says Walmsley, 21, of Drexel Hill.

Walmsley, who will graduate Sunday with a psychology degree, could stay on her parents' health insurance if she went for a master's degree. "My parents said I better get into graduate school. I'm covered by their insurance if I stay in school."

As commencement ceremonies get under way, graduates have more to worry about than a lousy job market. Graduation often marks the end of insurance coverage for young adults under their parents' employer-sponsored plans. Even graduates lucky enough to find jobs could end up in positions that don't provide health benefits.

Stefanie Swanson, 21, of Doylestown, who is graduating from Villanova University, recently caught up on her medical checkups in advance of her graduation - and loss of coverage - later this month. "I won't be covered by the end of May," she says. "Hopefully, nothing will happen between now and when I get a job."

Adults between the ages of 19 to 29 are among the largest and fastest-growing groups of uninsured people in the country, totaling 13.2 million in 2007, according to the Commonwealth Fund, a nonprofit research group.

Many young people lose coverage at 19 or when they graduate from high school. That's when they become ineligible for their parents' plans or for government programs, such as Medicaid and the Children's Health Insurance Program. Lower-income young people are hit especially hard.

The next big coverage drop occurs at college graduation.

"With the downturn in the economy, young people may now be even more vulnerable," says Sara Collins, an assistant vice president at the Commonwealth Fund. The unemployment rate for 20- to 24-year-olds reached 14.7 percent last month, up from 9 percent the year before, and "we know that when unemployment goes up, the number of uninsured goes up."

Young people can buy individual policies for \$40 to \$100 a month, but even a low-cost policy may be a stretch for someone who is working an entry-level job and has student loans. And some young people simply don't see the need for health insurance.

While young adults are generally healthy, they're at risk for serious problems, including accidents that land them in emergency rooms, and HIV and other sexually transmitted diseases. Chronic health problems, including obesity, high blood pressure, and diabetes, are on the increase among young people.

Lateefah Holder, 23, a Temple University senior and theater major, knows firsthand the steep cost of living without insurance. She lost coverage under her parents' plan three years ago after she became a part-time student. When she got the flu last year, she passed out, hit her head, and was hospitalized with a concussion. She's graduating this month with \$5,000 in medical bills, along with \$80,000 in college loans.

"At this age, you never think something is going to happen to you," says Holder, who is from Bloomfield, N.J., "but you're wrong."

Courtney Hope, 22, an aspiring screenwriter who graduated from New York University last year, has had no health insurance since August. She earns \$400 to \$500 a week working as a waitress and doing freelance work, but pays \$750 a month in rent and has little money left after buying food and other necessities. She knows many other young people in the same situation.

"They don't go to the doctor, they use herbal supplements, they use the Internet as their doctor," she says. After losing her insurance, Hope, who is from Allentown, stopped getting acupuncture treatment for headaches.

Some states are trying to help young adults stay insured. About half the states have enacted legislation that requires insurers to extend coverage to young adults under their parents' or guardians' plans, even if they don't attend past high school.

"Since 2006, we've seen an exponential increase in the number of states that have passed these types of laws," says Laura Tobler, a health-policy analyst at the National Conference of State Legislatures, which tracks legislation.

Tobler says the state laws typically allow for coverage of unmarried dependents up to age 25, though the age extension rises to 30 in a few states. The laws apply to group plans that are subject to state regulation, as well as to individual policies in some states. It's up to parents to decide whether to keep an adult child on their policy, she says.

New Jersey has had a law since 2006 that extends coverage to age 30, and recently raised the limit to 31. About 15,000 young adults have benefited from the extended coverage (which also applies to the benefit plan for state employees), including 10,000 who are currently getting coverage, says Edward Rogan, spokesman for the state Department of Banking and Insurance.

In Pennsylvania, a bill to extend coverage for dependents to age 30 passed the House in March and is in a Senate committee.

"This is one of these commonsense measures that doesn't solve the health-care crisis, but it does provide a solution for some of the uninsured," says Rep. Mark Longietti (D., Mercer), who is sponsoring the bill.

But Ross Schriftman, an employee-benefits consultant at Kistler Tiffany Benefits in Berwyn, which sells group and individual insurance, says the laws, while broadening coverage, may shift the cost to employers or parents, who could end up paying higher premiums.

In any case, he says, young people should learn how to take care of themselves.

"Some parents have never taught their children to be self-reliant," Schriftman says. He says it's far better for young people to buy low-cost plans and learn how to manage health-savings accounts, allowing parents to save for their own health problems in old age.

Many insurers are targeting new graduates by marketing to their parents or by advertising on the Internet. Their message: Insurance can be affordable.

Independence Blue Cross, for instance, offers its Keystone HMO program starting at \$76 per month.

Aetna offers individual plans to people ages 25 to 29 for as little as \$41 a month, but prices can vary based on many factors.

Low-cost products can protect against a catastrophe but may come with large deductibles. Consumers need to understand what they're buying, experts say.

Some parents may also be caught off guard when they realize their child is going to lose coverage. Kathy Staller, an executive secretary in the Philadelphia Law Department, says she panicked when she received notice from Independence Blue Cross that her son, Nicholas, who turned 23 in March, would be cut off from coverage May 1.

"God forbid if he got into a car accident," Staller says. She says her son, a business-finance major at Temple who recently lost his part-time painting job, could not afford a policy on his own. So she applied to enroll him in a basic Keystone HMO plan.

Temple senior Kevin Paris, 22, of Blakely, near Scranton, says his parents are insisting he get an interim policy to cover the few months when he's off their insurance plan but not yet covered through his teaching job with Teach for America in Mississippi.

"Both my parents are very adamant about me signing up for a private plan, while I'd be more willing to risk it," says Paris. He says he'll probably take his parents' advice. "As they put it, it's better to have it than not have it."

HEALTH INSURANCE DECISIONS

While some seniors are entering graduate school after graduation, many will no longer be full-time students, making them ineligible for health insurance from companies.

"If insurance companies had their way, they would only insure healthy people," said Anita Vogely, an adjunct in the health and physical education department. "That way they could make as much money as they can without having to pay anything at all."

Graduating seniors are often left with only two insurance options.

"One option is to remain uninsured," Vogely said. "The other is to find an insurance plan that fits your personal needs."

Being uninsured means you are taking a chance, she said. "You never know what your medical needs will be in the future."

There are many different health care options available and graduates need to do their own research to find a plan that's right for them.

While researching, students will need to look at the company's policy and their own state of health, Vogely said.

