



## WISCONSIN LEGISLATURE

P.O. BOX 8952 · MADISON, WI 53708

October 20, 2005  
FOR IMMEDIATE RELEASE

Contact: Senator Mark Miller at (608)266-9170  
Representative Chuck Benedict at (608)266-9967

### Press Release

#### **The Wisconsin Health Security Act Introduction**

*Sen. Miller and Rep. Benedict Discuss Bill on Comprehensive Health Care: A Solution to the Health Care Crisis, Economic Development for Wisconsin*

**Madison**—Sen. Mark Miller (D – Monona) and Rep. Chuck Benedict (D – Beloit) held a press conference today to describe the Wisconsin Health Security Act. The Wisconsin Health Security Act is legislation that would create a comprehensive health care system for Wisconsin and ensure that all residents have access to comprehensive and affordable health care. The legislation has been introduced in both houses. In the Senate it is Senate Bill 388 and is waiting for a bill number in the Assembly. The bills are being introduced with the Coalition for Wisconsin Health, a collaborative effort of 60 religious, social, human rights, health care and labor organizations, working to reform health care in Wisconsin. Also speaking at the press conference today was Linda Farley from the Coalition for Wisconsin Health, Amanda Killian a successful farmer from Blair who is uninsured, Dan Guerra company Chairman of Argus Innovations, and a medical student from the university.

“When I talk with residents across the state, they tell me health care is their number one concern,” stated Senator Miller. “They believe government needs to take the lead to make health care affordable and accessible for everyone.”

Rep. Benedict, coauthor of the bill and a retired physician said, “I have first hand experience with patients who cannot afford adequate care. These are hard working people who deserve to be treated at the same standard of care that wealthy people expect. We have an obligation to ensure our residents receive quality health care. A healthy citizenry equates to a healthy state.”

The Wisconsin Health Security Act establishes a health plan for Wisconsin, under which, beginning July 1, 2008, each state resident shall receive reasonable medical services necessary to maintain health, enable diagnosis, and provide treatment or rehabilitation for an injury, disability, or disease. This bill will ensure that every Wisconsin resident has access to health care. The legislation creates a Department of Health Planning and Finance and six regional offices which are advised by consumers and practitioners at the regional level. It creates accountability for specific health care needs, problems and concerns on a regional and on going basis. Consumers and practitioners will be involved in determining amounts and sources of funds for payment to providers, applying for waivers and obtaining federal funding, establishing a listing of approved medication and numerous other health-related matters.

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“We believe that health care is a right,” said Rich Bogovich, Communications Director for The Coalition for Wisconsin Health. “We support this bill because it guarantees comprehensive quality health care for everyone.”

“This legislation is not only about individual health, it is also about the health of our state economy,” said Miller. “A comprehensive health care system will reduce costs to employers and will encourage entrepreneurs to start businesses in Wisconsin.”

Wisconsin used to be ranked high for being one of the states with the smallest percentage of uninsured. However, in the last two years Wisconsin has slipped. Currently there are over 590,000 uninsured in our state. Of the uninsured, 50% are employed and 25% are children. In addition, more and more people are filing bankruptcy as a result of medical expenses. In Wisconsin, approximately 50% of the people filing bankruptcy file because of medical expenses.

In fact, the U.S. is spending more per capita than any other nation on health care spending, but helping less people. Life expectancy is lower and the infant mortality rate is higher in the U.S. than other industrialized countries.

“With health care costs spiraling out of control, we need to reform health care now. We need to put the ‘care’ back into health care,” stated Benedict. “People need to know they can go to a doctor if they are sick and have peace of mind that they won’t lose their homes or find themselves or their families under a mountain of debt due to medical bills. We should not be asking working families to choose between seeing the doctor and a mortgage payment when they are sick. People need health security.”

Organizational Sponsors and press conference participants include: Coalition for Wisconsin Health, Physicians for a National Health Program, SEIU WI State Council, Wisconsin Citizen Action, Wisconsin Farmers Union, WI State AFL-CIO, The Milwaukee Chapter of ACLU, Wisconsin Gray Panthers, National Association of Social Workers—WI Chapter, Wisconsin Council on Children and Families, Coalition of Wisconsin Aging Groups, Lutheran Office of Public Policy (ELCA), Wisconsin Coalition for Advocacy, and Mental Health Association in Milwaukee County.

Additional Legislative Sponsors: Senator Tim Carpenter, Representative Terese Berceau, Senator Jon Erpenbach, Representative Spencer Black, Senator Fred Risser, Representative Frank Boyle, Senator Judy Robson, Representative Jason Fields, Senator Bob Wirsch, Representative Tamara Grigsby, Representative Fred Kessler, Representative Joe Parisi, Representative Mark Pocan, Representative Sindy Pope-Roberts, Representative Mike Sheridan.

*Representative Chuck Benedict represents the 45<sup>th</sup> Assembly District (Beloit). He is a retired neurologist and practiced at Beloit Memorial Hospital for 19 years. Senator Mark Miller represents the 16<sup>th</sup> Senate District (Parts of Dane, Columbia and Sauk County).*

## 2005 SENATE BILL 388

October 17, 2005 - Introduced by Senators MILLER, CARPENTER, ERPENBACH, RISSER, ROBSON and WIRCH, cosponsored by Representatives BENEDICT, BERCEAU, BLACK, BOYLE, FIELDS, GRIGSBY, KESSLER, PARISI, POCAN, POPE-ROBERTS and SHERIDAN, by request of Coalition for Wisconsin Health. Referred to Committee on Health, Children, Families, Aging and Long Term Care.

1     **AN ACT** *to amend* 15.01 (3), 15.01 (4) and 59.17 (2) (c); and *to create* 15.07 (1)  
2         (a) 7., 15.07 (2) (n), 15.07 (5) (m), 15.07 (5m) (c), 15.20, 15.207, 20.430, 59.53 (25),  
3         62.09 (8) (cm) and chapter 152 of the statutes; **relating to:** establishing a  
4         publicly financed health care system for residents of this state, creating the  
5         Department of Health Planning and Finance, Health Policy Board, and  
6         regional consumer health councils, granting rule-making authority, and  
7         making appropriations.

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### *Analysis by the Legislative Reference Bureau*

Under current law, payment for medical services that residents of this state receive is made from a combination of federal moneys (such as under the Medicare, Medical Assistance (commonly referred to as "Medicaid"), and various block grant programs); general purpose revenues (such as the "state share" of the joint federal-state Medical Assistance Program, the Badger Care Program, state contributions to relief block grants for health care services, and moneys appropriated for specific medical purposes, such as cancer control grants); local moneys, such as funding for medical relief health care services and county nursing homes and hospitals; private health insurance coverage that individuals purchase or that is provided, in part, as employee benefits; and out-of-pocket payments that are made by health care consumers.

**SENATE BILL 388**

This bill establishes a health plan for Wisconsin, under which, beginning July 1, 2008, each state resident, with certain specified exceptions, shall receive reasonable medical services necessary to maintain health, enable diagnosis, and provide treatment or rehabilitation for an injury, disability, or disease. Specified persons who are excepted from the July 1, 2008, beginning date are phased in for eligibility that begins July 1, 2009.

To administer the health plan, the bill creates a Department of Health Planning and Finance (DHPF), with six regional offices, that is directed and supervised by an 11-member Health Policy Board that is also created in the bill. The Health Policy Board appoints the secretary of health planning and finance and is required to review that appointment after 36 months. The Health Policy Board also may appoint two advisory committees, which are advisory to the secretary of health planning and finance. The bill also creates six regional consumer health councils that are attached to DHPF and that report at least twice a year to the Health Policy Board on the health care needs, problems, and concerns of the region. Each regional consumer health council may create a regional advisory committee. The bill requires appropriation of general purpose revenues to DHPF for operation of the Health Policy Board for the 2005-07 fiscal biennium and requires that the Health Policy Board consider numerous specified issues related to the formation of a health plan in this state.

