

**CALIFORNIA RESEARCH BUREAU
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**Studies in the News:
Health Care Supplement**

Contents This Week

HEALTH

- [Cleaner air, longer lives](#)
- [Higher alcohol taxes, less drinking](#)
- [Statewide increase in Alzheimer's disease](#)
- [Communicating with doctors about asthma](#)
- [Family planning program saves money](#)
- [Children at risk of developmental delay](#)
- [The costs of current drug regulation](#)
- [Emergency visits during heat wave](#)
- [Mercury in high fructose corn syrup](#)
- [Electronic record systems in foster care](#)
- [California stands to gain from stimulus](#)
- [Controlling the cost of health care](#)
- [Reforming health care payments](#)
- [Special interests and health costs](#)
- [Becoming a healthier nation](#)
- [Lessons from the year of reform](#)
- [Massachusetts health reform](#)
- [A competitive health insurance market](#)
- [American's health insurance at risk](#)
- [California health plans and insurers](#)
- [Californians' losing health insurance](#)
- [Health-status insurance](#)
- [Making health exchanges work](#)
- [Why not to tax health benefits](#)
- [Bypass surgery in California](#)

[Financial and quality incentives for health IT](#)

[Improving health IT systems](#)

[Promoting telehealth](#)

[Using the stimulus for health IT](#)

[Blood lead level's decline](#)

[Enhancing enrollment in SCHIP](#)

[Help for Medicaid recipients](#)

[Help from the stimulus package](#)

[Medicare and Medicaid oversight](#)

[The health of Asian-Americans](#)

[Proximity of fast food contribution to obesity](#)

[Teen dietary habits](#)

[Girls getting cervical cancer vaccine](#)

Introduction to Studies in the News

Studies in the News is a current compilation of items significant to the Legislature and Governor's Office. It is created weekly by the California State Library's [California Research Bureau](#) to supplement the public policy debate in California. To help share the latest information with state policymakers, these reading lists are now being made accessible through the California State Library's website. This week's list of current articles in various public policy areas is presented below. Prior lists can be viewed from the California State Library's Web site at www.library.ca.gov/sitn

- When available, the URL for the full text of each item is provided.
- California State Employees may contact the State Information & Reference Center (916-654-0261); csinfo@library.ca.gov with the SITN issue number and the item number [S#].
- All other interested individuals should contact their local library - the items may be available there, or may be borrowed by your local library on your behalf.

The following studies are currently on hand:

HEALTH

AIR POLLUTION

"Fine-Particulate Air Pollution and Life Expectancy in the United States." By C. Arden Pope III and others. IN: New England Journal of Medicine, vol. 360, no. 4 (January 22, 2009) pp. 376-386.

Full text at: <http://content.nejm.org/cgi/content/full/360/4/376>

["A study has found that the reduction of fine particles given off by automobiles, diesel engines, steel mills and coal-fired power plants, have added as much as 15 percent of the 2.72 years of extra longevity seen in the United States since the early 1980s. Changes in smoking habits are the biggest reason why Americans are living longer.... But cleaner air was a big factor. Using life expectancy, economic, demographic and pollution data from 51 metropolitan areas, researchers found when fine-particle air pollution dropped by 10 micrograms per cubic meter, life expectancy rose by 31 weeks." Reuters (January 29. 2009) 1.]
[Request #S09-11-3305]

[\[Back to Top\]](#)

ALCOHOL & DRUG USE

"Effects of Beverage Alcohol Price and Tax Levels on Drinking: a Meta-Analysis of 1003 Estimates from 112 Studies." By Alexander C. Wagenaar and others. IN: Addiction, vol. 104, no. 2 (January 15, 2009) pp. 179-190.

Full text at: <http://www3.interscience.wiley.com/cgi-bin/fulltext/121639213/PDFSTART>

["Higher taxes on alcohol can do more than add cash to ailing government budgets. A new study reports 'statistically overwhelming evidence' that raising taxes also reduces the level of drinking.... As prices go up, the study found, people become less likely to drink. And when they do drink, they drink less. The findings were true for teenagers as well as adults." New York Times (January 19, 2009) 1.]
[Request #S09-11-3283]

[\[Back to Top\]](#)

ALZHEIMER'S DISEASE

Alzheimer's Disease: Facts and Figures in California: Current Status and Future Projections. By Leslie K. Ross and others, Institute for Health & Aging, University of California San Francisco. (California Department of Public Health, Sacramento, California) February 2009. 106 p.

Full text at:

<http://www.cdph.ca.gov/programs/alzheimers/Documents/CADataReport-full-corrected3-2.pdf>

["The cost of caring for Californians with Alzheimer's disease is expected to grow from \$50.5 billion to \$98.8 billion over the next 20 years, an increase of 96 percent. By 2030, Californians with Alzheimer's is expected to nearly double to 1.1 million due to the aging of the Baby Boomer generation and the growing longevity of the overall population. Alzheimer's disease, a progressive brain disease characterized by severe dementia, is the sixth most common disease that ends in death statewide, and it is increasing more rapidly than other leading causes of death. The study found that Californians age 55 and older have a 1 in 8 chance of developing the disease." San Francisco Chronicle (February 26, 2009) 1.]

