



HEALTH LAW INSTITUTE NEWSLETTER

Monitoring the pulse of health law

Health Care Transparency: Will Bush's New Plan Open the Door?

By Malcolm "Skip" Harsch

On August 22, 2006, in a move long overdue, President George W. Bush signed an executive order promoting quality and efficiency in health care programs run by the Federal Government. The purpose of the Executive Order is, "to ensure that health care programs administered or sponsored by the Federal Government promote quality and efficient delivery of health care through the use of health information technology, transparency regarding health care quality and price, and better incentives for program beneficiaries, enrollees, and providers."

According to the White House;

The Executive Order Directs Federal Agencies that Administer or Sponsor Federal Health Insurance Programs to:

1. **Increase Transparency In Pricing.** Share with beneficiaries information about prices paid to health care providers for procedures.
2. **Increase Transparency In Quality.** Share with beneficiaries information on the quality of services provided by doctors, hospitals, and other health care providers.
3. **Encourage Adoption Of Health Information Technology (IT) Standards.** Use improved health IT systems to facilitate the rapid exchange of health information.
4. **Provide Options That Promote Quality And Efficiency In Health Care.** Develop and identify approaches that facilitate high quality and efficient care.

Federal agencies cover close to one in every four Americans who currently have health insurance. However, until now, their operations have been invisible to the individuals they serve. In contrast, the private sector has been working diligently to promote transparency by sharing information about the quality of care given by doctors and hospitals, including prices paid to those providers. This order will bring together information from government and private health care providers with the goal of making health quality and price information available to all Americans.

In a Department of Health and Human Services (HHS) news release, HHS Secretary Mike Leavitt said, "people deserve to know what their health care costs, how good it is, and the choices available to them." Secretary Leavitt added, "The President's action today is a major step forward in giving consumers easy-to-use information about the quality and price of their health care. This is fundamental to achieving a health care system that delivers good value." It is still not clear whether Congress will have to pass legislation to create and properly implement quality initiatives. We will have to wait and see how President Bush's order affects our current health care system. □

References

The White House, *Executive Order: Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs* (Aug. 22, 2006), available at <http://www.whitehouse.gov/news/releases/2006/08/20060822-2.html>; The White House, *Fact Sheet: Health Care Transparency: Empowering Consumers to Save on Quality Care* (Aug. 22, 2006), available at <http://www.whitehouse.gov/news/releases/2006/08/20060822.html>; United States Department of Health and Human Services, *President Directs Federal Agencies to Provide Health Quality and Price Information for Consumers* (Aug. 22, 2006), available at <http://www.hhs.gov/news/press/2006pres/20060822.html>.

FDA Issues Warning Letters to Curb the Mass Production of Unapproved Inhalation Drugs

By Sarah Mick

The Food and Drug Administration (FDA) issued warning letters to three pharmaceutical firms demanding that they stop manufacturing massive amounts of unapproved inhalation drugs and distributing them across the country. The firms warned were RoTech Healthcare, Inc., CCS Medical, and Reliant Pharmacy Services. The letters asserted that if the firms do not address the identified violations, the FDA will initiate additional enforcement measures "including injunctions that prevent further violations and seizure of all products that violate the law."

The firms are manufacturing these drugs under the guise of traditional pharmacy compounding. Pharmacies typically use traditional compounding to meet the specialized medical needs of particular patients for whom commercially available approved drugs are inadequate or inappropriate.

Under these circumstances, firms are providing a service for specific patients in need, in response to a physician's prescription. A common example is manufacturing medication for a patient who is allergic to an ingredient in a mass-produced product.

All compounded prescription drugs are "new drugs" under federal law. Under the Federal Food, Drug, and Cosmetic Act (FDCA), a new drug, including a compounded new drug, may not be legally manufactured or sold in the United States unless it has been pre-approved by the FDA as safe and effective for its intended uses." However, historically, the FDA has chosen not to take enforcement action against firms involved in traditional pharmacy compounding because it has long recognized that it serves an important public health function.

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NEWS OF INTEREST

Governor Blagojevich Advocates Making Plan B Available Without a Prescription

By Amee Lakhani

Governor Rod Blagojevich, who has been a strong proponent of a woman's right to have access to contraceptives and other important health care services over the course of his administration, is an advocate of making Plan B, the morning-after pill, available to women over-the-counter. The FDA recently met with Barr Pharmaceuticals, the company that manufactures Plan B, to discuss making Plan B available without a prescription. The decision means that women will not have to go to a doctor first as long as they can prove they are 18 or older. Younger teenagers will still need a prescription.

The pills, which will be sold as Plan B, will probably cost about \$25 to \$40 per dose, and men will also be able to buy them. Barr Pharmaceuticals will be required to sell the pills in new packaging that clearly explains how to use them as well as the possible risks. The company will also be required to ensure that the pills are sold only through pharmacies, retail stores with pharmacists, and clinics with "licensed health care providers." The makers of the pill say that when it is taken within 72 hours of unprotected sex, it can reduce the risk of pregnancy by about 89 percent; however, studies show the treatment works best when taken within 24 hours.

Proponents argue that if the drug were available over-the-counter, women would have quicker access to it, leading to reductions in unintended pregnancies and abortions. "Over 3 million unintended pregnancies occur each year," said Dr. Carole Ben-Maimon, president of Barr Research, which is buying rights to the pill.

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HEALTH LAW INSTITUTE NEWSLETTER

The DePaul Health Law Institute Newsletter is published three times during the academic year by the Health Law Institute at DePaul University College of Law, 25 East Jackson Boulevard, Chicago, IL 60604. Please send subscription requests and address corrections to the above address, c/o Michele Goodwin. The Newsletter is also available at: www.law.depaul.edu/health

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NEWS OF INTEREST

Health Care Coverage and Cost: Top Governmental Priority According the American Public

By Valerie S. Smith

According to a recent survey performed by the Commonwealth Fund Commission on a High Performance Health System ("Commission"), Americans voiced strong public support for efforts to improve care, coordination and access to information. The telephone survey of 1,023 adults (over the age of eighteen) showed that patients are quite perceptive of wasteful care. Many Americans reported experiencing unnecessary care or treatment recommended by physicians, a failure to provide important information or test results, medical errors and wasteful duplicate tests. President of the Commission, Karen Davis, stated that, "When care isn't coordinated there is a higher risk for unsafe care and duplicative, wasteful medical spending." The survey indicates that stresses over health care coverage and cost are rising up the income ladder.

