Of Note

Stem Cells Safe, Improve Vision in Eye Disease

Use of stem cells is controversial not only because obtaining them may require the destruction of human embryos but also because of a fear that powerful stem cells may cause a tumor. A team of researchers at Advanced Cell Technology (ACT) in Massachusetts reports positive results of stem cell therapy in subjects with eye disease. In an article published in the *Lancet*, researchers reported improved vision in patients with two forms of macular degeneration, Stargardt's disease and an untreatable form known as "dry" macular degeneration. Dr. Robert Lanza of ACT finds these results to be encouraging, "It has been over a decade since the discovery of human embryonic stem cells. This is the first report of human embryonic stem cell-derived cells ever transplanted into patients, and the safety and engraftment data to date look very encouraging." (Maggie Fox, *National Journal*, January 23, 2012)

Study Suggests Breakthrough in Organ Transplants

A recent study suggests that the use of donor stem cells can assist a recipient in accepting a donated organ. If these findings are accurate, the use of significantly incompatible organs and the elimination of a lifetime of anti-rejection drugs may become a reality. Anti-rejection drugs are expensive, make patients vulnerable to diseases, and patients can still reject the new organ. The study, reported in the journal *Science Translational Medicine*, followed eight organ recipients who received kidneys that were less-than-perfect matches and then got an infusion of bioengineered immune cells from the donor. After one month, five patients achieved "complete chimerism" and were able to stop taking anti-rejection drugs a year later. James F. Markmann and Tatsuo Kawai, both transplant pioneers, wrote that the findings "may potentially have an enormous, paradigm-shifting impact on solid-organ transplantation." (Melissa Healy, *Los Angeles Times*, March 8, 2012)

Georgia High Court Strikes Down Assisted Suicide Law

In Georgia, a state law preventing assisted suicide was struck down because it included prohibitions of language protected by the First Amendment. The decision by the Georgia Supreme Court made assisted suicide legal in the state of Georgia. Eleanor Smith, director of Not Dead Yet, an advocacy group for people with disabilities, responded to the court ruling, "We were very shocked and surprised to learn that our [prior] Georgia law could be read in a way that assisted suicide could be legal. This was absolutely

news to us and to a lot of people." Members of the Georgia General Assembly, Majority Whip Edward Lindsey and Sen. Bill Hamrick, have proposed revisions to the law and look to rewrite it before the end of the session. (Alicia Gallegos and Kevin B. O'Reilly, *American Medical News*, February 20, 2012).

Higher Insurance Costs Loom for Employees Who Fail to Meet Health Goals

As health insurance costs continue to rise, companies are using not only wellness programs but also health metrics to reward employees and keep costs down. A survey conducted by Towers Watson concludes that 23 percent of companies will use biometrics to reward or penalize employees in 2013 which is up from 11 percent in 2012. Mark Cooper, president of the South Central Iowa Federation of Labor, accepts companies that link incentives and penalties to lifestyle decisions but objects to companies that do not take into account the role of genetics in health. Offering incentives based on health metrics instead of participation in programs requires following complicated rules under the Health Insurance Portability and Accountability Act (HIPAA). HIPAA states that all workers must have an opportunity to earn each incentive and if the goals are unreasonable for an employee, there must be an alternative way to receive the reward. (Adam Belz, *Des Moines Register*, March 30, 2012)

Gender Gap Persists in Cost of Health Insurance

Although the new health care law will prohibit "gender rating", a report by National Women's Law Center found that of the states who have not already banned gender rating, more than 90 percent of the most popular health plans charge women more than their male counterparts. Insurance companies claim that the cost difference is due to the fact that women use more health care services such as visiting the doctor and getting regular checkups. President of the National Women's Law Center, Marcia D. Greenberger, calls this reasoning "highly questionable" because the data differ depending on the insurer. This portion of the new health care law is not being directly challenged in court, but some assert that the new rating rules would not be possible without the individual mandate. The new health care law prohibits sex discrimination under "any health program or activity" but, for now, women will continue to pay more for health insurance. (Robert Pear, *New York Times*, March 19, 2012)

Who Are the Chronically Costly? Health Care's 1 Percent

The costliest 1 percent of patients in the U.S. account for more than 20 percent of what the country spends on health care. These patients are more likely to spend a significant amount of time in hospitals, use more end-of-life care, have three or more chronic conditions, and live with

untreated mental illness. One proposed method to limit national spending is to increase coordination of care. Geisinger Health System created Proven Health Navigator to provide active case management and remote monitoring for its sickest patients. This program reduced costs through decreased hospitalizations. Johns Hopkins created a program that identifies Medicaid patients as high, medium or low risk and assists them with preventive care based on their needs. The complex problem of patients enrolled in Medicare and Medicaid is being confronted by the CMS Center for Medicare and Medicaid Innovation through plans to test payment models to reduce or eliminate cost-shifting incentives. Even with new innovations, patients are falling through the cracks. AMA President Peter W. Carmel, MD calls upon patients to make better decisions to prevent costly care, "Physicians can help the nation get the most of our health care dollar by addressing lifestyle behaviors to reduce the prevalence of chronic disease in patients, and by leading new health care delivery models that improve care coordination while reducing costs." (Doug Trapp, *American Medical News*, March 5, 2012)

A student from the Center for Health Law Studies at Saint Louis University School of Law contributed the following items to this column. Amy N. Sanders, assistant director, Center for Health Law Studies, supervised the contributions of health law student Lindsey Weinberg (JD anticipated '13).

