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**Studies in the News:
Health Care Supplement**

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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

CELLULAR PHONES

Cellphones and Brain Tumors: 15 Reasons for Concern: Science, Spin and the Truth Behind Interphone. By L. Lloyd Morgan, Bioelectromagnetics Society, and others. (EM Radiation Research Trust, Exeter, United Kingdom) August 25, 2009. 44 p.

Full text at: http://www.radiationresearch.org/pdfs/reasons_us.pdf

["The report says the latest research indicates that regular use of cellphones can result in a 'significant' risk of brain tumors. Kids are at greater risk than adults because their still-developing brain cells are more vulnerable to electromagnetic radiation.... The potential risks of cellphone use have been debated for years. A number of reputable organizations say there's no conclusive evidence that using a cellphone is harmful to your health. But many consumer advocates, along with health officials around the world, say the jury's still out. They are awaiting the results of a long-delayed, 13-nation study begun almost a decade ago that was intended to settle the matter of cellphone safety once and for all. That study, dubbed Interphone, has been held up for years by squabbling among researchers over how to interpret the data." Los Angeles Times (September 9, 2009) 1.]
[Request #S09-26-4084]

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CHILDREN

Implementation Choices for the Children's Health Insurance Program Reauthorization Act of 2009. By Lisa Simpson, University of Cincinnati, and others. (The Commonwealth Fund, New York, New York) September 2009. 43 p.

Full text at: [implementation choices](#)

["The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 has the potential to transform children's health care in the United States. The authors of this report analyze selected provisions of the legislation that involve outreach and enrollment, as well as child health quality and measurement.... Recommendations include: giving funding priority to states that will adopt or maintain key simplifications, providing clarity on the relationship between express-lane procedures (which allow states to use relevant findings from other public programs when determining children's enrollment eligibility) and error measurement, ensuring quality measures focus on priority health needs for children, and building quality measurement and improvement capabilities into electronic health information systems, among others."]
[Request #S09-26-4092]

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HEALTH CARE

A Report on the First Year of the San Mateo County Adult Coverage Initiative and Systems Redesign for Adult Medicine Clinic Care. By Embry M. Howell, the Urban Institute, and others. (The Institute, Washington, DC) July 2009. 52 p.

Full text at: http://www.urban.org/uploadedpdf/411928_areportonthefirstyear.pdf

["This report presents an evaluation of San Mateo County's Health System Redesign and Adult Coverage Initiative (ACE), an effort to improve effectiveness, efficiency, and care coordination among uninsured and underserved adults in the county. Enrollment in the ACE program has exceeded expectations, yet sustained financing for the program has yet to be identified. We have observed reforms in scheduling, team-based care, and the implementation of electronic medical records. However, we found significant barriers to access for primary care and specialty appointments.... This report provides the context in which the system redesign and ACE coverage initiative are taking place; describes initial implementation of the program; updates the Board of Supervisors on the current status of the evaluation; and presents a synopsis of the next steps planned for the evaluation."]

[Request #S09-26-4069]

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Bending the Curve: Effective Steps to Address Long-Term Health Care Spending Growth. By Joseph Antos, American Enterprise Institute for Public Policy Research, and others. (The Brookings Institution, Washington, DC) August 2009. 11 p.

Full text at:

http://www.brookings.edu/~media/Files/rc/reports/2009/0826_btc/0826_btc_fullreport.pdf

["A group of 10 health care policy experts released a set of concrete, feasible steps that could achieve the goal to slow spending growth while improving value. Standard short-term measures to address rising costs, like reducing prices, are not sufficient to succeed. Instead, legislation must support necessary changes and improvements in health care by reforming payment systems, regulations, and institutions that currently prevent patients from consistently getting the best quality care at the lowest cost.... Provider payments should be redirected toward rewarding improvements in quality and reductions in cost growth, providing support for health care delivery reforms that save money while emphasizing disease prevention and better coordination of care. Individual patients should be given greater support for improving their health and lowering overall health care costs."]

[Request #S09-26-4094]

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How Does the Quality of U.S. Health Care Compare Internationally? By Elizabeth Docteur and Robert A. Berenson, the Urban Institute. (The Institute, Washington, DC) August 2009. 14 p.

Full text at: http://www.urban.org/UploadedPDF/411947_ushealthcare_quality.pdf

["There is a perception among many Americans that despite coverage, cost and other problems in the health care system, the quality of health care in the United States is better than it is anywhere else in the world and might be threatened by health reform.... The findings don't provide a definitive answer but suggest no support for the oft-repeated claim that 'U.S. health care is the best in the world.' The U.S. does relatively well in some areas, including cancer care, and less well in others, including conditions amenable to prevention and coordinated management of chronic conditions. The authors conclude that concerns that health reform could compromise currently excellent care are unwarranted; health reform can only help."]

