

Researchers have found huge variations in cost of end-of-life care. New research shows huge, unexplained variations in the amount, intensity and cost of care provided to Medicare patients with chronic illnesses at the nation's top academic medical centers. Dartmouth researchers recently said that total Medicare spending in the last two years of life ranges from an average of \$93,842 for patients who receive most of their care at UCLA Medical Center to \$53,432 at the Mayo Clinic's main teaching hospital in Rochester, Minn. Other top-ranked hospitals fell in between. The numbers, from the 2008 edition of *The Dartmouth Atlas of Health Care*, have caught the eye of federal officials, who say Medicare could save billions of dollars a year if doctors and hospitals in high-spending regions were as efficient as those in low-spending regions. (*The New York Times*, April 7, 2008)

Payers aim to rein in specialty-drug spending. Sharply rising expenditures for cancer drugs and other high-priced medicines are prompting employers, health plans and pharmacy-benefit managers to redouble efforts to rein in spending. To curb use, payers are pushing for legislation to permit generic drug companies to sell cheaper versions of biotech drugs. They are reinforcing rules about trying cheaper therapies first. Some seek novel solutions such as paying drug companies based on how well a drug works, rather than how much is used. The actions come amid fresh evidence that so-called specialty pharmaceuticals are among the biggest drivers of escalating health costs. Specialty-drug spending in the U.S. could reach \$99 billion by 2010, nearly

double the \$54 billion spent in 2006, says Steven Miller, chief medical officer of Express Scripts, which manages drug benefits for health plans that cover 55 million people. (*The Wall Street Journal*, March 20, 2008)

Rising health costs cut into wages. Spiraling health care costs have been whacking away at the wages of working-class Americans. Even though workers are producing more, inflation-adjusted median family income has dipped 2.6 percent, or nearly \$1,000 annually since 2000. Employees and employers are getting squeezed by the price of health care. The struggle to control health costs is viewed as crucial to improving wages and living standards for working Americans. Employers are paying more for health care and other benefits, leaving less money for pay increases. Benefits now devour 30.2 percent of employers' compensation costs, with the remaining money going to wages, the Labor Department reported recently. That is up from 27.4 percent in 2000. (*Washington Post*, March 24, 2008)

More advanced cancer seen in uninsured Americans. Uninsured Americans and those in a government health program for the poor are far more likely to have advanced diseases when diagnosed with cancer than those with private coverage, researchers said recently. A major factor seems to be that many of these people are not getting routine screenings for various types of cancer that could detect the disease in its early stages when it is most treatable and least deadly. The uninsured were 2.1 times as likely — and those covered by Medicaid 80 percent more likely — to

have advanced-stage cancer at the time of their first cancer diagnoses compared with those with private health insurance. The study published in *Lancet Oncology* also showed blacks and to a lesser extent Hispanics, regardless of insurance status, were more likely than whites to have advanced cancer when first diagnosed. (Reuters, February 18, 2008)

Gap in life expectancy widens for the nation. New government research has found "large and growing" disparities in life expectancy for richer and poorer Americans, paralleling the growth of income inequality in the last two decades. Life expectancy for the nation as a whole has increased, the researchers said, but affluent people have experienced greater gains, and this, in turn, has caused a widening gap. Gopal K. Singh, a demographer at the Department of Health and Human Services, said "the growing inequalities in life expectancy" mirrored trends in infant mortality and in death from heart disease and certain cancers. The gaps have been increasing despite efforts by the federal government to reduce them. Dr. Singh said that federal officials had found "widening socioeconomic inequalities in life expectancy" at birth and at every age level. (*The New York Times*, March 23, 2008)

Security gap growing between haves and have nots. The gap in health security is widening between low and high income Americans and between those covered by health insurance and those who are uninsured, according to findings from the second annual Health Security Index released today by Catholic Healthcare West. The Health

Security Index, based on a survey of more than 1,150 U.S. adults, also found that the uninsured are more than three times as likely to have to choose between basic necessities and health care. (Marketwire, April 8, 2008)

