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The seven most common chronic diseases cost the U.S. economy more than $1 trillion a year. If gains are not made in prevention and primary care, that cost could balloon to nearly $6 trillion by the middle of the century, according to a new report.

STATE NEWS

WHAT’S ON THE 2008 AGENDA? THREE LAWMAKERS GIVE THEIR VIEWS

At NCSL’s Fall Forum in Phoenix, Arizona, SHN sat down with legislative leaders in the health-care arena to discuss a number of leading health policy issues, ranging from the SCHIP stalemate to health information technology. SHN writer Matthew Gever spoke with Tennessee Representative Joseph E. Armstrong, chairman of the House Health and Human Resources Committee; New Jersey Assemblyman Herb Conaway, M.D., chairman of the Health and Senior Services Committee; and Alaska Representative Wes Keller, a recent staffer turned legislator. Interviews have been edited for clarity and length.

SHN: What is your state doing in the area of health information technology (HIT)? What are the biggest obstacles to increasing the use of HIT?

Assemblyman Conaway: In New Jersey we’re putting the finishing touches on legislation that will establish an Office of Health Information Technology within the Department of Banking and Insurance. This will be a public entity that will be in charge of safeguarding and securing the personal health information of New Jerseyans whose health information goes into the electronic system.

This bill is the starting point on the legislative side for a lot of work that’s already been done to drive HIT forward. It would establish a public process for developing a plan to ensure the broadest possible participation by key stakeholders. This patient-centered system will provide the information that patients need at the time that they encounter the health-care system. It also will enable public health officials to do surveillance and plan initiatives to improve public health and outcomes.
Representative Keller: We policymakers talk about the benefits of HIT and that’s real nice, but the real challenge is, you just can’t get traction on the issue with other players, like the consumers and providers. The consumers don’t see the benefits because we don’t have much ownership of our own health in general in the U.S. And in a third-party payer system like we have, you start talking HIT and the values of it, you get kind of a glassy stare. But to me, it’s very exciting.

In Alaska, we’ve had several physicians’ groups put together presentations for the Governor’s council. We have one physicians’ group who put together a business plan, proposing to spend $30 million (on HIT) over the next six years. I’m hoping those things will all come out in the Governor’s upcoming health-care strategy.

Another thing that is very interesting that the Alaska Native Tribal Health Consortium just got a grant to promote electronic health records. What’s exciting about that is they also manage a group in tele-health. They have 700 tele-health units across rural Alaska. As you know, we have very unique geographic challenges. Somebody in the village has a problem, they can go in and see a person with a PC-based unit. They can do the basic check of vitals, create a record and then link back to physicians in the urban areas. It’s relatively inexpensive—less than $100,000 per unit. The wall they’ve hit right now is getting more physicians to participate in the urban area. And of course, getting more of the units out there.

SHN: How is the stalemate in the debate over the State Children’s Health Insurance Program affecting your state?

Representative Armstrong: We’re one of the last states to really start pushing SCHIP. We did a very successful job over the fall when school started up. Our goal was to enroll 10,000 kids. So far this year, we’ve enrolled about 16,000. We feel there are about 40,000 kids out there who are eligible and are not enrolled, so we’re using the schools and classrooms to try and establish medical homes for all our kids. And we’ve partnered with Meharry Medical College and our institutes of higher learning to encourage medical students to get out there and help people get enrolled. We’ve taken a very aggressive stance. We’re going to use about $10 million that we have in the state for advertising and outreach.

(SHN: In the mid-1990s, Tennessee tried to provide universal coverage to its residents by creating “TennCare”—a program that extended coverage through managed-care plans to Medicaid enrollees, as well as uninsured Tennesseans. Enrollment grew until the state decided that TennCare was financially unsustainable. In 1994, the state started phasing in an overhaul that included dis-enrolling 300,000 people from TennCare, re-establishing a traditional Medicaid program, establishing a high-risk pool and starting CoverTennessee, a premium support program for small businesses. Please see “Highlights” in this issue for more on the premium support program.)

