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LSU lands grant for cardio studies
The Times-Picayune | 07.10.08
By Jennifer Evans
Staff writer

The LSU Health Sciences Center has received a $10 million grant to study cardiovascular disease, a leading cause of death in Louisiana.

The five-year grant from the National Center for Research Resources, a part of the National Institutes of Health, was announced Wednesday.

This award is a significant sign of recovery and recognition of the quality of research at LSU, said Dr. Larry Hollier, chancellor of the LSU Health Sciences Center.

This is the second such grant awarded to LSU for cardiovascular research since 2003, totaling more than $20 million over a 10-year period.

"The need for the development of a cardiovascular center of excellence here in the New Orleans area is pivotal and is demonstrated by the really tragic state of cardiovascular disease in the United States," said Dr. Daniel Kapusta, a pharmacology professor at the Health Sciences Center.

In the United States, an average of 2,006 people die each day from cardiovascular disease, or an average of one death every 36 seconds, according to the Centers for Disease Control and Prevention's National Center for Health Statistics. Carotid artery disease continues to be a major health care problem, contributing to at least 200,000 cases of stroke each year in the United States, statistics show.

In 2002, cardiovascular disease, including heart disease and strokes, accounted for 35 percent of the deaths in Louisiana, according to the Louisiana Department of Health and Hospitals and the American Heart Association's 2005 Louisiana State of the Heart and Stroke Report.

In 2002, Louisiana had the ninth-highest mortality rate due to cardiovascular disease and twelfth-highest mortality rate for strokes when compared to all states and the District of Columbia.

Kapusta, director of the cardiovascular program for the Center of Biological Research Excellence, said 75 percent of Louisiana residents ages 45 or older have symptoms of major risk factors for cardiovascular disease, including hypertension, high cholesterol, obesity and diabetes.

LSU officials said the research grant will help launch the careers of five young research scientists by providing start-up money for cardiovascular research projects.

With the grant, researchers will be able to purchase state-of-the-art equipment, hire new lab personnel and perform research that ultimately "helps them to gain national recognition and funding," Kapusta said.

The grants will support four research projects and one pilot study, one of which will focus on why diabetics who have stents placed in their coronary arteries are at increased risk for reclosing of the arteries.

Dr. Steve Nelson, dean of the School of Medicine at LSU Health Sciences Center, said an influx of grants will help new therapies to be discovered, developed and made available to Louisiana residents.

"It is our goal that our patients will no longer have to travel outside of Louisiana to have access to the latest breakthrough therapies," he said.

http://www.nola.com/news/t-p/metro/index.ssf?/base/news-29/1215668084145860.xml&coll=1

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N.O. health center wins $10.5 million grant
The Advocate | 07.10.08
By ALLEN M. JOHNSON JR.

NEW ORLEANS — Jubilant officials at LSU Health Sciences Center-New Orleans announced a $10.5 million research grant Wednesday they say will help fight Louisiana's No. 1 killer — cardiovascular disease.

The award also will help the health sciences center and the city recover from Hurricane Katrina, which flooded most of the city in 2005, officials said.

"This $10 million competitive award represents a significant sign of recovery and recognition of the quality of the research here at the LSU Health Sciences Center-New Orleans," said Dr. Larry Hollier, chancellor of the teaching hospital.

"I think our future is very, very bright," said Dr. Steve Nelson, dean of the health sciences center's School of Medicine.

The Center for Biological Research Excellence grant, awarded by an arm of the National Institutes of Health, will provide the health sciences center with five years of funding for cardiovascular research and the development of junior faculty investigators while they compete for more national research funding, officials said.

"We're on our way to helping these faculty (members) establish themselves nationally," said Dr. Daniel Kapusta, professor of pharmacology at the health sciences center and director of the Cardiovascular COBRE program.

The grant will support four research projects and a pilot project by five junior faculty investigators. Their work will help transform the health sciences center into a "self-sustained national center of cardiovascular disease (research)," Kapusta said.

Cardiovascular disease accounted for 35 percent of all deaths in Louisiana in 2002 — making the malady the No. 1 killer of Louisiana residents, according to a joint report released in 2005 by the Louisiana Department of Health and Hospitals and the American Heart Association.

"In the state of Louisiana, the incidence rate for cardiovascular disease is disproportionately high, particularly for African Americans," said Sidney McNairy, an associate director of the research at the NIH's National Center for Research Resources, which awarded the grant.

Nelson cautioned against high public expectations as a result of the funding infusion. The average time span from research developments to "bedside (treatment)" is 10 to 12 years."