[Request #S09-11-3416]

[\[Back to Top\]](#)

ASTHMA

Many Californians with Asthma Have Problems Understanding Their Doctor. By Susan H. Babey and others, UCLA Center for Health Policy Research. (The Center, Los Angeles, California) January 2009. 8 p.

Full text at:

http://www.healthpolicy.ucla.edu/pubs/files/Asthma_Doctor_PB_0109.pdf

["In California, 90,000 adults with current asthma have experienced problems understanding their doctors. There are significant disparities in who experiences these communication problems according to education, income, insurance status, English proficiency, race/ethnicity and nativity. In addition, adults with asthma who experience these problems are more likely to go to the emergency department or urgent care facility for asthma care and are less likely to receive asthma management plans from their health care providers. Improvements in education and communication strategies are needed to facilitate understanding between health care providers and asthma patients, especially when patients have limited English proficiency or have low health literacy."]

[Request #S09-11-3307]

[\[Back to Top\]](#)

BIRTH CONTROL

Next Steps for America's Family Planning Program: Leveraging the Potential of Medicaid and Title X in an Evolving Health Care System. By Rachel Benson Gold and others, Guttmacher Institute. (The Institute, New York, New York) February 2009. 44 p.

Full text at: <http://www.guttmacher.org/pubs/NextSteps.pdf>

["Publicly funded family planning prevents nearly 2 million unintended pregnancies and more than 800,000 abortions in the United States each year, saving billions of dollars. Rachel Benson Gold called the family planning program 'smart government at its best,' asserting that every dollar spent on it saves taxpayers \$4 in costs associated with unintended births to mothers eligible for Medicaid-funded natal care.... Without publicly funded family planning, the U.S. abortion rate would be nearly two-thirds higher, and nearly twice as high among poor women." Associated Press (February 24, 2009) 1.][Request #S09-11-3388]

[\[Back to Top\]](#)

CHILDREN

Measurement to Support Effective Identification of Children at Risk for Developmental Delay. AND: State Strategies to Support Practice Changes that Improve Identification of Children at Risk for or with Developmental Delays. AND: State Policy Improvements that Support Effective Identification of Children At Risk for Developmental Delay. By Neva Kay and others, National Academy for State Health Policy. (The Academy, Portland, Maine) March 2009.

["This briefing examines the efforts of 19 states, the District of Columbia and Puerto Rico to use measurement to support policy and practice changes that improve pediatric primary care providers' identification of children with or at risk for developmental delay. Measurement played an important role in making the case for change, developing and refining training targeted to primary care provider needs, and assessing whether changes produced the intended effect.... While individual states' approaches to this support function is varied, collaborative strategies between primary care providers delivering preventive services and state agencies has great potential to transform the health care system for this population."][Request #S09-11-3553]

Measurement. 9 p.

http://www.nashp.org/files/screening_academy_results.pdf

Strategies. 10 p.

http://www.nashp.org/files/State_Strategies.pdf

Policy Improvements. 9 p.

http://www.nashp.org/files/State_Policy.pdf

[\[Back to Top\]](#)

DRUG PRICES

Leviathan's Drug Problem: Federal Monopoly of Pharmaceutical Regulation and its Deadly Cost. By John R. Graham, Pacific Research Institute. (The Institute, San Francisco, California) March 2009. 55 p.

Full text at:

http://liberty.pacificresearch.org/docLib/20090319_Leviathan_Drug_Problem.pdf

["When a pharmaceutical innovator invents a new drug, ready for distribution in the United States, the federal government enforces an automatic ban on patients' use of the drug.... In 2007, the average time to remove the standard ban on a new prescription medicine was more than a year, coming at the end of up to 15 years of research and development. This ban is implicated in the deaths of about 200,000 Americans annually. Many believe that this failure is due to a lack of money for the FDA, but this is not the case. Great Britain's regulators are about one-third more productive than the FDA, and other European countries' regulators are even more productive. Countries in Europe have a policy of regulatory competition, where central and national regulators compete for user fees that they charge manufacturers to lift their bans on new drugs."]

[Request #S09-11-3494]

[\[Back to Top\]](#)

EMERGENCY CARE

"The 2006 California Heat Wave: Impacts on Hospitalizations and Emergency Department Visits." By Kim Knowlton and others. IN: Environmental Health Perspectives, vol. 117, no. 1 (January 2009) pp. 61-67.

Full text at: <http://www.ehponline.org/members/2008/11594/11594.pdf>

["The deadly heat that blasted much of California in 2006, killing more than 100 people, also sent thousands to emergency rooms with racing or faltering hearts and weakened kidneys. The heat wave pushed Sacramento emergency teams to assemble cooling centers and conduct door-to-door visits at downtown hotels and apartment buildings that had no air conditioning.... The biggest surprise was the spike in emergency room visits and hospitalizations in the coolest areas.... the San Francisco Bay Area and the Central Coast. As a result of the study, California plans to be more active in cooler areas next time a heat wave strikes. It will encourage those regions to set up cooling centers and be ready to check on isolated, elderly people." Sacramento Bee (March 3, 2009) 1.]

