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OUR NEWS LETTER

HRSI

Health-care overhaul will improve insurance options for part-time workers

HEALTH REFORM WILL NOT PROVIDE SOLUTION FOR PART-TIME WORKERS UNTIL 2014.
By Michelle Andrews Tuesday, June 29, 2010

Sarah Rose Nordgren works 25 to 30 hours a week as a waitress at an upscale restaurant in Chapel Hill, N.C. She also tutors high-schoolers on their college entrance essays and has an editorial internship at a book publisher. But if something were to go seriously wrong with her health, she'd be in trouble because none of her three jobs offers health insurance.

She's been looking for a full-time job with benefits for several months, but there's nothing on the horizon. So she shuttles between jobs and hopes that she stays healthy.

Nordgren's situation is not unusual. Fewer than a third of employers that offer health insurance make it available to their part-time workers, according to the Kaiser Family Foundation. (Kaiser Health News is a program of the foundation.) And even if health insurance benefits are offered, part-timers, who often work in lower-paid retail, restaurant and service jobs, may not be able to afford them.

The health-care overhaul will greatly improve insurance prospects for part-time workers -- but not right away. Starting in 2014, the state-based exchanges, designed to help people find affordable health insurance, will offer a choice of subsidized health plans with different levels of coverage for part-timers and others who don't get insurance through their jobs. The law also expands the Medicaid program to permit adults with incomes up to 133 percent of the poverty level (for an individual, that's $14,410 this year) to qualify for coverage.

But 2014 is more than three years away. In the interim, part-timers may have limited options. In Nordgren's case, she signed up for a program through the restaurant that allows her to get primary care services for $60 a visit through Piedmont Health Services, a network of six community health centers.

"It's not insurance, but it's accessible and affordable for ongoing needs," says Briggs Wesche, the general manager of A Southern Season, the gourmet market that houses the restaurant where Nordgren works.

Community health centers are a good option for part-timers and others without insurance. The centers serve all comers, and fees are generally charged on a sliding scale based on income. Center

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Dental Coverage for as

locations can be found on the Health Resources and Services Administration Web site, http://www.hrsa.gov; local public health departments and primary care associations may also list affordable programs.

Businesses are only beginning to grapple with the changes that the new health-care law will bring. Starting in the fall, health plans are required to eliminate lifetime limits on coverage as well as most annual limits on specific services. This could spell trouble for the many businesses that offer so-called limited-benefit plans to their part-time workers.

The YMCA of Greater Rochester in New York offers this type of plan to its 450 part-time workers. The plan pays for five in-network doctor visits a year, with $10 co-payments. It covers $11,000 annually for hospitalization. Prescription drug coverage maxes out at $500 a year. For these and other services, individuals pay $968 annually, and families pay $2,804.

Patient advocates have criticized such limited-benefit plans for offering skimpy coverage at a high price. Only 29 workers have signed up for the YMCA plan, according to Fernan Cepero, vice president of human resources at the Y. However, the Department of Health and Human Services may be thinking that these plans are better than no coverage at all. Guidance explaining the rules for eliminating the annual and lifetime limits says limited-benefit plans may request a delay.

Starting in 2014, businesses may face penalties if they don't cover full-time workers, but they won't be penalized for not covering employees who work less than 30 hours per week. In a recent survey of 800 employers by human resources consultant Mercer, more than half of those that don't provide insurance to workers at that threshold said they would consider reducing workers' hours.

Fortunately, even if employers trim workers' hours, the exchanges will offer an alternative for part-time workers.

That can't happen too soon for such workers as Cheneta Forest, who works 20 hours a week at a restaurant in New Orleans. Forest, 42, has diabetes. Her job doesn't offer health insurance. She goes to the emergency room two or three times every week because she feels sick or needs insulin. At $45 a visit, plus $50 for the insulin, her monthly ER expenses would easily cover a health insurance premium. But no one will insure her. "I'm a sickly person, and I need health insurance," she says. "It's a big problem."