Suddenly, Dr. Jack Strong, an internationally recognized expert in cardiovascular research at the health sciences center, stood up in the audience. He touted the kind of pioneering work that can be done at the university facility.

Dr. Strong, 80, was the first to link cigarette smoking to hardening of the arteries, health sciences center spokeswoman Leslie Capo said later. In addition, Strong spearheaded a landmark investigative study in the 1990s that showed how early heart disease begins in teenagers. The emperor of Japan last month bestowed that nation's oldest honor to Strong for his contributions to medicine to the Pacific island nation.

Hollier expressed amazement the hospital had even qualified for the $10.5 million COBRE grant, much less prevailed. "A year and a half ago, the question was — should we even compete for this (grant)?" Hollier said.

New Orleans City Council President Jackie Clarkson likened the funds to "seed money" for restoring the city's post-storm economy.

"Grants beget grants," Clarkson said. "Research begets research. It's like seed money to the rest of the world. Come on down. Bring the best of jobs to the best of cities in America."

Kurt Weigle, president and CEO of the city's Downtown Development District, got the biggest laugh at the news conference, hosted at the health sciences center's Medical Education Building in the struggling Bio-Medical District. "This announcement is so exciting it's giving me palpitations," Weigle joked, patting his chest. Seriously, Weigle added, every "life sciences" job that comes to the Bio-Medical District, stimulates the creation of 2.5 other occupations in the local economy.

http://www.2theadvocate.com/news/24286644.html

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Group calls for zero tolerance of doctor bullies
The Advocate | 07.10.08
By CARLA K. JOHNSON
Associated Press Writer

CHICAGO (AP) -- Bullying doctors can make nurses afraid to question their performance, resulting in medical errors, according to a hospital group that announced new requirements for cracking down on intimidating behavior.

Outbursts and condescending language threaten patient safety and increase the cost of care, according to a safety alert issued Wednesday by the Joint Commission, an independent organization that accredits most of the nation's hospitals.

Hospitals will be required by next year to have codes of conduct and processes for dealing with inappropriate behavior by staff, said the group's president, Dr. Mark Chassin. Hospitals without such systems risk losing their accreditation, he said.

Powerful doctors mean money for hospitals because they choose where to admit their patients, but they "should not be left off the hook," said Dr. Peter Angood, vice president of the group, which is based in suburban Chicago.

Grena Porto, a nurse involved in the group's efforts, said nurses need to be "appropriately assertive" and feel safe enough to ask a doctor, "Are you sure we're supposed to operate on the right leg, rather than the left?"

Nurses, pharmacists and hospital administrators also can be culprits, but it's the doctors who bully nurses that are the most significant for patient safety, said Dr. Alan Rosenstein, a researcher on the topic. He applauded the group's action.

Rosenstein, medical director of VHA West Coast, an alliance of nonprofit hospitals, surveyed 1,500 hospital employees for a 2005 study published in the American Journal of Nursing, and received comments like these:

- "Most nurses are afraid to call Dr. X when they need to, and frequently won't call. Their patient's medical safety is always in jeopardy because of this."

- "I have caught myself in the middle of mislabeling specimens after confrontations that have been upsetting."

Another survey in 2003 by the Institute for Safe Medication Practices found that 40 percent of health providers said they had kept quiet rather than question a known bully.

Hospitals have pecking orders and are stressful work environments, but "there's a right way and a wrong way to manage that stress," Chassin said.

http://hosted.ap.org/dynamic/stories/M/MED_HOSPITAL_BULLIES?SITE=LABAT&SECTION=HOME&TEMPLATE=DEFAULT&CTIME=2008-07-09-15-08-53

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BR loses, N.O. gains in latest census data
The Advocate | 07.10.08
By JEREMY HARPER

Baton Rouge's population declined faster than all but one large city in the nation a year ago, the U.S. Census Bureau said in a report released today that was sharply criticized by local officials.

Between July 1, 2006, and July 1, 2007, the latest period for which data are available, Baton Rouge lost 3,644 people, a decline of 1.6 percent, the report says. The bureau said the city's population grew by 3 percent the year before.

Only Columbus, Ga., had a larger percentage decrease in population during the same period, according to the Census Bureau's report on 266 cities with populations of at least 100,000. The bureau attributed the drop there to a decline in the number of people living in military barracks at Fort Benning, Ga.

New Orleans was the nation's fastest-growing city during the same period, regaining the title of Louisiana's most populous city from Baton Rouge for the first time since Hurricane Katrina displaced tens of thousands of people in August 2005.

