STATE NEWS

INVESTING IN HEALTH INFORMATION TECHNOLOGY: VERMONT CREATES AN E-FUND

Kory Mertz

Vermont is taking steps to help its small practice physicians adopt health information technology (IT).

In June, 2008, the Vermont legislature passed HB 891, creating a new funding stream to finance the statewide adoption of health IT. The Health IT Fund, as it is called, will help to establish a health information exchange infrastructure, and increase the use of electronic medical records (EMRs) among the approximately 800 primary care practitioners from the current rate of 13 percent to 50 percent by 2011.

Widespread adoption of health information technology, particularly among primary care practitioners, is major component of Vermont's Blueprint for Health, which among other things seeks to improve the quality of care and health care systems in the Green Mountain State. “This fund is an important step forward for reducing health care costs and improving care for Vermonters,” said Representative Steve Maier.

Over the next seven years, the Health IT Fund will be supported through a quarterly fee of 0.199 of one percent on all health care claims by health insurers and third party administrators who run employer’s self-insured plans in the state. The first payments into the fund are due this month.

"We explicitly included the third party administrators because we wanted to make it as broad-based as possible and to capture the self-insured population," Dr. James Hester Jr., director of the Health Care Reform Commission for the Vermont General Assembly said during a recent NCSL online conference.
The Health IT Fund is "transitional" and will operate until 2015 when the health IT infrastructure is in place, Hester said. Through the fund, the state expects to raise $32 million. The state Medicaid program will also make an annual payment to the fund, of a yet to be determined amount.

Obstacles
While many view EMRs as a vital way to improve the quality of care and achieve cost savings, two key obstacles stand in the way of this transformation in Vermont: cost and a reluctance on the part of some to invest in health IT.

While the implementation of electronic medical records provides savings to the health care system as a whole, these benefits often accrue first to stakeholders like payers and purchasers of care rather than providers. The financial outlay required on the part of small practices often overshadows the long-term benefits in care delivery and quality. As a result, small practices have a much lower adoption rate of health IT tools compared to large practices.

The Health IT Fund will provide financial assistance to small providers as they make the transformation to EMRs, and "connect the people who will be benefiting from the implementation of the EMR to the people who actually have to make the investment," Hester noted.

Under the Vermont health information technology plan—part of the Blueprint for Health—Vermont Information Technology Leaders, Inc. (VITL), a non-profit public-private partnership, has been charged with developing a health data infrastructure, an interoperable system that will allow individual providers, medical groups and hospitals to freely exchange patient data. Given the uncertainty surrounding whether the infrastructure created by VITL would be long-standing, larger health entities have been reluctant to invest in the health IT tools that exchange patient data. As a result, Vermont "took a hard look at the options" and realized that providing stable financial support through the Fund was the only way to ensure that the health data infrastructure would be created. "It could not be done any other way," explained Hester.

EMR Adoption Program
State government entities and VITL will be able to draw money from the Health IT Fund to pay for health information technology programs, including:

- A grant program to help primary care practitioners purchase and implement EMRs and practice management systems;
- Building a statewide health information exchange network;
- Technical assistance from VITL to help practitioners reengineer their clinical processes to fully utilize electronic health records.

The Health IT Fund will be administered by the state Agency of Administration (AOA) and advisory board. Requests for funds must include a detailed project plan, and the disbursement of funds must be approved by the Secretary of the AOA and the Legislature. The legislation requires an annual report on fund expenditures and an independent assessment of the effectiveness of supported projects.

VITL has been conducting a $1 million pilot project to evaluate the implementation electronic health record systems with independent primary care clinicians. Five primary care practices received grants to cover 75 percent of the cost of an EHR—up to $45,000 per provider—while practices paid
the remaining 25 percent of the cost. Practices in the pilot project could select from six products on VITL’s pre-screened EHR product list, which included six preferred vendors. In July 2008, VITL announced that three vendors have been identified as "electronic health records systems of choice". VITL will continue to provide assistance to the practices, as well as evaluate improvements in clinical performance as a result of EHRs.