Survey shows doctors support universal health care. More than half of U.S. doctors now favor switching to a national health care plan and less than a third oppose the idea, according to a survey published recently. The survey suggests that opinions have changed substantially since the last survey in 2002 and as the country debates serious changes to the health care system. Of more than 2,000 doctors surveyed, 59 percent said they support legislation to establish a national health insurance program, while 32 percent said they opposed it, researchers reported in the journal *Annals of Internal Medicine*. “We asked doctors directly and found that, contrary to conventional wisdom, most doctors support national health insurance,” said Dr. Aaron Carroll of the Indiana University School of Medicine, who led the study. (Reuters, March 31, 2008)

Insurance fears lead many to shun DNA tests. Many Americans are afraid that genetic information may be used against them by insurers. In some cases, patients who could make more informed health care decisions if they learned whether they had inherited an elevated risk of diseases refuse to do so because of the potentially dire economic consequences. Such discrimination appears to be rare, but thousands of people accustomed to a health insurance system in which known risks carry financial penalties are drawing their

own conclusions about how a genetic predisposition to disease is likely to be regarded. “It’s pretty clear that the public is afraid of taking advantage of genetic testing,” said Dr. Francis S. Collins, director of the National Human Genome Research Institute at the National Institutes of Health. “If that continues, the future of medicine that we would all like to see happens the chance of being dead on arrival.” (*The New York Times*, February 24, 2008)

Penalty for pharmacist’s refusal upheld. A state appeals court recently upheld sanctions against a Wisconsin pharmacist who refused to dispense birth control pills to a woman and wouldn’t transfer her prescription elsewhere. The 3rd District Court of Appeals ruled that the punishment the state Pharmacy Examining Board handed down against pharmacist Neil Noesen did not violate his state constitutional rights, specifically his “right of conscience” to religiously oppose birth control. “Noesen abandoned even the steps necessary to perform in a minimally competent manner under any standard of care,” the three-judge panel said. The decision upheld a ruling by Barron County Circuit Judge James Babler. (Associated Press, March 25, 2008)

ACOG may redo abortion conscience policy. Under fire from anti-abortion physicians and Health and Human Services Secretary Michael Leavitt, the American College of Obstetricians and Gynecologists (ACOG) announced in March that it will re-examine a controversial November 2007 opinion outlining the limits of conscientious refusal. The ACOG ethics committee opinion

said physicians who have religious or moral objections to “standard practices,” such as abortion, sterilization or the prescribing of contraceptives, are not ethically obligated to provide those services but do owe patients a timely referral to another doctor willing to deliver them. Some anti-abortion doctors fear their board certification would be at risk if they refuse to refer patients to doctors willing to perform abortions. (American Medical News, April 14, 2008)

Chinese son likely gave bird flu to father. A 24-year-old Chinese man who died of bird flu in December passed the virus directly to his father in a rare case of human-to-human transmission of the virus, doctors reported recently. Chinese officials had already said they believed the younger man infected his 52-year-old father, who survived, but genetic sequencing and other checks confirmed this was likely, the researchers said. “In this family cluster of confirmed cases of infection with highly pathogenic avian influenza A (H5N1) virus in mainland China, we believe that the index case transmitted H5N1 virus to his father while his father cared for him in the hospital,” they wrote in the *Lancet* medical journal. (Reuters, April 7, 2008)

Allocation guidelines for epidemics. A new report says doctors, health care workers and the public need to start thinking about how ventilators will be allocated in the event of an epidemic. The report by New York State health officials “Allocation of Ventilators in a Public Health Disaster,” appeared in the March issue of *Disaster Medicine and Public Health Preparedness*. Right now,

there are enough ventilators to go around. But in an epidemic, there could be a severe shortage. Doctors and hospitals would have no choice but to start taking some people off the machines so that others could live. Removal “is absolutely the crux of the problem,” said a lead author of the study, Dr. Tia Powell, who has spent much of her career studying medical ethics. “There are people who might survive who won’t get a chance at a ventilator if someone who is likely to die even with a vent is using it.” (*The New York Times*, March 25, 2008)

Study signals Dutch switch to drugs from euthanasia. Terminally ill patients in the Netherlands increasingly receive drugs to render them unconscious until death, according to a study that suggests people are substituting deep sedation for legal euthanasia. Researchers found that 1,800 people (7.1 percent of all deaths in the Netherlands in 2005) were drugged into so-called continuous deep sedation shortly before dying. “The increased use of continuous deep sedation for patients nearing death in the Netherlands and the limited use of palliative consultation suggests that this practice is increasingly considered as part of a regular medical practice,” Judith Rietjens of Erasmus University Medical Center in Rotterdam and colleagues wrote in the *British Medical Journal*. (Reuters, March 20, 2008)