Assemblyman Conaway: Clearly, states who see SCHIP as a building block to achieving more universal access to health insurance are going to find that achieving that goal is going to be harder. In New Jersey in particular, we expanded SCHIP according to the rules in place at the time. And now we’re told after we made commitments to the marketplace, after we’ve taken steps to bring people into the program, the federal government just comes along and pulls the rug out from under us.
It’s a huge effect for us and other states who followed the federal government’s lead, worked on the program, expanded the program and had a positive impact on health status because of the availability of the program. Now we’re seeing this program is going to be under-funded, or in some people’s minds de-funded, because of a change in the rules after the fact. In New Jersey and about ten other states, you’re probably going to see that fewer people are going to be covered under the program, particularly in tight budgetary times. And people are going to lose their insurance, and as a consequence their health status is going to decrease.

SHN: Do you see universal access as being possible?

Representative Armstrong: We had our experience with TennCare. You saw Tennessee ranked in the top 10 in terms of the number of people who had insurance at the height of TennCare. You had small businesses with employees who had access to coverage even though the employer didn’t provide it. But we in Tennessee chose not to continue funding the program (in its former state). The problem was there were people who saw the type of program we had and came into Tennessee to take advantage of our program. And we were not able to protect our borders from people coming in for transplants, for treatment for AIDS—because of the pharmaceutical benefit they were able to get their medications. It was just the influx of everyone else coming to Tennessee to get their health care. I think that if the country as a whole implemented a similar TennCare program, it would work.

SHN: What will be on your state’s 2008 health agenda?

Assemblyman Conaway: We’re certainly going to monitor the progress of the HIT legislation, and look to enact other measures that will help advance HIT. We’re going to spend some time looking at disparities in health care and addressing those. And we’re going to spend some time on the public health infrastructure. I want to take up this issue of how to strengthen and modernize public health departments. There is an issue of course with funding, but I think it’s time for us to put some legislative building blocks in place to make important changes there.

Representative Keller: We have several bills pending that would increase the income eligibility requirements for our version of SCHIP. But I don’t think they’re going to go anywhere. It’s not a statement on SCHIP so much as the economic situation in Alaska. We’re in a windfall mode, but our oil supplies are decreasing by 6 percent per year and 90 percent of our state revenue comes from oil. So we have a fiscal crisis coming.

Add to the fact that Medicaid has doubled from 2000-2005 in expenditures per person, and the Legislature feels cautious about expanding long-range entitlement programs. Probably the most exciting development is that Governor Sarah Palin by executive order last February put together an Alaska Health Planning Strategy Council and its report is due to the Legislature on Jan. 1, 2008. I suspect the report will generate some traction towards issues that relate to health care.

SHN: Representative Armstrong, during the Health Chairs’ Tea, you commented on the growing trend of churches pooling funds to pay for health care. Can you expand on this?

Representative Armstrong: You don’t see churches dividing anymore, you see more congregations coming together and growing into megachurches across the country. As they grow larger they will be looking to provide some level of care to fill a gap for people who aren’t insured. This is a first step toward the ultimate goal of universal access.
I absolutely think it’s the wave of the future, because here you have people who really, truly have a common interest. Generally people who are part of these ministries look to help carry others’ burdens.

(SHN: In separate remarks, Representative Armstrong explained that these church-based efforts run many of the same risks as payers and providers of care, such being defrauded or going under financially and then defaulting on payments owed to nurse practitioners or others.)

(To protect the churches and the patients) I think we need to establish federal guidelines for these health-care efforts, just like we did for HMOs, PPOs, whatever. They should be recognized as 501(c)3s by the IRS, and their administrative costs and what monies are actually going out to help their ministries should be monitored.

SHN: Representative Keller, you talked a lot about individual ownership of health. Are you a supporter of HSAs?

Keller: I think HSAs are a fabulous way to go. They’re really catching on. Philosophically, I think they’re great. It’s my money for my health. The last numbers I’ve read is 50 percent of the health-care costs that you will incur in your life will occur during the last five years of your life. So it just makes perfect sense for people to own and manage whatever money they can use for their own care.