[Request #S09-11-3419]

[\[Back to Top\]](#)

FOOD SAFETY

"Mercury from Chlor-Alkali Plants: Measured Concentrations in Food Product Sugar." By Renee Dufault and others. IN: Environmental Health, vol. 8. no. 2 (January 2009) 17 p.

Full text at: <http://www.ehjournal.net/content/pdf/1476-069x-8-2.pdf>

["A test of popular processed foods from some of the biggest names in the industry found trace amounts of mercury. The mercury came from food plants that use caustic soda laced with mercury to produce high fructose corn syrup for major food companies. Researchers tested 55 consumer items, finding mercury in one third of the samples. The amounts of mercury found was far less than seen in most fish and seafood, but turned up in many foods previously unknown to be sources of mercury, including many preferred by children. The type of mercury commonly found in fish and seafood is methyl mercury, and its effects are known to be toxic, but the type of mercury found in the packaged foods is not yet known." Minneapolis Star Tribune (January 26, 2009) 1.]

[Request #S09-11-3317]

[\[Back to Top\]](#)

FOSTER CHILDREN

Improving Health Outcomes for Children in Foster Care: The Role of Electronic Record Systems. By Stefanie Gluckman and Terri Shaw, The Children's Partnership. (The Partnership, Santa Monica, California) Fall 2008.

["Children in foster care have greater health care needs than other children. These needs are not being met due to insufficient information about these children and lack of care coordination. An Electronic Record System can be a powerful tool for facilitating better collection, storage, sharing, and analysis of health information. Investments in such systems for children in foster care would likely yield significant returns, including improved outcomes for children and more efficient use of current spending to meet their needs. Such solutions have not been widely deployed to meet the needs of the children in foster care."]

[Request #S09-11-3368]

Policy Brief. 20 p.

<http://www.childrepartnership.org/AM/Template.cfm?Section=Home&Template=/CM/ContentDisplay.cfm&ContentID=12942>

Executive Summary. 4 p.

<http://www.childrepartnership.org/AM/Template.cfm?Section=Home&Template=/CM/ContentDisplay.cfm&ContentID=12947>

[\[Back to Top\]](#)

HEALTH CARE FINANCE

What California Stands to Gain: The Impact of the Stimulus Package on Health Care. By the California HealthCare Foundation and Manatt Health Solutions. (The Foundation, Oakland, California) March 2009. 17 p.

Full text at:

<http://www.chcf.org/documents/policy/WhatCAStandsToGainStimulusPackage.pdf>

["Among the ARRA-related health care programs and issues discussed in the brief are: 1) Medi-Cal support, including increases in federal matching payments, increased Disproportionate Share Hospital funding, a moratorium on federal Medicaid provider reimbursement changes, and extension of Transitional Medi-Cal and Indian health care programs; 2) Assistance with health coverage, including subsidies for and extensions of COBRA coverage and expansion of the federal Health Care Tax Credit; 3) Investments in primary care, including grant opportunities, enhanced reimbursement for community health centers, and additional support for primary health care workforce programs; and 4) Elevated status for comparative effectiveness research, including establishment of a federal advisory board and dedication of substantial funding."]

[Request #S09-11-3555]

[\[Back to Top\]](#)

Options for Controlling the Cost and Increasing the Efficiency of Health Care. By Douglas W. Elmendorf, Congressional Budget Office. (The Office, Washington, DC) March 10, 2009. 18 p.

Full text at: http://www.cbo.gov/ftpdocs/100xx/doc10016/03-10-Health_Care.pdf

["Policymakers must seek to improve efficiency by changing the ways that public programs pay for health care services.... Analysts agree that payment systems should move away from a fee-for service design -- and should provide stronger incentives to control costs, reward value, or both. Alternative approaches could be considered -- fixed payments per patient, bonuses based on performance, or penalties for substandard care -- but their precise effects on spending and health are uncertain. Inevitably, reducing the amount spent on health care will involve cutbacks or constraints on many types of services provided to the currently projected levels."]

[Request #S09-11-3493]

[\[Back to Top\]](#)

Reforming Provider Payment: Essential Building Block for Health Reform. By Stuart Guterman and others, The Commonwealth Fund. (The Fund, New York, New York) March 2009. 37 p.

Full text at: [Reforming Provider Payment](#)

["Changing how the nation pays for health care is critical to improve value, achieve better quality, and slow cost growth.... The authors explore bundling payments to cover care over a specified period, revising fees to increase compensation for primary care, and offering providers financial incentives to serve as patient-centered medical homes. These strategies seek to encourage more collaboration among providers, accountability for patient outcomes, and efficient use of resources than exist in our current fragmented system of care. On a foundation of universal health insurance coverage and new systems to promote better decision-making and improve population health, these payment reforms could slow the growth of health spending by \$1 trillion through 2020, compared with current projections."]
[Request #S09-11-3549]

[\[Back to Top\]](#)

Health Care in Crisis: How Special Interests Could Double Health Costs and How We Can Stop It. By Larry McNeely and Michael Russo, California Public Interest Research Group. (The Group, Sacramento, California) March 2009. 24 p.

