STATE NEWS

CLONE WARS HIT STATE LEGISLATURES

Matthew Gever

The recent announcement from the Food and Drug Administration (FDA) asserting that meat and milk from cloned animals is safe has met with skepticism from some state lawmakers. In at least nine states, legislation has been introduced requiring that food derived from cloned animals be labeled as such.

In January, the FDA released a series of documents assessing the risk of human consumption of cloned animals. Their conclusion: foods derived from genetic reproductions provide no additional risk to humans.

“After reviewing additional data and the public comments in the intervening year since the release of our draft documents on cloning, we conclude that meat and milk from cattle, swine and goat clones are as safe as food we eat every day,” said Stephen F. Sundlof, director of the FDA’s Center for Food Safety and Applied Nutrition. The FDA has not reached a conclusion yet on the safety of other animal species, such as sheep.

Currently, the FDA does not require labeling, but it does give producers the option to label their products as “clone-free.” That’s not enough, say some legislators.

“There’s a yuck factor out there,” said Michigan House Speaker Pro Tempore Michael Sak, who has introduced a bill (HB 5611) to require that sellers of cloned animal products label them as such. He is still deliberating just who would do the labeling and when. “My intent is to make sure consumers have the opportunity to make an informed decision.”
“People have the right to know if food is organic, if it contains pesticides or growth-promoting hormones, or if it’s from cloned or naturally bred animals,” said California Senator Carole Midden, whose bill (SB 1121) would require producers to label any foods made with cloned animal parts. Those who failed to comply could be fined.

The Legislature passed a similar bill last session, but it was vetoed by Governor Arnold Schwarzenegger, who expressed concern that the bill would violate existing federal standards. “Federal law prohibits states from enacting labeling requirements for meat and poultry that are in addition to those federally established,” said the Governor. “Further, I am concerned that this bill would require tracking and labeling requirements that could be unworkable, costly and unenforceable.”

Lawmakers in New York are considering the opposite approach. AB 7421 would require that all retailed meat and dairy products not made from cloned animals be labeled “clone-free.” “Given the short history of cloning, little data from long-term, multigenerational studies is available,” said Assemblyman Michael Benjamin in a memo.

Other states considering labeling bills are Kentucky (HB 378), Massachusetts (SB 255), Missouri (HB 1555), New Jersey (AB 1325), Tennessee (SB 3850), and Washington (SB 5161).

Fear Mongering?
Animals are cloned by taking the nuclei of cells from adult animals and fusing them into egg cells from which the nuclei have been extracted. If done successfully, the result is an animal that is genetically identical. Many meat and dairy producers see cloning as a significant advance since it would allow them to reproduce their best animals, thereby creating high-quality meat and dairy products. The cloned animals themselves would be used for breeding only and not for food, given the high price tag—several thousands of dollars—of creating a clone. This means that foodstuffs would be made from the offspring of cloned animals, and not the cloned animals themselves. Additionally, producers do not expect cloned products to hit the marketplace for a number of years as they try to perfect the process and bring down the costs.

Risks certainly exist. Initial studies from the FDA have found certain health risks for the surrogates carrying the fused eggs as well as for the few offspring derived from clones. However, most health problems dissipate as a calf grows up, with adult health status similar to animals of traditional breeding, according to the FDA.

Some point out that consumers are already eating cloned foods. “All of this fear-mongering about clones has made Americans forget that cloning is nothing more than artificially creating twins,” said Arthur Caplan, director of the Center for Bioethics at the University of Pennsylvania, in an op-ed piece. “It has made us forget that every drop of wine we drink comes from cloned grapes. It has made us ignore the fact that if you want to worry about what you are eating, you’d be better off wondering if the FDA has enough inspectors at meat plants looking for salmonella and E. coli.”
New Mexico may become the first state in the nation to try to reduce prison recidivism by providing released prisoners with an anti-addiction drug.

If passed by lawmakers during the current 2008 session, HB 244 would create an opiate addiction treatment program. The pilot project would enroll 50 female prisoners with a history of heroin or other opiate addictions for outpatient treatment utilizing buprenorphine.

Approved by the Food and Drug Administration in 2002, buprenorphine treats opiate addiction by preventing symptoms of withdrawal. The New Mexico experiment would use a form of buprenorphine that has been combined with the opiate antagonist naloxone. By blocking the pleasurable effects of buprenorphine, naloxone helps prevent relapse as well as diversion of the drug (sold under the trade name Suboxone) to the black market.

Addiction experts say there are few available means of preventing relapses: they include AA or Narcotics Anonymous, and methadone. Advocates say buprenorphine is an improvement over methadone because it can be prescribed in an office setting by any certified physician, which allows patients to take a supply home and avoid making daily trips to a methadone clinic.

Approximately 600 women reside in the New Mexico Women’s Correctional Facility in the city of Grants and another 70 reside at the Camino Nuevo Correctional Center in Albuquerque. Of these women, 85 percent have a history of addiction and 40 percent have a history of injection drug use.