Concerns over the cost of health care are not limited to lower income families. Over one-half of middle and lower income families reported serious problems paying for care and insurance coverage. The financial hardship affects middle income families (\$35,000 to \$50,000 annual income) and one-third of higher income families (\$50,000 to \$75,000 annual income). This economic stress undermines the economic security of the workforce. The rising cost of health care places an increased financial burden on employers in the U.S., as well as on families who are unable to save as much for retirement in order to afford coverage. Americans are ready for a change. Three-fourths of those surveyed stated that the health care system needs to be rebuilt or fundamentally changed.

The shared belief that expanded use of information technology, care teams, and improved delivery of preventive ser-

vices could improve quality care is central across income groups, between Republicans and Democrats and among the insured and uninsured. According to the survey report, *Public Views on Shaping the Future of the U.S. Health Care System*, Americans believe that the top four priorities in health policy actions taken by Congress and the President should be: (1) adequate and reliable health insurance for all Americans; (2) controlling the increasing costs of health care; (3) decreasing the cost of prescription medicine; and (4) ensuring that Medicare is financially sound and long term. Outside of governmental policies, the American public has expressed a need for change among professionals in the health care industry. The Commission survey participants suggested reducing disputes related to medical bills and insurance problems, ensuring timely appointments, allowing easy access to one's medical records, increasing availability of information about quality of care provided by doctors and hospitals, and rewarding doctors and hospitals that provide efficient, high-quality care.

The Commission survey indicates that Americans are very aware of the need for change in the health care system. As health care costs increase and coverage decreases, the American public will pressure the President and Congress for adequate, reliable health care. □

References

Mary Mahon, *New Survey: Two-Fifths of Adults Report Experiencing Unsafe, Wasteful, or Poorly Coordinated Healthcare* (Aug. 17, 2006), available at http://www.cmwf.org/newsroom/newsroom_show.htm?doc_id=394529; C. Schoen et. al., *Public Views on Shaping the Future of the U.S. Health Care System* (Aug. 2006), available at http://www.cmwf.org/publications/publications_show.htm?doc_id=394606.

Medicare Part D Serving Beneficiaries for Less than Anticipated

By Danielle A. Horstman

The Centers for Medicare and Medicaid Services (CMS) has announced that prescription drug benefit premiums for individuals enrolled in Medicare Part D will be lower than originally anticipated. The decrease in price is a direct result of health plans' strong competitive bidding and the choices of consumers. The overall result in 2006 is a decrease in an average premium from an estimated \$37 per month to \$24 per month. In 2007, premiums are only expected to increase by .1 percent. The average senior already saves over \$1,100 a year with Medicare Part D, and hopefully, with lower costs these savings will continue to rise.

CMS Administrator Mark McClellan, M.D., PhD, explained that "Competition and smart choices have been the two most important factors in the success of Medicare drug benefit, which is serving beneficiaries at a far lower cost than expected. The power of Medicare beneficiaries making informed choices has already reduced the cost of the drug benefit to beneficiaries by 25 percent on average in 2006, and as a result of continuing strong competition, more savings are on the way." McClellan noted that this was the first time the cost of prescription drugs has stayed down for

both beneficiaries and the government.

Not only will this price decline have a direct impact on the individuals enrolled in Medicare Part D, but this price decline has the possibility of continuing. In 2007, most beneficiaries will have access to both stand-alone and Medicare Advantage prescription drug plans. If more consumers choose a lower cost plan in 2007, as many did in 2006, average premiums will decline again. Over two million prescriptions are filled daily under Medicare Part D, and almost 90 percent of the 38 million Americans enrolled in Medicare receive prescription drug benefits under Medicare Part D. If this trend continues, consumers might experience savings for many years ahead.

References

CMS, *National Benchmark Shows Impact of Strong Competitive Bidding and Smart Beneficiary Choices* (Aug. 15, 2006), available at <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1945>;
CMS, *Strong Competition and Beneficiary Choices Result in Drug Coverage with Lower Costs than Predicted Last Year* (Aug. 15, 2006), available at <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1946>.

NEWS OF INTEREST

Recent Developments in the U.S. Definition of Torture

By Kari Kammel

On September 21, 2006, the White House and the Senate temporarily agreed on a definition of "torture," which has some saying that the U.S. will be the first country to authorize violations of the Geneva Convention^[1]. Others, such as Human Rights First, claim that the compromise upholds Common Article 3 of the Geneva Conventions^[2], which the Supreme Court held applies to all detainees of the United States. The "Agreement Upon Common Article 3" essentially gives the President, not the judiciary, the ability to define torture and prevents individuals from being able to use Common Article 3 as a basis for a claim in U.S. courts^[3]. However, it prohibits cruel, inhuman and degrading treatment and punishment as well^[4].

Many in the U.S. have been opposed to President Bush's new definition of torture, which would apply retroactively in order to prevent prosecution of military and CIA officials who have engaged in such conduct. This attempt to redefine torture came as a response to the Supreme Court's ruling in *Hamdan v. Rumsfeld*^[5], which held that Common Article 3 of the Geneva Conventions applies to U.S. held detainees. Ironically, the strongest opponents of Bush's amendments have been the military and in particular, Senators John McCain, a former P.O.W., Senator Lindsey Graham, an Air Force Reserves judge, Senator John Warner, a former Navy secretary, and General Colin Powell, former head of the Joint Chiefs of Staff.