Under the bill, by July 1, 2007, DHPF must begin implementation of processes, in light of policies determined by the Health Policy Board, to effect numerous health-related matters, including specifying the amounts and sources of funds to finance payment to providers under the health plan, applying for waivers to federal Medicaid statutes and rules, and establishing a listing of approved medicinal substances and formulae. The secretary of health planning and finance and the secretary of administration must, until September 1, 2009, meet at least semimonthly to formulate decisions on issues concerning the health plan and DHPF and how the scope and functions of DHPF affect the scope and functions of the Department of Health and Family Services, the Office of the Commissioner of Insurance, the Board on Aging and Long-Term Care, and the duties or powers of any other state agency. The Health Policy Board must convey the decisions to the Legislative Reference Bureau for drafting of necessary proposed legislation for introduction in the legislature in 2008. The Legislative Reference Bureau must prepare, in proper form for introduction, the proposed legislation that relates to the decisions.

For further information see the *state and local* fiscal estimate, which will be printed as an appendix to this bill.

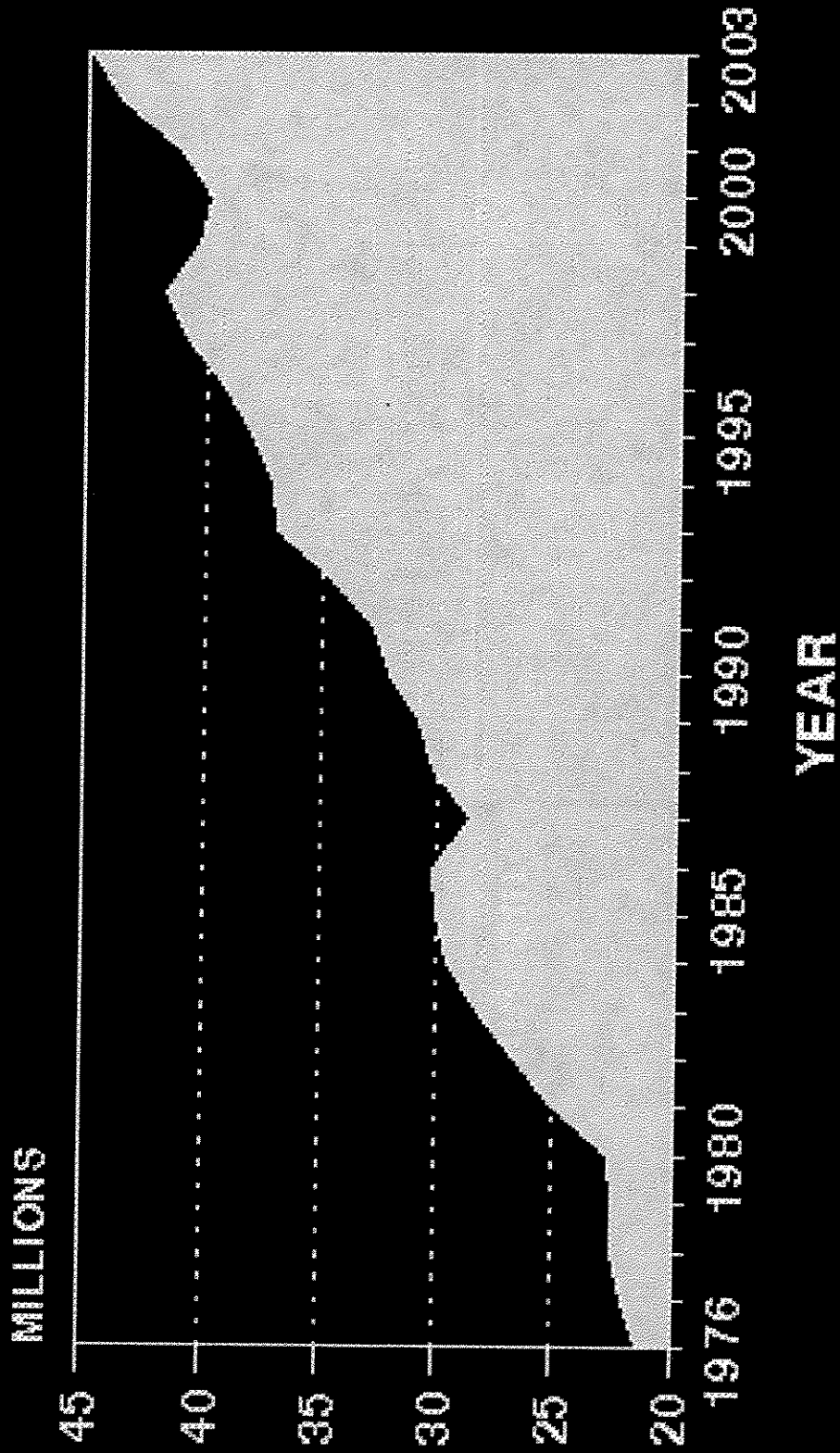
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***The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:***

1

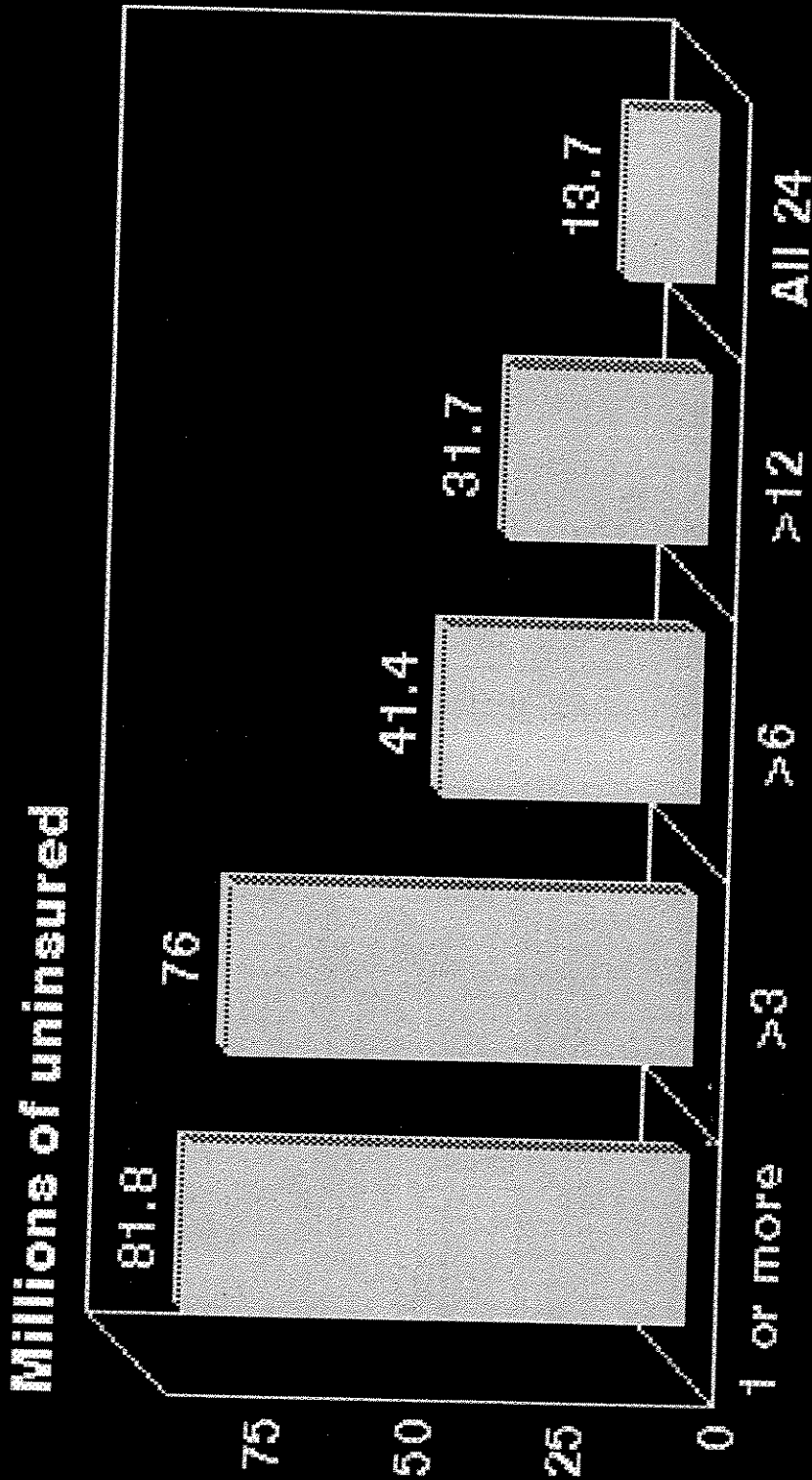
**SECTION 1.** 15.01 (3) of the statutes is amended to read:

# Number of Uninsured Americans 1976-2003



Source: Himmelstein, Woolhandler & Carrasquillo - Tabulation from CPS & NHIS Data

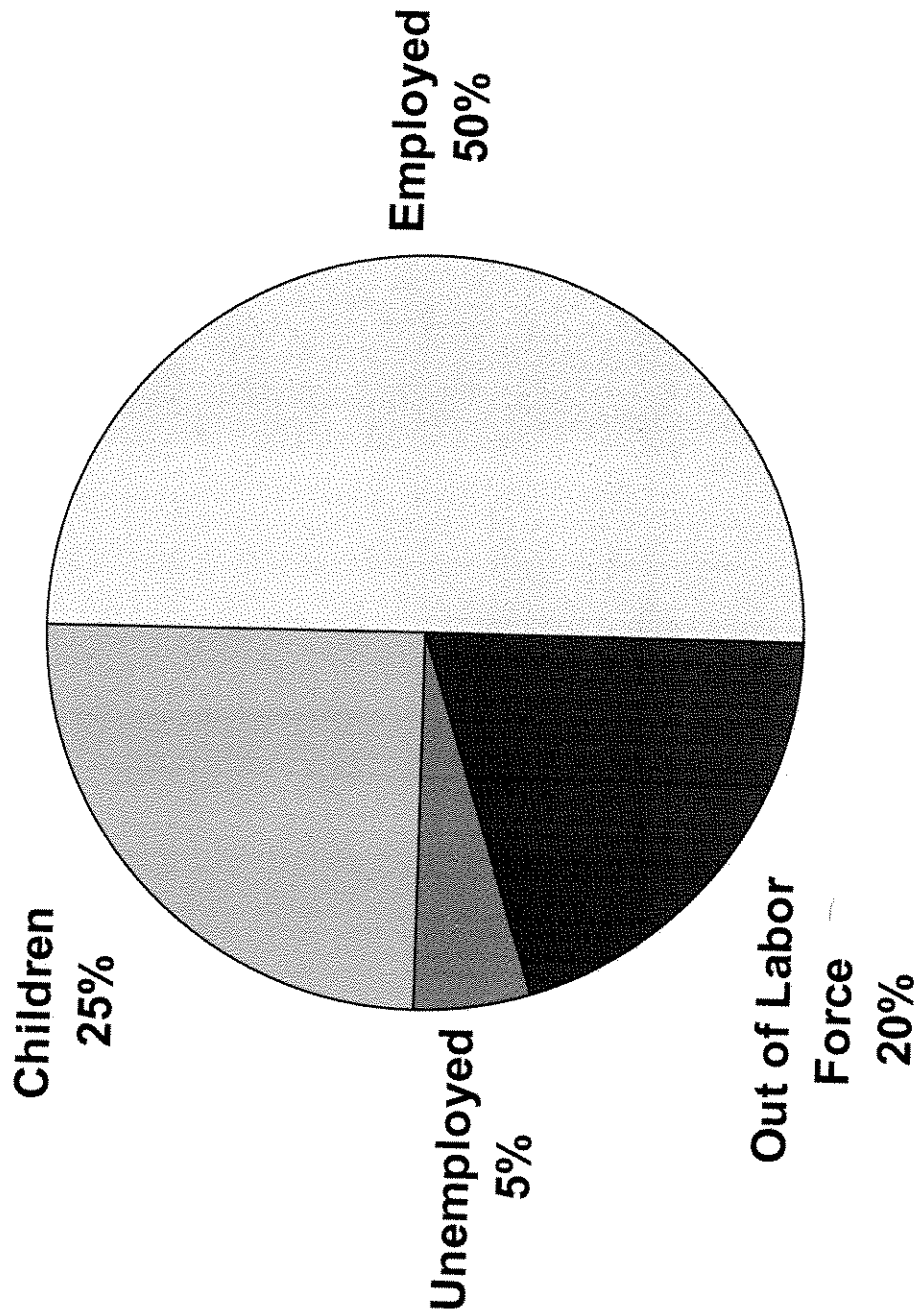
# Number of Uninsured During a 24 Month Period 2002-2003



Months Uninsured During 24 Month Period

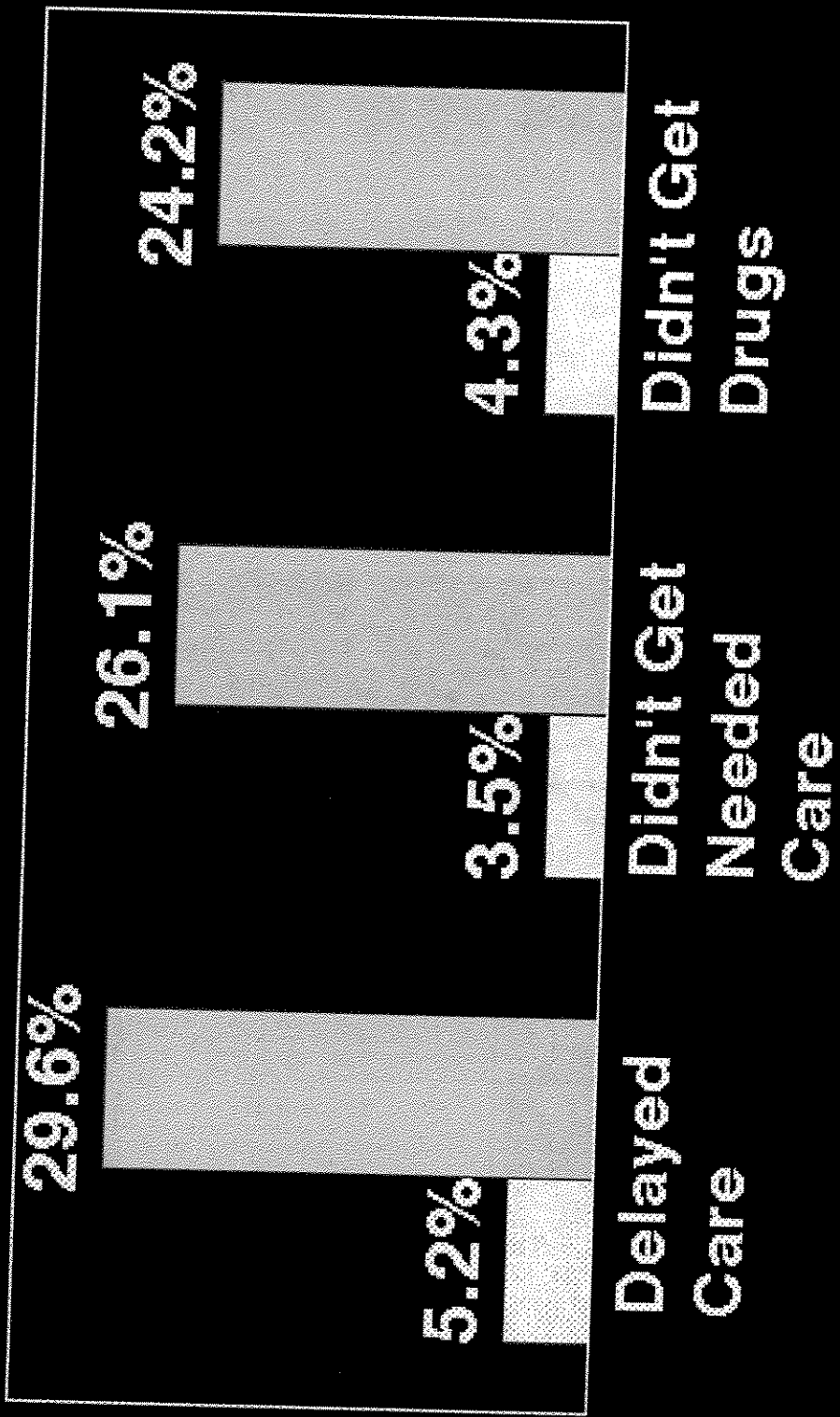
Source: Families USA - June, 2004 - Analysis of Census Bureau data