Assisted suicides increase in Oregon. Forty-nine Oregonians ended their lives in 2007 by taking a lethal drug dose prescribed under Oregon’s unique Death With Dignity Act, state officials reported recently. That’s the highest annual total in the decade-long history

of the law, three more than in 2006. It brings the 10-year total to 341, or a little more than 1 in 1,000 deaths in Oregon. As in previous years, most of the Oregonians who died this way last year had cancer and were older than 55, white and highly educated. They included 26 men and 23 women. All had some form of health insurance. Most died at home while under hospice care. (*The Oregonian*, March 19, 2008)

Federal legislation to prevent discrimination based on genetic information likely to become law. On April 24, the U.S. Senate approved the Genetic Information Nondiscrimination Act (commonly known as GINA) by a 95-0 vote. The bill will be sent back to the House in its current form and is expected to pass by a wide margin. President Bush supports the legislation. The bill prevents health insurance companies from using genetic information as a basis for eligibility for coverage or for setting premiums. In addition, employers are prohibited from using genetic information in employment or promotion decisions. (Associated Press, April 24, 2008)

Illinois Appellate Court denied guardian’s petition to sterilize a mentally disabled woman against her will. A three-judge panel ruled unanimously on April 18, 2008, to deny the request of a guardian to have her 29-year-old niece undergo a tubal ligation against her will. The woman (K.E.J.) sustained a traumatic brain injury after being struck by a car as a child. Her aunt, with whom she lives, was appointed her legal guardian in the 1990s. The petition, originally filed in probate court in 2003, requested the court order sterili-

zation in the best interest of K.E.J., who allegedly could not tolerate other types of birth control and was not competent to raise a child. However, during a 2005 bench trial on the issue, K.E.J. testified that she would like to have children one day and the petition was denied. K.E.J.’s aunt then appealed to the Illinois Appellate Court which issued the most recent denial. (*Chicago Tribune*, April 18, 2008)

Hospital’s obligations under EMTALA end when it admits patient in good faith. The U.S. District Court for the Eastern District of Tennessee upheld the validity of the EMTALA regulations that state a hospital’s obligations under the act end when it admits an individual as an inpatient in good faith for further treatment. The hospital in the case, accused of “patient dumping,” transferred the patient at the family’s request when the patient developed an emergency condition 17 days after admission. The court noted that EMTALA was enacted to prevent patient dumping based on perceived inability to pay, not to guarantee proper diagnosis. (*BNA Health Care Daily Report*, March 28, 2008)

Hospital may be liable under EMTALA for refusing to see patient en route to hospital in non-hospital owned ambulance. The U.S. Court of Appeals for the First Circuit decided on April 18 that a patient in an ambulance “comes to” the hospital for the purposes of EMTALA without reaching the hospital grounds if the hospital has been notified of the patient’s imminent arrival and the hospital is not on diversion. In such a circumstance, actions and conversations tantamount to refusals to

treat may expose hospitals to EMTALA liability. In the case, a woman was experiencing acute symptoms of a ruptured ectopic pregnancy and was being transported to the hospital where her obstetrician practiced. The ambulance was not owned by the hospital and the paramedics were not employed by the hospital. The paramedics called ahead to the emergency room and spoke with the director three times during transit. First, the director accused the plaintiff of inducing a voluntary abortion and told the paramedics to call back. The director later inquired about her health coverage status and abruptly ended the third conversation. After the last call, the paramedics interpreted the director's response as a refusal to treat and took the patient to another facility. (Morales v. Sociedad Española de Auxilio Mutuo y Beneficia, 1st Cir., No. 07-1951, April 18, 2008)

Universal coverage strains

Massachusetts care. Massachusetts currently faces an unintended consequence of its new universal health care system. The state must now deal with a massive shortage of primary care physicians. When the law took effect, some estimated 600,000 uninsured people gained insurance and are now looking for physicians to offer them long-deferred care. To combat this shortage, Massachusetts legislative leaders have proposed medical school debt forgiveness to physicians willing to practice primary care in underserved areas. (*The New York Times*, April 5, 2008)