The estimated 2007 population for New Orleans was 239,124, an increase of 28,926 but still just more than half of the city's pre-Katrina population of 453,726.

Baton Rouge's estimated population was 227,071.

Mayor-President Kip Holden said Wednesday that the Census report is a flawed estimate that dramatically underreported the city's population.

"They take a mathematical extrapolation — that they come up with themselves — and come up with erroneous numbers," Holden said. "Until we have a full census, they would do us all a favor if they would just go away for a couple of years until we can know the exact population."

Holden said the report contradicts what he said is clear evidence of Baton Rouge's ongoing growth: steady school enrollment, climbing sales tax revenue and booming business development.

"You can go virtually all over Baton Rouge and buildings are coming up everywhere," Holden said. "So if that number was correct, would banks be out here loaning all these people money to build condos and apartments and office buildings and restaurants?"

On the list of fastest-losing cities by percentage, Baton Rouge was followed by Hollywood, Fla.; Jackson, Miss.; and Coral Springs, Fla.

Cleveland had the largest numerical decline in population from 2006 to 2007, followed by Columbus, Ga. Baton Rouge was third.

Shreveport's population estimate was 199,569, a drop of 1,137 people and Lafayette's population estimate was 113,544, a loss of 675, according to the report.

Shreveport demographer and political analyst Elliott Stonecipher said the simultaneous population drop in Baton Rouge and growth in New Orleans was "anything but a surprise" given the ongoing resettling of Katrina victims.

"To me, it's just very logical; it was very expected," Stonecipher said.

Greg Rigamer, a New Orleans urban planner with GCR and Associates, said the shifts in both cities are related and most likely the result of major improvements in services in New Orleans during the summer and fall of 2006.

"When you look at when most people came back to New Orleans, it was really in that period," he said. "Many of the people from New Orleans were clearly in Baton Rouge."

The Census report is the second this year to estimate a population drop for the Baton Rouge area.

The bureau released population estimates for parishes and counties in March. That report estimated a population drop parishwide and was also criticized by city-parish officials.

East Baton Rouge Parish had an estimated population of 431,278 in July 2006, but that dropped to 430,317 by July 2007, or a loss of 961 residents, that report showed.

Holden said the estimates are "crippling" for Baton Rouge because federal and state funding is often tied to population. He said Congress should come up with a new method for calculating population between censuses.

Holden said the city has requested another full census before the federal government's official 2010 count but has not made any progress with the Census Bureau.

"In two more years, it's going to be really embarrassing when they realize that they have used bad figures," he said.

http://www.2theadvocate.com/news/24303444.html

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Pete Sepp: Time to cure what ails Medicare
Shreveport Times | 07.10.08

Medicare's fiscal woes are well known, and the demise of the program's hospital insurance component is looming ever closer. The so-called Trust Fund for "Part A" — consisting of government IOUs — will begin the slide toward bankruptcy in three years and reach total insolvency in 2019.

A lesser known fact, however, is Congress can take several cost-controlling measures to alleviate coming budget disruptions that won't require tax hikes, price controls and government bailouts. Louisiana's own Rep. Jim McCrery, R-Shreveport, holds a key position on the House Ways and Means Committee, which likely will undertake many of these proposals. Although solutions to preventing Medicare's collapse vary, the first step toward reform may begin with something as simple as dialysis — starting at the door of Fresenius Medical Care, which has 78 clinics and more than 4,600 patients in Louisiana.

Medicare currently serves as the secondary payer for a patient undergoing dialysis for end stage renal disease for the first 30 months of treatment, during which the beneficiary's own private insurance plan provides primary payment. Patients are forced to switch to Medicare as their primary payer after 30 months of treatment — regardless of their age or preferences.

Extending private coverage from 30 to 42 months, as proposed in the otherwise ill-advised Children's Health and Medicare Protection Act of 2007, would save $1.2 billion over 10 years, according to a Congressional Budget Office estimate. Given its tax and spending hikes, the CHAMP Act deserved to be buried by Presidential veto, but the bill's Patient Coverage Extension is worth salvaging.

In addition to common-sense changes such as the Patient Coverage Extension, Congress could save tens of billions of dollars annually lost to waste, fraud and abuse in federal health programs by expanding the use of private-sector Recovery Audit Contractors. RACs corrected nearly $443 million in improper Medicare payments in fiscal years 2006 and 2007, according to the Department of Health and Human Services. Every dollar paid to RACs has resulted in $15 of identified improper payments. Among the dubious cases RACs uncovered: seven appendectomies in one day for the same patient.