Full text at: <http://www.calpirg.org/uploads/Bc/vc/BcvchZevLBy8vu2-HczODg/Healthcare-in-Crisis.pdf>

["The yearly cost of the average employer-paid family health policy in California is projected to double from \$11,493 in 2006 to \$25,682 by 2016. In 2007, one out of every three dollars that Americans spent on health care -- went to the insurance bureaucracies, drug companies, and medical device manufacturers. Medicare and private insurance payment policies compensate doctors on how many tests and procedures are ordered, not whether effective treatment is delivered. Payment for care does not adequately support effective strategies that improve patient health and reduce the amount of unnecessary care prescribed."]
[Request #S09-11-3471]

[\[Back to Top\]](#)

HEALTH CARE REFORM

Health Stewardship: The Responsible Path to a Healthier Nation. By Elizabeth Olmsted Teisberg and others, The Aspen Institute. (The Institute, Washington, DC) 2009. 74 p.

Full text at:

http://www.aspeninstitute.org/sites/default/files/content/docs/pubs/AHSP_HS_Web_Report.pdf

["The time has come for America to realize that health is a national resource to foster and grow, or squander and lose. Stewardship, the careful and responsible management of resources, can protect and preserve the collective well-being of the American people.... Improving the health of all Americans is nothing less than an economic priority. Our country must have a healthy workforce to enable productivity and maintain its standing in the world. Health care spending has a dramatic impact on every sector of the economy, and in a service-based economy like ours, the consequences of misuse can be especially pronounced.... Yet, despite its importance, the health of the American people is declining. We must respond with vigilance to the gradual depletion of this resource, our efforts rooted in a clear understanding of what causes it."]

[Request #S09-11-3548]

[\[Back to Top\]](#)

"The Long And Winding Road: Reflections On California's 'Year Of Health Reform.'" By Marian R. Mulkey and Mark D. Smith. AND: "Affording Shared Responsibility For Universal Coverage: Insights From California." AND: "Designing Health Insurance Market Constructs For Shared Responsibility: Insights From California." By Rick Curtis and Ed Neuschler. IN: Health Affairs, vol. 28, no. 3 (March 2009) pp. 417-456.

["The first article analyzes California's 2007 efforts, when the state came close to enacting sweeping legislation that, if fully implemented, would have expanded health insurance coverage to about 3.6 million of California's 5.1 million uninsured residents. California's experience offers important insights for future coverage expansion efforts, namely that policy efforts are more likely to advance if they: are bipartisan; address the needs of both insured and uninsured residents; deliver short-term progress within the context of long-term goals; rely on broad and sustainable financing; strike a balance between specificity and flexibility; and occur within a clearer framework of state and federal responsibilities. Two accompanying articles examine California's efforts to design a universal health coverage approach based on 'shared responsibility' among individuals, employers, and government, and they identify implications for possible federal health reform efforts."]

[Request #S09-11-3554]

Long and Winding Road.

<http://content.healthaffairs.org/cgi/content/abstract/hlthaff.28.3.w446v1>

Affording Shared Responsibility.

<http://content.healthaffairs.org/cgi/content/abstract/hlthaff.28.3.w417v1>

Designing Health Insurance Market.

<http://content.healthaffairs.org/cgi/content/abstract/hlthaff.28.3.w431v1>

[\[Back to Top\]](#)

Massachusetts Health Reform: Solving the Long-Run Cost Problem. By John Holahan and Linda J. Blumberg, Urban Institute. (The Institute, Washington, DC) 2009. 11 p.

Full text at: http://www.urban.org/UploadedPDF/411820_mass_health_reform.pdf

["Many of Massachusetts's health reforms have brought about positive change: the number of uninsured has fallen by half, access to needed care has increased, and private insurance has not been 'crowded out' by public insurance programs. But the Massachusetts initiative has also seen higher than anticipated costs. This analysis summarizes the state's accomplishments, examine the challenges, and suggest four options for addressing long-term costs. According to the authors, much of Massachusetts's high spending growth is due to the concentration in the state's hospital and insurance markets."]

[Request #S09-11-3297]

[\[Back to Top\]](#)

HEALTH INSURANCE

Competitive Health Care: A Public Health Insurance Plan that Delivers Market Discipline. By Peter Harbage and Karen Davenport, Center for American Progress. (The Center, Washington, DC) March 2009. 12 p.