The prohibition of torture already exists in U.S. law^[6]: the Eighth Amendment of the U.S. Constitution^[7], the United Nations Convention against Torture and Other Cruel, Inhuman and Degrading Punishment ("CAT")^[8], the 1907 Hague Conventions on the Law and Customs of War on Land^[9], the 1949 Geneva Conventions^[10], the Uniform Code of Military Justice ("UCMJ")^[11], Title 18 Section 2340 of the United State Code^[12], and the Torture Victims Protection Act ("TVPA")^[13].

The proposed agreement would ban a person from invoking the Geneva Conventions or any of its protocols in an action before U.S. Courts^[14]. It further provides that no foreign or international sources of law can be a basis for decisions or interpretation by U.S. Courts, although the Supremacy Clause of the U.S. Constitution states that treaties are the supreme law of the land^[15]. Further, this proposed bill gives the President the power to interpret the meaning and application of the Geneva Conventions and to determine what constitutes a grave breach. This amendment will also be retroactively applicable, thus covering all acts of possible torture by U.S. agents in the past 10 years^[16]. Finally, it defines severe physical or mental pain or suffering as: "(1) a substantial risk of death; (2) extreme physical pain; (3) a burn or physical disfigurement of a serious nature, not to include cuts, abrasions, or bruises; or (4) significant loss or impairment of the function of a bodily member, organ, or mental faculty^[17]." The proposed definition of torture also does not include "pain or suffering incidental to lawful sanctions^[18]." Through this proposed law, U.S. agents who have tortured individuals will essentially be immune from any discipline or even charges being brought against them, and those who have been tortured can seek no civil claims in the United States.

The prevention of torture remains imperative, especially to those who have responsibilities to prevent it, such as those who work in the legal and medical professions^[19]. Recently, the medical and legal communities have made a stand against the U.S. use of torture, recognizing its horrible mental, physical and psychological effects^[20]. If the United States continues its open and blatant practice of torture, the use and legitimacy of torture will increase in other countries and will be used against Americans, as well as other nationals. It remains the constant duty of the legal and medical professions to uphold the law, as well as the standard for professional ethics. □

References

- [1] Marty Lederman, *Senators Snatch Defeat From Jaws of Victory: U.S. to be First Nation to Authorize Violations of Geneva*, available at <http://balkin.blogspot.com/2006/09/senators-snatch-defeat-from-jaws-of-victory.html> (last visited September 22, 2006).
- [2] Human Rights First, Press Release, *Key Senators Strike Deal with Bush Administration: Redefinition of Geneva Conventions Rejected, Acts of "Serious" Cruelty Criminalized* (September 21, 2006), available at <http://www.humanrightsfirst.org/media/etn/2006/alert/265/> (last visited September 22, 2006).
- [3] Text, available at <http://natseclaw.typepad.com/natseclaw/files/Admin.SASC.Agreement.pdf> (last visited September 22, 2006).
- [4] *Id.*
- [5] *Hamdan v. Rumsfeld*, 126 S. Ct. 2749 (2006).
- [6] See generally, M. Cherif Bassiouni, *The Institutionalization of Torture under the Bush Administration*, 37 Case W. Res. J. Int'l L. 389, 389-95 (2006).
- [7] U.S. Const. amend. VIII (prohibiting the infliction of cruel and unusual punishment).
- [8] Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Dec. 10, 1984, 1465 U.N.T.S. 85 [hereinafter CAT].
- [9] Agreement Respecting the Laws and Customs of War on Land, Oct. 18, 1907, 36 Stat. 2277, reprinted in 2 Am. J. Int'l L. 90 (Supp. 1908) [hereinafter Hague Convention].
- [10] Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field, art. 3, Aug. 12, 1949, 6 U.S.T. 3114, 75 U.N.T.S. 31; Geneva Convention for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea, art. 3, Aug. 12, 1949, 6 U.S.T. 3217, 75 U.N.T.S. 85; Geneva Convention Relative to the Treatment of Prisoners of War, art. 3, Aug. 12, 1949, 6 U.S.T. 3316, 75 U.N.T.S. 135; Geneva Convention Relative to the Protection of Civilian Persons in Time of War, art. 3, Aug. 12, 1949, 6 U.S.T. 3516, 75 U.N.T.S. 287 (all four conventions prohibiting torture as a war crime in article 3 of all of the conventions, which is referred to as "Common Article 3").
- [11] Uniform Code of Military Justice, 10 U.S.C. §§801-941 (2000) (prohibiting torture by U.S. military personnel and others to whom the UCMJ applies in its war crimes provision).
- [12] 18 U.S.C. §2340 (2000) (incorporating the CAT into U.S. criminal law).
- [13] Torture Victims Protection Act, 28 U.S.C. §1350 (2000).
- [14] Agreement Upon Common Article 3, supra note 3, Sec. 7, "Treaty Obligations Not Establishing Grounds for Certain Claims: (a) IN GENERAL. No person may invoke the Geneva Conventions or any protocols thereto in any habeas or civil action or proceeding to which the United States, or a current or former officer, employee, member of the Armed Forces, or other agent of the United States, is a party as a source of rights, in any court of the United States or its States or territories."
- [15] U.S. Const. art. IV.
- [16] Agreement on Common Article 3, supra note 3, "(2) RETROACTIVE APPLICABILITY. The amendments made by this section, except as specified in paragraph 2441(d)(2)(E) of title 10, United States Code, shall take effect as of November 26, 1997, as if enacted immediately after the amendments made by section 583 of Public Law 105-118 (as amended by section 4002 of Public Law 107-273)."
- [17] Agreement on Common Article 3, supra note 3, sec. 7 (D).
- [18] Agreement on Common Article 3, supra note 3, sec. 7 (b)(1)(A).
- [19] See generally, George J. Annas, *Unspeakably Cruel—Torture, Medical Ethics, and the Law*, 352 New Eng. J. Med. 2127-32.
- [20] See generally, P.R. Lee & S. Heiling, *Participation of Health Care Personnel in Torture and Interrogation*, 353 New Eng. J. Med. 1634-35 (2005); L. Rubenstein et al., *Coercive US Interrogation Policies: A Challenge to Medical Ethics*, 294 J. Am. Med. Ass'n 1544-49 (2005); J.A. Salo et al., *Adult Attachment: Posttraumatic Growth & Negative Emotions Among Former Political Prisoners*, 18 ANXIETY, STRESS & COPING: AN INTERNATIONAL JOURNAL 361-78 (2005); G. Hooks & C. Mosher, *Outrages Against Personal Dignity: Rationalizing Abuse and Torture in the War on Terror*, 83 SOCIAL FORCES 1627-46 (2005); M.J. Garcia, *U.N. Convention Against Torture (CAT): Overview and Application to Interrogation Techniques*, Cong. Rsch. Service Rep. for Congress, RL-32438, 1-20 (2006); D. Summerfield, *Fighting "Terrorism" With Torture*, 326 Brit. Med. J. 773-74 (2003).