# Who are the Uninsured?



Current Population Statistics, 1999

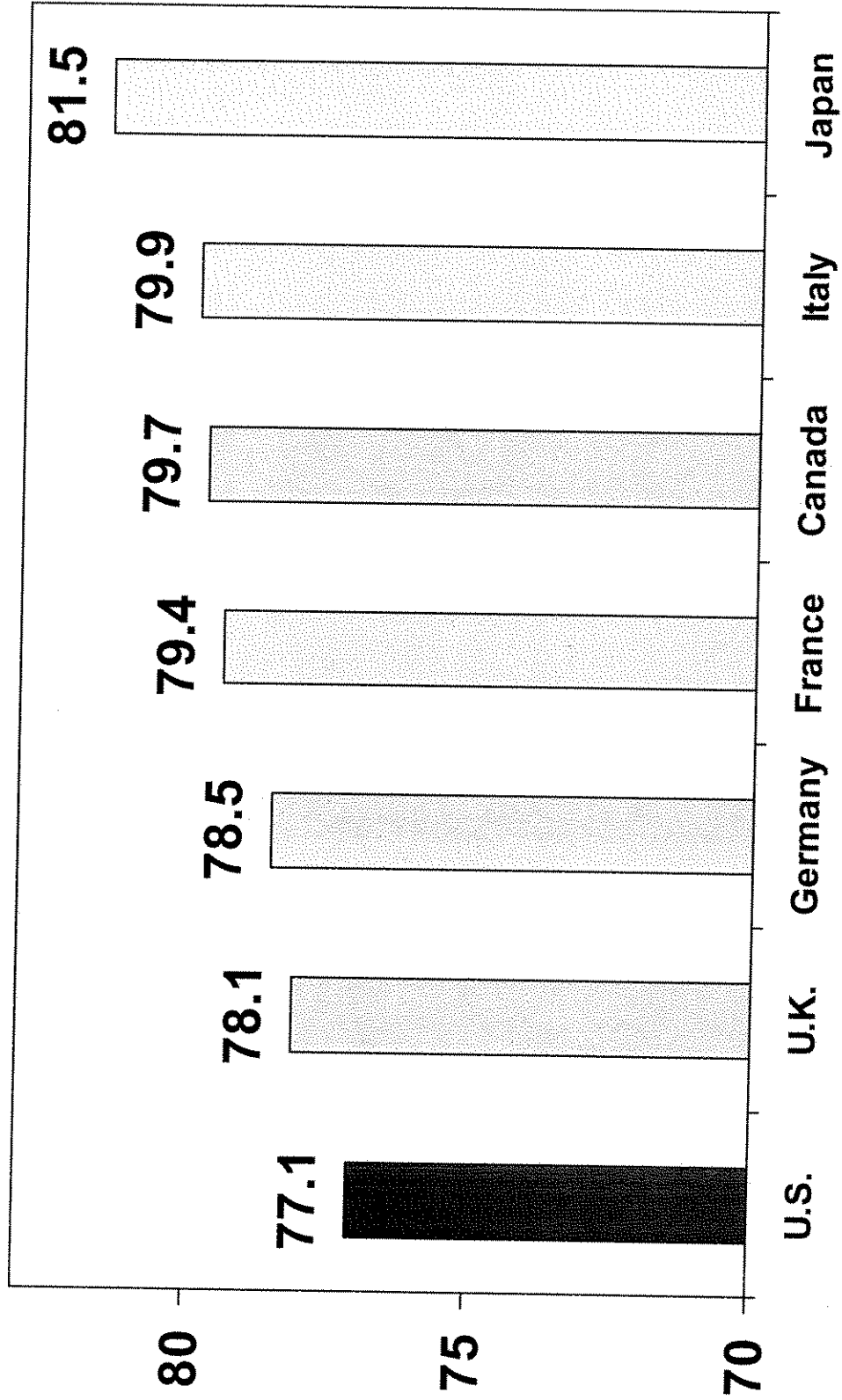
# Uninsured Veterans Go Without Care



■ Insured Vets < 65 ■ Uninsured Vets < 65

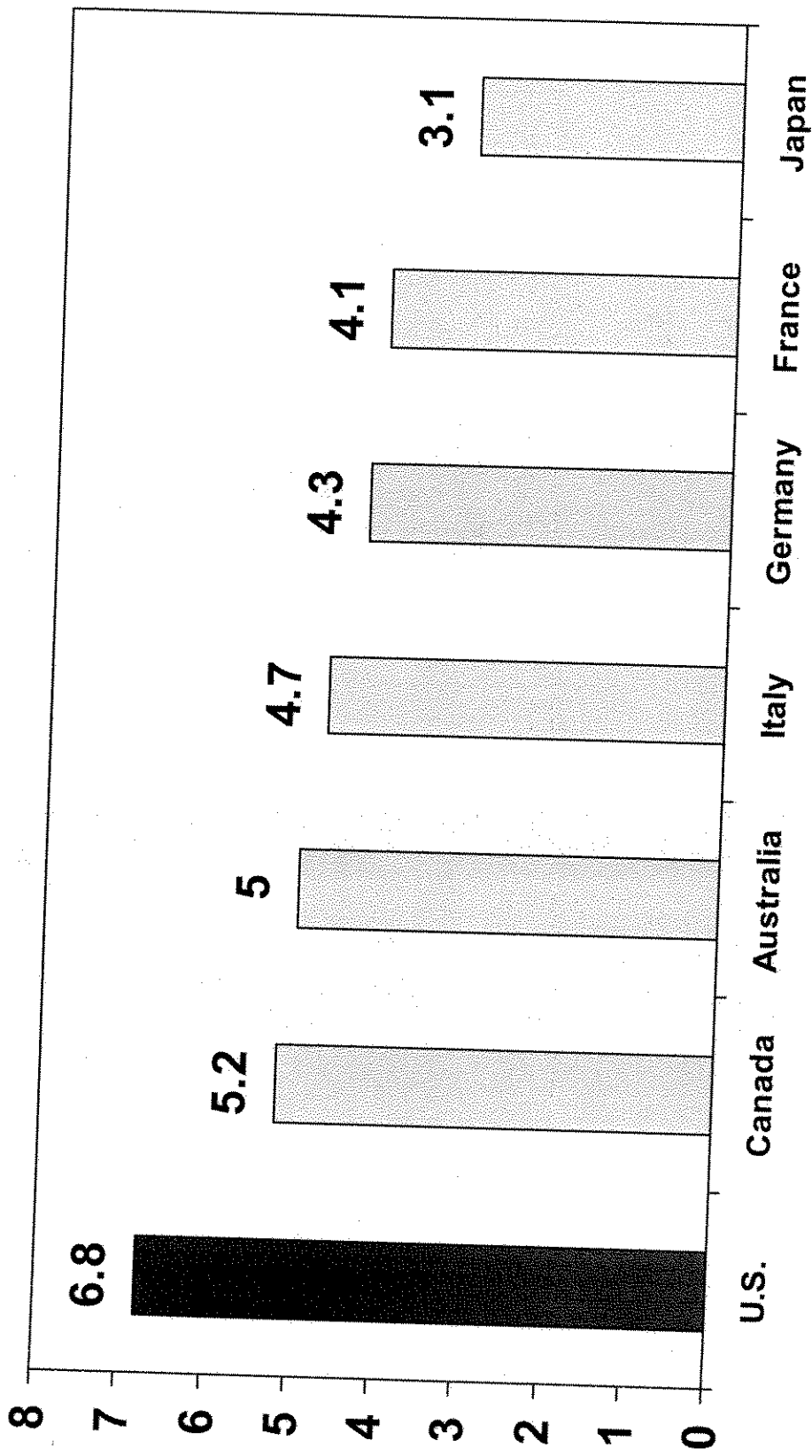
Source: Himmelstein & Woolhandler - Analysis of 2002 National Health Interview Survey