Lawmakers also should preserve another important accountability measure for Medicare: an "alarm bell" requiring Medicare Trustees to issue a warning (and Congress to respond) if overall funding from general federal revenues exceeds a 45 percent share in two consecutive annual reports.

Another way to rein in Medicare spending is means-testing, which would reduce cash and in-kind benefits on a sliding scale as income rises. A National Taxpayers Union Foundation study determined that modest limits for wealthier individuals could yield annual savings of more than $75 billion. Sen. John McCain recently proposed a slightly higher premium for those with incomes above $160,000 who get Medicare's Part D prescription benefit. This step alone has the potential to save the program several billion dollars.

Finally, Congress should enact health care reforms outside Medicare that could take pressure off the program in the future. The Health Care Choice Act, which would allow patients to purchase health insurance across state lines, is one proposal that would expand consumer choices, reduce onerous state regulations and lower prices. Health Savings Accounts should be expanded.

Containing Medicare's spiraling costs likely won't be accomplished by a single bill, but a multi-part approach. Whichever party wins this fall's election will witness firsthand the beginning of the end for Medicare's finances. The outcome of this drama depends on whether politicians enact modest reforms sooner to avoid catastrophe later.

Pete Sepp is vice president for Policy and Communications for the Alexandria, Va.-based National Taxpayers Union, a nonpartisan citizen group with 362,000 members nationwide and more than 3,200 in Louisiana. www.ntu.org.

http://www.shreveporttimes.com/apps/pbcs.dll/article?AID=2008807100317

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Many patients unhappy with breast conservation
By HealthDay News | 07.10.08

A third of women who opt for breast-conserving cancer surgery say they now have an asymmetry between their breasts that greatly affects their quality of life, a new study says.

Women whose affected breast looked noticeably different after surgery were twice as likely to fear their cancer returning and to have symptoms of depression when compared with women whose breast still appeared similar, according to the study by researchers at the University of Michigan Comprehensive Cancer Center.

Their findings are published in the July 10 issue of the Journal of Clinical Oncology.

“We found that one of the most important factors of postoperative quality of life and satisfaction was postoperative asymmetry or the aesthetic outcome that women experienced after their surgery,” said study author Dr. Jennifer Waljee, a resident in general surgery at the university’s Medical School.

Many women diagnosed with breast cancer can choose between surgery that removes just the tumor and some surrounding tissue or a mastectomy, which removes the entire breast.

Reconstructive surgery is possible after each type of operation.

“It’s important for women to think about all those issues at the time they are making their surgical decision and realize that although breast-conserving surgery may or may not be less disfiguring than mastectomy, they’re likely to experience some asymmetry afterwards that may impact their quality of life,” Waljee said.

Surgeons usually discuss prior to the operation the types of aesthetic changes mastectomy patients will see after.

The researchers believe the same level of counseling is not given those having breast-conserving surgery, leaving them with incorrect expectations of what their breast will look like after the operation.

“Its important for breast surgeons to have an open and honest dialogue with their patients so that they understand patients’ expectations before surgery and can better address postoperative recovery needs,” Wajee said.

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Breast Asymmetry after Cancer Surgery Linked to Psychosocial Problems
MedPage Today | 07.10.08
By Charles Bankhead, Staff Writer, MedPage Today

ANN ARBOR, Mich., July 9 -- Pronounced asymmetry after breast-conserving surgery for cancer can lead to significant psychosocial problems that may need preoperative counseling, investigators here concluded.
Action Points

* Explain to patients who ask that this study showed that breast asymmetry after breast-conserving surgery is associated with psychosocial dysfunction.

* Note that the findings are based on a survey and do not prove that breast asymmetry causes psychosocial problems.

Breast asymmetry correlated significantly with feelings of stigmatization and perceived lack of improvement in health after treatment, Jennifer J. Waljee, M.D., of the University of Michigan, and colleagues reported in the July 10 issue of the Journal of Clinical Oncology.

The occurrence of depressive symptoms increased with the extent of breast asymmetry, which also predicted worse quality of life.

"Identifying patients at risk for postoperative asymmetry at the time of consultation may allow for improved referral for supportive counseling, prosthetics, and reconstruction," the authors concluded.

The effect of surgery on psychosocial outcomes in breast cancer patients is controversial, and the potential underlying mechanisms are poorly understood. Prior studies have focused primarily on differences between mastectomy and breast conservation.