Los Angeles Introduces Innovative Legislation to Rescue Skid Row

By Patrice Perkins

Downtown Los Angeles is in dire need of a resolution to help its poorest inhabitants. In February 2006, a group of leaders including City Attorney Rocky Delgadillo, Councilman Jan Perry, Police Chief William Bratton and Senator Gilbert Cedillo, introduced the skid row legislation. This legislation would tackle the pervasive homelessness in Los Angeles' infamous skid row - described by Sen. Cedillo as a "national disgrace." A January 2006 report by the Los Angeles Services Authority estimated that each day 2,000 people live in homeless shelters on skid row and that an additional 1,674 sleep on city streets.

This legislation would allow for a \$150,000 pilot program in Los Angeles County Superior Court for probation supervision and treatment of nonviolent offenders with mental health or substance abuse problems. Moreover, it would impose an additional year of sentencing on persons who sells drugs, or conspire to sell drugs, on the grounds of or within 1,000 feet of drug treatment centers, detoxification facilities or homeless shelters. Senator Cedillo hopes that increased sentencing would discourage drug dealers from preying on the vulnerable.

The skid row legislation would also prohibit dumping, which occurs when outside communities actively encourage their "troubled residents" to move to existing skid rows. Senator Cedillo emphasized this problem and the need for community leadership. He explained that many communities in the Los Angeles area "get dumped on" and that "every community will have to take responsibility for poor people, homeless people and the various problems that lead to homelessness." According to this legislation, hospitals and law enforcement agencies will not be allowed to transport a person to a homeless shelter unless they: (a) confirm that the shelter has available accommodations for the individual; (b) get permission from the individual whom they are transporting; (c) transport the individual directly to the shelter; and (d) transport the individual directly to the receiving area of the shelter.

Additionally, the legislation would further encourage individual communities to take active steps to remedy homelessness. Counties and cities would maintain authority to identify areas, traditionally zoned for residential use, for the development of emergency shelters and transitional housing.

Community leaders agree that legislation of this type is necessary. Some critics are disappointed that the current legislation is milder than its original form. Others believe that tougher measures will be adopted once the current ones are proven successful. However, all spectators agree on one thing - that legislation of this kind couldn't be more timely. □

References

Jordan Rau & Cara Mia DiMassa, *Legislation to Help California's Homeless Advances*, L.A. TIMES, Aug. 18, 2006, available at <http://www.latimes.com/news/local/la-me-skidrow18aug18,1,6549073.story?coll=la-headlines-California>; Chris Coates, *State Senate Considers Homeless Legislation*, DOWNTOWN L.A. NEWS, Feb. 27, 2006, available at <http://democrats.sen.ca.gov/templates/SDCTemplate.asp?a=5123&z=112&cp=NewsArticle&pg=article&fpg=semnews&sln=Cedillo&sdn=22>.

Governor Blagojevich Responds to Illinois' Nursing Shortage with New Legislation

By Camille Gourdet

Illinois Governor Rod Blagojevich recently signed into law Senate Bill 931, which aims to solve the state's shortage of nursing educators and practitioners. The new nursing legislation is part of the Critical Skills Shortage Initiative, which aims to educate and prepare various health care industry workers with the necessary skills and training to meet Illinois' health care needs. Addressing the nursing shortage will improve Illinois' overall health care capabilities because, as Governor Blagojevich explained, "Nurses are on the frontlines of healthcare and have the most direct and continuing contact with patients." This legislation responds to the rapidly growing demand for nurses that is already outpacing the current number of qualified staff. One projection estimates that the total number of nurses will decrease by over 4 percent by the year 2020, while the demand for nurses will rise by 31 percent.

The nursing legislation provides more funding resources for deserving students, faculty and nursing programs. Student-focused educational initiatives include an Illinois Center for Nursing, a Nursing Educator Scholarship program, new merit-based criteria for existing student scholarships, and the Nurse Educator Loan Repayment Program. The Nurse Educator Fellowship Program grants nursing school faculty the opportunity to apply for a supplemental income fellowship. Assistance for nursing institutions will come in the form of school grants that will be awarded based on the number of students that nursing programs graduate.

In addition to raising the quality and affordability of nursing school, this new Illinois law will improve the efficiency of the professional licensing system by over 400 percent. As an incentive for Illinois-trained nurses to remain within the state to practice, licensing may now be extended to multiple medical specialties. Highly experienced nurses will no longer have to obtain additional graduate degrees in order to move into other medical areas. A groundbreaking externship program complements the new incentive to nurture nurses currently working in Illinois. The program enables nurses already licensed in another state to prepare for the National Council Licensure Examination by working directly under an Illinois registered nurse and taking an examination preparatory course.

This comprehensive legislation promises to be effective because it takes a two-pronged approach: it addresses educational needs by providing badly needed resources for nursing school students, faculty and institutional programs, while concurrently improving the licensing process to more effectively produce and retain nursing practitioners. Illinois Nurses Association President Kathleen Perry commented, "While this legislation is good for nurses, the real winners are the people in Illinois who need nursing care services." □

References

Illinois Government News Network, *Gov. Blagojevich signs critical nursing law* (July 11, 2006), available at <http://www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=19&RecNum=5055>.