There is a caveat to the financial support: any provider receiving state funding will be required to link up with the state wide health information exchange network. Practices will be required to demonstrate effective use of the electronic medical record system or risk losing their software license and support. The state estimates the Health IT Fund’s investments will provide a net savings of $320 million over 10 years.

STATE NEWS

MARYLAND COUNTY LOOKS TO TAKE LOCALIZED APPROACH TO COVERING THE UNINSURED

Matthew Gever

The crusade to cover the uninsured is moving to the local and county levels.

This month, Howard County, Maryland launched the Healthy Howard Access Plan, an initiative that provides health coverage to working adults who do not have insurance or qualify for public benefits. The County, located just southwest of Baltimore, is the third wealthiest in the nation, according to the Census Bureau. Despite this, "approximately 20,000 residents remain uninsured with virtually no access to primary and preventative care," said Peter Beilenson, Health Officer for the county.

The Healthy Howard Access Plan is not an insurance program but rather provides basic medical and preventive care at a greatly reduced cost to participants who would not otherwise be able to afford or obtain health insurance. The Access Program offers health care only in Howard County and is only available to eligible Howard County Residents. "We’re seeing it as a last option for people," said a spokesperson for the health department.

The plan provides or facilitates access to primary care, prescription drugs, mental health and substance abuse treatment, urgent and emergency room care, in-hospital treatment and specialty care. Plan members will be required to pay a monthly fee, depending on income, which range from between $50 and $85 for a single adult to between $65 and $115 for a couple. Healthy Howard, Inc., a non-profit organization, will administer the plan. The monthly fees are expected to cover about 65 percent of operating costs, with the county, private sources and foundations contributing the rest. Additionally, Howard County General Hospital has said it would forgive the existing medical debts of any enrollee.

To be eligible, an individual must be a between 19 and 64 years of age, a legal resident of the county for at least one year, earn less than 300 percent of the federal poverty level and be uninsured for at least six months. Minors are not eligible for the Access Plan as the county health instead hopes to
link up eligible children with other programs, such as Medicaid and SCHIP. The county expects to enroll about 2,000 people in the program in the first year.

The Healthy Howard Access Plan is part of the Health Howard Initiative, a broad health promotion campaign focused on improving overall the health of Howard County residents in school, home and restaurant settings. Disease prevention and wellness programs are an integral part of the Health Howard Initiative, and as such, the Access Plan includes a personalized health plan component. Participants "will be expected to work with a health coach and follow a health action plan developed specifically for them," said Beilenson. Personalized health plans are a common feature of many wellness plans for state employees and businesses, but generally only for those with chronic conditions. Howard’s plan requires a coach for all participants, regardless of health status. Failure to comply with the plan could result in loss of services, according to Beilenson.

Not Quite Insurance
In May 2008, the Maryland General Assembly passed HB 872, establishing new regulations to govern Healthy Howard and other public-private partnerships. The state "wanted to make sure it had its own section of regulations so as not deceive consumers," said Glenn Schneider, director of health policy and planning for Howard County. Among the regulations are:

- Any such plan has to have an agreement with the county, making it a public-private partnership;
- A plan has to state what it does and does not offer, so that consumers know what they are buying;
- A plan has to demonstrate that it has sufficient financial reserves.

In 2006, San Francisco passed a universal coverage law aimed at providing insurance to uncovered city residents who were ineligible for public programs. Funding for the program comes from a levy on businesses with 20 or more employees of between $1.17 and $1.76 per hour per employee in addition to funds from the city to cover a variety of health care services. Earlier this month, a federal appeals court upheld the program after businesses in the city filed a challenge under the Employee Retirement Income Security Act (ERISA), although further appeals are expected.

STATE NEWS

NEW REPORTS PROMPT STATE ACTIONS AGAINST CHEMICAL FOUND IN CHILDREN’S PRODUCTS

Matthew Gever

New information about a popular chemical in plastic products is getting attention from children’s health advocates and some policymakers.