"Students should assess what health risks are likely to affect them," she said. "Medications for certain allergies and other ailments can end up costing students a lot of money if they are not covered."

According to Vogely, as students start to age they become a greater risk to insurance companies.

"It tends to be easier to change or improve health coverage if you already have it," she said. "If you have been paying premiums throughout your life, insurance companies may consider you a worthwhile economic risk."

Many students are covered by their parents' health insurance, which will insure them as long as they are enrolled in a school as a full-time student.

"Last year I went home for medical reasons and my health insurance agency was informing me that I would not have health insurance for legal reasons," Gabrielle Federici, a senior English and creative writing major said. "It's a paradox that if you have to go home for medical reasons, you might not have medical coverage."

"My parents were freaking out because my medical bills were so high," she said. "They did not know if they could pay for it if I wasn't covered."

Zach Zelter, a senior English major, said he thought there should be an adjustment period until graduating seniors get settled and find a source of employment.

"Until I get a job, I have to buy health insurance and it sucks," he said.

There are certain requirements for students to be covered under an insurance policy, said Maggie D., a representative of UnitedHealthcare Student Resources who for legal reasons chose not to give her full name.

"After graduation you no longer meet the eligibility requirements for some insurance policies," she said. "In order to remain under some insurance policies, a student must actively attend classes for a certain number of days and have a certain number of credit hours."

Usually, she added, a student graduates and gets a job that allows them to pay insurance through an employer. Knowledge of family health history is also important when applying for health insurance. "Health risk factors can be passed on genetically and these risks need to be considered while selecting the appropriate plan," Vogely said.

Vogely advised students to have a discussion with their parents before selecting a health insurance policy. "Your parents have been dealing with insurance issues for a long time and probably have knowledge about them."

If students find a job that covers health insurance they may be set, Vogely said.

"Some companies will cover only some health expenses," she said. "An example is that some companies will cover medical but not dental."

Women also have the option of going to Planned Parenthood if they do not have full health insurance coverage.

"They provide women with some basic gynecological services such as contraception, basic testing and wellness needs, such as Pap smears," Vogely said. "This service is a great option for women who may not be employed to get some of the services they need."

MICHIGAN HEALTH REFORM

Insurance companies would be prohibited from rejecting the sick or elderly -- or hiking their rate -- and state health coverage would be expanded for children, under a package of proposed health care reforms unveiled by House Democrats today.

The package would guarantee health care access to all Michigan citizens. The plan also would rein in the skyrocketing cost of health care by creating a catastrophic health care fund to protect the sickest individuals.

[[State Democrats unveiled a new health care plan Monday. The plan would expand Mi-Child... the state's health care program for kids, and would call on insurance companies to contribute to a catastrophic protection plan to aid patients whose medical claims exceed 25-thousand dollars a year. Representative Mark Meadows said, "The bottom line is it's unacceptable for insurance companies to deny coverage to people or jack up their rates because they're sick, and in Washington we know the federal government is talking about this, and in Michigan we've been very lucky." The Democrats' plan will compete with Republican legislation which is supposed to be introduced in the State Senate within the next week. Sponsors of the GOP proposal say it will focus on helping more than 1.2 million people in Michigan who don't have health insurance.]]

"Our plan requires all insurance companies to guarantee health care coverage to Michigan citizens, and ends the outrageous practice of insurance companies refusing to cover the sick or elderly," House Speaker Andy Dillon, D-Redford Township, said in a statement released this morning. "Health care reform is too important to wait for Washington to act -- we need to take action here in Michigan to guarantee access to protect each and every Michigan citizen."

The house bills would:

- Guarantee access to health care by requiring insurance companies to cover people who have pre-existing conditions, such as diabetes or cancer.
- Prohibit insurers from raising rates on individuals who become sick.
- Ban unfair market practices like cherry picking the healthiest individuals to cover, which drive up insurance rates and prevent some of the most vulnerable residents from obtaining care.
- Expand the state's MIChild program to help cover every child in Michigan.
- Create the Michigan Catastrophic Protection Plan (MICAPP) Fund to rein in the soaring cost of health care and protect the sickest individuals.

The plan comes at a time when thousands of workers are losing their jobs and employer-based health care coverage -- putting them at risk of being rejected for new insurance plans due to pre-existing conditions.

Michigan's unemployment rate is 12.6 percent, the highest in the nation, and more than 1.1 million state residents are uninsured.

HEALTH INSURANCE MARKET CHANGES

One of the centerpieces of legislation to reform the individual health insurance market that Rep. Marc Corriveau, D-Northville, will introduce this week is the creation of a catastrophic insurance fund to reimburse health insurers for claims larger than \$25,000.

The catastrophic, or reinsurance, pool would be funded by assessments on health insurers that write policies in the individual market, including Blue Cross Blue Shield of Michigan, said Corriveau, chairman of the Michigan House Health Policy Committee.

"I have spoken with hospitals, physicians, insurers and consumers, and everyone agrees we have a problem in the individual market that we need to solve," said Corriveau, who last year was chairman of a House-Senate conference committee that tried to craft a bipartisan solution to individual market reform.

Last December, the Legislature failed to reach a compromise on two bills that would have reformed the individual health insurance market. A coalition of competing health insurers, unions and consumer groups opposed the bills that were supported by Blue Cross, which writes more than half of the state's individual market policies.

“We need a broad-based solution because we have a big problem,” said Corriveau. “We also will do something about rising costs and uncompensated care. The unemployed and underinsured are going to hospitals and driving up health care costs. Companies and individuals have to pay higher insurance costs because of it.”

Sen. Tom George, R-Kalamazoo, also has a plan. He is developing legislation that includes a basic benefit package that all insurers would be required to offer. George's proposal also would be funded through assessments on health insurers, third-party administrators and from various state government programs.

Both George and Corriveau want to reduce Michigan's growing number of uninsured — now about 1.2 million, or about 12 percent of the state population.

Corriveau said his bill will create a Michigan Catastrophic Protection Plan, or MCAPP, that would reimburse insurers for claims they pay greater than \$25,000.

“Individuals fear they will be rejected by health insurers. This bill will reduce the problem because the pool will reimburse carriers for catastrophic losses,” Corriveau said.

Under Corriveau's plan, the Office of Financial and Insurance Regulation would collect assessments on insurers based on the percentage of individual market premiums they collect.

David Waymire, a spokesman the Michigan Association of Health Plans and Put Michigan People First, a coalition of insurers, seniors and the disabled, said any insurance company assessment should be broad-based and include self-insured employers such as General Motors Corp. and Ford Motor Co.