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**HIGHLIGHTS**

**ACCESS**

**CoverTennessee to Expand**

Beginning Jan. 1, 2008, more Tennesseans will be eligible for CoverTN, the premium subsidy program for the working uninsured. When CoverTN was launched nearly six months ago, it covered workers who earned up to $41,000 in small businesses with 25 employees or less. The state pays one-third of the premiums, the employer may choose to pay one-third and the employee one-third. If the employer chooses not to participate, the employee may pay two-thirds. Premiums for the basic benefit plan are about $150 a month and coverage is portable. The state plans to expand the program by opening it to individuals with annual incomes of up to $43,000, and in companies with up to 50 employees. About 13,000 Tennesseans are currently enrolled, and administrators hope to increase enrollment to 100,000 by 2010. Come the new year, significant changes also will occur in Tennessee’s other public health insurance programs. CoverKids (the state’s SCHIP program) will begin offering dental and vision benefits. AccessTN, a high-risk pool, will increase its maximum payout from $120,000 per year to $200,000 per year, and will boost the amount of premium assistance that it provides.
PUBLIC HEALTH

MRSA Hospitalizations On the Rise
The number of hospitalizations in the United States due to methicillin-resistant Staphylococcus aureus, also known as MRSA, have doubled over six years, according to a study published in the journal Emerging Infectious Diseases. Researchers found that the number of hospitalizations associated with MRSA rose from 127,000 in 1999, to 278,000 in 2005. During the same period, regular staph infections increased by 62 percent. The rise in MRSA-related illnesses stemmed mostly from an explosion in the number of skin and soft-tissue infections, which are typically associated with strains acquired outside of hospitals, the study found. MRSA is difficult to treat because it has developed resistance to most common antibiotics. “Antibiotic-resistant infections are spreading more rapidly in the community, while the epidemic of drug-resistant infections in hospitals continues unabated,” said Ramanan Laxminarayan, the lead epidemiologist.

Prescription Drugs
Medicaid is now spending more money on antipsychotic drugs than any other category of pharmaceutical, the Wall Street Journal reports. Much of the rise is attributed to more nursing home residents receiving these drugs to mitigate symptoms of Alzheimer’s disease and other forms of dementia. About 30 percent of residents now receive antipsychotics, according to the Centers for Medicare & Medicaid Services. However, 21 percent of nursing home patients who do not have a diagnosis of psychosis are still on these medications. CMS spent $5.4 billion—or 13 percent of all drug outlays—in 2005 on what are known as atypical antipsychotic drugs. The drugs were introduced in the 1990s, mostly to fight schizophrenia, but are now common for bi-polar disorder and off-label treatment of dementia. Recently, the Arkansas Attorney General filed suit against Johnson & Johnson claiming the company “engaged in a false and misleading campaign” to market one of its antipsychotics to geriatric patients.

CHILDREN’S HEALTH

Data Source
The Child and Adolescent Health Measurement Initiative (CAHMI) just released a "point and click" online tool containing national- and state-level findings from the 2005-2006 National Survey of Children with Special Health Care Needs (NS-CSHCN). The web resource offers data for over 100 child health indicators, including ER usage, use of specific health-care services, insurance coverage, as well as household income level, race/ethnicity and family structure. Users can select and download findings for various population subgroups, create custom profiles of health use and compare findings across states. The NS-CSHCN is a national survey sponsored by the federal Maternal and Child Health Bureau and administered by the National Center for Health Statistics. The survey was conducted for the first time in 2000/01, and repeated again in 2005/06. For more information, visit cshcndata.org/Content/Default.aspx
The most common chronic diseases cost the U.S. economy $1.3 trillion annually, according to a new report from the Milken Institute, a nonprofit economic think tank. If current trends continue, those costs could balloon to nearly $6 trillion by the middle of the century.

An Unhealthy America: The Economic Burden of Chronic Disease examines the economic loss associated with seven chronic diseases: cancer, diabetes, hypertension, stroke, heart disease, pulmonary conditions and mental illness. The report also ranks all 50 states by the reported number of chronic diseases per capita, using numbers from 2003. The states with the lowest rates are Utah, Alaska, Colorado, New Mexico and Arizona.

If modest advances are made in prevention and treatment, the nation could avoid 40 million cases of chronic disease by 2023, reducing the economic impact of chronic disease by 27 percent or $1.1 trillion annually, researchers say. The most important factor is obesity—if rates of obesity declined, the nation could spend $60 billion less for treatment and increase productivity by $254 billion.

The report is free online. An interactive site with state-by-state data is posted at www.chronicdiseaseimpact.com.