[Request #S09-26-4088]

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National Healthcare Quality Report: 2008. AND: National Healthcare Disparities Report: 2008. By the Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services. (The Agency, Rockville, Maryland) March 2009. Various pagings.

Full text at: <http://www.ahrq.gov/qual/qrd08.htm>

["These reports measure trends in effectiveness of care, patient safety, timeliness of care, patient centeredness, and efficiency of care. The reports present, in chart form, the latest available findings on quality of and access to health care. The National Healthcare Quality Report tracks the health care system through quality measures, such as the percentage of heart attack patients who received recommended care when they reached the hospital or the percentage of children who received recommended vaccinations. The National Healthcare Disparities Report summarizes health care quality and access among various racial, ethnic, and income groups and other priority populations, such as children and older adults."]

[Request #S09-26-3924]

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Is Health Spending Excessive? If So, What Can We Do About It? By Henry J. Aaron, the Brookings Institution, and Paul Ginsburg, the Center for Studying Health System Change. (The Institution, Washington, DC) September 2009. 16 p.

Full text at:

http://www.brookings.edu/articles/2009/0910_health_spending_aaron.aspx

["The case that the United States spends more than is optimal on health care is overwhelming. But identifying reasons for excessive spending is not the same as showing how to wring it out in ways that increase welfare. To lower spending without lowering net welfare, it is necessary to identify what procedures are effective at reasonable cost, to develop protocols that enable providers to identify in advance patients in whom expected benefits of treatment are lower than costs, to design incentives that encourage providers to act on those protocols, and to provide research support to maintain the flow of beneficial innovations."]

[Request #S09-26-4093]

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HEALTH CARE REFORM

Employers and Health Reform Summary. By the Economic Policy Institute. (The Institute, Washington, DC) July 2009. Various pagings.

Full text at:

http://www.epi.org/publications/entry/employers_and_health_reform_summary/

["As the largest source of health insurance for non-elderly Americans, U.S. employers have an extremely large stake in health reform. In 2007, employer sponsored insurance (ESI) provided coverage to 62.9% of Americans under the age of 65.... The first Issue Brief looks at the phenomenon of 'deadbeat industries' that provide health insurance to comparatively few of their workers and their workers' dependents. While it has been relatively straightforward to document when workers in a given industry receive ESI coverage through a spouse, this Issue Brief is the first to document sources of ESI dependent coverage by industry.... The second Issue Brief uses previously unpublished data to examine variations by industry in employer contributions to workers' health insurance. It finds substantial variation in industry spending on health insurance premiums."]

[Request #S09-26-4096]

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LGBT Issues in Health Reform: Issue Brief on Making Health Reform Work for All Americans. By Josh Rosenthal, Center for American Progress. (The Center, Washington, DC) July 27, 2009. 7 p.

Full text at: <http://www.americanprogress.org/issues/2009/07/pdf/lgbthealth.pdf>

["Health care reform legislation will help lesbian, gay, bisexual, and transgender Americans in the same ways that it would help all Americans. Expanded access to meaningful health insurance coverage, effective preventive care, and delivery system reform provide same benefits regardless of sexual orientation and gender identity. But LGBT people often face additional barriers to coverage and care due to ongoing stigma and policies that do not fully recognize their identities.... Health care reform offers an opportunity to address these disparities.... This brief aims to draw out a few of these key principles, including the need to measure and address LGBT health disparities, ways to expand meaningful insurance coverage, the need for cultural competency, and privacy issues in health IT."]

[Request #S09-26-3968]

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Massachusetts Miracle or Massachusetts Miserable: What the Failure of the “Massachusetts Model” Tells Us about Health Care Reform. By Michael Tanner, Cato Institute. (The Institute, Washington, DC) June 9, 2009. 12 p.

Full text at: <http://www.cato.org/pubs/bp/bp112.pdf>

["When Massachusetts passed its pioneering health care reforms in 2006, critics warned that they would result in a spiral downward toward a government-run health care system. Three years later, those predictions appear to be coming true. The state has reduced the number of residents without health insurance, 200,000 people remain uninsured. The increase in the number of insured is due to the state's subsidies, not the individual mandate. Health care costs continue to rise faster than the national average. Total state health care spending has increased by 28 percent. Insurance premiums have increased by 8–10 percent per year, double the national average. New regulations and bureaucracy are limiting consumer choice and adding to health care costs. Program costs have skyrocketed. Despite tax increases, the program faces huge deficits.”]