Under scrutiny is the compound bisphenol-A. Known as BPA for short, the compound serves as a hardening agent in a number of plastic products. It is commonly used in baby and water bottles, sippy cups, and medical and dental devices and as coatings for food and beverage cans. About 93 percent of Americans are exposed to the chemical, according to studies from the National Institutes of Health (NIH).
Recently, a spate of research has suggested potential health risks associated with BPA, especially among infants. Of particular concern is the ability of BPA molecules to "leach out of the plastic, or the epoxy resin, into the food or drink that is contained within these bottles or cans," said Dr. Mike Shelby of NIH’s Center for the Evaluation of Risks to Human Reproduction. NIH recently issued a report expressing "some concern" with the effects of BPA on the brain, behavior and prostate gland in fetuses, infants and children, meaning that the researchers recognized "that there is something really going on here, but it’s not exactly clear [what the risks are]," said Dr. John Bucher, Associate Director of the National Toxicology Program of NIH.

Additionally, a recent study in the *Journal of the American Medical Association* found that adults with high concentrations of BPA in their urine had higher levels of cardiovascular disease and diabetes, and a study released by the School of Medicine at Yale University found that even low levels of BPA affected brain development in rats, though the authors did acknowledge that the full implications for humans are unclear.

Other agencies, however, have expressed doubt. The Food and Drug Administration "concludes that an adequate margin of safety exists for BPA at current levels of exposure from food contact uses, for infants and adults," affirmed a recent FDA assessment. Moreover, Andrew C. von Eschenbach, head of the FDA, added on his blog that the science does not recommend that anyone consider discontinuing the use of products that contain BPA. Additionally, some have argued that removing BPA from plastics makes the products more brittle and prone to breakage, creating choking hazards for infants.

**States Take Action**

Uncertainty notwithstanding, the research on BPA is catching the attention of state lawmakers and officials. "The preventable release of a toxic chemical directly into the foods we eat is unconscionable and intolerable," said Connecticut Attorney General Richard Blumenthal. On October 13, Attorney General Blumenthal, along with the attorneys general of Delaware and New Jersey, sent letters to eleven companies urging them to discontinue using BPA in baby bottles.

Legislatures have started to take up the issue as well, with 11 states this session considering bills to ban BPA products in their states. “Now is the time to remove dangerous toxics from store shelves,” said California Assemblywoman Fiona Ma.

In October 2007, Golden State lawmakers passed AB 1108, which would have banned BPA, as well as phthalates from children’s products. (Phthalates are chemicals added to plastics to make them more flexible.) Eventually, BPA was stricken from the bill because the science on the dangers of BPAs was not as conclusive as that for phthalates, according to a spokesperson for Assemblywoman Ma's office.

Later in the session, the legislature considered SB 1713, which focused exclusively on banning BPA from children's products. "There’s no acceptable excuse for playing Russian Roulette with the health of the most vulnerable among us by allowing known hazardous chemicals to remain in products for children and babies," said Senator Carole Migden. The bill passed the Senate, but not the Assembly.

The other states that considered a bill to ban BPA in products included Connecticut, Hawaii, Illinois, Maine, Maryland, Massachusetts, Minnesota, New Jersey, New York and Rhode Island. Hawaii also passed a resolution (SR 68) asking the department of health to monitor ongoing research into BPA and report to the legislature.
State legislatures aren’t the only ones wary of BPA. In April, retailers including Wal-Mart and Babies-“R”-Us announced they would stop selling products that contain BPA, with both companies phasing out the products by the end of the year. Also in April, the government of Canada announced it would ban the chemical from all baby bottles.

HIGHLIGHTS

COVERAGE

Hawaii Ends Children’s Coverage Program
State budget crises claimed another victim this week: Hawaii has withdrawn funding for its universal children’s coverage program just seven months after its launch. Governor Linda Lingle’s office cited budget cutbacks and improvements in enrolling kids in Medicaid and other programs in their decision to defund the "Keiki Care" program, effective November 1. State officials also cited concerns that families were dropping private coverage to enroll in the less-expensive public program, despite a policy mandating six months of uninsurance prior to enrollment. The three-year pilot program, signed into law last year by Governor Lingle, provides health coverage to uninsured children who are ineligible for other state programs. Coverage includes well-child visits and immunizations, and was free except for a $7 copay for office visits. The state’s Medicaid program enrolls children in families earning up to 300 percent of the federal poverty level, yet the state estimates that about five percent of Hawaiian children remain uninsured. In mid-2006, Illinois became the first state to establish a universal coverage program for all children, with cost-sharing based on a sliding scale of income. A number of other states—Pennsylvania, Florida, Tennessee, and Wisconsin—allow families ineligible for public coverage to buy into the SCHIP program, regardless of income. The state’s private partner in Keiki Care, the Hawaii Medical Service Association, will continue to provide plan benefits to enrollees through the end of the calendar year without state funding. HMSA Senior Vice President Cliff Cisco said, "We’re disappointed in the state’s decision, but we feel we have an obligation to the children and their families."