PATIENTS WARNED OF POTENTIAL MODERN INSURANCE PLAN "STICKER SHOCK"

Do your health homework -- or pay the price
More sticker shock is likely as insured patients pick up a growing share of medical costs.

By Daniel Lee INDYSTAR*COM June 29, 2010

Imagine shopping for clothes in an upscale mall with lots of stores but few, if any, price tags.

In fact, one shirt could have many different prices, depending on who's buying it.

That's what it's like for patients these days when they head to the doctor's office or hospital.

Despite mounting pressure on hospitals and insurers to provide consumers with more easy-to-understand information on the true cost of care, patients can still face a doozy of a medical bill when they least expect it.

The reasons, as with health care itself, are complicated. But one thing is clear: Modern insurance plans are forcing Americans to shop for their own health care in a system that lacks simple and transparent pricing information.

Cases of surprising medical bills abound:

Jodi Burtner, Noblesville, is still steamed that an MRI at St. Vincent she expected to cost $800 ended up costing her almost $1,800. She most likely could have saved hundreds by going to another imaging center.

Kathy Shafer, Eaton, couldn't figure out why she suddenly started getting bills from Clarian Health and her physician for visits to her doctor's office, when previously she was billed only by her doctor. She owes $910.64 from one visit in March, which was hundreds more than she expected.

Clarian now acknowledges it has changed its billing method in a way that, in most cases, will result in higher charges for insurers and patients. Shafer said she was never informed of any change.

Patient beware

Experts say patients must be vigilant to make certain they are not overcharged.

"There are going to be more and more of these kinds of problems as people's out-of-pocket responsibility increases," said Alwyn Cassil, a spokeswoman with the Center for Studying Health System Change, a nonprofit research group based in Washington. "I cannot tell you how it behooves people to understand how their coverage works."

But making savvy health-care choices isn't easy.

Insurance plans have become more costly and complicated. Reacting to the high cost of health care, employers in recent years have shifted more of the cost of care onto their workers.

Many patients face steep out-of-pocket costs before their insurance coverage kicks in.

The average family deductible for workers in PPO plans, the most common type of employer-sponsored coverage, rose from $1,034 in 2006 to $1,488 in 2009, according to the Kaiser Family Foundation.

Deductibles are commonly $5,000 or more for those who buy their health insurance on their own.

Cassil said the new health-insurance exchanges for individual or small-group coverage should help provide consumers with some clear information about what and how much coverage different health insurance plans provide.

But she added that much of the complexity around medical billing will remain even after health-care reforms take effect.

Hospitals and health insurers say they are taking steps to make medical pricing more transparent, including efforts such as WellPoint's Anthem Care Comparison feature. This online tool allows members to compare hospital prices for 59 procedures.

Anthem and other insurers offer customer service lines and tools on their websites for patients to do some research, such as checking to ensure that a doctor is within their provider network.

But, for the most part, U.S. medical care still lacks the kind of clear and simple pricing information Americans have come to expect when they purchase just about everything else.

Even those inside the medical system find it difficult to figure out exactly how much care is going to cost.

"It's not transparent at all," said Dr. Deanna Willis, associate professor of family medicine at the Indiana University School of Medicine.

Willis said she tries to help her patients figure out what prices may be upfront. But that's difficult because of the complexity of contracts between health providers and insurers.

Two patients carrying cards from the same insurer may have different benefits under contracts negotiated by their separate employers, Willis said.

Learn to shop around

Willis and Cassil recommend that patients, when possible in nonemergency situations, should check ahead with their insurance carriers on pricing and coverage before seeking potentially expensive care.

Ask how much will this cost? Is this doctor in my network?

Jodi Burtner thought she had done just that ahead of an MRI she underwent at Indianapolis-based hospital system St. Vincent Health this year.

Her physician, affiliated with St. Vincent Health, recommended the expensive medical scan because breast cancer is prevalent in her family. Her doctor's office even set up an appointment at a St. Vincent's Breast Center imaging facility, with a nurse telling her the MRI would cost around $800 if Burtner were paying cash.