[Request #S09-26-3830]

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How We Can Pay for Health Care Reform. By Robert A. Berenson and others, the Urban Institute's Health Policy Center. (The Institute, Washington, DC) July 2009.

["In this paper, we argue that there are many realistic sources of savings and many sources of revenue that could be used to support health reform. In some cases, policy initiatives plausibly would improve quality and patient experience with care while reducing spending. However, all of the measures could negatively affect some stakeholders financially and will likely be opposed by them because of that. Nevertheless, health reform will only happen if we are willing to take advantage of a variety of savings opportunities and revenue sources, thus spreading the costs broadly and minimizing burden on any single group. In this paper we show that it is possible to obtain more than enough savings or revenue to fully finance comprehensive health care reform."]

[Request #S09-26-4028]

Report. 33 p.

http://www.urban.org/uploadedpdf/411932_howwecanpay.pdf

Summary. 8 p.

http://www.urban.org/uploadedpdf/411932_howwecanpaysummary.pdf

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The \$3 Trillion Question: What Health Care Reform Can Save For Families, Businesses and Taxpayers. By Michael Russo, California Public Interest Research Group. (The Group, Sacramento, California) July 2009. 23 p.

Full text at: <https://www.calpirg.org/uploads/Jz/6Z/Jz6ZsJAL5uWGrMOfa0i8Og/3-trillion-question.pdf>

["Without health care reform, the United States is projected to spend over \$40 trillion on healthcare in the next decade. Experts estimate that thirty percent of that spending will be wasted on ineffective care, pointless red tape, and counterproductive treatments that can actually harm patients. As a result, American families and businesses are weighed down by high premiums that continue to increase twice as fast as inflation. Meanwhile, cost-benefit analyses show that, dollar for dollar, we get less for our health care spending than the rest of the industrialized world. Health care reform holds out the golden promise of addressing both of these problems at once. By aligning incentives within the health care system in favor of quality treatment, by investing in health information technology, and finding which treatments work, we can make health care both more affordable and higher quality."]

[Request #S09-26-4095]

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HEALTH CLINICS

The Impact of Federal Stimulus Funds on Community Health Centers in California. By Manatt Health Solutions. (California HealthCare Foundation, Oakland, California) July 2009. 13 p.

Full text at:

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

["California's community health centers provide primary care services regardless of a patient's ability to pay, making them a crucial part of the health care safety net -- and one that is particularly sensitive to the social and financial effects of an economic downturn.... The issue brief summarizes and examines the funding opportunities for community clinics under the American Recovery and Reinvestment Act (ARRA). It includes: the types of grants and funds, projected funding flow, and application deadlines; an overview of direct and indirect funding opportunities targeting community health centers and Indian Health Service facilities; and details of the Medi-Cal and Medicare payment incentives for adopting electronic health records."]

[Request #S09-26-3915]

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Federally Qualified Health Centers and State Health Policy: A Primer for California. By Mary Takach and Elizabeth Osius, National Academy for State Health Policy. (California HealthCare Foundation, Oakland, California) July 2009. 21 p.

Full text at:

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

["California's federally funded community health centers (CHCs) treat more than 2.3 million patients each year. Even as the economic slowdown results in cutbacks in their state and local funding, these clinics have become a more vital source of primary care for millions of low-income Californians. California has an opportunity to improve the performance and sustainability of federally qualified health centers by integrating technology, adapting to changes in health policy, and tapping new sources of funding. Topics include: 1) The operational history of CHCs, including their complex federal and state funding structure; 2) Effects of Medi-Cal and third-party payment structures and state regulatory and licensing; and 3) Other states' approaches to improving funding and operations, including collaborating with federal entities, technology initiatives, and medical home pilots."]

[Request #S09-26-4032]

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HEALTH INSURANCE

The Clock Is Ticking: More Americans Losing Health Coverage. By Families USA. (Families USA, New York, New York) July 2009. 8 p.

Full text at: <http://www.familiesusa.org/assets/pdfs/health-reform/clock-is-ticking.pdf>

["Nearly a million Californians, more than in any other state, will lose their health insurance coverage during a three-year period ending in 2010. This year alone, more than 330,000 people are expected to lose coverage in California. The report underscores the need for quick action on legislation aimed at overhauling the country's health system, said Ron Pollack, the group's executive director.... The downturn in the economy has added to the challenges, although federal officials eased the sting of unemployment by providing deep subsidies for those electing to extend employer-based health coverage under the COBRA insurance program." Sacramento Bee (July 16, 2009) 9B.]
[Request #S09-26-3972]

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Costly Coverage: Premiums Outpace Paychecks in California. By Families USA. (Families USA, New York, New York) September 2009. 16 p.

