

The Uninsured

At last count, there were 47 million Americans without health insurance. Between 2005 and 2006, roughly two million people joined their ranks.

Fast Facts



- ▲ *Often lacking access to primary and preventive care, 18,000 uninsured individuals die from treatable conditions every year, according to an Institute of Medicine (IOM) report. Page 57.*
- ▲ *According to Harvard researchers, nearly half of bankruptcies in the United States are due at least in part to unpaid medical bills. Researchers at the Commonwealth Fund estimate that, in 2003, nearly one in three Americans reported having problems paying medical bills. Page 60.*
- ▲ *Employers are becoming increasingly concerned that the rising price of health care is an unsustainable trend. Not only have they been hit by rising premiums, but they have to deal with the economic impact of lost work time when employees get sick and cannot see a doctor. Page 65.*

In recent years, the number of uninsured has risen steadily by about one million annually. That growth has been fueled by the combination of rising healthcare costs and the erosion in employer-sponsored coverage. Barring major reform, most experts predict that the number of uninsured will continue to rise, placing enormous strain on an already struggling healthcare infrastructure.

“The key issue that we continue to come back to is that a significant proportion of our population is uninsured, and that has very important and dramatic health impacts,” says John Lumpkin, MD, senior vice president and director of the Health Care

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#1
PRESCRIBED
SRI
NEW PATIENT STARTS
WITH PSYCHIATRISTS

For **DEPRESSION**
and **ANXIETY**

PROVEN EFFICACY for Major Depressive Disorder and Generalized Anxiety Disorder²

UP TO 90% of depressed patients present with symptoms of anxiety³

Lexapro
escitalopram oxalate



POWER TO ENJOY LIFE™

IMPORTANT SAFETY INFORMATION - Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Antidepressants increased the risk of suicidality (suicidal thinking and behavior) in children, adolescents, and young adults in short-term studies of major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of antidepressants in children, adolescents or young adults must balance the risk to clinical need. Patients of all ages started on antidepressant therapy should be closely monitored and observed for clinical worsening, suicidality or unusual changes in behavior, especially at the beginning of therapy or at the time of dose changes. This risk may persist until significant remission occurs. Families and caregivers should be advised of the need for close observation and communication with the prescriber. Lexapro is not approved for use in pediatric patients.

Lexapro is contraindicated in patients taking monoamine oxidase inhibitors (MAOIs), pimoziide [see DRUG INTERACTIONS - Pimoziide and Celexa], or in patients with hypersensitivity to escitalopram oxalate. As with other SSRIs, caution is indicated in the coadministration of tricyclic antidepressants (TCAs) with Lexapro. As with other psychotropic drugs that interfere with serotonin reuptake, patients should be cautioned regarding the risk of bleeding associated with the concomitant use of Lexapro with NSAIDs, aspirin, or other drugs that affect coagulation. The most common adverse events with Lexapro versus placebo (approximately 5% or greater and approximately 2x placebo) were nausea, insomnia, ejaculation disorder, somnolence, increased sweating, fatigue, decreased libido, and anorgasmia.

References: 1. Verispan Weekly VONA Data [Retail Only]. Twenty-four-week rolling average. September 2006. 2. LEXAPRO [package insert]. St. Louis, Mo: Forest Pharmaceuticals, Inc.; 2007. 3. Sadock BJ, Sadock VA. *Kaplan and Sadock's Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry*. 9th ed. Philadelphia, Pa: Lippincott Williams & Wilkins; 2003:552.

Please see brief summary of prescribing information for LEXAPRO on following page.

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LEXAPRO® (escitalopram oxalate) TABLETS/ORAL SOLUTION

Rx Only

Brief Summary: For complete details, please see full prescribing information for Lexapro.