“If the goal is to reduce uncompensated care, GM should pay in, because they stand to benefit from the reduced costs,” said Waymire, an executive with Martin Waymire Advocacy Communications in Lansing. “The broader the (assessment) pool, the lower everyone will pay and the fairer it will be.”

Corriveau said his bill also will prevent insurance companies from rejecting people who apply for coverage for any individual product they write. Currently, only Blue Cross, as the insurer of last resort, is barred from rejecting applicants.

“This will spread the risk in the marketplace and reduce cherry-picking” where some insurers choose to insure healthier individuals, Corriveau said. “This should drop prices by 20 percent for the entire market.”

Andrew Hetzel, Blue Cross vice president for corporate communications, declined to comment for this story.

Hetzel previously has said health insurance reform must be comprehensive and address “cherry-picking in the market by for-profit commercial insurers.”

Corriveau said the legislation also will prevent insurers from charging higher premiums for health factors, he said.

Corriveau said the legislation should help Blue Cross minimize its losses in the individual market. Last year, Blue Cross lost \$133 million in the individual market and projects even larger losses in 2009.

“If Blue Cross writes more policies for people who have claims of greater than \$25,000, they will receive more in return,” he said.

Corriveau also wants to expand the state's safety net program and reduce the number of the uninsured by creating a Health Affordability Fund.

By assessing Blue Cross and other nonprofit health insurers the annual value of their tax-exemption, Corriveau said the MIChild program, which provides health insurance to children under age 19 who are not eligible for Medicaid, could be expanded and subsidies made available for low-income people to purchase health insurance.

“Blue Cross' annual tax-exempt value is \$100 million, and the nonprofit health insurers' tax-exempt value is \$60 million,” Corriveau said. “This amount would be used to contribute into the fund on an annual basis.”

Corriveau estimated that the funding would be enough to cover all uninsured children in Michigan and provide funding to encourage the approximately 600,000 low-income people without insurance to buy individual policies.

Debbie Lantzy-Talpos, head of Aetna's Michigan market, said the key issue in Michigan is to provide an insurance program for the 15 percent to 20 percent of people seeking insurance who have high-risk medical conditions.

“Those folks need a separate solution, because they drive up prices for everyone else,” said Lantzy-Talpos. “It will take a source of subsidy to give those folks access to coverage, because some have overwhelming medical needs.”

The bills also would require all health insurers to offer three individual products: a health and wellness plan, a basic benefit package and an enhanced benefit package, Corriveau said. The benefits would include outpatient, inpatient, pharmacy and other services.

Corriveau also said the bills will require insurers to offer discounts for people who don't smoke and who maintain proper body weight.

Several other bills also will be introduced to address rising health care costs.

For example, one bill will require physicians to use electronic prescribing to order medications for their patients. Another would require individuals to fill out advance directives when they renew or apply for driver's licenses. Advance directives instruct doctors and hospitals what to do if a patient faces a life-threatening problem.

Another bill will help the state Medicaid program investigate and prosecute provider and member fraud.

Felicia Wasson, associate state director of government affairs with AARP Michigan, said Corriveau's bill has several good components that AARP could support.

“AARP believes that the use of a reinsurance mechanism will assist in coverage of high-cost claims that may be exhausted by the basic health care package,” said Wasson in a letter to Corriveau.

Corriveau said the bill also contains important consumer protections that include:

- Replacing 12-month pre-existing condition waiting periods with six-month waiting periods for all consumers in the individual market.
- Limiting commercial insurers from using health status as a rating factor.
- Prohibiting insurers from raising rates at renewal when a person becomes ill.
- Narrowing the range of rates a carrier can charge consumers.
- Protecting women in the individual market from gender discrimination. The bill would prohibit insurers from considering a person's gender when setting rates.
- Enabling the insurance commissioner to order rate refunds to consumers if their insurer is making excessive profits.

GAY COUPLES & HEALTH INSURANCE

“IT’S not easy being gay,” said Mary Jo Hudson, director of the Ohio Department of Insurance. She wasn’t referring to political opposition and other obstacles, but the plight of same-sex couples who are trying to get and keep health insurance.

Mary Jo Hudson, director of the Ohio Department of Insurance, is familiar with the difficulties in getting health insurance for a gay partner.

“You’ve got to go through a lot of hoops,” said Ms. Hudson, who is gay and has lived with her partner for eight years.

Same-sex couples have been making headlines; Maine followed the lead of Iowa and Vermont this week in legalizing same-sex marriage, and several other state legislatures are now considering it. But Ms. Hudson says that fairer and more comprehensive health care coverage for partners — whether they are legally married or not — is not necessarily part of the package.

“For the vast majority of gay couples,” she said, “getting health insurance for a domestic partner is still a challenge.”

Currently about one-third of companies with more than 500 employees offer domestic partner benefits. That’s up from about 12 percent in 2000, according to a study from Mercer, an employee benefits consulting firm. But the percentage drops off sharply when smaller employers are counted, Ms. Hudson said.

And there is no provision for domestic partner benefits for federal employees, although there are some legislative efforts to change that. Some states and municipalities offer their employees domestic partner coverage, depending on the state laws.

Even if the relationship is formalized with the state in a marriage or union, that does not always obligate the employer to cover a same-sex spouse. For one thing, self-insured employers are not regulated by the states.

And other benefit-providing employers that choose not to offer such coverage can sometimes use the Defense of Marriage Act — a law that forbids the federal government to recognize same-sex marriage — to trump state laws, said Ilse de Veer, a principal with Mercer.

On the flip side, self-insured employers are free to offer domestic partnership benefits, whether or not a state recognizes unmarried relationships. And some employers limit their domestic partner benefits only to homosexual couples, on the rationale that heterosexual couples can get married, while in most states gay couples still cannot.

If you're part of a same-sex couple and you're fortunate enough to work for an employer that will provide coverage for your partner, the process can still be cumbersome and costly. Here are some of the basics.

DOCUMENT YOUR RELATIONSHIP Many employers and insurance companies require proof of a domestic partnership before you can qualify for benefits. One of the most common documents is an affidavit signed by both partners, explaining the details of the relationship. For more information on what needs to be included in an affidavit, the Web site insure.com offers a check list. You may also need to provide copies of jointly signed leases, homeowners' insurance policies, joint bank account statements and other legal documents that show the two of you live together and are financially intertwined.

Many states, counties and cities, including New York City, have domestic partnership registries where unmarried couples can legally register their relationships. Registration is not the same as a marriage certificate, but it is a good way to prove the legitimacy of your relationship to employers and insurers, Ms. Hudson said.