Although breast-conserving surgery is considered the least disfiguring surgical option, outcomes vary widely, the authors noted. Moreover, patients who undergo breast-conserving surgery are not counseled in advance about reconstruction and may have more limited options, compared with women who have mastectomies.

In an effort to clarify associations between breast asymmetry and psychosocial outcomes in breast cancer survivors, Dr. Waljee and colleagues examined survey responses from 714 patients treated with breast-conserving surgery from January 2002 through May 2006. The survey covered five aspects of psychosocial functioning: overall quality of life, depression, fear of recurrence, stigmatization, and perceived change in health status.

Postoperative breast asymmetry was assessed by means of the Breast Cancer Treatment and Outcomes Survey.

The results showed that women with significant breast asymmetry were more than four times as likely to feel stigmatized as were women with minimal postsurgical breast asymmetry (OR 4.58, 95% CI 2.77 to 7.55). Additionally, women with significant breast asymmetry were almost 60% less likely to report improved or unchanged health status (OR 0.43, 95% CI 0.27 to 0.66).

The frequency of depressive symptoms increased from 16.2% in women with minimal breast asymmetry, to 18% in those with moderate asymmetry, to 33.7% in women with pronounced breast asymmetry (P=0.002). Women with minimal breast asymmetry had a mean quality-of-life score of 86.3 compared with 82.4 for women with pronounced asymmetry (P0.001).

The authors noted that the study was retrospective and cross-sectional. They could not determine causality or rule out the possibility that the associations between aesthetic outcome and psychosocial functioning may be mediated by other factors such as sexual function, body image, and use of psychological counseling.

They also pointed out that the study sample was drawn from a single institution and was homogenous with respect to sociodemographic factors so that it may not be generalizable to other groups of women.

http://www.medpagetoday.com/HematologyOncology/BreastCancer/tb/10056

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F.D.A. Revises Its Letter for Nonapproval of Drugs
The New York Times | 07.10.08
By BLOOMBERG NEWS

Drug makers whose products are not ready for approval in the United States will soon get the word from regulators in a new format intended partly to avoid scaring investors.

The Food and Drug Administration will send “complete response letters” when drugs are not cleared for sale, calling them “more neutral” replacements for the “approvable” or “not approvable” letters used in the past, the agency said Wednesday in a statement on its Web site. The changes take effect Aug. 11.

The agency’s approvable and not-approvable letters leave analysts and investors guessing what signal the agency is sending about a drug’s prospects. The new format may ease criticism from companies that say the F.D.A. is slow to act on drugs and misleading in its statements about new product applications.

“In the past, some drug manufacturers expressed concern that a not-approvable letter sent an unintended message that a marketing application would never be approved, which could adversely affect a company’s ability to raise capital,” the F.D.A. said in a 122-page overview of its new policies.

The agency proposed the switch to complete response letters in July 2004 and is already using the format for medicines made through biotechnology.

The new letters to drug makers will describe what is missing from an application and, when possible, give advice on how to fix it, according to the F.D.A.

Because the F.D.A. letters are not released to the public, investors may be less informed than they are now when companies announce that they have received an approvable or not approvable letter, said Jon LeCroy, a pharmaceutical analyst at Natixis Bleichroeder in New York.

“While this new plan may provide more detailed information to the company regarding issues that need to be addressed, investors will likely be kept in the dark on the status of a drug’s approvability,” Mr. LeCroy said in a note Wednesday to clients. “Investors will no longer know whether a drug is dead in the eyes of the F.D.A.”

Investors already are confused because the qualifications for an approvable letter have been “distorted by the agency,” said Ira Loss, who follows the F.D.A. for the firm Washington Analysis.

“Years ago, an approvable letter meant there were a few things left to resolve,” Mr. Loss said in a phone interview. “Nowadays, some approvable letters require significant studies.”

By law, makers of brand-name drugs pay application fees to the F.D.A. in exchange for the agency’s commitment to act within 180 days. The new rules include standards for how long review cycles will be extended when companies file amendments to applications or resubmissions.

The revisions may reduce review times for as many as 40 percent of supplementary applications with effectiveness data filed each year, the agency said. Review times may increase for as many as 11 percent of these filings and as many as 6 percent of manufacturing supplements, the F.D.A. said.

While the changes mostly concern semantics as sought by drug makers, the burden will now be on them to explain to their investors how much work is needed on an application, Mr. Loss said.