(Suicidality and Major Depressive Drugs Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of antidepressant disorder (MDD) and other psychiatric disorders. Anyone considering the use of Lexapro or any other antidepressant in a child, adolescent, or young adult must balance this risk with the clinical need. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction in risk with antidepressants compared to placebo in adults aged 65 and older. Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Families of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Patients and caregivers should be advised of the need for close observation and communication with the prescriber. Lexapro is not approved for use in pediatric patients. (See WARNINGS: Clinical Worsening and Suicide Risk, PRECAUTIONS: Information for Patients, and PRECAUTIONS: Pediatric Use)

CONTRAINDICATIONS Concomitant use in patients taking monoamine oxidase inhibitors (MAOIs) is contraindicated (see WARNINGS). Concomitant use in patients taking pimozide is contraindicated (see Drug Interactions – Pimozide and Celexa). Lexapro is contraindicated in patients with a hypersensitivity to escitalopram or citalopram or any of the inactive ingredients in Lexapro. **WARNINGS** **WARNINGS: Clinical Worsening and Suicide Risk** Lexapro is contraindicated in patients with major depressive disorder (MDD), both adult and pediatric, may experience worsening of their depression and/or the emergence of suicidal ideation and behavior (suicidality) or unusual changes in behavior, whether or not they are taking antidepressant medications, and this risk may persist until significant remission occurs. Suicidality is a known risk of depression and certain other psychiatric disorders, and these disorders themselves are the strongest predictors of suicide. There has been a long-standing concern, however, that antidepressants may have a role in inducing worsening of depression and the emergence of suicidality in certain patients during the early phases of treatment. Pooled analyses of short-term placebo-controlled trials of antidepressant drugs (SSRIs and others) showed that these drugs increase the risk of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults (ages 18-24) with major depressive disorder (MDD) and other psychiatric disorders. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction with antidepressants compared to placebo in adults aged 65 and older. The pooled analyses of placebo-controlled trials in children and adolescents with MDD, obsessive compulsive disorder (OCD), or other psychiatric disorders included a total of 24 short-term trials of 9 antidepressant drugs in over 4400 patients. The pooled analyses of placebo-controlled trials in adults with MDD or other psychiatric disorders included a total of 295 short-term trials (median duration of 2 months) of 11 antidepressant drugs in over 77,000 patients. There was considerable variation in risk of suicidality among drugs, but a tendency toward an increase in the younger patients for almost all drugs studied. There were differences in absolute risk of suicidality across the different indications, with the highest incidence in MDD. The risk differences (drug vs placebo), however, were relatively stable within age strata and across indications. These risk differences (drug-placebo difference in the number of cases of suicidality per 1000 patients treated) are provided in Table 1. **Table 1. Age Range and Drug-Placebo Difference in Number of Cases of Suicidality per 1000 Patients Treated: Drug-Related Increases;** <18 (14 additional cases), 18-24 (5 additional cases), 25-64 (1 fewer case), >65 (6 fewer cases). No suicides occurred in any of the pediatric trials. There were suicides in the adult trials, but the number was not sufficient to reach any conclusion about drug effect on suicide. It is unknown whether the suicidality risk extends to longer-term use, i.e., beyond several months. However, there is substantial evidence from placebo-controlled maintenance trials in adults with depression that the use of antidepressants can delay the recurrence of depression. **All patients being treated with antidepressants for any indication should be monitored appropriately and observed closely for clinical worsening, suicidality, and unusual changes in behavior, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases.** The following symptoms, anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, and mania, have been reported in adult and pediatric patients being treated with antidepressants for major depressive disorder as well as for other indications, both psychiatric and nonpsychiatric. Although a causal link between the emergence of such symptoms and either the worsening of depression and/or the emergence of suicidal impulses has not been established, there is concern that such symptoms may represent precursors to emerging suicidality. Consideration should be given to changing the therapeutic regimen, including possibly discontinuing the medication, in patients whose depression is persistently worse, or who are experiencing emergent suicidality or symptoms that might be precursors to worsening depression or suicidality, especially if these symptoms are severe, abrupt in onset, or were not part of the patient's presenting symptoms. If the decision has been made to discontinue treatment, medication should be tapered, as rapidly as is feasible, but with recognition that abrupt discontinuation can be associated with certain symptoms (see PRECAUTIONS AND DOSAGE AND ADMINISTRATION—Discontinuation of Treatment with Lexapro, for a description of the risks of discontinuation of Lexapro). **Families and caregivers of patients being treated with antidepressants for major depressive disorder or other indications, both psychiatric and nonpsychiatric, should be alerted about the need to monitor patients for the emergence of agitation, irritability, unusual changes in behavior, and the other symptoms described above, as well as the emergence of suicidality, and to report such symptoms immediately to health care providers. Such monitoring should include daily observation by families and caregivers.** Prescriptions for Lexapro should be written for the smallest quantity of tablets consistent with good patient management, in order to reduce the risk of overdose. **Screening Patients for Bipolar Disorder:** A major depressive episode may be the initial presentation of bipolar disorder. It is generally believed (though not established in controlled trials) that treating such an episode with an antidepressant alone may increase the likelihood of precipitation of a mixed/manic episode in patients at risk for bipolar disorder. Whether any of the symptoms described above represent such a conversion is unknown. However, prior to initiating treatment with an antidepressant, patients with depressive symptoms should be adequately screened to determine if they are at risk for bipolar disorder; such screening should include a detailed psychiatric history, including a family history of suicide, bipolar disorder, and depression. It should be noted that Lexapro is not approved for use in treating bipolar depression. **Potential for Interaction with Monoamine Oxidase Inhibitors in patients receiving serotonin reuptake inhibitor drugs in combination with a monoamine oxidase inhibitor (MAOI), there have been reports of serious, sometimes fatal, reactions including hyperthermia, rigidity, myoclonus, autonomic instability with possible rapid fluctuations of vital signs, and mental status changes that include extreme agitation progressing to delirium and coma. These reactions have also been reported in patients who have recently discontinued SSRI treatment and have been started on an MAOI. Some cases presented with features resembling neuroleptic malignant syndrome. Furthermore, limited animal data on the effects of combined use of SSRIs and MAOIs suggest that these drugs may act synergistically to elevate blood pressure and evoke behavioral excitation. Therefore, it is recommended that Lexapro should not be used in combination with an MAOI, or within 14 days of discontinuing treatment with an MAOI. Similarly, at least 14 days should be allowed after stopping Lexapro before starting an MAOI. Serotonin syndrome has been reported in two patients who were concomitantly receiving linezolid, an antibiotic which is a reversible non-selective MAOI. **Serotonin Syndrome:** The development of a potentially life-threatening serotonin syndrome may occur with SNRIs and SSRIs, including Lexapro treatment, particularly with concomitant use of serotonergic drugs (including triptans) and with drugs which impair metabolism of serotonin (including