Quality improvement initiatives redirect scarce nursing resources from direct patient care. A study released March 20, 2008, reported that

although hospital leaders believe nurses are in the best position to head quality improvement initiatives, their involvement in such programs may divert resources away from direct patient care. Contributing factors include nursing shortages, participation in duplicative quality improvement activities, and lack of quality improvement curricula in nursing education. (*BNA Health Care Daily Report*, March 20, 2008)

Physician referrals to specialty hospitals threaten hospitals' financial security. A recent study found that physician referral practices adversely affect the financial security of hospitals. Hospitals depend on privately insured patients to subsidize the cost of providing services to indigent, uninsured and Medicaid patients, but are receiving a disproportionately low amount of these referrals. Instead, physicians are diverting up to 90 percent of privately insured patients to physician-owned ambulatory surgical centers, which perform services similar to hospital outpatient departments. (*BNA Health Care Daily Report*, March 18, 2008)

Institute of Medicine report predicts baby boomers will overwhelm health system. The American medical system is desperately unprepared for the flood of retiring baby-boomers. An Institute of Medicine report estimates that there is only one physician certified in geriatrics for every 2,500 older Americans and that turnover among nurses' aides averages 71 percent annually. Today's elderly population will live longer with less chronic disability, making their growing numbers a problem for the health care system. The IOM reported that there are currently 7,128 certified

geriatricians but that the nation will need 36,000 by 2030. Bills on the federal and state levels are in motion to provide loan forgiveness for physicians pursuing geriatric specialties. (*Los Angeles Times*, April 15, 2008)

Missouri prison refusing to provide inmate with access to elective, non-therapeutic abortion violates Fourteenth Amendment. The United States Court of Appeals for the Eighth Circuit held that a Missouri Department of Corrections (MDC) policy refusing transportation to abortion services for pregnant inmates was unconstitutional. MDC's original policy provided transportation for inmates to off-site providers if they wanted to terminate their pregnancies. On Sept. 5, 2005, the MDC altered its policy such that prison inmates would be transported for abortions only if the pregnancy presented an imminent threat to the mother's life or health. The lower court held the policy was unconstitutional under the Eighth Amendment's cruel and unusual punishment prohibition. The Court of Appeals, instead, ruled that while the policy did not violate the Eighth Amendment, it remained unconstitutional because the policy placed an undue burden on the inmate by effectively eliminating all access to abortion services. (*Roe v. Crawford*, 514 F.3d 789, 8th Cir. 2008)

Study reports uninsured not responsible for overcrowding in emergency departments. A study published recently in the *Annals of Emergency Medicine* found that the rise in emergency department visits over the last 13 years is not related to an increase of visits by the uninsured. Although the rate of

emergency department visits increased 28 percent between 1992 and 2005, utilization by the uninsured remained constant. Instead, the increase was, in part, attributable to increased utilization by those with coverage and whose usual source of care is a provider's office. (Weber et al., "Are the Uninsured Responsible for the Increase in Emergency Department Visits in the U.S.?" *Annals of Emergency Medicine*, advanced electronic publication April 11, 2008)

New Wyoming law requires health insurers to cover the cost of routine care associated with clinical trials for cancer. On March 12, 2008, the Wyoming governor signed a bill that requires health insurance companies to pay for the costs of routine care and care for adverse reactions for patients who participate in phases 2, 3, and 4 clinical trials for cancer. The trials must be accredited by a nationally recognized agency, but trial sites outside the state of Wyoming are included in the coverage mandate. (*BNA Health Care Policy Report*, March 17, 2008)

Office of the Inspector General approves electronic kiosks placed by pharmaceutical companies in physician waiting rooms. The OIG issued an advisory opinion stating that a pharmaceutical company could place freestanding electronic kiosks in physicians' waiting rooms without violating prohibited payment provisions of the anti-kickback statute. The kiosks would offer interactive questionnaires about four disease states to help patients decide whether they should discuss any of the four disease states with their physicians. However, the kiosks would not mention

the company's products or contain any incentives, advertisements or coupons and physicians would not receive any payments for hosting the kiosks. (*BNA Health Care Daily Report*, Feb. 25, 2008)