So -- feeling good about that charge because she had Anthem insurance -- she was shocked to receive a bill from St. Vincent asking her to pay $1,798.28.

"You should know the price ahead of time, and I thought I did," Burtner said of the $800 price quoted by the nurse. "That's what I thought the insurance would be billed for."

Burtner paid her bill for the MRI but was steamed about how much more it cost than she expected.

She wrote a letter of complaint to the Better Business Bureau, the Indiana attorney general's office and the state's Department of Insurance.

In a letter to Burtner, the Department of Insurance responded: "You do not know if the nurse gave you the correct information." The department also said a review found no unfair claims practices.

St. Vincent spokesman Johnny Smith confirmed that: He said an $800 charge would be "inconsistent" with its pricing for MRI images. He added that it is not St. Vincent policy to have clinicians provide patients and their families with pricing information.

Burtner's bill likely would have been much lower if she had scheduled her MRI at another facility. She said her physician's office, which is affiliated with St. Vincent, scheduled her MRI at a St. Vincent facility.

According to Anthem Care Comparison data, the cost of an MRI in Indianapolis ranged from $300 to about $2,500. Typically, hospitals charge higher rates for such high-tech scans than prices charged by specialty imaging centers.

The price for Burtner's MRI and accompanying pharmacy charge -- when you add the portion paid by her and Anthem -- was about $2,991.

Burtner said she is pleased with the care she receives from St. Vincent and likes staying within that system. But she remains frustrated with the unexpectedly hefty price she paid for it.

An expensive change

Kathy Shafer also got a case of medical-billing sticker shock.

For years, she's been going to the Arthritis Care Center, a physician office owned by Indianapolis-based hospital system Clarian Health, to get injections to treat arthritis in her knees, hips and right index finger.

The office would bill her, and she'd pay the portion that insurance didn't cover.

But for a visit in March, her doctor's office charged her $165. Then came the surprise: a statement from Clarian saying she owed $1,790.66.

For the Clarian bill, her insurance plan covered $187.37. And, through its financial assistance program, Clarian reduced that bill to $910.64.

Shafer said previously the doctor's office shots would cost roughly $80 or $90 apiece, with insurance covering most of that.

The change came when Clarian decided that some of its outpatient services -- including those provided by the Arthritis Care Center -- would now be billed as a hospital service instead of a physician service.

Generally, Medicare and private insurers provided greater reimbursement for services billed as hospital care than those provided in physician offices. So hospitals that own physician practices and clinics have financial motivation to bill care rendered there as a hospital- rather than physician-based service.

At first, Clarian said the change in billing was made to comply with Medicare guidelines.

But when asked whether Medicare had required the change, Clarian acknowledged it had not.

According to Clarian spokesman Gene Ford, the change is in line with Medicare's plans to increasingly reimburse health-care services based on episodes of care rather than individual medical services.

Some in the health-care industry say organizing all the care needed to treat a condition -- such as a broken ankle -- into a single "episode of care" increases efficiency and reduces the fragmented nature of medical billing.

But for now, the primary result seems to be increased costs.

Shafer, who said she sought an explanation from her doctor's office and insurer, remains frustrated and unsure of what bills she may face next.

"I can't afford that," Shafer said. "These bills were unbelievable."

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Healthcare.gov: How to figure out your health care options.

Healthcare.gov is a new federal website launched Thursday. It's a central repository for news and information about the sweeping health care reform law.

By Peter Grier, Staff writer / July 1, 2010.

Washington

Healthcare.gov is up and running – and that should be good news for the many US citizens who are trying to understand the brave new world of US health care following this year's passage of

sweeping reform legislation.

The website is mandated by the new law, as is its July 1 start date. It is intended to be both a one-stop-shopping site for individuals looking to see what their insurance options are, and a central repository for news and information about the health bill's rollout.