MAOIs). Serotonin syndrome symptoms may include mental status changes (e.g., agitation, hallucinations, coma), autonomic instability (e.g., tachycardia, labile blood pressure, hyperthermia), neuromuscular aberrations (e.g., hyperreflexia, incoordination) and/or gastrointestinal symptoms (e.g., nausea, vomiting, diarrhea). The concomitant use of Lexapro with MAOIs intended to treat depression is contraindicated (see **CONTRAINDICATIONS** and **WARNINGS – Potential for Interaction with Monoamine Oxidase Inhibitors**.) If concomitant treatment of Lexapro with a 5-hydroxytryptamine receptor agonist (triptan) is clinically warranted, careful observation of the patient is advised, particularly during treatment initiation and dose increases (see **PRECAUTIONS – Drug Interactions**). The concomitant use of Lexapro with serotonin precursors (such as tryptophan) is not recommended (see **PRECAUTIONS – Drug Interactions**). **PRECAUTIONS General Discontinuation of Treatment with Lexapro** marketing of Lexapro and other SSRIs and SNRIs (serotonin and norepinephrine reuptake inhibitors), there have been spontaneous reports of adverse events occurring upon discontinuation of these drugs, particularly when abrupt, including the following: dysphoric mood, irritability, agitation, dizziness, sensory disturbances (e.g., paresthesias such as electric shock sensations), anxiety, confusion, headache, lethargy, emotional lability, insomnia, and hypomania. While these events are generally self-limiting, there have been reports of serious discontinuation symptoms. Patients should be monitored for these symptoms when discontinuing treatment with Lexapro. A gradual reduction in the dose rather than abrupt cessation is recommended whenever possible. If intolerable symptoms occur following a decrease in the dose or upon discontinuation of treatment, then resuming the previously prescribed dose may be considered. Subsequently, the physician may continue decreasing the dose but at a more gradual rate (see **DOSAGE AND ADMINISTRATION**). **Abnormal Bleeding** Published case reports have documented the occurrence of bleeding episodes in patients treated with psychotropic drugs that interfere with serotonin reuptake. Subsequent epidemiological studies, both of the case-control and cohort design, have demonstrated an association between use of psychotropic drugs that interfere with serotonin reuptake and the occurrence of upper gastrointestinal bleeding. In two studies, concurrent use of a nonsteroidal anti-inflammatory drug (NSAID) or aspirin potentiated the risk of bleeding (see **Drug Interactions**). Although these studies focused on upper gastrointestinal bleeding, there is reason to believe that bleeding at other sites may be similarly potentiated. Patients should be cautioned regarding the risk of bleeding associated with the concomitant use of Lexapro with NSAIDs, aspirin, or other drugs that affect coagulation. **Hypotension** Cases of hypotension and SIADH (syndrome of inappropriate antidiuretic hormone secretion) have been reported in association with Lexapro treatment. All patients with these events have recovered with discontinuation of escitalopram and/or medical intervention. Hypotension and SIADH have also been reported in association with other marketed drugs effective in the treatment of major depressive disorder. **Activation of Mania/Hypomania** In placebo-controlled trials of Lexapro in major depressive disorder, activation of mania/hypomania was reported in one (0.1%) of 715 patients treated with Lexapro and in none of the 592 patients treated with placebo. One additional case of hypomania has been reported in association with Lexapro treatment. Activation of mania/hypomania has also been reported in a small proportion of patients with major affective disorders treated with racemic citalopram and other marketed drugs effective in the treatment of major depressive disorder. As with all drugs effective in the treatment of major depressive disorder, Lexapro should be used cautiously in patients with a history of mania. **Seizures** Although anticonvulsant effects of racemic citalopram have been observed in animal studies, Lexapro has not been systematically evaluated in patients with a seizure disorder. These patients were excluded from clinical studies during the product's premarketing testing. In clinical trials of