CASE NOTES

C.W. v. Cooper Health System No., A-6100-04T2, 2006 WL 2286377 (N.J. Super. A.D. Aug. 10, 2006)

By Courtney Quilter

A patient and his sexual partner sued a hospital, the director of the hospital's pathology department, and hospital staff physicians for breach of the duty of care for failure to inform the patient of the results of his positive HIV test. The patient further claimed that because he was unaware of his HIV positive status, he did not take precautionary measures to avoid transmitting HIV to his partner and child.

The patient was hospitalized and underwent several tests, including an HIV test. The hospital's discharge notes did not indicate that an HIV test had been ordered or that the results were pending. Although test reports from the outside laboratory were sent back to the hospital, neither of the patient's physicians were notified of the test results. After the patient's hospitalization, the patient and his partner became sexually involved and had a child. Subsequently, the patient learned he had AIDS and that his partner was infected with HIV. Their child tested negative for HIV.

The Court held that the hospital had a duty to notify the patient

of the positive result of his HIV test. The Court found that a health care provider who orders an HIV test for a patient has a duty to take reasonable measures to notify the patient of the results of the test. This duty is especially significant when the patient tests positive for HIV because the patient may need immediate medical treatment. A health care provider who breaches this duty will be civilly liable to the patient, as well as all reasonably foreseeable individuals who contract the virus from the HIV positive patient.

The Court further held that the hospital's duty of care extended to the patient's partner as well. The Court found that it was foreseeable that the patient was or would be sexually active. One of the main responsibilities of the hospital was to advise the patient on how to avoid transmitting HIV. The Court found that the patient's partner fell within the scope of foreseeable individuals who would be harmed by the hospital's failure to inform the patient he was infected with HIV. However, the hospital had no duty to notify the partner directly of the patient's test results. □

U.S. v. Phillip Morris USA, Inc., 2006 WL 2380632 (D.D.C. Aug. 17, 2006)

By Erin Cullen

On August 17, 2006, Judge Gladys Kessler, of the Federal District Court for the District of Columbia, found that nine cigarette manufacturers and two tobacco-related trade organizations had violated the Racketeer Influenced and Corrupt Organizations Act (RICO), by unlawfully conspiring to violate RICO by deceiving the American public and fraudulently denying that smoking causes lung cancer, emphysema and other cancers, that nicotine is a highly addictive drug which they manipulated, and that they marketed cigarettes to young people.

Judge Kessler enjoined Defendants from using deceptive brand labels such as "low tar," "light," "natural," or with other "deceptive brand descriptors which implicitly or explicitly convey to the smoker and potential smoker that they are less hazardous to health than full-flavor cigarettes." Defendants were also ordered to issue corrective statements in major newspapers and on television networks regard-

ing the adverse effects of smoking, the addictiveness of smoking and nicotine, the lack of any health benefit of smoking low tar cigarettes, and the adverse effects of exposure to secondhand smoke.

The Court had to follow *U.S. v. Philip Morris USA, Inc. et al.* in determining remedies. There, the Court of Appeals held that the RICO statute only allows forward-looking remedies to prevent and restrain violations, not any forfeiture of ill-gotten gains from past conduct. *Id.* at *2, *See* 396 F. 3d 1190 (D.C.Cir. 2005). This limited the ability to impose harsh remedies on the Defendants, who Judge Kessler noted have profited from "selling a highly addictive product which causes diseases that lead to a staggering number of deaths per year, an immeasurable amount of human suffering and economic loss, and a profound burden our national health care system." □

Miami Valley Hosp. v. Community Ins. Co., No. 3:05-cv-297 (D. Ohio Aug. 7, 2006)

By Garrett Kerr

Recently, the U.S. District Court for the Southern District of Ohio found the Employee Retirement Income Security Act ("ERISA") did not preempt an Ohio hospital's claims against an insurance plan administrator.

Thomas Griffith went to Miami Valley Hospital ("Hospital") in need of emergency services. Griffith identified Community Insurance Co. ("Community"), an ERISA-governed plan, as his insurance carrier and agreed to remit all benefits entitled to him by Community to the Hospital. Community authorized medically necessary hospital services. After Griffith's discharge, the Hospital sent Community a \$23,455.39 bill. Without notice to the Hospital, Community sent Griffith a \$3,869.97 check, who failed to turn it over to the Hospital. Furthermore, Community did not notify the Hospital that it was denying payment of the remaining balance.

The Hospital sued Community in state trial court alleging that Community violated Ohio's direct-pay and prompt-pay statutes. These statutes require third-party payors to honor an assignment of benefits to a hospital providing medically necessary services and prohibit unfair delay in claims processing. The payor must also remit payment in a timely fashion. Ohio Rev. Code Ann. §§ 3901.381, 3901.385, and 3901.386.

Community requested removal to district court arguing that ERISA preempted the Hospital's claims. The district court disagreed and remanded the case to state court because the Hospital was neither a benefactor under the insurance plan nor were its claims a derivative of Griffith's ERISA rights. Additionally, the Court noted that the claims under the prompt-pay and direct-pay statutes were independent of ERISA and thus not preempted. □

***Henderson v. Med. Ctr. Enter.*, No. 1:05-cv-823-MEF, 2006 WL 2355467 (M.D. Ala., Aug. 14, 2006)**

By Valerie S. Smith

A federal court in Alabama allowed a pregnant woman's Emergency Medical Treatment and Active Labor Act (EMTALA) claim to go forward, holding that a jury could reasonably conclude that the hospital failed to offer her an appropriate screening and unreasonably delayed treatment.

Plaintiff Ginger Henderson sustained injuries in a minor car accident when she was thirty-eight weeks pregnant. Henderson's obstetrician recommended she be evaluated at Medical Center Enterprise Hospital (MCE) due to its close proximity. When Henderson arrived at MCE, she notified the clerk on duty of the car accident and that her contractions were four minutes apart. After waiting, the clerk told Henderson that the on-call obstetrician was being contacted and would decide whether or not to treat Henderson because she was not one of MCE's OB patients. Henderson left MCE and went to her regular obstetrician.