"Healthcare.gov will take some of the mystery out of shopping for health insurance," said Secretary of Health and Human Services Kathleen Sebelius on the White House blog Thursday morning.

People looking for insurance can visit healthcare.gov, answer a few questions about their age, health status, and family size, and then look at a list of private plans in their state that are accepting new enrollees. The site contains information on Medicaid, Children's Health Insurance Program plans, and state plans that cover people with preexisting conditions as well.

The site can handle over a billion different search scenarios, according to Secretary Sebelius. Say you are the head of household of a family in Maryland who lost insurance when your job changed. Enter that info, and healthcare.gov comes up with a list of at least eight plans you might be able to enroll in, from Aetna to Time Insurance Co.

Click through to find more information, though, and you may find it lacking. Price information is not yet posted. The website says that such data are coming in October, when a more detailed version of the website is supposed to debut. Large insurance companies have complained about providing the government with such detailed price information, however, so stay tuned.

You can't enroll in insurance plans directly from the site. Instead, it provides phone numbers and other contact information so you can reach insurers directly.

Another section of the website lists news about the implementation of the new health reform law, including a time line of when various provisions take effect. The site also links to "Hospital Compare," another HHS Web service, where consumers can check various quality indicators on their local hospitals.

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SOCIAL SECURITY RETIREMENT PLANNER.

http://www.ssa.gov/planners/faqs.htm.

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PASSPORT FEES INCREASE JULY 13, 2010

For anyone looking to get their first passport or renew an expiring one, now is the time to do it. On July 13, new and renewed adult passport fees will increase by $35 and passports for children under the age of 16 will cost an additional $20.

For more details on the prices and to download a passport application form from the State Department at go to this government website:
http://www.travel.state.gov/passport/passport_1738.html.

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Rush, 6 doctors named in whistle-blower suit

Surgeon, former hospital executive say orthopedic center fraudulently billed Medicare for surgeries for which they were not present.

By Melissa Harris July 8, 2010

A group of doctors at Rush University Medical Center's prestigious orthopedic department routinely overbooked their schedules and relied heavily on residents to perform surgeries, violating federal Medicare billing rules, according to a newly unsealed whistle-blower lawsuit filed in U.S. District Court in Chicago.

The suit alleges that in one instance, a surgeon never entered the operating room to supervise a procedure. In others, a surgeon monitored residents performing operations via video feed while simultaneously performing his own operations in nearby rooms.

The lawsuit, filed by another Rush surgeon, Dr. Robert Goldberg, along with a former hospital executive, portrays Rush's orthopedic center as a business focused on quantity over quality, risking patient health in pursuit of "monetary rewards and celebrity status." To do that, doctors sidestepped specific Medicare billing rules that require teaching physicians to be present during critical portions of procedures, the suit said.

Six surgeons are named as defendants; the lawsuit mainly focuses on procedures performed in 2004 and 2005.

Among the group, Dr. Richard Berger is the most high profile. He pioneered "minimally invasive" hip-replacement surgery and for many years was a star consultant for Zimmer Holdings, an implant-maker.

Whistle-blower lawsuits relate to claims in which the government is victimized, and plaintiffs stand to share in a portion of any monetary awards. In this case, some of the plaintiffs' accusations, related to the use of office space in return for patient referrals, have been settled by the Justice Department, with the medical center agreeing to pay more than $1.5 million but not admit wrongdoing.

After that settlement in March, the other accusations relating to surgical practices were unsealed. They were amended in June. The government has declined to intervene in the remaining portion, but has a right to do so later, according to court documents.

Besides Berger, doctors named in the suit are Brian Cole, Mitchell Sheinkop, Aaron Rosenberg, Craig Della Valle and Wayne Paprosky. Also named are the medical center; Rush SurgiCenter, an outpatient surgery center; and Midwest Orthopaedics, a practice that counts many of the city's professional sports teams and a bevy of celebrities among its clients.