Full text at: <http://www.familiesusa.org/assets/pdfs/costly-coverage/california.pdf>

["Insurance premiums continuing to rise briskly while policymakers consider an overhaul of the country's health care system. The cost of providing health insurance to a typical California family has more than doubled since 2000. The average cost of health premiums paid by an employer and worker with family coverage has risen to \$13,026 – an increase of \$6,799 from nine years ago. By comparison, the median earnings of California workers rose by about 25 percent to \$32,304, during the same time period. 'Rising health care costs threaten the financial well-being of families in California and across the nation,' said Ron Pollack of Families USA. 'If health care reform does not happen soon, more and more families will be priced out of the health coverage they used to take for granted.'" Sacramento Bee (September 16, 2009) 1.]

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The Small Business Dilemma: How Rising Health Care Costs are Tough on Small Business. By Larry McNeely, CALPIRG Education Fund. (The Fund, Sacramento, California) July 2009. 28 p.

Full text at: <http://www.calpirg.org/uploads/IJ/Ry/IJRy77H0VINwirDUdJAV3A/The-Small-Business-Dilemma>

["Our efforts revealed that small businesses who do not currently offer coverage would overwhelmingly like to, but are stymied by high costs, complications and red tape. We discovered that those entrepreneurs who do make the sacrifices necessary to provide health care consider it less a moral obligation than a smart business strategy to increase employee productivity and attract and retain talented employees. Finally, we discovered that only a fraction of small business owners surveyed believed that their voices were being heard in the current health care debate. 78% of small businesses who do not offer coverage would like to do so. 80% of those owners who would like to offer coverage cite cost as a barrier."] [Request #S09-26-3953]

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Report: California Small Business Healthcare Survey. By the Small Business Majority. (The Majority, Sausalito, California) August 2009. 41 p.

Full text at:
http://www.smallbusinessmajority.org/pdfs/California_research_report_82709.pdf

["Two-thirds of California small business owners say more people would become entrepreneurs if they knew they could get health insurance despite pre-existing health conditions.... 62% of small businesses (66% of Latino businesses and 60% of rural businesses) believe their company has a responsibility to provide health coverage for its employees. 68% of the states believe that to make healthcare more affordable, it's important to share the responsibility among individuals, employers, insurance companies, providers and government. 81% support the creation of a health insurance exchange from which small businesses could choose coverage from competing health plans. Overall, 45% of small businesses do provide coverage, and 86% of those that don't say they can't afford it." Orange County Register (September 3, 2009) 1.] [Request #S09-26-4090]

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The Economic Effects of Health Care Reform on Small Businesses and their Employees. By the Council of Economic Advisors, Executive Office of the President. (The Council, Washington, DC) July 25, 2009. 25 p.

Full text at: <http://www.whitehouse.gov/assets/documents/CEA-smallbusiness-july24.pdf>

["Due to high broker fees, fixed administrative costs, and adverse selection, small businesses pay up to 18 percent more per worker than large firms for the same health insurance policy. Some of these higher costs are passed on to small firm employees in the form of lower wages, and some eat into the profits of small businesses that could otherwise be used for research and development and for much-needed investments. This implicit tax disadvantages small firms in both the market for the best workers and the market for their products.... Properly designed health care reform has the potential to improve the competitiveness of small businesses and the economic condition of workers in this crucial sector of the economy."]

[Request #S09-26-3967]

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Health Insurance Coverage in California Keeps Shrinking as Premiums, Family Costs Continue Climbing. By Health Care for America Now. (Health Care for America Now, Washington, DC) June 2009. 20 p.

Full text at: http://hcfan.3cdn.net/5d632642d159adf50a_12m6i66a5.pdf

["Health insurance premiums for California working families have skyrocketed, increasing 96 percent from 2000 to 2007. For family health coverage in California during that time, the average annual combined premium for employers and employees rose from \$6,227 to \$12,194. The combined cost to employers and workers of health insurance for a California family of four is equal to 21 percent of the state's median family income. Given current trends, that share will grow to 41 percent in 2016. The full cost of employer-sponsored health insurance is projected to grow at an annual rate of 8.4 percent, compared to a 1.1 percent growth rate for income. About 3.6 million working non-elderly adults in California do not have health insurance. In California 7.4 percent of working adults reported spending 20 percent or more of income on out-of-pocket health care expenses in 2004."]