# Life Expectancy



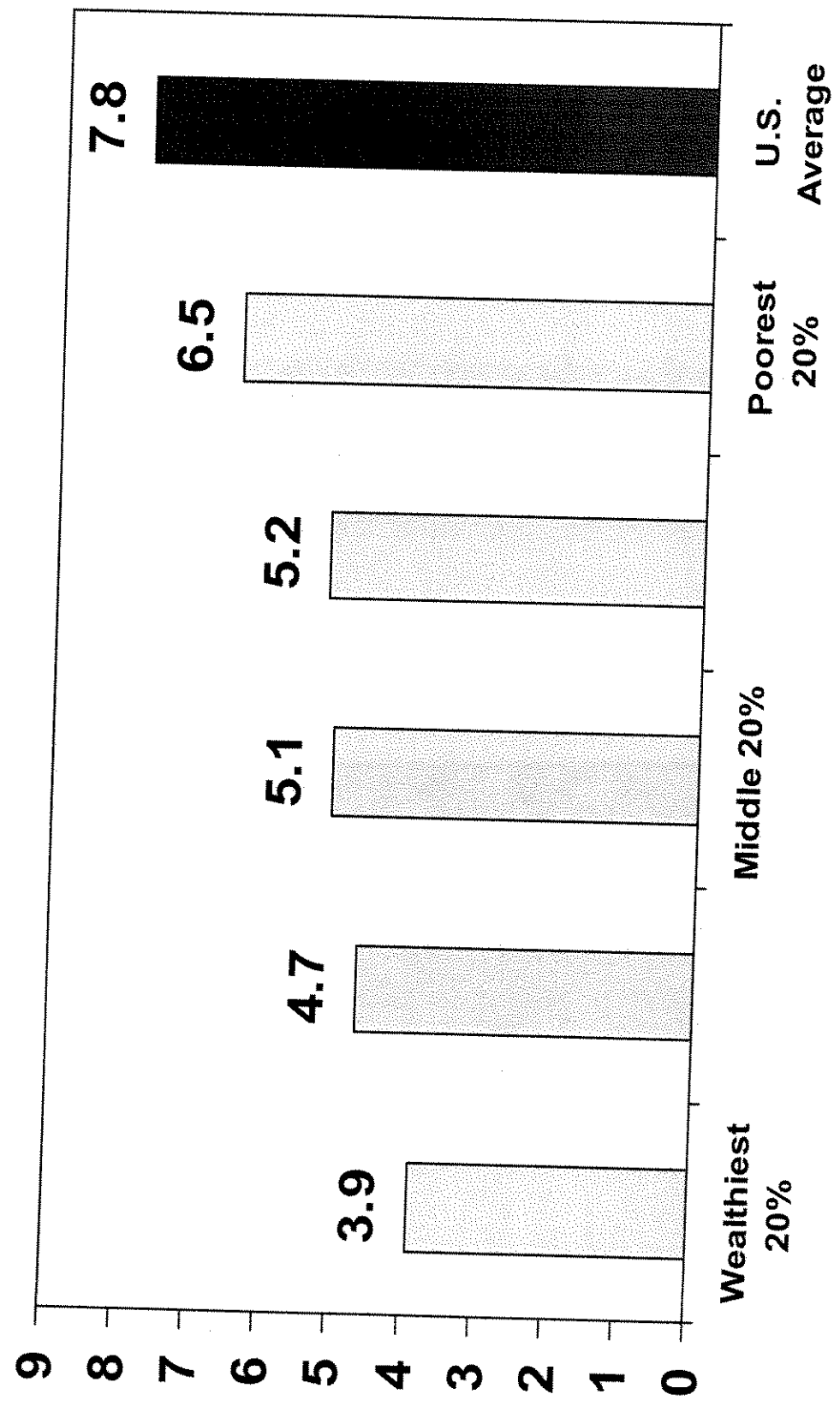
OECD, 2004, (2001 Data)

# Infant Mortality per 1000 Births



OECD, 2004, (2001 Data)