Sheinkop left Midwest Orthopaedics' practice about two years ago, said his attorney, and is no longer on staff at Rush. The rest of the doctors remain at Midwest and at Rush, according to Midwest's attorney, Jeffrey Rogers.

"We note that the government has declined intervention in these allegations (regarding patient safety),

and we also want to point out that we had no participation in the settlement (involving office space) whatsoever," Rogers said. "I don't know what their proof is or where they get this. It's too early to tell; we've only had this complaint a week. But we would deny that there were any overlapping surgeries that violated applicable rules and regulations, or threatened the health or safety of any patient."

In a statement, the hospital said, "Rush believes that the lawsuit has no merit and intends to vigorously defend the case."

Mark Fedota, an attorney for Sheinkop, said his client had not been served with the lawsuit and "would not want to comment on something he has not seen."

James Helmer, a Cincinnati lawyer who specializes in whistle-blower suits, said the fact that the federal government hasn't intervened should not be interpreted by the defendants as "good news'' because the government reserved the right to do so later.

The focus of the suit is reimbursement rules from Medicare for surgical procedures. The federal government requires the teaching physician to "be present during all critical portions of the procedure and immediately available to furnish services during the entire service," according to rules cited in the suit.

On April 22, 2004, the complaint alleges, Sheinkop, who performs hip and knee replacements, never entered operating room 9 to perform a knee replacement on a 67-year-old patient. He performed another procedure in operating room 7.

According to the complaint, one of the residents who performed the surgery "admitted that Dr. Sheinkop had never been present for any of Ms. S's surgery, but stated that he had been instructed by Dr. Sheinkop to falsify the medical record."

On the morning of Oct. 21, 2004, Cole, who specializes in sports medicine and cartilage restoration, had five surgeries scheduled; two at 7:30 a.m., another at 8 a.m., another at 8:30 a.m. and another at 9:30 a.m., the suit said. The 8 a.m. operation was in Rush's operating room 5, while the others were in the outpatient SurgiCenter, the suit said.

According to the complaint, when Cole had concurrent surgeries, he would "remain physically present in one operating room, while 'monitoring' a second operating room through an electronic video link that projected images through the fiber optic arthroscopy camera onto a large monitor."

Rogers said the video system was used "to determine room readiness, such as when it was clean for another patient and sometimes also for teaching purposes.'' But Rogers said it wasn't used to remotely manage surgeries.

Rogers added that "it's a big mistake" to rely on a schedule to determine when "critical portions" of a surgery took place.

"It's simply a schedule," he said. "That doesn't mean that's when the operation took place. … It's like you're reserving a conference room."

In the suit, Goldberg alleges that other doctors' schedules were so packed that it was "physically impossible" for them to be there for the critical portions required by Medicare.

In July 2005, the year after Goldberg filed his lawsuit, Berger abandoned Medicare altogether, and was quoted by Orthopedics Today as saying: "For the most part I wanted to eliminate the burden of Medicare's rules and regulations and the fear of possible penalty. … Performing over 750 joint replacements a year, I was drowning in paperwork, which took away time from my practice and my two little girls at home. Despite my constant efforts to maintain compliance, I worried about making an honest mistake and being penalized, with triple damages, and possible criminal prosecution."

In 2008, the Tribune reported about his relationship with Zimmer Holdings, which paid Berger handsomely, more than $2 million in 2007, for training other doctors and promoting Zimmer devices.

Two years later, Zimmer and Berger have parted ways, the doctor confirmed Wednesday. The New York Times recently reported that Berger questioned the safety of at least two of the Warsaw, Ind.-based manufacturer's products.

The complaint suggests a link between the alleged overbooking and the pursuit of income from Zimmer.

But Berger in an interview Wednesday said Goldberg and his lawyers are uninformed.

"From the time that I make the incision to putting the implants in, it usually takes about 45 minutes," Berger said. "The fact that I did six procedures in eight hours meant that I had a fair amount of down time. … I can only talk about me personally, but I do every procedure myself, from the start to putting the implants in. I do not personally do the closure myself, and I tell all of my patients that. The reason is that I have people who are better at it than I."