Full text at:

http://www.americanprogressaction.org/issues/2009/03/pdf/competitive_health.pdf

["Lack of competition in this critical marketplace means poor transparency and accountability, resulting in costly health care that harms our national health, bleeds our personal finances and the federal budget, and hinders our economic competitiveness. None of this is acceptable amid the worst slide in economic growth in 60 years. Fortunately, our nation's health insurance market can be fixed with a big dose of what fixes most sectors of our economy -- healthy, well-supervised competition. One of the best ways to introduce this much-needed competition is for the federal government to offer a public health insurance plan

that can compete with private insurers within an insurance 'exchange' that ensures public and private health insurance plans compete equally and transparently in the public marketplace."]

[Request #S09-11-3544]

[\[Back to Top\]](#)

Americans at Risk: One in Three Uninsured. By Kim Bailey and others, Families USA. (Families USA, Washington, DC) March 2009. 24 p.

Full text at: <http://www.familiesusa.org/assets/pdfs/americans-at-risk.pdf>

["One out of three California residents went without health insurance for some point in the last two years. About 12.1 million Californians, or 37% of non-senior residents, were uninsured for at least one month during 2007 and 2008. Most were uninsured for at least six months, and more than 80% of them were in working families. Minorities were more likely to be uninsured; 53% of Latinos and 38% of blacks were uninsured during the two-year period; for whites, 25% were uninsured.... According to the U.S. Census Bureau, the number of people who had no health insurance for any part of 2007 was 45.7 million, down from 47 million in 2006. Experts attribute the drop to rising enrollment in government health programs for the poor and children." Los Angeles Times (April 3, 2009) 1.]

[Request #S09-11-3535]

[\[Back to Top\]](#)

California Health Plans and Insurers. By Katherine Wilson, California HealthCare Foundation. (The Foundation, Oakland, California) January 2009. 36 p.

Full text at: <http://www.chcf.org/documents/insurance/AlmanacHealthPlans09.pdf>

["Private health insurance carriers form the backbone of California's market-based health care system, providing coverage to 67% of its population. Health insurance carriers not only serve the privately insured, but also large portions of the publicly insured, in Medi-Cal, Healthy Families, Medicare, and other public programs.... This report provides an overview of market share, enrollment, financial performance, consumer satisfaction, and pay for performance participation for California's health plans and insurers. Key findings include: 1) Five insurers account for 76% of the \$91.9 billion in health insurance revenue; 2) Medicare Advantage plans cover nearly a third of California's Medicare beneficiaries; and 3) Half of all Medi-Cal beneficiaries are enrolled in managed care plans."]

[Request #S09-11-3315]

[\[Back to Top\]](#)

No Recovery in Sight: Health Coverage for Working-Age Adults in the United States and California. By Ken Jacobs and Dave Graham-Squire, UC Berkeley Center for Labor Research and Education. (The Center, Berkeley, California) April 2009. 12 p.

Full text at: http://laborcenter.berkeley.edu/healthcare/no_recovery_in_sight09.pdf

["About 500,000 working-age Californians have lost health insurance since the start of the recession, and an additional 100,000 could lose theirs by 2012 even if the economy fully recovers.... The report paints a bleak picture for the future if the current trends of increasing health premiums and decreasing employer-backed coverage continue.... Berkeley researchers considered their report's estimate to be conservative. The numbers account for workers who join their spouse's plan or find alternative coverage.... Even if the economy fully recovers and employment rates return to pre-recession levels, the number of uninsured working-age adults in California would increase 1.4 percent. That translates into 600,000 more uninsured Californians, or 4 million Americans, by 2012." San Francisco Chronicle (April 2, 2009) 1.]

[Request #S09-11-3542]

[\[Back to Top\]](#)

Health-Status Insurance: How Markets Can Provide Health Security. By John H. Cochrane, University of Chicago. (Cato Institute, Washinton, DC) February 18, 2009. 12 p.

Full text at: <http://www.cato.org/pubs/pas/pa-633.pdf>

["None of us has health insurance, really. If you develop a long-term condition such as heart disease or cancer, and if you then lose your job or are divorced, you can lose your health insurance. You now have a preexisting condition, and insurance will be enormously expensive -- if it's available at all. Free markets can solve this problem, and provide life-long, portable health security, while enhancing consumer choice and competition. 'Health-status insurance' is the key. If you are diagnosed with a long-term, expensive condition, a health-status insurance policy will give you the resources to pay higher medical insurance premiums. Health-status insurance covers the risk of premium reclassification, just as medical insurance covers the risk of medical expenses."]

[Request #S09-11-3369]

[\[Back to Top\]](#)

Rules of the Road: How an Insurance Exchange Can Pool Risk and Protect Enrollees. By Sarah Lueck, Center on Budget and Policy Priorities. (The Center, Washington, DC) March 31, 2009. 13 p.

Full text at: <http://www.cbpp.org/files/3-31-09health.pdf>

["Many health reform proposals would establish an insurance 'exchange' to provide coverage options that are affordable, comprehensive, and easy to compare. But unless an exchange has certain features, it will not function properly. Legislation establishing an exchange will need features which assure that: 1) insurance plans compete on the basis of price and quality, not on the basis of which insurers are best at attracting healthier enrollees and deterring sicker ones; 2) less-healthy individuals are not charged higher premiums for the same coverage simply because they end up in plans that disproportionately enroll less-healthy people; 3) all enrollees get at least a basic level of comprehensive benefits; and 4) consumers are able to compare plans and make informed decisions."]