“Now you’re going to have to really rely on the honesty of the management who gets these letters,” he said. “Everybody is going to have to wait and see what a company says and try to read between the lines.”

http://www.nytimes.com/2008/07/10/business/10drug.html?ref=health

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A List of Drugs That Increase Falling Risk
The New York Times | 07.10.08
Tara Parker-Pope

Researchers at the University of North Carolina have published a lengthy list of prescription drugs that increase the risk of falling among older patients.

Falls are the leading cause of both fatal and nonfatal injuries in adults 65 and older. An estimated 300,000 hip fractures occur each year, often as a result of falling. Head injury is also a problem among adults who fall.

Adults who take four or more medications at a time are at highest risk for falling. But certain types of drugs can also make someone more prone to falling, said Susan Blalock, an associate professor at the U.N.C. Eshelman School of Pharmacy.

The medications on the list cover a wide range of common prescription seizure medications and painkillers, among others. Also on the list are popular antidepressants like Celexa, Effexor, Wellbutrin, Prozac and others.

Researchers said the “common denominator” among the drugs on the list is that they all work to depress the central nervous system, which makes patients less alert and slower to react. The list was published in the June issue of The American Journal of Geriatric Pharmacotherapy.

Stefanie Ferreri, the lead author of the paper and a clinical assistant professor in the pharmacy school, said that patients need to be wary of more than just prescription medications, because many over-the-counter medications can also contribute to falls.

“Some allergy medications, sleep aids and some cold and cough remedies can have the same effects as prescription drugs,” Dr. Ferreri said. “Anything that can cause drowsiness can put you at increased risk of falling.”

The researchers warned that if patients see a drug they are taking on the list, they should not stop taking it. Many drugs can trigger serious side effects if stopped abruptly. But patients should talk to their doctors about falling risk and possible alternative medications, the researchers said.

Physicians should look for medications that have been proven safe and effective in older adults and look for medicines that have less of a sedating effect. Physicians should be especially wary of anticholinergics, a class of drugs that affect nerve cells used to treat a wide range of conditions.

http://well.blogs.nytimes.com/2008/07/10/a-list-of-drugs-that-increase-falling-risk/

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McCain Plan to Aid States on Health Could Be Costly
The New York Times | 07.09.08
By KEVIN SACK

PIKESVILLE, Md. — If Senator John McCain's radical plan for remaking American health care is to work, he will have to find a way to cover people like Chaim Benamor, 52, a self-employed renovator in this Baltimore suburb. Mr. Benamor never found it necessary to buy insurance before having a mild heart attack last year and now, 13 years shy of Medicare, has little hope of doing so.

The heart attack left Mr. Benamor with a $17,000 hospital bill, $400 in monthly prescription costs and a desperate need for insurance. After being rejected by a number of commercial carriers, he turned to the Maryland Health Insurance Plan, one of 35 state programs for high-risk applicants whom no private company is willing to insure.

He decided that the annual premium — $4,572 for a plan with heavy deductibles — was more than he could handle on an income of about $35,000. Yet his earnings were too high for him to qualify for state subsidies.

"I'd like to get it, but what do you pay first?" Mr. Benamor asked at his dining room table. "Do you pay the mortgage? Do you pay your child support? Do you pay your car insurance? Do you pay for your medicine?"

In late April, Mr. McCain, Republican of Arizona, announced that if elected president he would seek to insure people like Mr. Benamor by vastly expanding federal support for state high-risk pools like Maryland's, or by creating a structure modeled after them. But as Mr. Benamor's case demonstrates, even well-regarded pools have served more as a stopgap than a solution.

Though high-risk pools have existed for three decades, they cover only 207,000 people in a country with 47 million uninsured, according to the National Association of State Comprehensive Health Insurance Plans. Premiums typically are high, as much as twice the standard rate in some states, but are still not nearly enough to pay claims. That has left states to cover about 40 percent of the cost, usually through assessments on insurance premiums that are often passed on to consumers.

Health economists say it could take untold billions to transform the patchwork of programs into a viable federal safety net. The McCain campaign has made only a rough calculation of how many billions would be needed and has not identified a source for the fi-nancing beyond savings from existing programs. Finding the money will only get more difficult now that Mr. McCain has pledged to balance the federal budget by 2013, which already requires a significant reduction in the growth of spending.

Mr. McCain's proposal stands in sharp relief to that of his Democratic rival, Senator Barack Obama of Illinois, who wants to require insurers to accept all applicants, regardless of their health. That is now the law in five states, including New York and New Jersey.

For those who can afford the premiums, or who qualify for subsidies in the 13 states that provide them, the high-risk programs can be a godsend.