[Request #S09-26-3973]

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Building a National Insurance Exchange: Lessons from California. By Elliot K. Wicks, Health Management Associates. (California HealthCare Foundation, Oakland, California) July 2009. 7 p.

Full text at:

<http://www.chcf.org/documents/insurance/BuildingANationalInsuranceExchange.pdf>

["The difference between a government program that works and one that fails spectacularly can be razor thin. A few words here, a loophole there, and you can turn a boon for the consumer into a windfall for big business.... Here in California we know all about the pitfalls of an exchange that doesn't work, because we established a statewide version in 1992 and attended its funeral in 2006.... But the exchange's fatal flaw was that it was voluntary. Insurers could offer competing policies outside the exchange. Employers weren't required to offer insurance and didn't have to use the exchange if they did. The promise of a big mass of potential customers therefore faded fast. At its peak, the exchange enrolled 150,000 members, but that represented only about 2% of the state's small-group market." Los Angeles Times (September 14, 2009) 1.]
[Request #S09-26-4091]

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Managing Risk in Health Insurance Markets: A Challenge for States in the Midst of Health Care Reform. By Courtney Burke, Rockefeller Institute of Government's Health Policy Research Center, and Katherine Swartz, Harvard School of Public Health. (The Institute, Albany, New York) September 2009. 22 p.

Full text at: http://www.rockinst.org/pdf/health_care/2009-09-HPRC_Managing_Risk.pdf

["Regardless of federal actions, states still will have considerable jurisdiction over managing risk in their small group and individual insurance markets. Insurers in these markets constantly face the threat of adverse selection -- the outcome when a larger share of the people purchasing policies have higher medical care costs than would be found in a random sample of the population. When this happens, it is difficult, if not impossible, for insurers to accurately estimate the medical costs of those they are insuring. The risk of adverse selection is a major reason that premiums per person in the two markets are higher than in large group markets and why some people are denied coverage in states that permit denials of applications. When states can manage this risk, competition between the insurers will make premiums more affordable and more people will have access to health insurance."]
[Request #S09-26-4089]

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HOSPITALS

California Hospitals and the Economy: Ongoing Credit Crisis Jeopardizes Seismic Compliance Mandate. By the California Hospital Association. (The Association, Sacramento, California) July 2009. 4 p.

Full text at: <http://www.calhospital.org/Download/CHASpecialRpt-Seismic709.pdf>

["The report, which is based on a survey of hospital chief financial officers (CFOs) conducted in April 2009, shows that 64 percent of hospitals report that they will not be able to access the capital necessary to comply with the state's 2013/2015 seismic deadlines. More than a quarter of hospitals statewide (28 percent) have seen their interest expenses increase during the first quarter of 2009, while many other hospitals have been frozen out of the credit market entirely. As a result, hospitals throughout California are faced with limited access to capital and increased costs of borrowing. These dual challenges come at a time when hospitals are facing an unfunded mandate for seismic improvements estimated to cost up to \$110 billion without financing charges." California Hospital Association press release (July 30, 2009) 1.]

[Request #S09-26-3963]

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"Medical Bankruptcy in the United States, 2007: Results of a National Study." By David U. Himmelstein and others. IN: The American Journal of Medicine, vol. 122, no. 8 (August 2009) pp. 741-746.

Full text at: <http://download.journals.elsevierhealth.com/pdfs/journals/0002-9343/PIIS0002934309004045.pdf>

["Using a conservative definition, 62.1% of all bankruptcies in 2007 were medical; 92% of these medical debtors had medical debts over \$5000, or 10% of pretax family income. The rest met criteria for medical bankruptcy because they had lost significant income due to illness or mortgaged a home to pay medical bills. Most medical debtors were well educated, owned homes, and had middle-class occupations. Three quarters had health insurance. Using identical definitions in 2001 and 2007, the share of bankruptcies attributable to medical problems rose by 49.6%. In logistic regression analysis controlling for demographic factors, the odds that a bankruptcy had a medical cause was 2.38-fold higher in 2007 than in 2001."]

[Request #S09-26-4079]

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LEAD POISONING

"Childhood Lead Poisoning: Conservative Estimates of the Social and Economic Benefits of Lead Hazard Control." By Elise Gould. IN: Environmental Health Perspectives, vol. 117, no. 7 (July 2009) pp. 1162-1167.