[Request #S09-11-3550]

[\[Back to Top\]](#)

Not-So-Easy Money: Taxing Health Benefits Comes with Costs. AND: Who Loses if We Limit the Tax Exclusion for Health Insurance? By Elise Gould, Economic Policy Institute, and Alexandra Minicozzi, Congressional Budget Office. (The Institute, Washington, DC) March 2009.

["Unlike wages, health insurance premiums are not subject to taxation. Proposals to end this tax exclusion are emerging in the discussions of how to pay for health care reform. In a climate of substantial budget deficits, the prospect of recouping upwards of \$200 billion by taxing these benefits is enticing. But we should proceed with extreme caution before moving to cap or eliminate this tax exclusion. In trying to pay for coverage expansions, taxing health care benefits shouldn't be the first place we look, but rather the last, and only after large-scale health reform is in place to cover everyone.... Taxing high-priced health coverage will heavily burden two groups: workers in small firms and workers in employer pools with higher health risks, such as those with a high percentage of older workers."]

[Request #S09-11-3551]

Not-So-Easy Money. 2 p.

<http://www.epi.org/page/-/pdf/pm139.pdf>

Who Loses. 4 p.

http://epi.3cdn.net/c97fefbd77ccd8192f_nnm6i2vah.pdf

[\[Back to Top\]](#)

HEART DISEASE

Coronary Artery Bypass Graft Surgery in California: 2005-2006 Hospital & Surgeon Data. By Joseph P. Parker, Office of Statewide Health Planning and Development, and others. (The Office, Sacramento, California) March 2009.

["If you need heart bypass surgery in California, your chances of surviving are slightly better at hospitals that do hundreds and hundreds of the operations every year. The office has calculated mortality rates for every surgeon in the state who does coronary artery bypass grafts, which involve taking vessels from elsewhere in the body to bypass a blocked artery. It has also produced hospital-by-hospital listings. Both analyses are risk-adjusted, which means the state tried to make better comparisons by taking into account how sick each patient was, and how likely he or she might have been to survive surgery." Sacramento Bee (April 8, 2008) 1.]
[Request #S09-11-3556]

Report. 109 p.

http://www.oshpd.ca.gov/HID/Products/Clinical_Data/cabg2009/CABG0506.pdf

Executive Summary. 4 p.

http://www.oshpd.ca.gov/HID/Products/Clinical_Data/cabg2009/ExecutiveSummary.pdf

[\[Back to Top\]](#)

INFORMATION TECHNOLOGY

“Financial Incentives, Quality Improvement Programs, and the Adoption of Clinical Information Technology.” By James C. Robinson and others. IN: **Medical Care**, vol. 47, no. 4 (April 2009) pp. 411-417.

Full text at:

<http://www.chcf.org/documents/chronicdisease/FinancialIncentivesClinicalIT.pdf>

["Physician use of clinical information technology, such as electronic medical records, can positively impact the management of chronic illnesses. Yet clinical IT adoption by physician practices has lagged behind other market sectors.... Direct external incentives include pay-for-performance initiatives that provide financial compensation when organizations adopt specific technological capabilities. Indirect incentives include pay-for-performance arrangements that reward achievement based on quality scores, under the assumption that success on these measures is likely for organizations with robust electronic capabilities.... The research also showed that quality improvement stimulates the demand for clinical IT, independent of financial incentives."]

[Request #S09-11-3546]

[\[Back to Top\]](#)

Lessons from Amazon.com for Health Care and Social Service Agencies. By Eric Brown and Larry Fulton, Forrester Consulting. (California HealthCare Foundation, Oakland, California) 2009. 7 p.

Full text at:

<http://www.chcf.org/documents/chronicdisease/LessonsFromAmazonComSOA.pdf>

["Information systems in large health care organizations and social service agencies are laden with redundant, uncoordinated, and incorrect data. Consumers must repeatedly provide personal information into one database, only to find conflicting information exists in another. Service-oriented architecture (SOA) is a software system that increases efficiency and reduces redundancy and errors. It rests on the notion that common data resources can be systematically shared and reused throughout the enterprise. This issue brief describes how SOA works and how it might be applied to health care organizations and social agencies -- which have been slow to tap system integration."]

[Request #S09-11-3505]

[\[Back to Top\]](#)

Connecting California: The Impact of the Stimulus Package on Telehealth and Broadband Expansion. By the California Center for Connected Health. (The Center, Sacramento, California) April 2009. 14 p.

Full text at: <http://www.connectedhealthca.org/pdf/CCCH-StimulusPackageIB04022009.pdf>

["The American Recovery and Reinvestment Act (ARRA) includes more than \$7 billion to expand broadband access and use, promote the adoption of telehealth and establish a framework for future investments in broadband and telehealth. Given the competition for these funds and the tight statutory timelines for their expeditious distribution by federal agencies, California must act promptly and in a coordinated fashion to take maximum advantage of this opportunity. California's telecommunication research and development prowess puts it in a strong position to blaze the telehealth trail. ARRA funds would enable California to ensure access to high-quality health care, optimize telehealth in the most efficient way possible, create a significant number of jobs and spur economic growth."]