The recidivism rate among this population is high. “Seventy-five percent of women who go to prison for the first time for narcotic-related crimes will re-offend and return to prison within 2.5 years,” says an analysis from the Legislative Finance Committee. These female recidivists cost the state $3 million per year, according to the Department of Health (DOH).

Currently, Medicaid does not cover outpatient substance abuse treatment in New Mexico. The state often ranks near the top of the list of states in the numbers of people who need treatment but do not receive it. The Drug Policy Alliance of New Mexico attributes much of the problem to lack of insurance coverage.

To qualify for the new program, inmates would have to be within two months of release and not pregnant. Participants also would be on parole or probation for at least one year following release, and they must meet with a case manager regularly during the course of the project. Those released to a community within 60 miles of a physician certified to prescribe buprenorphine would receive priority.

The state would appropriate $250,000 from its general fund to cover the full costs of the two-year project. DOH and the Department of Corrections would be responsible for evaluating the project, measuring decreases in recidivism, relapse and cost savings. Additionally, state officials will look for...
changes in the physical and mental health, employment status and other quality of life indicators among participants, comparing these indicators to women with a history of opiate addiction who were not treated with buprenorphine.

Some believe that the program will help not only the former inmates, but their families. “Most women in prison are mothers,” said Angie Vachio, executive director emeritus of PB&J Family Services, a child welfare organization that serves children whose parents are in prison. According to DOH, the 600 incarcerated women in New Mexico leave behind 1,800 children. “When children watch their mothers do well and see effective treatment, that’s the best possible investment we can make in families,” added Vachio.

HB 224 has cleared the House Judiciary Committee and will now move to the House Appropriations and Finance Committee. The Legislature passed a similar bill during the 2007 session, but it was vetoed by Governor Bill Richardson, who said there was not enough money in the budget at the time.

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**STATE NEWS**

**E-PRESCRIBING: MISSIVES FROM THE FRONT**

*Kory Mertz*

As spring approaches, states are stepping up their efforts to expand the use of health information technologies. Prominent among these is e-prescribing, the electronic generation and transmission of a prescription between the prescriber and pharmacy. By reducing medication errors, e-prescribing is expected to one day save billions of dollars and thousands of lives.

**New Hampshire** hopes to be the first state in which all providers can e-prescribe. The state is working with the New Hampshire Citizens Health Initiative, which brings together payors, providers, employers and citizens, to achieve that goal by October 2008. Anthem Blue Cross Blue Shield, the state’s largest payor, is helping practitioners adopt e-prescribing by offering access to a discounted wireless plan, free e-prescribing software and free personal data assistants (PDAs).

**Minnesota** is expanding e-prescribing to state employees. By 2009, the state employee health plan will require all in-network pharmacies to accept e-prescribing. By 2011, all network providers must e-prescribe. Failure to meet these deadlines could mean removal from the network.

A growing number of states are adding health and insurance information to the list of items protected against a breach of confidence.

**California** enacted a bill (AB 1298) during its last session that seeks to protect the privacy of personally identifiable unencrypted medical and health insurance information. Any state agency or business that operates in California would have to inform any potentially affected state resident of the loss of that individual’s health information. In addition, the bill would prohibit any organization...
that holds electronic personal health record data from disclosing that information without patient consent.

**Medicaid Too**

Meanwhile, 21 states have initiatives to add or expand e-prescribing in their Medicaid programs, according to a recent report from the Office of the Inspector General at the Department of Health and Human Services.

**Florida** and **Mississippi** have given personal data assistants (PDAs) to participating providers to enable them to perform such actions as viewing patient medication history, sending prescriptions to pharmacies and being alerted to potentially adverse drug interactions.

Mississippi estimates that its program costs the state about $35,000 per month, but has saved around $1.2 million per month in prescription drug costs and nearly $27,000 per month in foregone hospitalizations. Florida documented savings of $40 per patient per month in 2006, for a total savings to Medicaid of $25 million.

**Missouri**, **Kansas** and **Tennessee** have incorporated e-prescribing systems into Medicaid electronic health records (EHRs). Providers can go to a Web-based portal (a single point of access for EHR data) to see Medicaid prescription drug claims data for their patients, as well as information about the state Medicaid drug formulary.

At the federal level, on January 31, U.S. Health and Human Services Secretary Mike Leavitt launched a 40-city tour to tout a five-year, $150 million pilot to help physicians in small practices adopt EHRs, the *AP/Chicago Tribune* reports. The pilot will focus initially on Medicare, but could be expanded to include Medicaid.

Physicians would have to pay for the technology, and up-front costs could range from $20,000 to $40,000. However, Leavitt said that in the first year of the project, the Center for Medicare & Medicaid Services (CMS) would pay doctors extra for adopting EHRs, while in the second year, doctors would receive bonuses for reporting data on quality. In the last three years of the pilot, CMS would pay physicians for boosting quality.