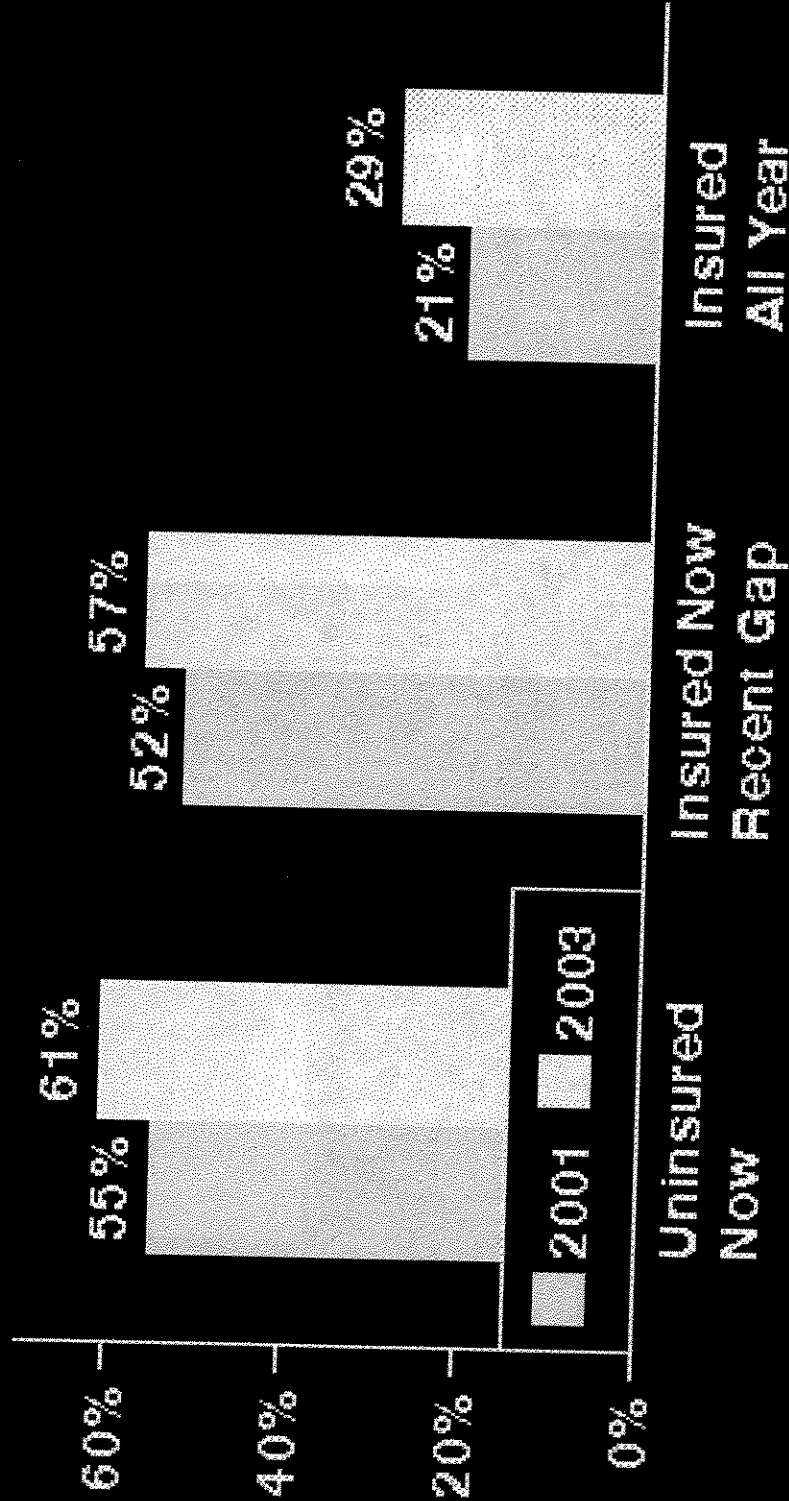
# Infant Deaths by Income



# Worsening Access Problems, 2001-2003

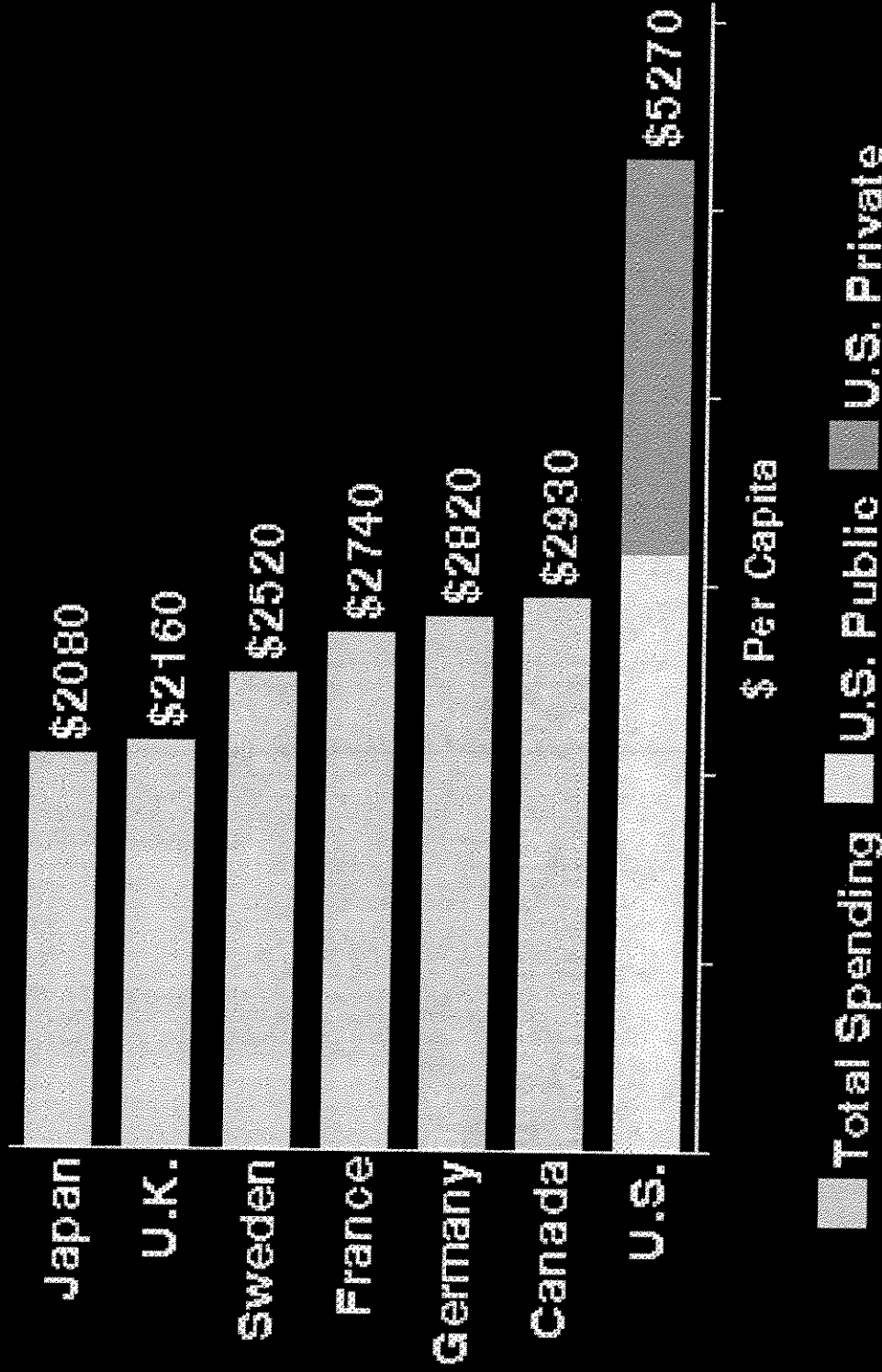
Adults Age 19-64

Percent foregoing needed care or medications  
in past year because of costs



Source: Commonwealth Fund Health Insurance Surveys 2001 & 2003 - Released March, 2004

# U.S. PUBLIC Spending Per Capita for Health is Greater than TOTAL Spending in Other Nations

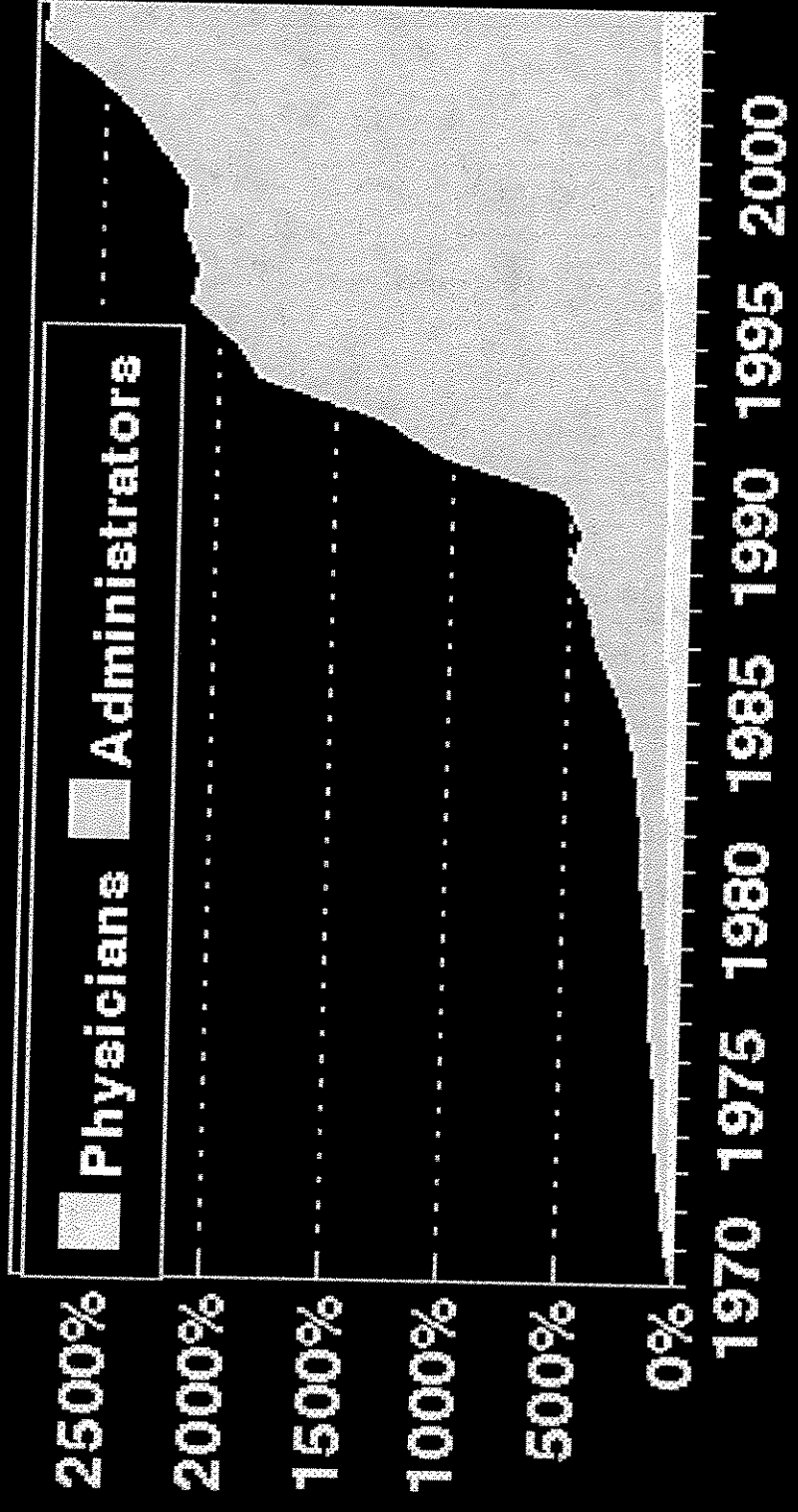


Note: Public includes benefit costs for govt. employees & tax subsidy for private insurance