PREPARE TO PAY MORE TAXES Unlike married couples, domestic partners must pay federal and sometimes state taxes on health care benefits. That's because the Internal Revenue Service counts the value of the domestic partner's benefit as income for the employee. What's more, pretax dollars from an employee's flexible spending accounts or health savings accounts cannot be used to cover the domestic partner's benefits.

Let's say, hypothetically, that the cost for a partner benefit is \$10,000 a year, and the employee is at the 40 percent marginal tax bracket. In addition to the share of premiums the employee pays, he or she would pay about \$300 a month in taxes.

"That really adds to the cost of the benefit," Ms. Hudson said. "It may be why so few couples take advantage of domestic partner benefits when they are available."

She cited a Williams Institute study that shows unmarried partners are two to three times more likely to be uninsured than married people.

Ms. Hudson says that in rare cases, companies have been willing to increase employees' paychecks to make up for the extra tax burden. So be sure to ask your human resources department about this.

A POSSIBLE TAX EXCEPTION For some people, there may be a way around the tax bind.

If your partner lives in your household for the entire tax year, receives 50 percent of his or her support from you and generally meets the criteria laid out in section 152 of the tax code, then you are legally entitled to receive domestic partnership health benefits tax-free. A lawyer or accountant well versed in domestic partnership law can help determine if you're eligible for this break.

"This break is confusing and misunderstood because it is a special exemption for health care benefits only," said Ms. de Veer. "Employers don't always understand this part of the code themselves, so they often fail to tell employees about it. Lots of couples are paying taxes on health benefits that don't have to."

To determine if your partner receives 50 percent support from you, fill out the worksheet on page 33 of I.R.S. Publication 17, at www.irs.gov/pub/irs-pdf/p17.pdf

COVERAGE FOR CHILDREN Most employers that cover domestic partners also cover the children of that partner, considering it a parental relationship on the employee's part, even if it has not been formalized legally.

With individual policies, though, depending on the insurer, you may have to prove you are a legal custodian of your partner's child, said Ms. Hudson.

"Filing for custody rights is probably something you should do anyway," advises Ms. Hudson. "You'll need that document for everything from signing school permission slips to getting health benefits."

WHAT ABOUT COBRA? If you are covered under your partner's employer-sponsored insurance, and your partner is then laid off, many firms will offer you the opportunity to buy the same health care coverage for up to 18 months under the federal law known as Cobra. If the relationship ends, you may also be able to elect Cobra coverage, just as you would if you were divorcing.

Because Cobra is a federal law, employers are not obligated to offer this coverage to unmarried partners, but many do, says Ms. de Veer. As with all Cobra coverage, you must be sure to make the election within 60 days of the last day of coverage under the employer's plan.

Paul Krugman -- Is this the end for Harry and Louise?

Harry and Louise were the fictional couple who appeared in advertisements run by the insurance industry in 1993, fretting about what would happen if “government bureaucrats” started making health care decisions. The ads helped kill the Clinton health care plan, and have stood, ever since, as a symbol of the ability of powerful special interests to block health care reform.

But on Saturday, excited administration officials called me to say that this time the medical-industrial complex (their term, not mine) is offering to be helpful.

Six major industry players — including America’s Health Insurance Plans (AHIP), a descendant of the lobbying group that spawned Harry and Louise — have sent a letter to President Obama sketching out a plan to control health care costs. What’s more, the letter implicitly endorses much of what administration officials have been saying about health economics.

Are there reasons to be suspicious about this gift? You bet — and I’ll get to that in a bit. But first things first: on the face of it, this is tremendously good news.

The signatories of the letter say that they’re developing proposals to help the administration achieve its goal of shaving 1.5 percentage points off the growth rate of health care spending. That may not sound like much, but it’s actually huge: achieving that goal would save \$2 trillion over the next decade.

How are costs to be contained? There are few details, but the industry has clearly been reading Peter Orszag, the budget director.

In his previous job, as the director of the Congressional Budget Office, Mr. Orszag argued that America spends far too much on some types of health care with little or no medical benefit, even as it spends too little on other types of care, like prevention and treatment of chronic conditions. Putting these together, he concluded that “substantial opportunities exist to reduce costs without harming health over all.”

Sure enough, the health industry letter talks of “reducing over-use and under-use of health care by aligning quality and efficiency incentives.” It also picks up a related favorite Orszag theme, calling for “adherence to evidence-based best practices and therapies.” All in all, it’s just what the doctor, er, budget director ordered.

Before we start celebrating, however, we have to ask the obvious question. Is this gift a Trojan horse? After all, several of the organizations that sent that letter have in the past been major villains when it comes to health care policy.

I’ve already mentioned AHIP. There’s also the Pharmaceutical Research and Manufacturers of America (PhRMA), the lobbying group that helped push through the Medicare Modernization Act of 2003 — a bill that both prevented Medicare from bargaining over drug prices and locked in huge overpayments to private insurers. Indeed, one of the new letter’s signatories is former Representative Billy Tauzin, who shepherded that bill through Congress then immediately left public office to become PhRMA’s lavishly paid president.

The point is that there’s every reason to be cynical about these players’ motives. Remember that what the rest of us call health care costs, they call income.

What’s presumably going on here is that key interest groups have realized that health care reform is going to happen no matter what they do, and that aligning themselves with the Party of No will just deny them a seat at the table. (Republicans, after all, still denounce research into which medical procedures are effective and which are not as a dastardly plot to deprive Americans of their freedom to choose.)

I would strongly urge the Obama administration to hang tough in the bargaining ahead. In particular, AHIP will surely try to use the good will created by its stance on cost control to kill an important part of health reform: giving Americans the choice of buying into a public insurance plan as an alternative to private insurers. The administration should not give in on this point.

But let me not be too negative. The fact that the medical-industrial complex is trying to shape health care reform rather than block it is a tremendously good omen. It looks as if America may finally get what every other advanced country already has: a system that guarantees essential health care to all its citizens.

And serious cost control would change everything, not just for health care, but for America's fiscal future. As Mr. Orszag has emphasized, rising health care costs are the main reason long-run budget projections look so grim. Slow the rate at which those costs rise, and the future will look far brighter.

I still won't count my health care chickens until they're hatched. But this is some of the best policy news I've heard in a long time.

INSURANCE FOR NEW GRADUATES

My daughter is graduating from college this month, but she hasn't found a job that offers health insurance. Can she stay on my policy?