Henderson sued MCE alleging violations of EMTALA. MCE

moved for summary judgment but the U.S. District Court for the Middle District of Alabama denied the motion.

Henderson argued that MCE failed to provide an appropriate medical screening. The Court concluded that a jury could find that MCE did not follow its policy for OB patients, which requires evaluation by an ER physician for all patients over twenty weeks gestation who have been in a motor vehicle accident because an ER physician did not see Henderson. The Court also found that a jury could conclude that MCE violated its obligation under EMTALA to provide appropriate medical screening by treating Henderson differently than other patients presenting with the same symptoms.

In addition, the Court found that a jury could find that the wait for the OB's decision unreasonably delayed screening or treatment. The Court found no merit in MCE's claim that because she left, Henderson voluntarily withdrew her request for treatment. □

***Robley v. Blue Cross Blue Shield*, No. 2003-CT002209 (Miss. Aug. 10, 2006).**

By Sarah Flotte

According to the Mississippi Supreme Court, health insurers do not owe a fiduciary duty to maintain the confidentiality of their client's medical records. The Mississippi high court held that medical records should be kept confidential, except where the information in the records would be useful to the insured's physicians. To support its finding, the Court cited past cases which refused to acknowledge the existence of a fiduciary duty. The Court emphasized the severity of burdens inherent in a fiduciary relationship and went on to explain that there was no language in the policy at issue which indicated the existence of such a duty.

Plaintiff Kelly Robley was hospitalized for severe abscesses that required continual medical attention. A representative from the hospital contacted Robley's insurer, defendant Blue Cross Blue Shield ("Blue Cross"), to seek approval of in-home visits by a home health care nurse. During the conversation Robley's case manager

from Blue Cross told the hospital representative that Robley was a "drug seeker," meaning she abused prescription drugs even though she did not need the medication. The hospital representative then informed Robley's husband what the case manager had said. Robley overheard the conversation and subsequently entered into a psychotic state and was bedridden for several days. Since then, Robley's migraines have become more severe and she periodically becomes enraged and cries over minor events. Robley sought to recover damages from Blue Cross for negligent infliction of emotional distress as well as breach of confidentiality.

The Court found that Blue Cross has wide discretion to release its client's medical records when necessary. However, the Court noted that its discretion is not unfettered, and that confidential information should only be disclosed if reasonably necessary. □

***In re Bextra and Celebrex Marketing Sales Practices and Prod. Liability Litig.*, No. M: 05-1699 CRB (N.D. Cal. Aug. 16, 2006).**

By Elese Hanson

Pfizer faced a class action suit brought by plaintiffs representing consumers and third-party payers who had purchased the company's drug, Celebrex. The claims alleged both that Pfizer failed to warn that Celebrex was associated with cardiovascular risks and that Pfizer falsely advertised that Celebrex had fewer gastrointestinal side effects than other similar products. The U.S. District Court for the Northern District of California granted Pfizer's motion to dismiss, but only in part.

The Court granted Pfizer's motion to dismiss with regard to the plaintiffs' failure-to-warn claims. The Court paid deference to the Food and Drug Administration's (FDA) own interpretation of the preemptive effect of its regulations. The Court reasoned that Congress gave the FDA the authority to implement the Food, Drug and Cosmetic Act (FDCA) because of the required level of scientific expertise. Furthermore, the Court explained that the plaintiff's the-

ory that Celebrex has cardiovascular risks greater than other products was found not to be scientifically proven by the FDA. The Court granted the motion to dismiss regarding this issue because plaintiffs' "state law failure-to-warn claims conflict with the FDA's determination of the proper warning and pose an obstacle to the full accomplishment of the objectives of the FDCA."

However, the Court did not grant Pfizer's motion to dismiss regarding the claim of false advertising. Although Pfizer submitted its Celebrex advertisements to the FDA without any objections, the FDA has not stated an opinion as to whether lawsuits challenging false claims in prescription drug advertisements are preempted by prior FDA review and acceptance. The Court held that this silence "suggests that the FDA does not intend its review of promotional materials to preempt false advertising claims." Thus, dismissal of the false advertising claims was improper. □

CASE NOTES

The Dept. of Revenue of the State of IL v. Provena Covenant Med. Ctr., IL. Dep't of Rev. (Sept. 26, 2006).

By Jason Greis¹

I. INTRODUCTION

The Illinois Department of Revenue (“IDR”) issued its Final Administrative Decision (the “Provena Decision”) on September 26, 2006 upholding the ruling of the Champaign County, Illinois’ taxing authority denying Provena Covenant Medical Center’s (“Provena”) appeal to regain its property tax exemption². Provena is a full-service, general acute care hospital located in Urbana, Illinois. Provena is a division of Provena Hospitals, the parent corporation of which is Provena Health, which is a Catholic health system that includes several Illinois hospitals.

Although the application of this decision is arguably limited by the statutory and case law upon which it was decided, hospitals and charitable not-for-profit organizations around the country have taken notice of this extraordinary decision, which may have nationwide application if other taxing bodies begin scrutinizing similarly drafted local property tax laws. Many legislators and state attorneys general, however, view the Provena Decision merely as the most recent step in a national movement, led by Senator Charles F. Grassley (R-IA), to review or revise federal Community Benefit Standards in order to make non-profit hospitals accountable for providing greater amounts of charity care to their constituents—a vision shared by Illinois’ Attorney General, Lisa Madigan (D-IL)³.

In fact, Anne Murphy, Senior Counsel to the Illinois Attorney General, stated in the wake of the Provena Decision that the Attorney General’s Office believes that the case was correctly decided consistent with the Illinois Constitution and case precedent⁴. Her statement is unsurprising in light of the Illinois Attorney General’s recent unsuccessful efforts to pass a charity care bill requiring Illinois hospitals to devote at least 8% of their annual operating income to providing charity care⁵.

