POLICY & PRACTICE

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State Sees Some Obesity Progress

California is making some headway on childhood obesity, with the percentage of overweight and obese children in the state dropping 1.1% from 2005 to 2010, according to a report from the University of California, Los Angeles Center for Health Policy Research and the California Center for Public Health Advocacy. The report credited the slight decrease to local policies and programs to improve access to playgrounds and other open spaces, to increase the availability of healthy foods, and to educate the public on the dangers of childhood obesity. Still, 31 of California's 58 counties experienced an increase in their childhood overweight and obesity rates during the 6-year study period. Statewide, 38% of public school students in the fifth, seventh, and ninth grades were overweight or obese in 2010, the report said.

New Tools for Health Advice

To help physicians discuss healthy lifestyles and physical activity with their adult patients, the American Medical Association has released continuing medical education materials including videos and patient handouts. "By using these tools, physicians will gain a better understanding of why patients make unhealthy decisions and will learn how to initiate conversations about healthy eating and physical activity," said AMA President Dr. Peter W. Carmel in a statement. Study and use of the materials have been certified for AMA PRA Category 1 Credit. They are available at www.ama-assn.org/go/obesity.

AMA Says Tone Down the Energy

Caffeinated, sugary, "energy" drinks such as Red Bull, Rockstar, Monster, and Full Throttle need closer scrutiny, said the AMA House of Delegates at its interim meeting last month. The association's Michigan delegation introduced the successful resolution. The state is one of several that have banned "Four Loko," a drink that is similar but includes alcohol. The energy drinks can be dangerous when combined with alcohol, according to the resolution. It also urged the FDA to regulate the drinks and to seek federal legislation to mandate warning labels listing potential side effects, "particularly when combined with alcohol."

More Docs Using E-Rx

Just over half of all office-based physicians are sending prescriptions electronically, according to statistics from the e-prescription network Surescripts. That percentage is up from 36% at the end of 2010 and just 10% in 2008. "This represents one of the most significant milestones achieved to date in the nationwide effort to adopt and achieve meaningful use of health information technology," according to Harry Totonis, president and CEO of Surescripts. E-prescribing is one of the requirements for physicians to qualify for Medicare and Medicaid health IT incentive payments, in order to meet meaningful use standards for electronic medical records. States with the highest rates of e-prescribing were Massachusetts, Delaware, Michigan, Connecticut, and Rhode Island, according to Surescripts.

Medical Homes a Challenge

Nearly half of physician practices do not meet national standards to qualify as patient-centered medical homes, according to a study from the University of Michigan Health System. Nearly three-quarters of multispecialty groups would meet criteria of the National Committee on Quality Assurance, but only half of solo and partnership practices meet those standards, the researchers reported. About 40% of primary care practices would not qualify as a medical home under the current standards. Market forces pushing patients toward medical homes might force practices to close that don't have the infrastructure to qualify, said Dr. John Hollingsworth, the study's lead author. This could disproportionately affect patients in rural areas, and policy makers should address the challenges facing small and rural practices, the researchers said in their report.

Insurance Competition Low

Four out of five U.S. metropolitan areas lack a competitive health insurance market, according to an analysis from the AMA. In addition, in about half of all metropolitan markets, one health insurer controls 50% or more of the market. In half the states, competition is limited to two health insurers who together control about 70% of the market. According to the study, Alabama, Alaska, Delaware, Michigan, Hawaii, the District of Columbia, Nebraska, North Carolina, Indiana, and Maine have the least competitive health insurance markets in the country.

–Naseem S. Miller

IMPLEMENTING HEALTH REFORM

Battle Continues Over the CLASS Act

In October, officials at the Health and Human Services department announced plans to suspend the CLASS (Community Living Assistance Services and Supports) Act. CLASS was passed as part of the Affordable Care Act and would have set up a voluntary long-term care insurance program. It came under fire from ACA critics who said it would not save federal dollars. After a lengthy fiscal evaluation, government officials announced that CLASS would not be implemented because it could not be sustained without taxpayer support.

Under CLASS, working adults would have paid premiums and received a minimum average daily benefit of $50 should they need long-term care services. The money was available for either nonmedical services in the community or for institutional care.

Long-term care advocates aren't giving up on the program. Instead, they are urging the Obama administration, which did not fully repeal CLASS, to find a way to salvage the program.

Larry Minnix, president and CEO of LeadingAge, an association of 5,600 not-for-profit organizations focusing on aging and long-term care, offers his views on CLASS and the state of long-term care financing in the United States.

CLINICAL ENDOCRINOLOGY NEWS: HHS officials have said they don't plan to repeal CLASS. Could the program come back at a later date in a revised form?

Mr. Minnix: We're very supportive of the administration's position not to repeal CLASS. We think what it offers is a construct – now in the law – that forces policy makers and others to have to deal with the issue. A growing number of people are going to need help for basically nonmedical services to be able to stay at home. A large, national insurance pool is a very efficient way to try to help with that need. Every physician's office is full of people who are coping with multiple chronic conditions who have needs beyond what health insurance will cover. Medicaid is their only option, along with private long-term care insurance. We're hoping that Congress will keep the CLASS Act as a construct.

'CLASS is just plain less expensive than the expansion of existing entitlement programs.'

MR. MINNIX

CEN: What options do older Americans have today to meet their long-term care needs?

Mr. Minnix: Economically, there are three options. You can deplete your assets and go on Medicaid. If you purchased private long-term care insurance earlier, you will get some help from that. But the problem is long-term care insurance is a limited market and it screens for preexisting conditions, so few people have purchased it. Your third option is to pool family resources and pay out of pocket. The services that people need aren't primarily medical. For example, they need help getting up, bathed, and dressed while their caregiver goes to work. CLASS was designed to cover in part some very practical needs that help families and individuals to be as independent as they can be. The need for these services grows every day.

CEN: A recent opinion piece in the New York Times suggested that Medicare should pay for long-term care. Is this is a viable option?

Mr. Minnix: That idea has been kicked around for years. Others have suggested that the Medicaid program be expanded. I don't think anyone in today's economic environment thinks that either of those ideas will be acted upon. What CLASS would have done was allow people to insure themselves. We already know they're spending money on these things. Therefore, if there was a large pool of self-insurance that allowed people to spend the benefit as they needed, that is a much more viable option than another centralized Medicare or Medicaid program.

CEN: The CLASS program was voluntary. Is that why it ended up being financial unsustainable and would a mandatory program be a better option?

Mr. Minnix: Mandate vs. choice was central in the formation of the CLASS Act by Congress. We did our own study at LeadingAge and looked at the options industrialized countries have chosen to deal with this issue. Germany is probably the closest to our situation. About 15-20 years ago, they had the same problem we do and they tried to punt the problem to their states through their equivalent to Medicaid. That didn't work because the states couldn't handle it. German officials finally came up with a mandated long-term care tax. It effectively cut their previous Medicaid-type expenditures for long-term care in half. In our own study, we showed that if a plan like CLASS were in place today and all working people were mandated to participate in it, Medicaid expenditures for long-term care would be about 50%. Politically, everyone says you'll never get a mandate. But the truth is that a program like CLASS is just plain less expensive than the expansion of existing entitlement programs. ■

MR. MINNIX *is president and CEO of LeadingAge and has been a long-term care advocate for more than 35 years. He also chairs Advance CLASS Inc.*