Full text at: <http://www.ehponline.org/members/2009/0800408/0800408.pdf>

["While public health initiatives, combined with laws limiting lead content in gasoline, household paint, food canning, and industrial emissions have substantially reduced lead exposure among children, lead poisoning poses a threat to some at-risk groups. Significant neurological damage to children occurs even at very low levels of exposure.... Recent research has broadened the scope of our understanding of the societal costs of lead poisoning. For example, new studies have begun to analyze the correlation of lead poisoning to crime rates and their associated costs, as well as linking early lead exposure to adult-onset health problems.... This paper comprehensively addresses the costs and benefits of household lead hazard control. Each dollar invested in lead paint hazard control results in a return of \$17–\$221 or a net savings of \$181–269 billion."]

[Request #S09-26-3964]

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MEDICAID

Supporting Integrated Care for Dual Eligibles: Policy Options. By the Center for Health Care Strategies. (The Center, Hamilton, New Jersey) July 2009.

["Adults who are dually eligible for Medicaid and Medicare (the "duals") are among the nation's most chronically ill and costliest patients, accounting for close to 50 percent of all spending within Medicaid and 25 percent within Medicare. Yet, most of the nation's more than eight million duals receive fragmented and poorly coordinated care.... The brief outlines the rationale for integrating care for duals, reasons why integration has been slow to progress, and emerging vehicles to accelerate the pace of fully integrated care. A companion resource paper provides additional details on promising integrated care models and the challenges and opportunities for supporting integrated approaches."]

[Request #S09-26-3970]

Policy Brief. 5 p.

http://www.chcs.org/usr_doc/Integrated_Care_Policy_Brief.pdf

Resource Paper. 14 p.

http://www.chcs.org/usr_doc/Integrated_Care_Resource_Paper.pdf

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Pay-for-Performance in the Medi-Cal Managed Care and Healthy Families Programs: Findings and Recommendations. By Bailit Health Purchasing. (California HealthCare Foundation, Oakland, California) August 2009. 56 p.

Full text at:

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

["Pay-for-performance (P4P) strategies are typically devised as a means for aligning provider or managed care plan financial incentives to improve access to care or quality of care. States and large employer purchasers and purchasing coalitions use P4P strategies with contracted plans, while states and insurers employ the strategies with providers. This paper explores how pay-for-performance might promote improved quality of care in California's Medi-Cal and Healthy Families programs.... The analysis finds that P4P presents a promising opportunity to improve plan performance -- a conclusion generally endorsed by leading stakeholders. However, the paper cautions that the financial pressures facing California are a deterrent to implementation in the near future."]

[Request #S09-26-4075]

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Equal-Burden-for-Equal-Benefit Medicaid Matching Rates. By Thomas W. Grannemann, Centers for Medicare and Medicaid Services, and Mark V. Pauly, Wharton School, University of Pennsylvania. (American Enterprise Institute, Washington, DC) July 6, 2009. 27 p.

Full text at: <http://www.aei.org/docLib/EBEB%20Matching%20Rates%2007-05-2009.pdf>

["Federal Medicaid payments to the state have long been based on a formula that calculates a Federal Medical Assistance Percentage for each state based on its per capita income. The formula generally provides higher percentages for lower-income states, and lower percentage for high-income states subject to a lower limit of 50 percent which ensures the federal government pays at least half the cost of Medicaid in every state. We suggest a new approach to setting federal Medicaid matching rates -- one that is relatively easy to understand and has some desirable properties of interstate equity. The objective is to determine what would it take to provide for equal benefits for the poor and equal tax burdens for state taxpayers."]

[Request #S09-26-3971]

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MENTAL HEALTH

"Influence of Gender, Sexual Orientation, and Need on Treatment Utilization for Substance Use and Mental Disorders: Findings from the California Quality of Life Survey." By Christine E Grella and others. IN: BMC Psychiatry, vol. 9, no. 52 (August 2009) 10 p.

Full text at: <http://www.biomedcentral.com/content/pdf/1471-244x-9-52.pdf>

["Prior research has shown a higher prevalence of substance use and mental disorders among sexual minorities, however, the influence of sexual orientation on treatment seeking has not been widely studied. We investigate factors related to treatment for alcohol or drug use disorders and mental health disorders, focusing on the contributions of gender, sexual orientation, and need.... Compared with individuals without a diagnosed disorder, those with any disorder were more likely to receive treatment. After controlling for both presence of disorder and other factors, lesbians and bisexual women were most likely to receive treatment and heterosexual men were the least likely.... The study highlights the need to better understand the factors beyond meeting diagnostic criteria that underlie treatment utilization among sexual minorities."]