It depends on where you live. In the past, children were generally dropped from their parents' health insurance when they turned 18 or 19, or when they graduated from college. But more than 20 states now require insurers to cover dependent children on their parents' policies until the kids are in their mid twenties -- and sometimes up to age 30 -- even after they've graduated. It's one way that the states hope to cut down on the large number of uninsured people in that age group.

The new rules were designed to help in situations like your daughter's, and many other graduates will likely have similar experiences as they struggle to find a job with health benefits in this economy. To qualify for the extended coverage, adult children generally must be unmarried and live in the same state as their parents. But they usually don't have to live with their parents or even be considered dependents for tax purposes to qualify (the rules vary by state). For a list of each state's laws, see the National Conference of State Legislatures Web site.

In many states, you may not need to pay extra to keep an adult child on your policy if you would have kept a family policy anyway to insure younger siblings. But if the insurer bases premiums on the number of children, or if you're insuring only one child and could otherwise switch from family coverage to rates for a single person or a couple, it's important to compare that extra cost with the price of buying an individual policy for your daughter.

If she's healthy and lives in a state with a competitive health-insurance marketplace (not New York or New Jersey), then she could get a better deal on her own. In many states, healthy people in their twenties can purchase insurance on their own for less than \$100 per month. Go to eHealthInsurance.com or find an insurance agent in your area through the National Association of Health Underwriters.

A good way to lower the price for healthy young adults is to buy a high-deductible policy and pair it with a health savings account. Your daughter can make tax-deductible contributions to the account and use the money she saves tax-free for out-of-pocket medical expenses (see Health Savings Account Answers for more information). You can give your daughter money to make the HSA contributions, if you'd like. Even if she eventually gets a job with health insurance, she can keep the money she's already contributed to the HSA and use it for out-of-pocket medical expenses at any time.

If your daughter has any medical issues, though, she might have a tough time finding an affordable health-insurance policy on her own. In that case, keeping her on your policy may be your best bet. And if she still doesn't have insurance after reaching the cutoff age (often 25), then she may be able to remain on your policy for up to 36 months through COBRA, a federal law that requires employers to continue coverage of former employees and family members after they are no longer eligible for group insurance (former employees can keep health insurance through COBRA for up to 18 months after they leave their jobs).

The price will jump significantly under COBRA, however, because your daughter will need to pay the entire price of coverage herself -- there's no employer subsidy after she no longer qualifies as a dependent (and there's no government subsidy, either -- that only applies to certain people who have been laid off).

Even if you think your daughter might get a good deal on her own coverage, it's important to apply for a policy before she loses eligibility under your policy or to sign up for COBRA while she shops around. You can always drop the COBRA coverage if she finds other insurance later, but it's important not to lose the opportunity to have that as a backup.

Keep in mind that COBRA applies only to companies with 20 or more employees (although some states have COBRA-like rules for smaller companies), and COBRA is discontinued if the employer stops offering health insurance to its employees or goes out of business. See [What Happens If Your Employer Goes Broke?](#) for more information.

INDIVIDUAL HEALTH INSURANCE

If you are an individual living in Texas you may want to make sure that you have health insurance. According to studies there are 1 in 4 people living in Texas without health insurance, this is a huge number even compared to the average of the United States which is 1 in every 6 people in uninsured. There are many complications that can arise as a result of not having health insurance. One of the biggest complications is the cost of medical bills if something were to happen to you or a loved one. The cost of medical bills can be devastating to an individual if they get injured and they don't have health insurance.

One of the most common reasons why people across the United States do not have insurance is because they have lost their jobs. Not only is the economy struggling but people are struggling financially and they have to choose between putting food on the table and insuring their family. Many of these people who have lost their jobs have lost the insurance that goes along with the job, and even if they haven't lost their job many people have not opted to get insurance from their company because the cost for coverage is taken out of their paycheck, and when they are trying to make ends meet it isn't a huge priority.

Another reason why people are not being covered by individual health insurance in Texas is because Medicaid is cutting costs and as a result people are being dropped from their Medicaid plans which may be the one thing that was helping them afford health insurance, without help from Medicaid many people are unable to pay for coverage. Many of the people who are being dropped from Medicaid are adults who are enrolled, the worst part about this lost coverage is that it is by people who are really dependant on Medicaid for coverage because they are in low-income homes. If these people get injured or get sick without coverage they are in a very bad situation because most of them will not be able to afford coverage without help. This is a very unfair situation because they are stuck in the middle, they can't afford coverage but at the same time they can't afford to not be insured.

One of the ways that people in the state of Texas are dealing with this crisis is by purchasing individual health insurance in Texas. For people who are looking to be insured individually there are many options for low cost insurance and one of the ways that most people purchase insurance is through Individual health insurance Texas. These plans are typically inexpensive and can be purchased easily no matter where you live in Texas whether you live in one of the big cities or if you live in rural areas.

Ronnie Hamilton shares his knowledge on health insurance that makes you able to find the plans that best fits your needs. If you want to know about Affordable health insurance, affordable family insurance, Individual health insurance Texas and Georgia health insurance visit our quote page.

INSURING CHILDREN

In all the fuss and fear over the swine flu pandemic, it is wise for everyone to take some commonsense precautions. One of the best is to see a doctor if you or your child has the symptoms of the flu.

Good advice, but for an estimated 1.5 million children in Texas that simply can't be followed. You see, they have no health insurance and their parents simply cannot afford to pay for a visit to the doctor or for any medication that might be prescribed.

Texas has the highest rate of insured children in the country, as well as the lowest rate of employer-sponsored health coverage in America. That isn't something to be proud of.

Too often, uninsured Texans are forced to go to the emergency room for care. That can be expensive -- for the rest of us. According to a study by the Harris County Hospital District in Houston, treating a child's mild asthma attack costs about \$100 in a doctor's office. But if that child goes to the emergency room, the cost soars to \$7,300.

And who pays that bill? The rest of us who use the hospital, or at least the insurance companies that pay the bills. As a result, private health-care premiums are 13 percent higher to help pay for treatment of the uninsured. In addition, local property taxes must be higher to pay for county reimbursements to local hospitals for charity care.

There is a solution available right now: Medicaid and the Children's Health Insurance Program, or CHIP. Medicaid provides coverage for the poorest of the poor, while CHIP provides coverage for the next tier of children whose families make up to 200 percent of the federal government's shockingly low poverty level.

The Texas Legislature is working on the state budget for the next two years and it is critical that adequate funding for CHIP and Medicaid be included. Both the state Senate and state House have included funding for the programs in their budget bills, but they differ considerably and a compromise acceptable to both sides must be worked out in conference committee.