Lexapro, cases of convulsion have been reported in association with Lexapro treatment. Like other drugs effective in the treatment of major depressive disorder, Lexapro should be introduced with care in patients with a history of seizure disorder. **Interference with Cognitive and Motor Performance** In a study in normal volunteers, Lexapro 10 mg/day did not produce impairment of intellectual function or psychomotor performance. Because any psychoactive drug may impair judgment, thinking, or motor skills, however, patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that Lexapro therapy does not affect their ability to engage in such activities. **Use in Patients with Concomitant Illness** Clinical experience with Lexapro in patients with certain concomitant systemic illnesses is limited. Caution is advisable in using Lexapro in patients with diseases or conditions that produce altered metabolism or hemodynamic responses. Lexapro has not been systematically evaluated in patients with a recent history of myocardial infarction or unstable heart disease. Patients with these diagnoses were generally excluded from clinical studies during the product's premarketing testing. In subjects with hepatic impairment, clearance of racemic citalopram was decreased and plasma concentrations were increased. The recommended dose of Lexapro in hepatically impaired patients is 10 mg/day (see **DOSAGE AND ADMINISTRATION**). Because escitalopram is extensively metabolized, excretion of unchanged drug in urine is a minor route of elimination. Until adequate numbers of patients with severe renal impairment have been evaluated during chronic treatment with Lexapro, however, it should be used with caution in such patients (see **DOSAGE AND ADMINISTRATION**). **Information for Patients** Physicians are advised to discuss the following issues with patients for whom they prescribe Lexapro. Patients should be cautioned about the risk of serotonin syndrome with the concomitant use of Lexapro and triptans, tramadol or other serotonergic agents. In a study in normal volunteers, Lexapro 10 mg/day did not impair psychomotor performance. The effect of Lexapro on psychomotor coordination, judgment, or thinking has not been systematically examined in controlled studies. Because psychoactive drugs may impair judgment, thinking, or motor skills, patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that Lexapro therapy does not affect their ability to engage in such activities. Patients should be told that, although Lexapro has not been shown in experiments with normal subjects to increase the mental and motor skill impairments caused by alcohol, the concomitant use of Lexapro and alcohol in depressed patients is not advised. Patients should be made aware that escitalopram is the active isomer of Celexa (citalopram hydrobromide) and that the two medications should not be taken concomitantly. Patients should be advised to inform their physician if they are taking, or plan to take, any prescription or over-the-counter drugs, as there is a potential for interactions. Patients should be cautioned about the concomitant use of Lexapro and NSAIDs, aspirin, or other drugs that affect coagulation since the combined use of psychotropic drugs that interfere with serotonin reuptake and these agents has been associated with an increased risk of bleeding. Patients should be advised to notify their physician if they become pregnant or intend to become pregnant during therapy. Patients should be advised to notify their physician if they are breastfeeding an infant. While patients may notice improvement with Lexapro therapy in 1 to 4 weeks, they should be advised to continue therapy as directed. Prescribers or other health professionals should inform patients, their families, and their caregivers about the benefits and risks associated with treatment with Lexapro and should counsel them in its appropriate use. A Patient Medication Guide about "Antidepressant Medicines, Depression and other Serious Mental Illness, and Suicidal Thoughts or Actions" is available for Lexapro. The prescriber or health professional should instruct patients, their families, and their caregivers to read the Medication Guide and assist them in understanding its contents. Patients should be given the opportunity to discuss the contents of the Medication Guide and to obtain answers**