The plaintiffs' attorney, Colin Wexler, declined comment.

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Tired of airlines' baggage fees? Box it up, ship it out.

UPS sells cardboard 'suitcases' to use in lieu of luggage; will send them directly to your destination.

By Hugo Martin, Tribune Newspapers 5:24 p.m. CDT, July 7, 2010

Only days after federal officials announced that the nation's airlines had collected 33 percent more revenue this year from checked-luggage fees, UPS offered its alternative to the hassle and expense of lugging a suitcase through an airport.

The world's largest package-delivery service announced last week that it was selling boxes designed to resemble suitcases. Passengers can ship the "luggage boxes" to their final destination to avoid the airlines' check-in lines and luggage fees.

The new UPS boxes include carrying handles and come in two sizes.

The UPS announcement came a few days after the Department of Transportation reported that the nation's 10 largest airlines collected nearly $770 million in checked-baggage fees in the first three months of the year, a 33 percent increase over the same period last year.

Despite the increase, the total amount collected by the same airlines from all ancillary fees dropped by 1 percent during the same period, to $1.86 billion.

The numbers suggest that travelers are paying to check bags but are forgoing other fees, particularly charges to fly standby, transport pets, change flights and buy frequent-flier award miles.

The new luggage boxes are also hitting the market as demand for airline seats begins to rebound from a two-year slump.

The International Air Transport Association announced that international airline traffic jumped nearly 12 percent in May from a year earlier, to about 1 percent above pre-recession levels.

UPS officials say they created the new boxes simply to make life easier for frustrated travelers.

"It's meant to be a convenience," said UPS spokeswoman Susan Rosenberg.

She conceded that airlines can usually deliver luggage faster than UPS but said luggage shipped by UPS can cost $30 to $80 less per package, depending on the route and the weight of the box.

Rosenberg noted another advantage to the UPS luggage box: A tracking number lets passengers know its exact location.

That's something airlines don't offer.

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Small businesses, charities face more reporting rules.

By Sandra Block, USA TODAY

A little-known provision in the health care reform law could significantly increase tax recordkeeping requirements and costs for nearly 40 million self-employed workers, small businesses and charities, the IRS' national taxpayer advocate said Wednesday.

Starting in 2012, self-employed workers, small businesses, charities and government agencies will be required to issue Form 1099s to every vendor from which they purchase more than $600 in goods during the year.

For example, a self-employed consultant who buys a $700 computer from an office supply store would be required to send a Form 1099 to the store and the IRS.

Currently, businesses are required to provide Form 1099s for services, such as payments to independent contractors, but not for goods.

IRS: Lacks clout to enforce mandatory health insurance

The provision is designed to provide the IRS with more information about income and deductions reported by small businesses. Underreported income from small businesses accounts for a significant portion of the $300 billion "tax gap," according to the IRS. The tax gap is the difference between the amount owed the government and the amount taxpayers actually pay.

The Congressional Budget Office estimates that the new reporting requirement will raise $17 billion in tax revenue over 10 years, which would be used to offset some of the costs of health care reform.

But in an interview, IRS taxpayer advocate Nina Olson said the requirement could force small-business owners and charities to purchase new software and hire additional accounting services.

Businesses that make qualified purchases from at least 250 vendors during a year will be required to file their 1099s electronically, generating an additional expense, she said.

"I'm not sure that the information that we get from this will be so valuable that the burden it puts on taxpayers is justified," she said.

IRS spokesman Terry Lemons said the IRS has proposed exempting some small-business purchases made with credit or debit cards from the new reporting requirement.

"We're looking at ways to try to minimize the burden on businesses as much as possible," he said.

Under a law enacted in 2008, starting in 2011, financial institutions and payment processors must report businesses' credit and debit card payments to the IRS. That means the IRS will already have a record of those transactions, Lemons said

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Suburban hospital scores Cleveland Clinic deal

UPS sells cardboard 'suitcases' to use in lieu of luggage; will send them directly to your destination.