[Request #S09-11-3545]

[\[Back to Top\]](#)

An Unprecedented Opportunity: Using Federal Stimulus Funds to Advance Health IT in California. By the California HealthCare Foundation and others. (The Foundation, Oakland, California) February 2009. 22 p.

Full text at:

<http://www.chcf.org/documents/chronicdisease/AnUnprecedentedOpportunity.pdf>

["Based on an analysis of provisions of the stimulus legislation, the issue brief calls on the state to take specific steps to assist physicians, hospitals, community health centers, and others to qualify for federal incentive payments to adopt and implement electronic health records, and to be competitive as various new federal grant programs become available. The legislation provides some \$36 billion over six years for health information exchange infrastructure and incentive payments to physician practices adopting electronic health records, chronic disease management systems, and other technologies. In California, the funding could add up to more than \$3 billion."]

[Request #S09-11-3543]

[\[Back to Top\]](#)

LEAD POISONING

"Trends in Blood Lead Levels and Blood Lead Testing Among US Children Aged 1 to 5 Years, 1988–2004." By Robert L. Jones and others. IN: Journal of the American Academy of Pediatrics, vol. 123, no. 3 (March 1, 2009) pp. 376-385.

Full text at: <http://pediatrics.aappublications.org/cgi/reprint/123/3/e376>

["Lead can interfere with the developing nervous system and cause permanent problems with learning, memory and behavior. Children in poor neighborhoods have generally been more at risk because they tend to live in older housing and in industrial areas. Far fewer kids have high lead levels than 20 years ago, a testament to aggressive efforts to get lead out of paint, water and soil. The 84 percent drop extends a trend that began in the 1970s when efforts began to remove lead from gasoline. The researchers credited continuing steps to reduce children's exposure to lead in old house paint, soil, water and other sources." Associated Press (March 2, 2009) 1.]

[Request #S09-11-3415]

[\[Back to Top\]](#)

MEDICAID

Nine in Ten: Using the Tax System to Enroll Eligible, Uninsured Children into Medicaid and SCHIP. By Stan Dorn, and others, Urban Institute. (The Institute, Washington, DC) 2009. 28 p.

Full text at: http://www.urban.org/UploadedPDF/411844_tax_system.pdf

["In 2004, 89.4 percent of uninsured children who qualified for Medicaid or the State Children's Health Insurance Program lived in families who filed federal income tax forms. This substantially exceeds the proportion of uninsured but eligible children who can be reached through many other outreach strategies. Federal lawmakers could cover uninsured children in these families by: (a) changing federal income tax forms so parents can identify their uninsured children and request coverage; (b) investing in information technology allowing data exchange between states and the Internal Revenue Service; and (c) letting states cover uninsured children if tax information shows they qualify."]
[Request #S09-11-3498]

[\[Back to Top\]](#)

States Should Tap New Tools to Help Medicaid Beneficiaries Maintain Coverage. By Sarah Lueck, Center on Budget and Policy Priorities. (The Center, Washington, DC) March 2009. 4 p.

Full text at: <http://www.cbpp.org/files/3-12-09health2.pdf>

["States should adopt two important new options, enacted under the American Recovery and Reinvestment Act (ARRA), that would help more low-income Medicaid beneficiaries maintain their health coverage when they reenter the workforce or see their earnings increase, while also lowering states administrative costs. ARRA extends the Transitional Medical Assistance (TMA) program and allows states to improve participation among TMA-eligible families. These changes make it more likely that low-income families some of whom have recently become eligible for Medicaid because job losses can maintain access to needed medical services when the parents in these families eventually find new jobs, increase their work hours, or switch to higher-paying employment. These changes also allow states to greatly reduce the administrative burdens associated with providing TMA coverage."]
[Request #S09-11-3497]

[\[Back to Top\]](#)

What Does the American Recovery and Reinvestment Act of 2009 Mean for California? By the California Budget Project. (The Project, Sacramento, California) March 9, 2009 10 p.

Full text at: http://www.cbp.org/pdfs/2009/090309_ARRA.pdf

["California could receive nearly \$51 billion from the federal stimulus package, if the state makes some changes in programs such as Medi-Cal. To receive the federal funding policymakers must reinstate annual eligibility renewals for children in Medi-Cal and ensure that this change takes effect before July 1, 2009. If the state misses the deadline, it will lose an estimated \$3.7 billion in federal funding for Medicaid in 2008-09 -- and will lose even more federal funds for every quarter that it delays making this change." San Francisco Chronicle (March 10, 2009) 1.]
[Request #S09-11-3429]

[\[Back to Top\]](#)

Medicare and Medicaid Participating Facilities: CMS Needs to Reexamine Its Approach for Funding State Oversight of Health Care Facilities. By the U.S Government Accountability Office. GAO-09-64. (The Office, Washington, DC) February 13, 2009. 90 p.