II. THE RULING

IDR framed the issue in the Provena Decision as “whether the property used by [Provena] is owned by a charitable organization and if so whether the property is used by the organization exclusively for charitable purposes⁶.” Illinois law provides an exemption from property taxation if the subject property is “actually and exclusively used [by an institution of public charity] for charitable or benevolent purposes, and not otherwise used with a view to profit⁷.” The Provena Decision explained that the “exclusively” standard should not be interpreted literally, but instead that the standard would be met where providing charity care is the primary purpose and is not merely an “incidental act of beneficence⁸.” An organization generally will be deemed to have a charitable purpose if

(1) the benefits derived are for an indefinite number of people . . . ; (2) the organization has no capital, capital stock or shareholders, earns no profits or dividends, but rather derives its funds mainly from public and private charity . . . ; (3) the organization dispenses charity to all who need and apply for it; (4) it does not provide gain or profit in a private sense to any person connected with it; and (5) it does not . . . place obstacles in the way of those who need and

would avail themselves of the charitable benefits it dispenses⁹.

IDR ultimately concluded that Provena did not qualify for a property tax exemption because Provena failed to prove by clear and convincing evidence that it uses its property “exclusively for charitable purposes¹⁰.” IDR considered several factors in reaching its conclusion.

A. Amount of Charity Care Provided. One of the critical issues that IDR grappled with in the Provena Decision was determining what, if any, minimum amount of free care a hospital must provide before IDE would recognize the institution’s primary purpose as the provision of charity care. According to IDR, however, Provena failed to come close to such a threshold as it spent only 0.7% (\$831,724) of its 2002 income (\$113,000,000) on providing charity care. IDR therefore found that Provena had failed to prove that its “primary purpose” was providing charitable care because the small amount of charity care provided was “so seriously insufficient that it simply [could not] withstand the constitutional scrutiny required to justify a property tax exemption¹¹,” especially in light of the fact that the value of the \$1,100,000 property tax exemption sought was worth more than the amount of charity care provided by Provena.

B. Provision of Emergency Services. The Provena Decision also held that Provena’s primary purpose was not charitable despite the fact that Provena treated anyone seeking treatment for emergency medical conditions¹². Instead, IDR urged that Provena was merely complying with Emergency Medical Treatment and Active Labor Act (EMTALA)—a federal law requiring acute care facilities to examine and treat emergency medical conditions and women in labor¹³. “For example, a patient whose portion of billed charges was \$50,000 and whose income was at a level allowing for a 50% waiver of charges would be left with a \$25,000 bill after application of the sliding scale, [while] a patient at the same level on the poverty income scale with billed charges of \$1,000 would be left with an outstanding bill of only \$500 after the sliding scale is applied¹⁵.” IDR stated that the mechanical application of this sliding scale was inconsistent with providing meaningful charity care because if failed to consider a patient’s true ability to pay for services rendered in relation to the amount of the outstanding portion of the bill. IDR also criticized Provena’s failure to publicize its charity care policy within the community and its charity care policy’s statement that Provena would dispense charity care “to the extent that it is financially able” to do so, as further evidence that Provena did not provide charitable services to all who need and apply for it¹⁶. Additionally, IDR made much of the fact that 97.7% of Provena Health’s annual operating income came from patient revenue despite the guidelines set forth in *Methodist Old People’s Home v. Korzen* suggesting that the funds of a charitable organization should be derived mainly from public and private charities¹⁷. Finally, IDR flatly rebuffed as inconsistent with case precedent Provena’s attempt to

Continued on page 9

Provena Covenant Med. Ctr. continued

argue that it should be able to characterize unreimbursed Medicaid and Medicare costs as charity care¹⁸.

Both Illinois non-profit hospitals and the Illinois Hospital Association are outraged by the Provena Decision and believe that it will be overturned on appeal¹⁹. In the meantime, however, it provides critical guidance to stunned Illinois non-profit hospitals searching for ways to avoid challenges to their property tax exemption and attempting to identify clues regarding the legislative direction of state policy makers. We have therefore compiled below a checklist of lessons learned from the Provena Decision and other non-profit charity care best practices that may help your organization insulate itself from similar challenges²⁰. We note, however, that each organization must determine whether the costs of implementing such practices outweighs the benefits realized from property tax exemption. In light of both federal and state trends to re-evaluate whether hospitals are deserving of such exemptions and recently decided IDR cases, there is no guarantee that implementing any or all of the below suggestions will inoculate an organization from the growing tide of scrutiny. Instead, hospitals may be better advised to contact their local lobbying organization to express their concern and determine how to become involved in local efforts to eliminate this growing threat.

III. CHARITY CARE BEST PRACTICES**A. Executive Compensation**

1. Ensure independence of compensation committee and outside compensation consultants.
2. Ensure quality of the comparability data to be used to determine compensation.
3. Value total cash compensation and the total value of all benefits (e.g. entertainment expenses, travel, automobile expenses, social club dues, executive travel and other discretionary expenditures).
4. Make the Compensation Committee's decision-making process transparent to the full Board of Directors.
5. Make a record explaining how and why the Compensation Committee and Board made certain executive-level compensation decisions.

B. Charity Care Practices

1. Ensure that sure the amount of charity care provided *at least* equals the amount of any property tax exemption sought.
2. Implement bilingual or multilingual charity care policies.
3. Identify clear financial eligibility standards based upon a patient's relation to federal poverty standards that meaningfully considers a patient's true ability to pay charges.
4. Offer more significant charity care assistance to patients shouldering catastrophic expense beyond their financial means.
5. Implement effective strategies to communicate the availability of charity care to the community.
6. Train clinical and registration staff to identify patients in need of assistance.
7. Implement patient-friendly application procedures.
8. Remove any statements from your charity care policy stating that the organization will provide charity care based upon its financial situation.

9. Aggressively seek charitable forms of revenue (e.g., grants, charitable gifts, etc.) and make a record of such attempts.
10. Require third-party contractors to provide a certain minimum percentage or dollar amount of charitable care each year that is consistent with your organization's charitable care policies.
11. Differentiate in your financial statement among charity care based upon financially determined need, other discounted programs, uncompensated shortfall from government payout programs and bad debt.