By Bruce Japsen, Tribune reporter 8:57 p.m. CDT, July 15, 2010.

Chicago lost out on the NBA talent of LeBron James, but the city is getting possibly the next best thing Cleveland can offer: a partnership with its internationally renowned clinic.

In a move likely to shake up the market for heart care in the Chicago area, the Cleveland Clinic's cardiac surgery program has signed an affiliation agreement with Central DuPage Hospital in west suburban Winfield. The deal, announced Thursday, is designed to enhance the heart care provided at the 313-bed hospital and potentially bring Cleveland Clinic patient referrals at a time when fewer heart surgeries are needed than were a decade ago.

Heart care typically is a hospital's most lucrative service, drawing tens of millions of dollars to the average community hospital. The Cleveland Clinic is reaching out nationwide for patients as changes in technology and increased use of medications like cholesterol drugs lead to a declining need for surgery. Open-heart surgery volumes have been dropping nationally since 1998, according to American Heart Association statistics.

The clinic also wants to broaden its reach as a center of excellence, a model encouraged under the new health care reform law, which puts an emphasis on quality care with fewer costly hospital readmissions. The more procedures a facility does, experts reason, the better they are at doing them.

The Cleveland Clinic was regularly cited by President Barack Obama and members of Congress as a model for quality and cost-effective medical care in the last year of the health reform debate.

The deal will give west suburban doctors and patients access to Cleveland Clinic research and clinical trials, and potentially gives Cleveland patient referrals when the cases are too complex for Central DuPage. The clinic performed more than 4,100 heart surgeries last year, triple the number at Advocate Christ Medical Center in Oak Lawn, which performs more heart surgeries than any other hospital in Illinois.

The partnership is the first one the Cleveland Clinic has made west of Ohio. The clinic has affiliations with several other hospitals, mainly on the East Coast.

"This affiliation brings world-class heart surgery resources, research and practices to the patients of Central DuPage Hospital," said Luke McGuinness, CEO of the suburban facility.

This week, U.S. News & World Report rated the Cleveland Clinic No. 1 in heart care for the 16th consecutive year. Because of its reputation, the clinic draws patients from more than 85 countries for routine and complicated cardiac procedures, from open-heart surgery and valve replacements to heart transplants.

The competition of attracting the sickest of heart patients is certain to escalate when the deal is finalized in the coming weeks.

Some Chicago-area health care providers don't think consumers need to fly to Cleveland to get high-quality cardiac services at a fair price. They say well-established heart care programs have long existed at the University of Chicago Medical Center, Loyola University Medical Center and at suburban hospitals, including Edward Hospital in Naperville and facilities operated by Advocate Health Care.

At Northwestern Memorial Hospital in Chicago, executives say they already have established top-quality heart-care service when they lured noted heart surgeon Dr. Patrick McCarthy away from the Cleveland Clinic six years ago. That move has helped Northwestern Memorial hire more doctors and nurses from Cleveland and nearly quadruple the academic medical center's heart surgery volumes to a projected 900 this year, from 250 the year before his arrival.

"We do the whole gamut here, from left ventricular assist devices like (former Vice President) Dick Cheney just had, to heart transplants," McCarthy, Northwestern Memorial's chief of the division of cardiothoracic surgery, said in an interview. "Regional centers of excellence is kind of our buzzword now. You don't need to get on a plane and fly across the country."

For several months, the Cleveland Clinic has been reaching out to Chicago-area doctors, encouraging them to refer patients with serious heart cases, noting the clinic is just an hour's flight away. The clinic told these Chicago doctors in a letter in late May that its cardiac teams performed more than 4,500 "missions" that flew patients to the heart-care facility from around the world.

"No patient is ever too far," Cleveland Clinic CEO Dr. Delos "Toby" Cosgrove said in the May 28 letter. "We have retrieved patients from five continents, 16 countries and 36 states."