In addition to our moral responsibility to ensure that all children in Texas have access to adequate medical care, there is a financial incentive to consider as well. For every dollar the state puts into the Children's Medicaid program, the federal government puts in \$1.47. For CHIP, the dividend is even greater: For every dollar Texas spends on the program, the federal government provides \$2.53. But the state has to invest its money first before the federal government pays its share.

There are several aspects of both the House and Senate versions that must be preserved in the final compromise bill. The Senate measure increases payments to health-care providers who see Medicaid and CHIP patients. Keeping that provision would ensure that more doctors would accept those patients.

The Senate bill also includes a critical program to assist families who earn barely more than 200 percent of the federal poverty level to buy into the CHIP program. Keeping this provision could lead to adding 80,000 more Texas children to the roll.

The House version addresses some non-medical issues that hinder the ability of the working poor to enroll. Current regulations require families eligible for Medicaid to re-enroll in the program every six months, while the House bill would extend that to once a year. That is important because it can take up to three months for a Medicaid application to be processed in Texas (it only takes eight days in Louisiana). The House bill would provide adequate staffing for the Health and Human Services Commission to cut down the waiting period to a more reasonable time.

All children in Texas should have access to needed medical care. We are all better off if all children are healthy. Illnesses such as the swine flu will have a harder time spreading if children can see a doctor when they need to.

We all need to let our state lawmakers know that we support CHIP and Children's Medicaid -- and we expect them to do so, too.

HEALTH INSURANCE MOBILIZATION

Tom Barkley knows about the difficulties of dealing with the health care system: As a psychologist, he spends hours billing several dozen insurance companies with different sets of requirements.

But Barkley's dissatisfaction reached a new level a year ago, when his father was dying of lung cancer and he couldn't get straight answers from a health insurer on coverage.

"No one should have to argue with health insurance companies while their father is dying," Barkley said last week. As a taxpayer, he's outraged by the high costs for care and the nearly 50 million Americans without coverage.

He recently joined a local group that is mobilizing support for a federal insurance program for all Americans. That idea recently won the backing of the Republican-controlled City Council, which voted 4-1 vote in support of HR-676 — the National Health Insurance Act, which would create a single-payer system. And the community debate mirrors a national conversation about the state of health care.

The local 676 movement has drawn the support of health professionals, such as nurse Patricia Reed and Dr. George Jolly, as well as past and present city officials and area clergy.

Meanwhile, people opposed to national health care proposals and the creation of a carbon tax to combat global warming have banded together under the name Common Sense. The group started with eight members and has grown to 20, member Wilma Koss said.

Nationalizing the industry will take away individual choices in health care, and could lead to cost rationing by the government and less prospective doctors, Koss said.

"I have not seen a single government program that has saved money," Koss said. "We're trading one set of problems for a worse set."

But health care decisions now are made by the managed care business based on what is most cost effective, advocates of a not-for-profit model say.

What's certain is that costs have exploded. The city operates on a \$37 million budget, and this year has budgeted \$5.2 million for health care costs. That's an increase of almost \$550,000 from last year, and a \$3 million jump from just seven years ago.

Health care costs for the city school district increased to \$12.4 million from \$6.7 million during the same period.

Reformers say the present system is unsustainable, bankrupts families and strains city and school budgets. They support a publicly financed, privately delivered system proposed by Rep. John Conyers Jr., D-Mich., that would expand the existing Medicare program to all U.S. residents. The effort has 75 co-sponsors but is stuck in committee. There aren't enough votes in Congress to pass universal health care, Sen. Charles Schumer, D-N.Y., said in a statement.

"I believe that a single-payer system would be the best way to ensure that all Americans have access to health care, but we cannot let the perfect be the enemy of the good," Schumer said. The best way to increase coverage is to include a public plan option to compete against private insurance, he said.

HEALTH GROUPS

President Barack Obama on Monday called a pledge by health industry groups to shave \$2 trillion from rising costs voluntarily "a watershed event" in a years-long campaign to make coverage available to all Americans.

Their voluntary commitment suggests that these interests, some of which fought President Bill Clinton's health care overhaul attempts in 1993-94, now think that some congressional action is inevitable and want a hand in controlling how they're affected.

"Politically, I think it's a very important event," said Emory University health policy professor Kenneth E. Thorpe. "I think it's realistic. There's no reason why we can't get growth in spending down if we do a lot of the stuff they've talked about."

Industry experts, however, said that the voluntary target won't mean much unless Congress requires some of the cost-containment mechanisms by law.

"Do I have confidence in their ability to deliver? Absolutely not," said economist Paul Ginsburg, president for the Center for Studying Health System Change. "It'll be great if they not only looked into things they can do voluntarily, but also supported concrete efforts, through legislation, that would make sure that these savings are achieved."

Meanwhile, some Republicans who resist Obama's talk of creating a public alternative to private insurance as part of a national health care overhaul suggested that the president was trying to use the new private-sector pledge to create the impression of funding in the absence of a real revenue stream.

"Reining in costs is important," said Rep. Roy Blunt, R-Mo., the chairman of the House Health Care Solutions Group, "but we cannot overlook the fact that this pledge alone doesn't save the federal government any money." Blunt said Americans deserve to know how Obama would pay for a plan that has been estimated to cost more than \$1.2 trillion over a decade, and "we still haven't seen a plan."

A coalition of insurance, hospital and pharmaceutical makers presented their cost-containment plan Monday in a letter to Obama and a private meeting at the White House.

The president, in remarks following the meeting, was careful to characterize the groups' pledge as "complementary to" and "completely compatible with" the effort Democrats are leading in Congress — but not a substitute for it.

"By curbing waste, fraud, and abuse and preventing avoidable hospital re-admissions and taking a whole host of other cost-saving steps, we can save billions of dollars, while delivering better care to the American people," he said.

He said the voluntary pledge was significant, but that "the only way these steps will have an enduring impact is if they are taken not in isolation, but as part of a broader effort to reform our entire health care system."

Key lawmakers, including the chairman of the Senate Finance Committee, Max Baucus, D-Mont., have talked for months about the need for many of the ideas the industry offered Monday.

These include bundling payments to hospitals and doctors, and increasing preventive coverage and coordination of care for people with chronic diseases.

"The times demand and the nation expects that we, as health care leaders, work with you to reform the health care system," said the letter to Obama. It was signed by representatives of the Advanced Medical Technology Association, American Medical Association, America's Health Insurance Plans, the Pharmaceutical Research and Manufacturers of America, the American Hospital Association and the Service Employees International Union.