Richard and Susan Logan, both of whom have battled cancer this decade, said they were grateful to have coverage for themselves and their daughter through the Maryland plan, even though it will cost $22,232 this year. They had been rejected by 25 commercial insurers, said Mrs. Logan, 57, a part-time billing clerk for a physician.

The Logans, who live in Gambrills, near Annapolis, estimate that without the high-risk pool, they would pay $40,000 a year for medication alone.

"The plan's worth its weight in gold for that," said Mr. Logan, 62, an aviation accident investigator. "Otherwise, we'd be paying for the medications out of our retirement."

A fifth of the 14,000 participants in the Maryland plan receive subsidies that drop their premiums below the market rates charged to healthy people, said Richard A. Popper, the plan's director. But many in the

middle find the policies both unaffordable and intolerably restrictive, and Mr. Popper estimates that two-thirds of those eligible have not enrolled.

Almost all of the state pools impose waiting periods of up to a year before covering the health conditions that initially made it impossible to obtain insurance. In some states, fiscal pressures have forced heavy restrictions in coverage and enrollment. Florida, which has 3.8 million uninsured people, closed its pool to new applicants in 1991, and the membership has dwindled to 313.

An informal survey by the American Cancer Society recently found that only 2 percent of nearly 2,700 callers to its insurance hot line enrolled in high-risk pools within two months of being referred to them. “In most cases, we know they probably didn’t apply because they discovered high premiums or pre-existing condition clauses and just didn’t bother,” said Stephen Finan, associate director of policy for the group’s Cancer Action Network.

There is no census of the medically uninsurable. But in 2006, insurers turned down 11 percent of all individual applicants for medical reasons, including 22 percent of those 50 or older, according to America’s Health Insurance Plans, an industry trade group.

Finding a way to cover the sickest of the uninsured is critically important because 15 percent of the population is responsible for three-fourths of health care spending. Many wind up in emergency rooms, which cannot legally reject them, leaving hospitals with more than $30 billion in unpaid bills each year. Mr. McCain’s proposal, which he calls the Guaranteed Access Plan, would be part of a market-based restructuring that is in many ways more fundamental than the universal coverage proposed by Mr. Obama.

With the goal of making the insurance marketplace more equitable and competitive, Mr. McCain would end the longstanding exclusion from income taxes of health benefits paid by employers. The 17 million nonelderly people covered by directly purchased insurance do not enjoy that advantage.

Mr. McCain would replace the exclusion with refundable health care tax credits of $2,500 per person and $5,000 per family in the hope of driving consumers into the individual insurance market. To help push down premiums, he would allow the purchase of policies across state lines.

Currently, those who buy insurance individually often face higher costs because their risks are not spread across broad groups of workers. Though insurers cannot discriminate against participants in group plans, they evaluate consumers seeking individual coverage case by case to determine if they are worth the risk of coverage, and at what price. Insurers contend that if they had to charge the same rates to all comers, many would wait until they were sick to buy policies.

The McCain campaign recognizes that in an invigorated individual market, even larger numbers of chronically ill people would go without the protection afforded by group coverage. High-risk pools would theoretically serve to fill the gaps.

Critics argue that, to date, insurers have benefited from the state pools as much as the uninsured. As long as premiums remain above market rates, the pools insulate commercial insurers from the greatest risks while giving customers little incentive to abandon their private policies.

“They are run in ways that protect the profitability of commercial insurers,” said Karen Pollitz, a professor at Georgetown University who has studied high-risk pools and who has served on the board of the Maryland plan. “They leave the illusion that there’s a safety net without there really being much of one.”

Mr. Obama’s plan differs from Mr. McCain’s in several ways. In addition to requiring insurers to accept all applicants, he would require that parents obtain insurance for their children. To make premiums affordable, he would create a Medicare-like government plan that would be open to all and pump up to $65 billion a year into subsidies. The money would come from repealing President Bush’s income tax cuts for those earning more than $250,000 a year.

When Mr. McCain unveiled his high-risk pool proposal, his chief domestic policy adviser, Douglas Holtz-Eakin, the former director of the Congressional Budget Office, estimated the federal cost at $7 billion to

$10 billion. Mr. Holtz-Eakin said five million to seven million uninsured people would be singled out for coverage.

But in a recent interview, Mr. Holtz-Eakin emphasized that the projections “could change dramatically” depending on how the program was structured.

Mr. Holtz-Eakin and other McCain health advisers, including Thomas P. Miller, a resident fellow at the American Enterprise Institute, and Stephen T. Parente, a health economist at the University of Minnesota, said premiums would probably be capped at twice the standard rates. They said subsidies might be available to those making up to four times the federal poverty level, or $41,600 for a single person.