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Cataracts linked to medications for allergies, other ailments

By Joe Graedon and Teresa Graedon, King Features Syndicate 1:26 p.m. CDT, July 28, 2010

Q I used Flonase for one year to ease nasal congestion caused by allergies. I am 37 and have just learned I have cataracts in both eyes.

The optometrist was as surprised as I was that I would have cataracts at this age, particularly because I am in really good health. I saw a commercial for Veramyst, and it says cataracts are a possible side effect. I'm angry because I was never warned that Flonase might cause this problem.

ABoth Veramyst and Flonase nasal sprays contain the corticosteroid ingredient fluticasone. Cataracts have been reported as side effects of this type of medicine.

A surprising range of other medications are linked to cataracts. They include inhaled steroids (both nasal sprays and asthma medicine like Advair, Flovent, Pulmicort and Symbicort), the osteoporosis drug Actonel (risedronate), the blood pressure pill Cozaar (losartan) and the asthma inhaler Spiriva (tiotropium).

Most physicians and patients are unaware that cholesterol-lowering drugs such as Crestor, Lipitor and simvastatin also may be linked to an increased risk of cataracts. There is no warning in the official prescribing information, but an article in the British journal BMJ (online May 20, 2010) suggests that this is an important side effect.

Q I have been diagnosed with osteoporosis, with the most severe bone loss in my spine and hips. I have taken Fosamax, Actonel and Boniva. Fosamax didn't work, and Actonel and Boniva caused terrible musculoskeletal pain and a flulike malaise that lasted a long time. I have discussed this with several rheumatologists, but none of them believed that these drugs could cause such side effects.

I cannot take Forteo or Evista, so I am pretty much out of treatment options. In fact, my last rheumatologist gave up and said there was nothing he could do for me.

As a result, I am looking for other ways to combat my osteoporosis. What suggestions do you have?

A One possibility to discuss with your doctor is calcitonin (Fortical, Miacalcin). This prescription drug mimics a natural hormone that helps with bone remodeling and is administered as an injection or in a nasal spray. It can cause side effects such as nausea, flushing or allergic reactions, but it reduces the risk of fracture in the spine.

The side effects you experienced with Actonel and Boniva (muscle and bone pain and flulike symptoms) have been recognized by the Food and Drug Administration. We're not sure why your doctors were skeptical.

Q You wrote recently about mosquito bites. I am a mosquito magnet myself and get bitten every day during the summer. I find that rubbing the bite with hand sanitizer stops the itch right away. This is the best discovery I have made!

A We don't know why an alcohol-based hand sanitizer would ease itching, but we're glad to hear that it works so well for you. Someone else may benefit as well

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www.healthcareil.com

Study Challenges Vitamin A Benefits.

Donald G. McNeil Jr. McClatchy Tribune Newspapers July 23, 2010

Giving women vitamin A capsules did not save their lives or the lives of their new babies, according to a surprising study from Ghana reported by the medical journal Lancet.

The results contradicted an earlier study in Nepal that showed a huge drop in deaths among child-bearing women taking vitamin A, and disappointed experts who hoped pills could be a cheap, easy lifesaver. Scientists did establish in the 1980s that giving vitamin A to malnourished children prevented stunting and deaths from measles and diarrhea.

The 1999 study in Nepal suggested the vitamin also saved young mothers, although that result was regarded somewhat skeptically because so many of the women had died of unrelated causes, including burns, drowning, snakebite and hanging.

Writing in a Lancet commentary, Anthony Costello and David Osrin of the global health institute of University College London noted that the new study recruited an "astonishing" number of women—nearly 208,000 in more than 1,000 villages or family compounds.

Half got a weekly low dose of vitamin A, and half got a placebo. Few in either group died, but the vitamin also did not reduce hospitalization for childbirth complications. Nor did it reduce stillbirths or deaths of newborns. Recent trials in Bangladesh and Indonesia had similar results.

Finding ways to get more food to young women might be more effective than getting them vitamin pills, the commentary's authors said.

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