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Mental Health: Overlooked and Disregarded in Rural America. By Dianne Travers Gustafson, Creighton University, and others. (Center for Rural Affairs, Lyons, Nebraska) May 2009. 5 p.

Full text at: <http://files.cfra.org/pdf/Mental-Health-Overlooked-and-Disregarded-in-Rural-America.pdf>

["Living and working in rural America presents a variety of distinct stresses and strains as varied as rural America itself. Regardless of differences, state leaders from across the nation indicate that mental and behavioral health problems are a major, widespread rural concern.... And mental health care is the most expensive care for people, accounting for nine percent of their personal health spending. Unfortunately, this need for mental health care has not been met with widely available and accessible mental health services in rural areas. Among other factors, the problem of inadequate mental health care is strongly tied to a lack of affordable, meaningful health insurance coverage. This problem must be addressed for prosperous rural families, economies and communities."]

[Request #S09-26-3965]

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NUTRITION

Healthy Food for All: Building Equitable and Sustainable Food Systems in Detroit and Oakland. By Sarah Treuhaft, PolicyLink, and others. (PolicyLink, Oakland, California) 2009. 64 p.

Full text at: [healthy food for all](#)

["Far too many Americans live in neighborhoods where high-fat processed snacks and fast food are aplenty but affordable, nutritious food is nowhere to be found.... Across the country, there is a growing movement to transform our broken food system into one that promotes health, economic and social equity, and sustainability. This report provides case studies of two cities -- Detroit and Oakland -- that are taking innovative steps to repair their food delivery networks. Residents and advocates in Detroit and Oakland are working to improve health and expand the economy in neighborhoods that food retailers have largely abandoned. They are re-imagining their local food system, seeking to transform it into one that truly provides healthy food for all."][Request #S09-26-4071]

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OBESITY

Local Government Actions to Prevent Childhood Obesity. By Lynn Parker and others, Committee on Childhood Obesity Prevention Actions for Local Governments; National Research Council. (National Academies Press, Washington, DC) September 2009.

["In the United States, 16.3 percent of children and adolescents between the ages of two and 19 are obese. The prevalence of obesity is so high that it may reduce the life expectancy of today's generation of children and diminish the overall quality of their lives. Local governments can play a crucial role in creating environments that make it easier for children to eat healthy diets and move more.... This report recommends nine healthy eating strategies and six physical activity strategies that local governments should consider. These strategies are organized under three healthy eating goals and three physical activity goals. For each strategy, the report recommends a set of actions that have the potential to make a difference. The report also highlights 12 actions that the committee believes have the greatest potential, based on an assessment of the available research evidence."][Request #S09-26-4074]

Book. 120 p.

http://books.nap.edu/catalog.php?record_id=12674toc

Executive summary. 25 p.

http://www.nap.edu/nap-cgi/report.cgi?record_id=12674&type=pdfxsum

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Moving to the Land of Milk and Cookies: Obesity among the Children of Immigrants. By Jennifer Van Hook, Pennsylvania State University, and others. (Migration Policy Institute, Washington, DC) September 2009. Various pagings

Full text at: <http://www.migrationinformation.org/Feature/print.cfm?ID=739>

["Thirty-four percent of kindergarten-age immigrant boys are obese or overweight, compared with 25 percent of the sons of native-born Americans. No similar discrepancy was found among girls. It was most prevalent among newly arrived Hispanic immigrants and non-Hispanic white immigrants. Black children of immigrants do not face a higher rate of obesity than their native counterparts, and the problem does not show up among Asian children of new arrivals.... Although the report did not study the reasons for the discrepancy, it cited likely factors such as the prevalence of high-calorie, low-nutrient foods and beverages in schools and in advertising directed at children, and the fact that new immigrants are often unaware of the risks of too much junk food or of opportunities for exercise." The Washington Post (September 4, 2009) 1.]

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Reducing Obesity: Policy Strategies from the Tobacco Wars. By Carolyn L. Engelhard, University of Virginia, and others. (The Urban Institute, Washington, DC) July 2009. 73 p.

Full text at: http://www.urban.org/UploadedPDF/411926_reducing_obesity.pdf

["For the average affected individual, obesity has a much greater impact on health status and health care costs than either smoking or heavy drinking.... To combat the epidemic of obesity, lawmakers can adapt policy approaches that have substantially cut tobacco use. A 10 percent tax on fattening food, identified based on a model used by the British government to determine the foods that may not be advertised to children, would reduce consumption while raising more than \$500 billion over 10 years. Adding simple, 'traffic light' nutrition labels to the front of each food package would change consumers' buying habits, as would listing calories on menus at chain restaurants. Consumption of fattening food would be further reduced by banning its advertisement in the mass media."]