MEDICAID

Expected Growth
An actuarial report released by the Centers for Medicare & Medicaid Services estimates that state and federal spending on Medicaid will total about $339 billion in 2008 and will rise at a rate of 7.9 percent annually to $674 billion by 2017. Medicaid spending growth is expected to increase at a faster rate over the next decade than the economy in general, which is expected to increase by 4.8 percent annually, and health care spending in general, which is expected to rise by 6.7 percent annually, according to a report. The same study estimates that in 2017, Medicaid will comprise 3 percent of the gross domestic product, and Medicaid and Medicare combined will make up 6.9 percent of GDP. Over the next 10 years, enrollment in these two programs will grow by an estimated 1.2 percent annually to 55.1 million in 2017, according to CMS. "If nothing is done to rein in these costs, access to health care for the nation’s most vulnerable citizens could be threatened," Health and Human Services Secretary Michael Leavitt told CQ HealthBeat. CMS each year informs the public about the financial status of Medicare and Social Security, but the actuarial report is the first to project Medicaid spending growth.
CHILDREN’S HEALTH

Autism Coverage
Autism is out of the wings and into the mainstream. In the past two years, five states—Arizona, Florida, Louisiana, Pennsylvania and South Carolina—passed laws requiring insurance companies to provide coverage for treatment associated with autism. A handful of other states—California, New Jersey, New York, Michigan, Ohio and Virginia are considering legislation in 2009, according to Autism Speaks, a patient advocacy group. Patient therapy uses applied behavior analysis (ABA), which focuses on applying experimental principles of behavior to improve socially significant behavior. The therapy can cost up to $50,000 annually and has mixed support. Proponents of the therapy say research has demonstrated its effectiveness in increasing communication and IQ, as well as proved to be cost-saving. However, much remains unknown about which therapy works best for autistic kids, whether long-term gains can be claimed and whether it works with older children. Some states require behavior therapy coverage up to age 18 or 21, even though the scientific evidence for ABA is strongest for the youngest, ages 2 to 5. There is also an ongoing debate about whether behavioral therapy should be classified as a medical or educational treatment. The American Academy of Pediatrics includes behavioral therapy in its clinical report on autism but classifies it as an "educational intervention." Autism is a range of disorders that hinder the ability to communicate and interact, and most doctors believe there is no cure. An estimated 1 in 150 American children have been diagnosed with the condition.

GRAPHICALLY SPEAKING

Disparities in Trauma Care

Anna C. Spencer

Minorities and the uninsured are more likely to die after trauma than whites, even if they have similar injuries, according to a recent study from the Archives of Surgery. The study, based on the medical records of more than 310,000 trauma patients, found that when compared with whites, blacks had a 17 percent increased risk of death after trauma and Hispanics had a 47 percent increased risk. Among those who were insured, Hispanics were 51 percent more likely than whites to die after being treated for a trauma injury, and blacks had a 20 percent higher mortality rate than whites. Lack of insurance was the most significant predictor of health outcomes, and minorities were more likely than whites to be uninsured. Researchers said that uninsured and minority patients might be more likely than whites to have pre-existing medical conditions that lower their chances of survival. Blacks and Hispanics also are more likely to receive treatment at trauma centers that have limited resources and tend to have worse patient outcomes, Romana Hasnain-Wynia, director of Northwestern University’s Center for Healthcare Equity, told the Chicago Sun-Times. Researchers pointed out that the results refute the "notion that racial disparities in trauma care are merely a reflection of insurance status."
Adjusted odds of mortality by race and insurance status