For more information, please go to NCSL’s LegisBrief on e-prescribing: [www.ncsl.org/programs/pubs/summaries/08LBJan_eprescribe-sum.htm](http://www.ncsl.org/programs/pubs/summaries/08LBJan_eprescribe-sum.htm)

Helpful resources:

NCSL’s Kory Mertz at Kory.Mertz@NCSL.org; (202) 624-5400, ext. 3580

NCSL Health Information Technology Champions (HITCh) Website: [www.ncsl.org/programs/health/forum/hitch](http://www.ncsl.org/programs/health/forum/hitch)

The Henry J. Kaiser Family Foundation has prepared a toolkit on health information technology: [http://www.kaiseredu.org/topics_im.asp?id=655&imID=3&parentID=70#EPrescribing](http://www.kaiseredu.org/topics_im.asp?id=655&imID=3&parentID=70#EPrescribing)
HIGHLIGHTS

ACCESS

Shopping for Deals
California introduced a website January 25 that will help consumers find out how much hospitals are willing to discount care for uninsured patients. The site makes California the second state, after New York, to give consumers a tool to compare prices or discount payment policies at nonprofit hospitals. Hospitals have been criticized in recent years for being overly aggressive in trying to collect payments from patients, many of whom are uninsured. The Hospital Fair Pricing Program site stems from a 2006 California law that prohibits the state’s hospitals from charging moderate- to low-income patients—those who earn up to 350 percent of the federal poverty level (FPL)—more than the highest rates charged by Medicare or any other government program in which the hospital participates. On the site, consumers can search a hospital by name or location to find the hospital’s discount pricing policy, determine the income levels that qualify for discounts and download applications to participate. Policies vary among hospitals, but patients who are uninsured or have inadequate coverage can qualify for low-priced or free care if they earn less than 350 percent of the FPL, or if their medical costs exceed 10 percent of their annual family income. The site also lists a number of hospitals that offer discounts to patients earning up to 500 percent of the FPL. So far, policies for 82 percent of California’s 405 acute-care hospitals have been posted.

Clinic, Heal Thyself
CheckUps, a New York company providing health clinics in retail settings, announced January 18 that it plans to close 23 clinics operating in Wal-Mart Stores in Florida, Louisiana, Alabama and Mississippi because of an inability to make payments to nurses and other vendors. CheckUps ended payments to some nurses in December 2007 and owes $108,000 to Med Tracker Personnel, an employment agency that provided nurses to the clinics. Wal-Mart has leased space to about 80 clinics in stores across the country, all of which are operated by independent firms. While some of the Wal-Mart clinics are headed by doctors, most are run by nurse practitioners who are limited to providing routine medical care like giving flu shots or prescribing drugs for sore throats. Operators say their main clients are mothers with small children, and that about 30 percent do not have a family doctor. Wal-Mart said it hoped the CheckUps clinics would not stay vacant for long. “We are working to reopen the clinics as quickly as possible,” Deisha Galberth, a Wal-Mart spokeswoman told the New York Times. Galberth said Wal-Mart was proceeding with plans to lease space for several hundred clinics in the next two years, and expanding to as many as 2,000 clinics by 2014.

MEDICAID

Premature Babies Not Getting Follow-Up
Infants born weighing less than 3 pounds are particularly vulnerable to vision, hearing and speech impairments. But a new study of more than 2,000 very low birth-weight babies in Medicaid found that less than one-quarter received follow-up care for those conditions. Study investigators reviewed the records of 2,182 children born in South Carolina between 1996 and 1998, focusing on how hearing and vision loss were managed after the babies were discharged. Only 20 percent of infants who could benefit from hearing rehabilitation services received them by 6 months of age, and only
23 percent received routine vision exams between ages 1 and 2, according to the study, which will be published in the February issue of *Pediatrics*. “This study shows just how badly these vulnerable babies are falling through the cracks of our health care system,” says lead study author Jason Wang, a Robert Wood Johnson physician faculty scholar. “We spend about $250,000 on each of these babies while they are in the hospital to make sure they survive the NICU...the least we can do is guarantee them the resources and attention they need so they can hear and see when they go home.” Hospitals should make efforts to improve the coordination of the complex care that these babies require once they leave the hospital, he added. “Very low birth-weight babies go home with multiple health problems,” says Wang. “It’s often too much for parents and one pediatrician to manage. Families need a support team to ensure that their babies get the care they need through early childhood.” Nearly 60,000 very low birth-weight babies are born in the United States every year.

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**GRAPHICALLY SPEAKING**

**DISPARITIES IN ALCOHOL-RELATED HEALTH PROBLEMS**

*Matthew Gever*

While black, white and Hispanic Americans have similar lifetime rates of problem drinking, the rate of alcohol-related health problems for African-Americans is significantly higher. Seeking to answer why this is, RAND researchers analyzed intake and discharge records from all publicly funded outpatient and residential alcohol treatment recovery programs in Los Angeles County from 1998 to 2000. The resulting report from the RAND Drug Policy Research Center found that black Americans are less likely than whites or Hispanics to complete addiction treatment. Many of the disparities could be explained by patient characteristics, such as income differentials, and differences in the neighborhoods of the treatment facilities, researchers said. Additionally, the paper suggests that the disparities could be reduced if blacks received more residential (as opposed to outpatient) treatment. Whites were more likely to get residential treatment than were blacks. The graph below represents completion rates among the three ethnic groups examined.

![Bar chart showing % completing treatment by ethnicity](chart.png)