Source: OECD 2004; Health Aff 2002; 21(4):98 - Data are for 2002

# GROWTH OF PHYSICIANS & ADMINISTRATORS 1970-2004

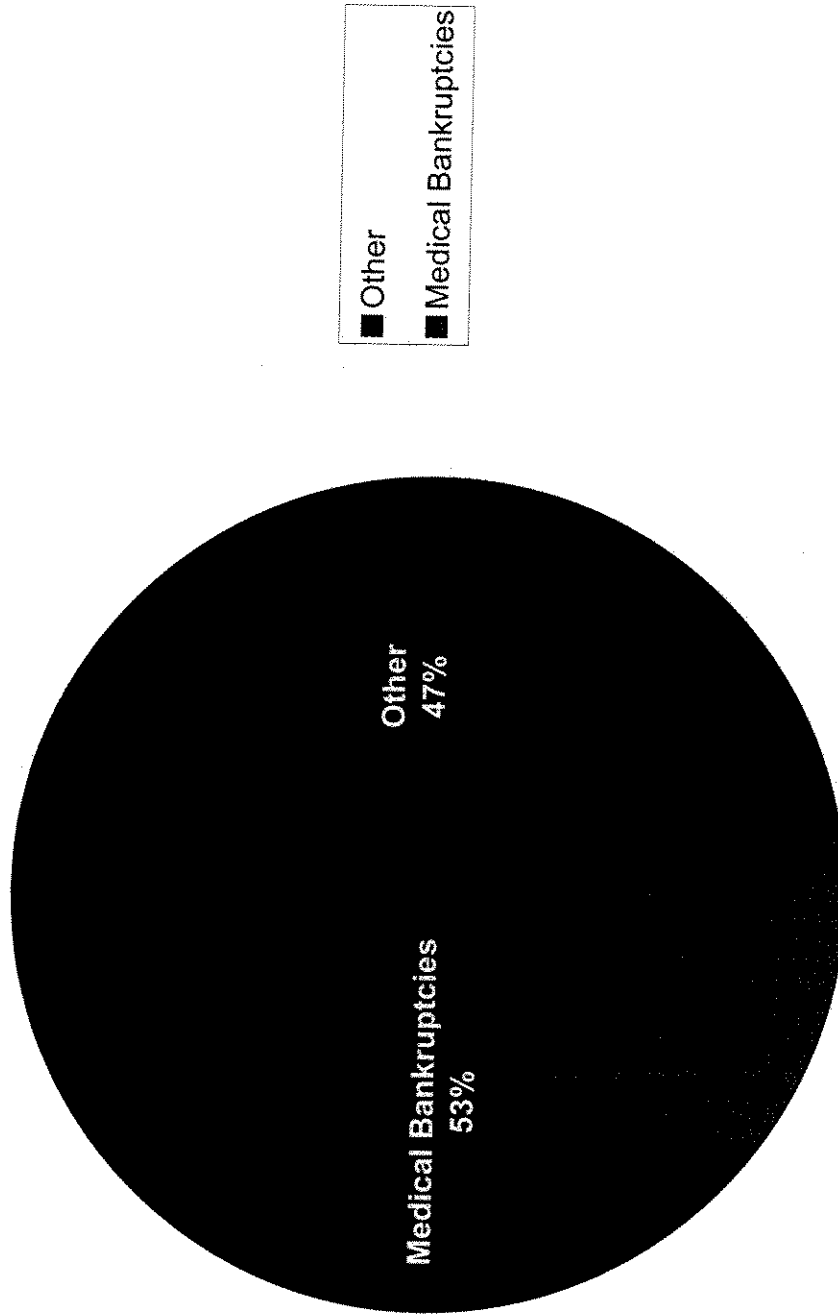
## GROWTH SINCE 1970



Source: Bureau of Labor Statistics; NCHS; and analysis of CPS

# Medical Bankruptcies

(As a percentage of Total Bankruptcies 2001)



"Illness and Injury as Contributors to Bankruptcy," Himmelstein et al, *Health Affairs* Web Exclusive, February 2, 2005.

The Capital Times August 9, 2005

# Here's how to fix health care system

Guest columnist Jake Sunshine is right on target ("Health care crisis calls for change now," July 31), but there is a major issue that we must first come to grips with before the right fix can be applied. That is, why do we expect U.S. corporations to foot the medical bill for their employees when no other country burdens their employers with this cost?

This puts U.S. businesses at a severe competitive disadvantage, and it is only by historical accident that we do it this way. We must change the method of medical payments if we are to keep corporations and jobs in Wisconsin and the United States.

Sunshine points to General Motors, but GM is just one of thousands that are moving to Canada and other countries that have removed the cost of medicine from their manufacturers' bottom line. More Big Three autos are manufactured in Ontario today than in Detroit, and Toyota just selected Canada over the U.S. for its new RAV4 plant.

GM must spend \$6,500 per employee annually for medical costs in the U.S., but only pays an \$800 annual per-employee tax in Canada.

The U.S. and South Africa are the only two industrialized nations that do not provide a universal health care plan. We've opted for a market-driven (read: for-profit) system and have seen yearly double-digit increases as a result. How long must this continue before business and political leaders correct the problem?

What's the best answer? We must implement a universal health care system much like Canada's, but without their wait times (though their wait times for urgent care are the same as ours). It must be funded by the very people who are funding our antiquated system today: we the taxpayers.

We taxpayers are paying for our current, inefficient system through dozens of circuitous routes, the most obvious being that companies add their health care costs to their product price and we pay at the cash register. We also pay through the tax breaks corporations get for providing medical coverage, deductibles, co-pays and the taxes we pay to support the uninsured who show up at the emergency room.

As well, our system is terribly inefficient, with 30 percent administrative costs compared with Canada's 8 percent and Medicare's 3 percent. Yet even with the wait times — that special interests on both sides of the border love to bash — Canada's life expectancy is two years longer than ours, its infant mortality is 35 percent less, and they cover 100 percent of their population rather than our 85 percent. They also have longer per-person hospital stays and more doctor visits.

## Jack Lohman

GUEST COLUMNIST

The attacks of 9/11 killed 3,000 people; 18,000 Americans die prematurely each year because they do not have health coverage. How can we let this continue?

It is because the health care interests in the U.S. like things just as they are, thank you, and their campaign contributions give them great influence over the political process. They make money from inefficiency, over-ordering and under-treating. But the business interests must show their muscle, and the business associations that have health care members must bow out of the discussion because they can't represent both sides of the same issue.

It can be done: Appoint a seven-member health care committee with guaranteed 14-year staggered terms to run the system (that keeps the politicians at arm's length). This voting team should be comprised of seven retired physicians and seven business leaders with no active connection to either side of the issue. Appoint another team of working physicians and business leaders who advise the group but have no vote on the outcome. Of course, public hearings should also be held.

Transition from where we are today to where we want to be over an eight-year period. Create a process that (a) transfers current employer health payments to a health care fund, (b) slowly reduces those payments to zero over the eight years and (c) slowly adds sales and other taxes to rebuild the fund (like increased tobacco, alcohol and luxury taxes).

Hospitals should be paid an annually negotiated operational budget and a separately negotiated capital budget. Physicians and hospitals should remain independent and patients should retain their right to choose. One (or it could be up to six regional) insurance company would administer payments, just as WPS does for Medicare today. The system would replace Medicaid and Badger-Care, and could even allow Medicare to buy in if the feds chose to do so.

• • •

The system can be fixed but the politicians and business leaders must sideline the health care interests to get it done. The big question is: Will Wisconsin legislators appoint an independent committee with the powers necessary to fix the system?

Jack Lohman is a retired CEO in Milwaukee, a Medicare recipient and lifelong Republican. He is currently writing a book on campaign finance reform.  
E-mail: jlohman@execpc.com



# HEALTH & SCIENCE

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Last update July 8, 2005 at 10:07 AM

## Study: Health costs hurt women

By LAWRENCE M. O'ROURKE, McClatchy Washington Bureau

July 8, 2005

WASHINGTON (SMW) - Millions of American women cannot afford to go to the doctor or get their drug prescriptions filled, according to a study released Thursday. "A sizeable share of women are falling through the cracks, either because they don't have insurance or even with insurance can't afford to pay for medical care or prescription drugs," said Alina Salganicoff, director of women's health policy at the Kaiser Family Foundation, sponsor of the study.

Latina women are the least likely U.S. women to have a regular doctor, with one in three saying they have delayed or skipped care because of cost, the study said.

Salganicoff said that the growth in health-care costs has become a central women's health issue. She said that poor women, working at low-paying jobs to support their families, are less likely than more affluent women to seek medical care.