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to any questions they may have. Patients should be advised of the following issues and asked to alert their prescriber if these occur while taking Lexapro. **Clinical Worsening and Suicide Risk:** Patients, their families, and their caregivers should be encouraged to be alert to the emergence of anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, mania, other unusual changes in behavior, worsening of depression, and suicidal ideation, especially early during anti-depressant treatment and when the dose is adjusted up or down. Families and caregivers of patients should be advised to look for the emergence of such symptoms on a day-to-day basis, since changes may be abrupt. Such symptoms should be reported to the patient's prescriber or health professional, especially if they are severe, abrupt in onset, or were not part of the patient's presenting symptoms. Symptoms such as these may be associated with an increased risk for suicidal thinking and behavior and indicate a need for very close monitoring and possibly changes in the medication. **Laboratory Tests:** There are no specific laboratory tests recommended. **Concomitant Administration with Racemic Citalopram:** Citalopram - Since escitalopram is the active isomer of racemic citalopram (Lexela), the two agents should not be coadministered. **Drug Interactions Serotonergic Drugs:** Based on the mechanism of action of SSRIs and SSRIIs including Lexapro, and the potential for serotonin syndrome, caution is advised when Lexapro is coadministered with other drugs that may affect the serotonergic neurotransmitter systems, such as triptans, linezolid (an antibiotic which is a reversible non-selective MAOI), lithium, tramadol, or St. John's Wort (see **WARNINGS-Serotonin Syndrome**). The concomitant use of Lexapro with other SSRIs, SNRIs or tryptophan is not recommended (see **PRECAUTIONS - Drug Interactions**). **Triptans:** There have been rare postmarketing reports of serotonin syndrome with use of an SSRI and a triptan. If concomitant treatment of Lexapro with a triptan is clinically warranted, careful observation of the patient is advised, particularly during treatment initiation and dose increases (see **WARNINGS - Serotonin Syndrome**). **CNS Drugs -** Given the primary CNS effects of escitalopram, caution should be used when it is taken in combination with other centrally acting drugs. Alcohol - Although Lexapro did not potentiate the cognitive and motor effects of alcohol in a clinical trial, as with other psychotropic medications, the use of alcohol by patients taking Lexapro is not recommended. Monoamine Oxidase Inhibitors (MAOIs) - See **CONTRAINDICATIONS and WARNINGS. Drugs That Interfere With Hemostasis (NSAIDs, Aspirin, Warfarin, etc.)** Serotonin release by platelets plays an important role in hemostasis. Epidemiological studies of the case-control and cohort design that have demonstrated an association between use of psychotropic drugs that interfere with serotonin reuptake and the occurrence of upper gastrointestinal bleeding have also shown that concurrent use of an NSAID or aspirin potentiated the risk of bleeding. Thus, patients should be cautioned about the use of such drugs concurrently with Lexapro. Cimetidine - In subjects who had received 21 days of 40 mg/day racemic citalopram, combined administration of 400 mg/day cimetidine for 8 days resulted in an increase in citalopram AUC and C_{max} of 43% and 39%, respectively. The clinical significance of these findings is unknown. Digoxin - In subjects who had received 21 days of 40 mg/day racemic citalopram, combined administration of citalopram and digoxin (single dose of 1 mg) did not significantly affect the pharmacokinetics of either citalopram or digoxin. Lithium - Co-administration of racemic citalopram (40 mg/day for 10 days) and lithium (300 mg/day for 5 days) had no significant effect on the pharmacokinetics of citalopram or lithium. Nevertheless, plasma lithium levels should be monitored with appropriate adjustment to the lithium dose in accordance with standard clinical practice. Because lithium may enhance the serotonergic effects of escitalopram, caution should be exercised when Lexapro and lithium are coadministered. Pimozide and Celebrex - In a controlled study, a single dose of pimozide 2 mg co-administered with racemic citalopram 40 mg given once daily for 11 days was associated with a mean increase in QTc values of approximately 10 msec compared to pimozide given alone. Racemic citalopram did not alter the mean AUC or C_{max} of pimozide. The mechanism of this pharmacodynamic interaction is not known. Sumatriptan - There have been rare postmarketing reports describing patients with weakness, hyperreflexia, and incoordination following the use of an SSRI and sumatriptan. If concomitant treatment with sumatriptan and an