Still, it's not clear how long the stakeholders' affable attitudes will last.

Health and Human Services Secretary Kathleen Sebelius said that in the private meeting with stakeholders Obama made clear "he wants them at the table" beyond the photo op. However, "once details begin to be identified, that's where tension often begins," said Sebelius, a former Kansas governor and insurance commissioner. "Everybody right now says, 'I want to pass health reform.' An underlying and often unsaid piece of that is, 'as long as it looks like I want it to look.'"

One group promoting comprehensive legislation, the National Coalition on Health Care, issued a statement saying that "voluntary efforts — without legislated requirements and enforcement — have not worked well in the past," and urging legislation that imposes "short-term constraints to slow the rate of increase in reimbursements of health care providers, sooner rather than later."

Ron Pollack, the executive director of the consumer health organization Families USA, said of the voluntary pledge, "I believe they will follow through, but I also think it's important that we get the specifics and enforceability of these promises. You can trust the statements being made and still want a guarantee."

One free-market health care advocate, Grace-Marie Turner, president and founder of the Galen Institute, said the letter released Monday lays out general ideas but not details on how they would be implemented.

"It's a great promise. But I don't see anything here that tells me mechanically how they're going to do it," she said.

And Ginsburg, the economist, said the pledge may be an attempt to do an "end-run around the Congressional Budget Office," which would have to analyze and estimate the cost and savings if the plan was introduced as legislation.

The average cost of family coverage rose 119 percent from 1999 to 2008; that's roughly four times faster than the rate of inflation — 29 percent — during the same period, according to a recent survey by the Kaiser Foundation and the Health Research and Educational Trust.

In 2008, workers paid an average of \$3,354 — about 27 percent — toward the \$12,680 annual cost for family coverage. Workers with single coverage pay about \$721 a year, or about 16 percent of the \$4,704 annual cost of their coverage. Both rates are up about 5 percent from 2007, which is the slowest annual growth rate since the survey began in 1999.

Because of the recession, government experts say the portion of the U.S. economy that's devoted to health-care spending will experience its largest annual increase ever this year. Total public and private health-care spending will go from nearly \$2.4 trillion — 16.6 percent of the gross domestic product last year — to more than \$2.5 trillion, or a projected 17.6 percent of the GDP this year, government experts have predicted.

EXTENDING HEALTH INSURANCE BENEFITS

a comment -- Even if you've done everything you're supposed to do to prepare for a layoff - built up an emergency fund, paid off your credit cards, set up an account on LinkedIn - losing your employer-provided health insurance could demolish your finances. Your health could suffer, too.

While many insurers offer individual policies, they're primarily targeted at the young and healthy. Individuals who are older or have medical problems are often turned down or charged prohibitively high rates.

The economic stimulus package enacted this year seeks to address this problem by lowering the cost of continuing your former employer's health insurance. Unfortunately, many laid-off workers are discovering that they're ineligible for this subsidy. Others may need to take extra steps to demonstrate they're qualified.

Under the federal Consolidated Omnibus Budget Reconciliation Act, or COBRA, laid-off workers can continue their former employer's health coverage for up to 18 months. In the past, participants had to pay 102 percent of the premiums, making COBRA unaffordable for most unemployed workers. The stimulus package subsidizes 65 percent of COBRA premiums for up to nine months for individuals who were laid off between Sept. 1, 2008, and the end of this year. With the subsidy, the average family will pay \$377 a month or \$140 for an individual, according to the Kaiser Family Foundation.

That's still more than most employees pay for insurance while they're working. But if you're eligible for the subsidy, you should try to take advantage of it, says Ron Pollack, executive director of Families USA, a health care advocacy group. Signing up for COBRA will allow you to continue the same coverage you had when you were working, even if you or anyone in your family has medical problems. In addition, it will preserve your ability to get insurance in the future, even if you have a pre-existing medical condition.

Reasons you may be ineligible for the COBRA subsidy:

- Your former employer has gone out of business or terminated its group coverage. These companies are no longer covered by COBRA, says Michael Langan, principal at Towers Perrin, a human resources consultant.
- You lost your job because of gross misconduct or left voluntarily.

However, recently issued guidelines from the IRS "take a very liberal position" on what constitutes involuntary termination, Langan says. For example, if you're unemployed because your employer closed your branch, that counts as an involuntary termination, Langan says, even if your company offered you a job in another part of the country. Similarly, employees who accepted a buyout because their employer said the offer would be followed by layoffs qualify for the subsidy, he says.

The Labor Department has an appeals process for unemployed workers who were denied the subsidy

BI-PARTISON HEALTH PLANS

It's taken a few years for Oklahoma's Republican legislative leadership to embrace an innovative program conceived by the state's Democratic governor for reducing the number of Oklahomans who don't have health insurance.

But GOP lawmakers have finally come around to support Gov. Brad Henry's Insure Oklahoma premium assistance program in a bipartisan coalition that is working to address an issue that concerns Republicans and Democrats alike: health care.

Last week, Henry signed Republican-backed legislation designed to enhance Insure Oklahoma, originally enacted in 2004 to help small businesses provide health care coverage for their low- and middle-income employees and reduce the state's estimated 619,000 uninsured residents.

Funded by revenue from the state's tobacco tax and federal matching dollars, the public-private partnership has enrolled more than 18,000 Oklahomans in employee-sponsored or individual health insurance plans and is signing up new participants at the rate of about 1,000 a month.

GOP lawmakers, some of whom were only lukewarm about Insure Oklahoma when it first was proposed, now say it has gained national notoriety and is being used as a model by other states who are developing their own premium assistance plans.

They say the improvements they proposed will help increase enrollment and make health insurance more accessible while reducing the cost of health insurance plans.

"It's the kind of bipartisanship that gets things done. I think the people of Oklahoma would want that from their elected officials," said Republican House Speaker Pro Tem Kris Steele, who lives in the governor's hometown of Shawnee and worked closely with Henry in developing additions to Insure Oklahoma.

"This is a step in the right direction in reducing the number of uninsured," Steele said. "I feel very fortunate to be able to work with Governor Henry on this issue."

WOMEN STRUGGLE WITH HEALTH CARE

Even before the slowdown in the economy began, women were more likely than men to have trouble meeting rising health-care costs to get the care they need.

So finds a report released Monday by the nonprofit research foundation The Commonwealth Fund.

More than half of women surveyed said they had problems getting care because of cost issues, including skipping a needed medical test, prescription medication or other treatment.

"What it shows is that getting and paying for health care is an even bigger problem for women than for men," said report co-author Michelle Doty, director of survey research for the organization.