The Kaiser report said that as health care costs have grown, some 27 percent for non-elderly women and 67 percent of uninsured women say they decided not to seek health care they believed they need. The percentages, taken on a survey conducted last summer, were higher than percentages in a comparable survey in 2001.

A federal official said the drop in health-care usage coincides with a government policy that encourages the shifting of health-care costs from insurers to individuals.

People will cut their use of health services if they have to pay out of pocket, said Carolyn Clancy, director of the U.S. Agency for Healthcare Research and Quality.

Clancy said there is "growing concern" among doctors that women are cutting back on mammograms. The study said that mammography rates fell from 73 percent in 2001 to 69 percent in 2004. Some 40 percent of uninsured women over 40 had a mammogram in the past year, compared to about 75 percent of women on Medicare and with private insurance coverage.

Pap test rates among women aged 18 to 64 also fell from 81 percent in 2001 to 76 percent in 2004, according to the

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Kaiser report.

Some 38 percent of women 50 and older said they have had a colon cancer screening test in the past two years and 37 percent of women 45 and older said they received a test for osteoporosis in the same period.

The survey said that women are more likely than men to use a prescription drug on a regular basis, but are also more likely to report difficulties in affording the medication.

The Kaiser report was based on interviews of 2,766 women by Princeton Survey Research Associates and the University of California at Los Angeles.

A separate report said that higher prices for health services such as prescription drugs, hospital stays and doctor visits is the major reason why Americans spend far more for health care than citizens in other industrialized nations.

"There is a popular misconception that we pay much more for health care in the United States compared to European and other industrialized countries because malpractice claims drive up costs and there are waiting lists in most other countries," Gerald Anderson, a health policy professor at Johns Hopkins Bloomberg School of Public Health, wrote in the journal Health Affairs.

"What we have found is that we pay more for health care for the simple reason that prices for health services are significantly higher in the United States than they are elsewhere," Anderson said. "We have less access to most health services and higher costs associated with malpractice insurance have only a marginal effect on overall health spending."

The Society for Women's Health Research announced Thursday that women's fear of heart disease has almost doubled since 2002, but that breast cancer remains the single most feared disease. It said that fear of AIDS and HIV has declined.

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**Las Vegas SUN**

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July 27, 2005

## **Study: Gaps in Insurance Affects Kids**

**By ALICIA CHANG**

ASSOCIATED PRESS

For every child who lacks health insurance, another has gaps in coverage and is just as likely to miss out on seeing a doctor or getting a prescription refilled, suggests a new comprehensive study of federal data.

The research also reveals some surprises: About four out of five children with insurance coverage gaps have parents who work; two-thirds of them live with both parents; and more than half are white.

At least 9 million U.S. children, or about 12 percent, lack health insurance, based on a federal survey in 2003. Researchers who produced the latest study say that number is likely higher because many kids who lack health insurance during part of their childhood aren't included in that number.

"There is an oversimplified view of what is uninsured," said Lynn Olson of the American Academy of Pediatrics, who led the study. "We should be measuring who is uninsured in multiple ways in order to understand what the true burden is."

Many studies have documented the health barriers faced by uninsured children, such as missing regular checkups and visiting hospital emergency rooms for routine care. But this is one of the few analyses of what happens to children when their families have intermittent coverage.

"It really calls attention to an important group of children we often don't consider," said Dr. Glenn Flores, director of the Center for the Advancement of Underserved Children at the Medical College of Wisconsin, who was not connected to the research.

Marian Blackmon, a telephone operator in Jackson, Miss., said that when her husband retired last year, her three sons were dropped from his health plan.

Blackmon recalled how she avoided taking one of her 6-year-old twins to the pediatrician when he became feverish because she did not want to pay out-of-pocket for the visit. But when 12-year-old Nicholas fell off a horse last year and was rushed to the emergency room, Blackmon had no choice, but to pay the medical bill.

"It's very stressful," said the 43-year-old mother, who recently applied to enroll her kids in a public health insurance program for poor children.

The researchers analyzed data from a national health survey in 2000 and 2001. They estimated that almost 7 percent of children were uninsured, but another 8 percent lacked coverage for part of the year.

The researchers found that the children with intermittent coverage were more likely to postpone medical care than uninsured kids. For example, 20 percent of children who were uninsured for part of the year

delayed getting medical attention because parents worried about cost compared to 16 percent without insurance and 4 percent with public and private coverage.

Results appear in Thursday's New England Journal of Medicine. Among the study's findings:

-About 58 percent of children with coverage gaps were white, while 46 percent of those with no insurance were Hispanic.

-Eighty-two percent of kids with coverage gaps lived with at least one working parent, and 61 percent lived with both parents.

-A third were in preschool, an age when children typically get immunized.

- Thirteen percent of children who were insured only part of the time missed doctor appointments and one in 10 did not get prescriptions refilled because of the cost - percentages virtually equal to those for uninsured children.

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On the Net:

New England Journal of Medicine: <http://content.nejm.org>

American Academy of Pediatrics: <http://www.aap.org>

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## **Middle-Class Workers With Health Coverage Represent Most Medical Bankruptcies In America (Health Affairs)**

**February 2, 2005**

EMBARGOED for release

Wednesday, Feb. 2, 2005, 12:01 a.m. EST

Contact: Jon Gardner

[jgardner@projecthope.org](mailto:jgardner@projecthope.org)

301-347-3930

### **Middle-Class Workers With Health Coverage Represent Most Medical Bankruptcies In America, Health Affairs Article Says**

#### **Authors Say Trend Shows Need For Safety-Net Program For Chronically Ill, Importance Of Separating Health Coverage From Employment**

BETHESDA, MD—About 2 million Americans a year are in families that experience a bankruptcy following illness or injury, representing about half of all bankruptcies in the United States. Most of those filings were middle-class workers who had health insurance at the onset of their medical difficulties, according to an article posted today on the Health Affairs Web site.

David U. Himmelstein, associate professor of medicine at Harvard Medical School, and three colleagues reviewed 1,771 personal bankruptcy documents in five federal judicial districts in 2001, and conducted follow-up surveys with 931 of those debtors to determine how illness contributes to bankruptcy in America.

While the number of overall bankruptcies was 3.6 times higher in 2001 than in 1980, the number of health-related bankruptcies increased 23-fold over the same period, which suggests that high medical bills were a major contributor to the growth in the number of individuals seeking federal bankruptcy protection.

“The medical debtors we surveyed were demographically typical Americans who got sick,” Himmelstein says. “They differed from others filing for bankruptcy in one important respect: They were more likely to have experienced a lapse in health coverage. Many had coverage at the onset of their illness but lost it. In other cases, even continuous coverage left families with ruinous medical bills.”

#### **Among the survey’s findings:**

—Between 1.9 million and 2.2 million Americans (filers plus dependents) were affected by medical bankruptcies in 2001

—Three-quarters of the debtors had insurance at the onset of the bankrupting illness

- Out-of-pocket costs for those bankruptcy filers since the onset of illness or injury averaged \$11,854
- Medical debtors were 42 percent more likely than other debtors to experience a lapse in health insurance coverage
- As they experienced financial trouble, 61 percent of the filers failed to seek medical treatments they needed

“As in Canada and most of western Europe, health insurance should be divorced from employment to avoid coverage disruptions at the time of illness,” Himmelstein says. “Insurance policies should incorporate comprehensive stop-loss provisions, closing coverage loopholes that expose insured families to unaffordable out-of-pocket costs. Additionally, improved programs are needed to replace breadwinners’ incomes when they are disabled or must care for a loved one.”

Himmelstein’s coauthors are Elizabeth Warren, a professor at Harvard Law School in Boston; Deborah Thorne, assistant professor in the department of sociology and anthropology at Ohio University in Athens; and Steffie Woolhandler, associate professor of medicine at Harvard.

You can read the article at [content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.63](http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.63)

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Health Affairs, published by Project HOPE, is a bimonthly multidisciplinary journal devoted to publishing the leading edge in health policy thought and research. Additional peer-reviewed papers are published weekly online as Health Affairs Web Exclusives at [www.healthaffairs.org](http://www.healthaffairs.org). Health Affairs Web Exclusives are supported in part by a grant from the Commonwealth Fund.

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