C. Billing and Collection Policies

1. Provide payment plans to hospital patients to stretch out payment over time.
2. Make charity care and discount policies readily available to patients at all times.
3. Do not send outstanding balances to collection before a reasonable period of time goes by for a patient to pay or establish a payment plan.
4. Do not send outstanding balances to collection while a charity care application is pending.
5. Avoid aggressive or harassing collection practices.
6. Use legal action sparingly and only when authorized by senior management. □

References

- [1]The author, Jason S. Greis, is an associate in Seyfarth Shaw LLP's Business Services Group. The author wishes to thank his colleagues, Nathaniel Sack and James Fortcamp, for their helpful comments on this article. This article should not be construed as legal advice or a legal opinion on any specific facts or circumstances. The contents are intended for general information purposes only, and you are urged to consult a lawyer concerning your own situation and any specific legal questions you may have. Any tax information contained herein is not intended to be and cannot be used by any taxpayer for the purpose of avoiding tax penalties that may be imposed on the taxpayer. Copyright © Seyfarth Shaw LLP. All rights reserved.
- [2]Provena Covenant Medical Ctr., II. Dep't of Rev., 2 (Sept. 26, 2006).
- [3]See Senate Finance Committee, *Taking the Pulse on Charitable Care and Community Benefits at Nonprofit Hospitals* (Sept. 13, 2006).
- [4]Anne Murphy, Esq., Remarks at the Illinois Association of Healthcare Attorneys Symposium (October 4, 2006).
- [5]H.B. 5000, 94th Gen. Ass., Reg. Sess. (Il. 2005).
- [6]Provena Covenant Medical Ctr., II. Dep't of Rev., 2 (Sept. 26, 2006).
- [7]*Id.* at 4 (citing 35 ILCS 200/15-65 (West 2006)).
- [8]*Id.*
- [9]*Id.* at 6 (quoting *Methodist Old People's Home v. Korzen*, 233 N.E.2d 537 (Il. 1968)).
- [10]*Id.* at 2 (Sept. 26, 2006).
- [11]*Id.* at 6-7 (Sept. 26, 2006).
- [12]Provena Covenant Medical Ctr., II. Dep't of Rev., 7 (Sept. 26, 2006).
- [13]42 U.S.C. §1395dd et. seq. (2006).
- [14]Provena Covenant Medical Ctr., II. Dep't of Rev., 8-10 (Sept. 26, 2006).
- [15]*Id.* at 9.
- [16]*Id.* at 11.
- [17]*Id.*
- [18]*Id.* at 12.
- [19]Kenneth C. Robbins, Re: Illinois Department of Revenue Denial of Tax-Exemption for Provena Covenant Medical Center of Urbana (Sept. 29, 2006), available at <http://www.ihatoday.org/issues/payment/charity/provenastmt.pdf>.
- [20]Michael W. Peregrine et al., *Grassley, The IRS Questionnaire And Community Benefit: Are We Done Yet?*, HEALTH LAWYERS WEEKLY (Sept. 22, 2006).



DePaul University College of Law
Health Law Institute
25 East Jackson Boulevard
Chicago, IL 60604
www.law.depaul.edu/health

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EVENTS: FALL 2006

Please join us for the 2nd Annual Linda E. Saltzman Symposium, presented by the American Medical Association National Advisory Council on Violence and Abuse.

Identification of Violence and Abuse Across the Lifespan

Date: November 4, 2006
Time: 10:00am — 2:00pm
Location: DePaul Center, Room 8005

Please join us for a half-day colloquium that will bring together scholars to discuss the ethical, moral, legal and social implications of markets in babies and children.

Baby Markets Roundtable

Date: November 10, 2006
Time: 12:00pm — 5:00pm
Location: The University Club, 76 East Monroe Street

For more information about events, please contact Rhea Banks at (312) 362-7271 or rbanks2@depaul.edu

FDA Issues Warning Letters *continued from page one*

In contrast, the three firms warned by the FDA were found to be manufacturing compounded drugs in high volumes without any documentation of patient-specific medical need. They were producing unapproved new drugs that were merely commercial copies of approved drugs. In essence, they were acting more like representatives of drug manufacturers than public health advocates.

In response to the health problem posed, the FDA has urged consumers using inhalation drugs to discuss their medications with their physicians and verify that the medications they received are what their physicians ordered. The FDA also warned consumers that using drugs not approved by the FDA, including

compounded inhalation drugs, can expose them to unnecessary risks, explaining that these drugs “are not reviewed for safety and effectiveness, often are not produced according to good drug manufacturing practice, and typically are not sterile.” □

References

U.S. Food and Drug Administration, *FDA Warns Three Pharmacies to Stop Mass-Producing Unapproved Inhalation Drugs* (Aug. 10, 2006), available at <http://www.fda.gov/bbs/topics/NEWS/2006/NEW01428.html>; Warning Letter to Philip L. Carter, President and CEO, Rotech Healthcare, Inc. (Aug. 9, 2006), available at http://www.fda.gov/foi/warning_letters/g5964d.htm; Warning Letter to Joseph Capper, CEO, CCS Medical (Aug. 9, 2006), available at http://www.fda.gov/foi/warning_letters/g5963d.htm

Plan B *continued from page two*

“Half of the unintended pregnancies result in abortion. And again, it’s estimated that up to 50 percent of these unintended pregnancies could be prevented with the use of emergency contraception.” Women’s health and family-planning advocates consider the decision a long-overdue milestone that will make it much easier for women to prevent an unwanted pregnancy when they have unprotected sex or when another form of contraception fails. The FDA decision, however, does not resolve other controversial issues pertaining to the pill, including the refusals of hospi-

tals run by religious organizations to offer them, of some pharmacies to stock them, and of some anti-abortion pharmacists to dispense them. □

References

Illinois Government News Network, *Gov. Blagojevich urges the FDA to approve Plan B as an over-the-counter contraceptive* (Aug. 9, 2006), available at <http://www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=19&RecNum=5165>CNN.com, *Panel backs over-the-counter ‘morning-after’ pill* (December 17, 2003), at <http://www.cnn.com/2003/HEALTH/12/16/morning.after.pill/>.