Hospitals with Radioactive Materials Expose Weakness in Anti-terror Rules

After the terrorist attacks of September 11, 2001, the Nuclear Regulatory Commission launched a campaign to make radioactive materials harder for terrorists to steal. However, Congressional auditors have recently found serious hospital violations of the rules established in 2005 where radioactive materials used for medical diagnoses and cancer treatment were not adequately protected from possible tampering or outright theft.

While the materials in question do not present a nuclear threat, their potential use could entail that of a "dirty bomb," possibly resulting in radiation contamination in significant areas. The Energy Department has accounted for 1,500 hospitals and medical buildings that use radioactive materials today which have spent about $96 million to secure them. However, about 22,000 entities hold licenses to possess radioactive materials. In the face of inadequate rules and known violations, talks ensue in order to strengthen domestic radiological security requirements in order to prevent unauthorized access to the materials. (*Hospitals with Radioactive Materials Expose Weakness in Anti-terror Rules*, Matthew L. Wald, The New York Times, March 14, 2012) http://www.nytimes.com/2012/03/14/us/hospital-audit-finds-radioactive-materials-unsecured.html?pagewanted=print

Hospital Did Business with Firms Tied to its CEO, Board Members

In response to a series of *New York Times* articles highlighting an obtrusive supplemental pension and severance package received by the former chief executive of Salinas Valley Memorial Healthcare System, the State of California conducted an audit evaluating the Monterey County public hospital district. The report revealed that the Salinas Valley Health System regularly did business with firms in which its top officials and board members had financial stakes. While violations of state conflict-of-interest laws have yet to be confirmed, the audit found 11 instances between 2006 and 2010 in which board members had reported significant economic ties to vendors with which the district did business.

In total, the report found that the health system had $21 million in transactions over the last five years with the firms, and further indicated that the law may have been broken in two cases. In contrast to the hospital's attempt to discredit the report and defend its contracting decisions, certain officials believe that the report "sheds light on some of the most egregious fiscal practices…which were certainly the norm at the hospital for many years." (Hospital Did Business with Firms Tied to its CEO, Board Members, Sam Allen and Hector Becerra, *Los Angeles Times*, March 9, 2012) http://www.latimes.com/health/la-me-hospital-spending-20120309,0,6391713,print.story

Premium Rebates, Coverage Labels, Reduced Medicare Drug Costs Highlight 2012 Health Law Changes

While the controversy over the constitutionality of health care reform continues, implementation of the law has been underway for two years now. Certain provisions which have already taken effect include adult children remaining on their parents' health plans until age 26, as well as seniors who reach the doughnut hole in their prescription drug plans obtaining a 50 percent discount on brand-name drugs.

Should the Supreme Court uphold the law, a decision which is expected in the summer of 2012, significant new provisions will affect consumers this year. These provisions include: free contraception coverage for women in certain health plans, rebates for consumers if insurers do not spend at least 80 to 85 percent of premium revenues on medical claims and quality improvement, health plans being required to give customers clear and consistent plan information up front, the diminishing of drug costs in order to slowly eliminate the doughnut hole, and the operation of 32 health-care organizations participating in the Pioneer Accountable Care Organization program, aimed at providing better coordinated care. (Premium Rebates, Coverage Labels, Reduced Medicare Drug Costs Highlight 2012 Health Law Changes, Michelle Andrews, *Kaiser Health News*, March 12, 2012) http://www.kaiserhealthnews.org/Features/Insuring-Your-Health/2012/Health-Law-

Anniversary-Michelle-Andrews-031312.aspx?p=1

Access, Quality, Costs Vary Widely, says Commonwealth Report

The Commonwealth Fund is a New York-based not-for-profit which examines local health systems and releases national scorecard reports. These reports shed light on how healthcare systems are performing at the local level in providing access to care, providing timely preventive care and treatment, improving patient health, and providing affordable health care.

Using 43 metrics, the Commonwealth Fund researchers found that of 306 hospital referral regions across the country, geographic patterns of performance surfaced. Specifically, the top communities overall were St. Paul, Minn., Dubuque, Iowa, and Appleton, Wis., while Shreveport, La., and Jackson, Miss., were ranked among the bottom ten. This report therefore revealed that not only were the communities of the North and South divided in performance on the 43 indicators, but significant gaps existed within individual states as well. In the authors' release, they noted that if all 306 communities performed as well as those at the top, "Medicare would save billions of dollars on preventable hospitalizations and readmissions." (Access, Quality, Costs Vary Widely, says Commonwealth Report, Maureen McKinney, Modern Healthcare.Com, March 14, 2012) http://www.modernhealthcare.com/article/20120314/NEWS/303149962

OCR Deputy: Lessons for Providers in HIPAA Settlement

Blue Cross and Blue Shield of Tennessee recently agreed to pay federal regulators $1.5 million and promised to enter into a corrective action plan after the theft of 57 hard drives. The computer drives contained unencrypted private health information for more than one million people. The Office of Civil Rights at HHS which enforces the Health Insurance Portability and Accountability Act privacy and security laws found that the insurer committed violations when it did not perform a required security evaluation in response to operational changes and did not have appropriate access controls at a leased facility.

According to the deputy director of the Office of Civil Rights at HHS, this incident should signal to providers moving locations that they must, according to HIPAA and the Health Information Technology for Economic and Clinical Health Act, implement a risk assessment to identify where their data is going during a transition, which includes safeguards of patient data encryption to ensure that wherever the data is as it moves, only authenticated parties will have access. (*OCR Deputy: Lessons for providers in HIPAA settlement*, Rich Daly, Modern Healthcare.Com, March 18, 2012) http://www.modernhealthcare.com/article/20120318/NEWS/303189977