The study is based on data from The Commonwealth Fund's 2007 Biennial Health Insurance Survey, which polled more than 3,500 adults aged 19 and older in the United States. The latest findings focus on 2,616 adults, aged 19 to 64.

The survey found that seven out of every 10 working-age American women (64 million women) either had no health insurance, insufficient health care coverage, trouble paying medical bills or a lack of access to needed health care due to cost.

Overall, 52 percent of working-age women surveyed said they had problems accessing needed health care due to costs, compared to 39 percent of men. For example, prohibitive costs meant that women often did not fill a prescription, did not see a specialist when recommended, skipped a test or treatment or follow-up visit that was recommended, or did not see a doctor or other health-care professional even though they had a medical problem.

Medical bills tend to plague women longer than they do men, as well. "Women are more likely than men to be paying off health care bills over time," Doty said. "Forty-five percent of women had problems with medical bills, compared to 36 percent of men."

"Most surprising is, all these problems are so pervasive across all income levels," Doty said. For instance, she said, 34 percent of women with a family income of \$60,000 or more did not get the care they needed.

Women also reported that they are less likely than men to get employer-provided health-care coverage, Doty said, sometimes because they work part time.

Health-care costs impact women to a greater degree than men, in general, the study authors said, because women have lower average incomes and higher out-of-pocket health costs than men. They also use the health-care system more often.

Other experts in women's health care said the report rings true with their own research.

"The findings in the issue brief underscore the persistent problems with adequate access and coverage to health-care services that women experience," said Roberta Wyn, associate director of the University of California Los Angeles Center for Health Policy Research.

"The percent of women with inadequate health coverage, experiencing problems with medical bills or debt, and forgoing needed care is staggering and these data were collected in 2007, before the recession hit," Wyn noted. She said the findings underscore the urgency to expand health-care coverage and access, a move that was seconded by the study authors.

The findings "echo a long line of research showing that women face a great burden from medical bills due to both their greater health-care needs and higher out-of-pocket costs," said Chloe Bird, senior sociologist at the Rand Corp. and author of *Gender and Health: The Effects of Constrained Choice and Social Policies*.

The problem with access to health insurance for women has been worsening since 1980, Bird said, citing other research.

The findings offer a clear message to younger women, Bird said: If you do manage to acquire health-care coverage, take advantage of it and "recognize the importance of investing in your health."

PRIVATE HEALTH RIPOFF

False assumptions that drive the current U.S. health care reform debate are often expressed as common buzzwords:

1) Choice - To free-market advocates, choice applies to "affordable" private insurances -- often, inadequate minimum benefit health insurances that render many at health and financial risk. Private insurances further limit choice of providers to in-plan doctors. By contrast, Single Payer permits full choice of health care providers.

2) Competition - Health care competition invoked by free marketers implies competition among for-profit insurances, whose primary goal is to maximize shareholder profits -- often by reducing coverage with low-value products, like minimum-benefit health insurance. Progressives assert that competition should be restored where it belongs -- among providers and hospitals, based on quality of care.

3) Government Bureaucracy - It is somewhat ironic that opponents of a single-payer financing system argue that a government bureaucracy will come between patients and doctors. There is nothing more obstructive to patient care than the \$20 billion annual private health insurance bureaucracy that games the system for profit by frequently denying or delaying health care claims, fracturing both the patient-provider relationship and U.S. primary care infrastructure. Fully one-third of U.S. health insurance claims are initially denied -- compared to many European countries, where T.R. Reid reported (*Sick Around the World*) claims are paid within two weeks.

Perhaps the greatest distortion is the notion that the uninsured are primarily responsible for rising health costs -- the health care cost-shift to the insured and taxpayers. John Sheils, VP of the Lewin Group (a scheduled witness at the May 12 Senate Finance Committee hearing) previously headed the team that evaluated 5 Colorado health care reform proposals in 2007. Sheils told the Colorado Blue Ribbon Commission on Health Care Reform that fully half of the uninsured pay their own medical bills.

In fact, the numbers of underinsured are growing at a faster rate than the numbers of uninsured, and contribute as much if not more, to growing rates of uncompensated medical care and to U.S. personal medical bankruptcy rates. Underinsurance has increased since the '90s, when escalating health care premiums precipitated the move by employers and individuals toward catastrophic coverage (euphemistically branded 'consumer-directed' or HSA health plans by free-market advocates). Coincident with the expanding catastrophic health insurance market, out-of-pocket costs also soared.

As out-of-pocket health costs rose about 70% from 1995-2005, the American Hospital Association TrendWatch Reports simultaneously tracked an approximate 65% increase in uncompensated medical care - costs that are picked up by taxpayers and consumers. In other words, as private insurers pass on more and more of their costs, they are subsidized big-time by taxpayers.

A 2008 study by the University of Colorado Medical School demonstrated a growing rate of underinsured in Colorado -- 36.3% who delay or ignore recommended care due to inability to pay. Add the rising numbers of uninsured Coloradans, and a total of over 50% are uninsured and underinsured -- a very different picture than that painted by Colorado Republicans who assert that major health care reform is unnecessary because "80% are fully covered and content with their coverage."

Nationally, a study by the LWV reported that 25 million adults under age 65 were underinsured during 2007, despite having insurance all year. The study estimated that 42 percent of all U.S. adults (86.7 million) were either uninsured or underinsured during 2007.

The model of Massachusetts health care reform reportedly being advanced by some in Congress is the worst of all worlds for consumers and taxpayers. It creates a mandate to purchase taxpayer-subsidized private insurance -- often high out-of-pocket cost minimum benefit plans. Massachusetts-style health care reform grants a windfall (sort of a taxpayer-funded bailout) to private for-profit health insurances, while leaving people at financial and health risk.

Dr. David Himmelstein testified on April 23 in a hearing of the Health, Employment, Labor, and Pensions Subcommittee that the Massachusetts Plan costs have skyrocketed, rising 23% between 2005 and 2007. He reported that "one in five Massachusetts residents went without care last year because they couldn't afford it. Hundreds of thousands remain uninsured, and the state has drained money from safety net hospitals and clinics..." to fund the plan.

If the private health insurance industry prevails, as they did in writing Medicare prescription drug reform, Obama's parallel 'public option' for health care coverage would quickly turn into a public subsidy for the mandated purchase of private for-profit health insurance. By contrast to the U.S., most industrialized nations save administrative costs and cover all by utilizing not-for-profit insurances.

www.FloridaHealthInsuranceWeb.com