SSRI (e.g., fluoxetine, fluvoxamine, paroxetine, sertraline, citalopram, escitalopram) is clinically warranted, appropriate observation of the patient is advised. Theophylline - Combined administration of racemic citalopram (40 mg/day for 21 days) and the CYP1A2 substrate theophylline (single dose of 300 mg) did not affect the pharmacokinetics of theophylline. The effect of theophylline on the pharmacokinetics of citalopram was not evaluated. Warfarin - Administration of 40 mg/day racemic citalopram for 21 days did not affect the pharmacokinetics of warfarin, a CYP3A4 substrate. Prothrombin time was increased by 5%, the clinical significance of which is unknown. Carbamazepine - Combined administration of racemic citalopram (40 mg/day for 14 days) and carbamazepine (titrated to 400 mg/day for 35 days) did not significantly affect the pharmacokinetics of carbamazepine, a CYP3A4 substrate. Although trough citalopram plasma levels were unaffected, given the enzyme-inducing properties of carbamazepine, the possibility that carbamazepine might increase the clearance of escitalopram should be considered if the two drugs are coadministered. Triazolam - Combined administration of racemic citalopram (titrated to 40 mg/day for 28 days) and the CYP3A4 substrate triazolam (single dose of 0.25 mg) did not significantly affect the pharmacokinetics of either citalopram or triazolam. Ketoconazole - Combined administration of racemic citalopram (40 mg) and ketoconazole (200 mg), a potent CYP3A4 inhibitor, decreased the C_{max} and AUC of ketoconazole by 21% and 10%, respectively, and did not significantly affect the pharmacokinetics of citalopram. Ritonavir - Combined administration of a single dose of ritonavir (600 mg), which a CYP3A4 substrate and a potent inhibitor of CYP3A4, and escitalopram (20 mg) did not affect the pharmacokinetics of either ritonavir or escitalopram. CYP3A4 and -C19 Inhibitors - *In vitro* studies indicated that CYP3A4 and -C19 are the primary enzymes involved in the metabolism of escitalopram. However, coadministration of escitalopram (20 mg) and ritonavir (600 mg), a potent inhibitor of CYP3A4, did not significantly affect the pharmacokinetics of escitalopram. Because escitalopram is metabolized by multiple enzyme systems, inhibition of a single enzyme may not appreciably decrease escitalopram clearance. **Drugs Metabolized by Cytochrome P4502D6 - In vitro** studies did not reveal an inhibitory effect of escitalopram on CYP2D6. In addition, steady state levels of racemic citalopram were not significantly different in poor metabolizers and extensive CYP2D6 metabolizers after multiple-dose administration of citalopram, suggesting that coadministration, with escitalopram, of a drug that inhibits CYP2D6, is unlikely to have clinically significant effects on escitalopram metabolism. However, there are limited *in vivo* data suggesting a modest CYP2D6 inhibitory effect for escitalopram, i.e., coadministration of escitalopram (20 mg/day for 21 days) with the tricyclic antidepressant desipramine (single dose of 50 mg), a substrate for CYP2D6, resulted in a 40% increase in C_{max} and a 100% increase in AUC of desipramine. The clinical significance of this finding is unknown. Nevertheless, caution is indicated in the coadministration of escitalopram and drugs metabolized by CYP2D6. Metoprolol - Administration of 20 mg/day Lexapro for 21 days in healthy volunteers resulted in a 50% increase in C_{max} and 82% increase in AUC of the beta-adrenergic blocker metoprolol (given in a single dose of 100 mg). Increased metoprolol plasma levels have been associated with decreased cardiorespiratory. Coadministration of Lexapro and metoprolol had no clinically significant effects on blood pressure or heart rate. Electroconvulsive Therapy (ECT) - There are no clinical studies of the combined use of ECT and escitalopram. **Carcinogenesis, Mutagenesis, Impairment of Fertility** **Carcinogenesis:** Racemic citalopram was administered in the diet to NMRI/BOM strain mice and DOBS WJ strain rats for 18 and 24 months, respectively. There was no evidence for carcinogenicity of racemic citalopram in mice receiving up to 240 mg/kg/day. There was an increased incidence of small intestine carcinoma in rats receiving 8 or 24 mg/kg/day racemic citalopram. A no-effect dose for this finding was not established. The relevance of these findings to humans is unknown. **Mutagenesis:** Racemic citalopram was mutagenic in the *in vitro* bacterial reverse mutation assay (Ames test) in 2 of 5 bacterial strains (Salmonella TA98 and TA1537) in the absence of metabolic activation. It was clastogenic in the *in vitro* Chinese hamster lung cell assay for chromosomal aberrations in the presence and absence of metabolic activation. Racemic citalopram was not mutagenic in the *in vitro* mammalian forward gene mutation assay (HPRT) in mouse lymphoma cells or in a coupled *in vitro* unscheduled DNA synthesis (UDS) assay in rat liver. It was not clastogenic in the *in vitro* chromosomal aberration assay in human lymphocytes or in two *in vivo* mouse micronucleus assays. **Impairment of Fertility:** When racemic citalopram was administered orally to 16 male and 24 female rats prior to and throughout mating and gestation at doses of 32, 48, and 72 mg/kg/day, mating was decreased at all doses, and fertility was decreased at doses \geq 32 mg/kg/day. Gestation duration was increased at 48 mg/kg/day. **Pregnancy, Pregnancy Category C.