Testimony before the U.S. House of Representatives indicates uninsured Americans are sicker, die sooner and add to Medicare costs. The House held a hearing on April 15, 2008, to seek information about the state of health care coverage across the country. Witnesses told the panel that the uninsured delay medical care at a much higher rate than the insured. This delay means individuals often enter the Medicare program in very poor health and require more ongoing care once enrolled. The delay also causes premature deaths and costs the U.S. economy as much as \$200 billion each year. The executive vice president of the Kaiser Family Foundation testified that 47 million Americans are currently uninsured. (*BNA Health Care Policy Report*, April 21, 2008)

Co-payments soar for high cost drugs. Some health insurance companies are rapidly adopting a new pricing system for very expensive drugs. They now ask patients to pay hundreds to thousands of dollars for life saving medications. The new pricing plans abandon the fixed co-pay amounts, like \$10, \$20 or \$30 for a prescription, no matter the drug's actual cost. Instead, insurers are moving towards charging patients a percentage of the cost of certain high-priced drugs, roughly 20 to 33 percent, which can amount to thousands of dollars a month for the consumer. (*The New York Times*, April 14, 2008)

Companies that service health care providers show excellent profit potential as country ages. With one out of every six dollars of the national gross domestic product going to health care, the number of young health care related companies has rapidly grown. For example, one Chicago-based start-up is experiencing success providing patient feedback to physicians regarding potential areas of improvement. Receiving grants from the government and strong interest from health care organizations, this company and others like it are succeeding and multiplying quickly. (*Chicago Tribune*, March 17, 2008)

Wisconsin law mandates access to emergency contraception for victims of sexual assault. A law enacted in March requires all hospitals that provide emergency services and their employees to notify victims of sexual assault of the option of emergency contraception and provide the contraception if requested, including follow-up doses. The Wisconsin law, A.B. 377, also requires hospital employees to provide victims with "unbiased, medically and factually correct information about emergency contraception use and efficacy." Hospitals must also inform the victim of her options to report the crime to law enforcement and undergo an exam to gather evidence. Hospitals will be monitored for compliance by the Wisconsin Department of Health and Family Services. (*BNA Health Care Policy Report*, March 17, 2008)

Pennsylvania lawmakers pass bill to allow health care facilities to donate unused cancer drugs to low income patients. The Cancer Drug Repository Program Act was approved by the

Pennsylvania legislature on April 8, 2008. The act, if signed by the governor, will provide low-income cancer patients access to costly cancer drugs for a small handling fee. Under the program, in certain circumstances, health facilities can donate unused cancer treating medications to participating pharmacies. Participating pharmacies would then distribute them to patients for whom the drugs are prescribed. (*BNA Health Care Policy Report*, April 21, 2008)

Legalization of medical marijuana will appear on November ballot in Michigan.

The Michigan Coalition for Compassionate Care spearheaded a petition drive to present the issue of medical marijuana to the legislature. On March 8, 2008, the state certified the petition and the legislature had until April 11 to act on the issue. Because the legislature took no action, the initiative will appear on the November ballot. If passed by a majority of Michigan voters, the law will allow patients with serious illnesses to use,

possess and grow marijuana for medical use with their physician's approval. (*BNA Health Care Policy Report*, March 17, 2008; Michigan Coalition for Compassionate Care website, April 25, 2008)

Agency for Healthcare Research and Quality publishes proposed process to allow health care providers to self-report medical errors without fear of liability.

On Feb. 12, 2008, AHRQ published proposed rules to establish patient safety organizations (PSOs) that would be responsible for the collection and analysis of medical data reported by providers. The PSO's analysis of the data would allow for the identification of trends and implementation of policies to reduce medical error. The establishment of PSOs was authorized under the Patient Safety and Quality Improvement Act of 2005. (*BNA Health Care Policy Report*, February 18, 2008)

University of Pittsburg bans gifts from pharmaceutical and device industry representatives. In February 2008, the

university implemented a policy that prohibits faculty, staff and students at the Medical Center and Schools of Health Sciences from accepting gifts from industry representatives. Under certain circumstances and after completion of specific training modules, industry representatives are allowed access to the facilities at the invitation of a provider. The policy also restricts the ability of providers to participate in industry sponsored events and meetings. (*BNA Health Care Fraud Report*, Feb. 27, 2008)

Students from the Center for Health Law Studies and Student Writers Association at Saint Louis University School of Law contributed to this installment of "Of Note." This edition was edited by Kelly Dineen, assistant director, Center for Health Law Studies. Health law student contributors were Gina Geheb, Mark Guest and LeAnne Hargett.