Financial incentives would probably be provided to those who effectively manage their diseases. No decision has been made about waiting periods for pre-existing conditions, the advisers said.

Mr. McCain’s proposal would represent a huge increase over the $50 million a year that Congress now appropriates in grants to the state pools, in a program that began in 2002. But several analysts questioned whether even $10 billion would be nearly enough, given that the states now spend about $2 billion to insure 207,000 people.

“I do not for a minute think it will cost 7 to 10 billion dollars a year,” Ms. Pollitz said. “It may cost 7 to 10 billion dollars a week.”

In an admonition for Mr. McCain, Maryland’s five-year-old plan, like others before it, has quickly become a victim of its growth. As enrollment expanded by 30 percent in each of the last two years, actuaries forecast insolvency as soon as 2010 and compelled the plan’s board to apply the brakes.

Over the last two years, it has raised premiums, deductibles and co-payments, increased out-of-pocket maximums, lowered the lifetime cap on payments and added a waiting period for pre-existing conditions, which rose to six months from two months on July 1. It also increased the amount applicants must pay to buy their way out of the waiting period.

At the same time, the plan is making more people eligible for subsidies. To keep it afloat, the state is raising the assessment on hospital bills that provides two-thirds of its financing.

“It’s not easy when you see there is strong demand for something and you need to temper that demand,” Mr. Popper, the plan’s director, said. “But you either find a way to slow enrollment through economic forces or you close the plan and no one gets in, which is a solution that no one wants.”

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Senate passes Medicare bill
AHA News | 07.09.08

The Senate today passed H.R. 6331, legislation that would prevent a July 1 Medicare physician payment cut from taking effect.

The bill received a vote of 69-30, exceeding the 60 affirmative votes needed to invoke cloture and begin debate on the bill, which overwhelmingly passed the House last month.

The bill subsequently passed on a voice vote. Sponsored by Reps. Charles Rangel (D-NY) and John Dingell (D-MI), H.R. 6331 would freeze physician payments for 2008 and provide a 1.1% increase for physicians in 2009.

It also contains several rural hospital provisions and would delay for 18 months the competitive bidding program for Durable Medical Equipment (DMEPOS).

The Senate last month failed to invoke cloture on both this bill and similar legislation (S. 3101) sponsored by Senate Finance Committee Chairman Max Baucus (D-MT).

The bill will now be sent to President Bush for signature, although he has said he will veto the measure due to the provisions that would cut payments to Medicare Advantage plans.

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Big Pharmas Join to Speed Discoveries
The Wall Street Journal | 07.10.08
By JEREMY SINGER-VINE

BOSTON -- Merck & Co., Eli Lilly & Co. and Pfizer Inc. are teaming up to create new drug-discovery methods, which the companies say could save them large sums by reducing the failure rate of clinical trials.

The three companies, normally archrivals, and Boston venture-capital firm PureTech Ventures LLC have invested $39 million to launch Enlight Biosciences LLC, which aims to speed the way drugs are found and developed.

While drug makers have collaborated in nonprofit consortia for projects like sequencing the mouse genome, Enlight is the only for-profit venture in which Merck or Lilly collaborates with its rivals, according to the companies. Barbara Dalton, vice president for venture capital at Pfizer, also said she was unaware of any other collaborations.

Merck, Lilly and Pfizer don't see competitive conflicts because they view the technologies Enlight seeks to develop, including advanced body-imaging methods, as "pre-competitive," said David Steinberg, Enlight's chief executive.

"Today, drug discovery is tremendously tech-dependent, and many of the pharmaceutical companies are falling behind," said Enlight co-founder Raju Kucherlapati, a genetics professor at Harvard Medical School.

"If you can find the winners earlier, and lose faster with the failures, you can really improve R&D productivity," said Steven Paul, executive vice president for science and technology at Lilly. He said that 70% of industry trials fail at the Phase II stage, the level just before final human trials. That is "just too high," he said, "and that's where these technologies come into play."

When a technology looks promising, Enlight will spin off new companies that aim to exploit it. The first of these, Endra Inc., uses sound and light imaging to examine the effects of drugs on internal organs. As Enlight creates a new company like Endra, members have the chance to license the technology and buy shares in it.

Daphne Zohar, the managing partner of PureTech, said other areas Enlight may explore include methods to deliver drugs across the blood-brain barrier, the production of cell lines and the identification of new biomarkers, or ways to detect diseases.

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