[Request #S09-26-3969]

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PHYSICIANS

Identifying Gaps in Specialty Physician Performance Measurement. By the National Quality Forum. (The Forum, Washington, DC) August 2009. 54 p.

Full text at:

http://www.qualityforum.org/Publications/2009/08/Consensus_Reports_Physician_Gaps.aspx

["Over the past decade, the use of performance measures to provide information about and improve the quality of healthcare has increased dramatically. Despite increased adoption of performance measures nationally, however, many significant gaps remain, both in the development of performance measures and in their widespread adoption. Individual clinician-level measurement is an area where measure development and implementation can make a difference, but these efforts have not been widespread, particularly for specialty areas.... This report indicates the areas in which future measure development and endorsement is needed and identifies areas for which harmonization of current measures is necessary. Finally, this report presents a discussion of the challenges and limitations involved in the development and implementation of clinician-level measures."]

[Request #S09-26-4072]

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PRESCRIPTION DRUGS

Pilot Study of Internet Drug Availability, Pricing, and Quality. By Roger Bate, American Enterprise Institute, and others. (The Institute, Washington, DC) August 2009. 21 p.

Full text at: <http://www.aei.org/docLib/20090820-BateHessBrush.pdf>

["Internet-sourced drugs are often considered suspect. Some pressure groups and politicians have called for banning Internet drug purchasing -- even while others laud it as a convenient, cost-effective way for consumers to access drugs.... This study examines drug purchasing over the Internet, by comparing the sales of five popular drugs from a selection of websites stratified by National Association of Boards of Pharmacy or other ratings. The drugs were assessed for price, conditions of purchase, and basic quality.... Some websites did not comply with purchaser requests for brand-name drugs, which limited the ability to assess quality. Of those which could be assessed, most drugs (except Viagra) passed spectrometry testing. Of those which failed, few could be identified either by a country of manufacture listed on the packaging, or by the physical location of the website pharmacy."]

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PUBLIC HEALTH

Public Health Preparedness and Response to Chemical and Radiological Incidents: Functions, Practices, and Areas for Future Work. By Tom LaTourrette and others, RAND Corporation. (RAND, Santa Monica, California) 2009. 67 p.

Full text at: http://www.rand.org/pubs/technical_reports/TR719/

["Public health emergencies may arise directly or indirectly from a wide variety of events. One area that has not been examined in much detail is public health emergency preparedness for incidents involving the release of chemical or radiological agents. This report characterizes the public health service's role in preparing for and responding to such incidents, describes practices in use by local public health departments, and identifies functional areas of public health emergency preparedness and response for chemical and radiological incidents that may warrant further practice development... While the fundamentals of crisis and emergency risk communication are well-known and widely adopted, application to chemical and radiological incidents will require special considerations and approaches."]

[Request #S09-26-4086]

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Key Indicators of Health by Service Planning Area. By the Los Angeles County Department of Health, Office of Health Assessment and Epidemiology. (The Department, Los Angeles, California) June 2009. 36 p.

Full text at:

http://publichealth.lacounty.gov/ha/docs/2007%20LACHS/Key_Indicator_2007/KIR_2009_FINALr1.pdf

["In addition to highlighting statistics regarding death and disease, this report describes the Los Angeles county population's access to care, health behaviors, and measures of the social and physical environment that impact health. The report also presents key trend data for important public health indicators. The information compiled here reveals significant, persistent health disparities among people living in different geographic parts of the County. For many indicators of health, from poverty status to rates of communicable and chronic disease, where in the County people reside greatly affects how well or poorly they fare."]

[Request #S09-26-4073]

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RESEARCH

"Connecting The Ivory Tower To Main Street: Setting Research Priorities For Real-World Impact.' By Claudia L. Schur and others. IN: Health Affairs, doi: 10.1377/hlthaff.28.5. (August 11, 2009) pp. 886-899.

Full text at:

<http://content.healthaffairs.org/cgi/reprint/hlthaff.28.5.w886v1?ijkey=VIRPRCzfMPILE&keytype=ref&siteid=healthaff>

["Health care decision-makers face increasing pressure to use resources more efficiently, but the information they need to assess policy options often is unavailable or not disseminated in a useful form. Findings from stakeholder meetings and a survey of private sector health care decision-makers in California begin to identify high-priority issues, perceived adequacy of current information, and preferred formats and other desired attributes of research. This is a first step toward establishing a systematic approach to linking the information priorities of private sector decision-makers with those who fund and conduct research."]

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