Full text at: <http://www.gao.gov/new.items/d0964.pdf>

[" Americans receive care from tens of thousands of health care facilities participating in Medicare and Medicaid. To ensure the quality of care, CMS contracts with states to conduct periodic surveys and complaint investigations. GAO evaluated survey funding, state workloads, and federal oversight of states' use of funds since fiscal year 2000 to determine if federal funding had kept pace with the changing workload. GAO analyzed: 1) Federal funding trends from fiscal years 2000 through 2007; 2) CMS data on the number of participating facilities and completed state surveys; and 3) CMS oversight of state spending. GAO recommends several actions to address survey funding weaknesses, such as state funding inequities, limited data on the impact of funding on facility oversight, and limited oversight of state spending. GAO also recommends that CMS broadly reexamine its current approach to funding and conducting surveys."]
[Request #S09-11-3499]

[\[Back to Top\]](#)

MINORITIES

The State of Asian American, Native Hawaiian and Pacific Islander Health in California Report. By Ninez Ponce and others, University of California Asian American & Pacific Islander Policy Multi-Campus Research Program. (California Asian Pacific Islander Joint Legislative Caucus, California State Assembly, Sacramento, California) April 2009. 68 p.

Full text at:

http://democrats.assembly.ca.gov/members/a49/pdf/AANHPI_report_091.pdf

["Asian Americans, Native Hawaiians and Pacific Islanders (AANHPIs) in California now number over five million and comprise over 14% of the population, making this minority group one of the fastest growing racial populations in the state, as well as in the nation.... We examine this diverse population through the lens of socioeconomic factors that differentiate the various AANHPI ethnic subgroups, as well as the social circumstances and health system conditions that may predispose or influence AANHPIs in their health behaviors. Understanding these population characteristics, socioeconomic determinants and health system factors contextualizes the state of AANHPI health in California and thus more effectively guides policy formulation addressing both systemic and specific causes of AANHPI health disparities."]

[Request #S09-11-3552]

[\[Back to Top\]](#)

OBESITY

The Effect of Fast Food Restaurants on Obesity. By Stefano DellaVigna, University of California Berkeley, and others. (The University, Berkeley, California) January 2009. 50 p.

Full text at: <http://www.econ.berkeley.edu/~sdellavi/wp/fastfoodJan09.pdf>

["Researchers have found a statistical connection between the proximity of fast food restaurants to obesity among California's ninth-graders and pregnant women. The study found that ninth-graders were 5.2 percent more likely to be obese if their schools were within a tenth of a mile of a fast-food restaurant, but the statistical correlation faded at longer distances. A similar correlation was found for pregnant women living near fast-food outlets. The statistical connections, were markedly higher for Latinos and African Americans than for whites. The overall contribution of the expansion of the fast-food industry to the increase in obesity rate remains unclear, was the report's bottom line." Sacramento Bee (March 4, 2009) 1.]

[Request #S09-11-3422]

[\[Back to Top\]](#)

Teen Dietary Habits Related to Those of Parents. By Allison L. Diamant and others, UCLA Center for Health Policy Research. (The Center, Los Angeles, California) February 2009. 6 p.

Full text at:

http://www.healthpolicy.ucla.edu/pubs/files/Teen_Diet_Habits_PB_0209.pdf

["In California, adolescents drink soda and eat fast food every day but do not eat adequate amounts of fruits and vegetables. These eating patterns are linked with the eating patterns of their parents. Policymakers and health educators can alter these patterns by developing supportive environments at home, at school and in the community. Make healthy food affordable in communities and at school. Increase the presence of supermarkets, farmer's markets, and community gardens in inner city areas with limited consumer options. Eating together as a family has been associated with better dietary behaviors and lower rates of obesity. Community and school gardens can increase the number of venues for growing food that families prepare for themselves as well as the availability of fresh produce."]
[Request #S09-11-3351]

[\[Back to Top\]](#)

VACCINES

One in Four California Adolescent Girls Have Had Human Papillomavirus Vaccination. By David Grant and others, UCLA Center for Health Policy Research. (The Center, Los Angeles, California) February 2009. 6 p.

Full text at: http://www.healthpolicy.ucla.edu/pubs/files/HPV_PB_0209.pdf

["The cervical cancer vaccine Gardasil is gaining widespread acceptance in California despite its newness and some controversy over its safety, researchers have found. One in four teenage girls in the state -- about 378,000 out of 1.5 million -- received at least one dose of the vaccine in 2007, its first full year of distribution. Among those who had not started the series of shots, a majority of teens and young adult women expressed interest in receiving the vaccine, as did their parents. Gardasil provides protection against four strains of the human papilloma virus, which are associated with about 70% of all cervical cancers in the United States and 90% of genital warts. The vaccine is administered in three shots over a six-month period." Los Angeles Times (February 18, 2009) 1.]
[Request #S09-11-3365]

[\[Back to Top\]](#)