** In a rat embryo/fetal development study, oral administration of escitalopram (56, 112, or 150 mg/kg/day) to pregnant animals during the period of organogenesis resulted in decreased fetal body weight and associated delays in ossification at the two higher doses (approximately \times 5 times the maximum recommended human dose [MRHD] of 20 mg/day on a body surface area [mg/m² basis). Maternal toxicity (clinical signs and decreased body weight gain and food consumption), mild at 56 mg/kg/day, was present at all dose levels. The developmental no-effect dose of 56 mg/kg/day is approximately 28 times the MRHD on a mg/m² basis. No teratogenicity was observed at any of the doses tested (as high as 75 times the MRHD on a mg/m² basis). When female rats were treated with escitalopram (6, 12, 24, or 48 mg/kg/day) during pregnancy and through weaning, slightly increased offspring mortality and growth retardation were noted at 48 mg/kg/day which is approximately 24 times the MRHD on a mg/m² basis. Slight maternal toxicity (clinical signs and decreased body weight gain and food consumption) was seen at this dose. Slightly increased offspring mortality was seen at 24 mg/kg/day. The no-effect dose was 12 mg/kg/day which is approximately 6 times the MRHD on a mg/m² basis. In animal reproduction studies, racemic citalopram has been shown to have adverse effects on embryo/fetal and postnatal development, including teratogenic effects, when administered at doses greater than human therapeutic doses. In two rat embryo/fetal development studies, oral administration of racemic citalopram (32, 56, or 112 mg/kg/day) to pregnant animals during the period of organogenesis resulted in decreased embryonic/fetal growth and survival and an increased incidence of fetal abnormalities (including cardiovascular and skeletal defects) at the high dose. This dose was also associated with maternal toxicity (clinical signs, decreased body weight gain). The developmental no-effect dose was 56 mg/kg/day. In a rabbit study, no adverse effects on embryo/fetal development were observed at doses of racemic citalopram of up to 16 mg/kg/day. Thus, teratogenic effects of racemic citalopram were observed at a maternally toxic dose in the rat and were not observed in the rabbit. When female rats were treated with racemic citalopram (4.8, 12.8, or 32 mg/kg/day) from late gestation through weaning, increased offspring mortality during the first 4 days after birth and persistent offspring growth retardation were observed at the highest dose. The no-effect dose was 12.8 mg/kg/day. Similar effects on offspring mortality and growth were seen when dams were treated throughout gestation and early lactation at doses \geq 24 mg/kg/day. A no-effect dose was not determined in that study. There are no adequate and well-controlled studies in pregnant women; therefore, escitalopram should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. **Pregnancy-Nonteratogenic Effects** Neonates exposed to Lexapro and other SSRIs or SNRIs, late in the third trimester, have developed complications requiring prolonged hospitalization, respiratory support, and tube feeding. Such complications can arise immediately upon delivery. Reported clinical findings have included respiratory distress, cyanosis, apnea, seizures, temperature instability, feeding difficulty, vomiting, hypoglycemia, hypotonia, hypertonia, hyperreflexia, tremor, irritability, and constant crying. These features are consistent with either a direct toxic effect of SSRIs and SNRIs or, possibly, a drug discontinuation syndrome. It should be noted that, in some cases, the clinical picture is consistent with serotonin syndrome (see **WARNINGS**). Infants exposed to SSRIs in late pregnancy may have an increased risk for persistent pulmonary hypertension of the newborn (PPHN). PPHN occurs in 1-2 per 1000 live births in the general population and is associated with substantial neonatal morbidity and mortality. In a retrospective, case-control study of 377 women whose infants were born with PPHN and 636 women whose infants were born healthy, the risk for developing PPHN was approximately 2-fold higher for infants exposed to SSRIs after the 20th week of gestation compared to infants who had not been exposed to antidepressants during pregnancy. There is currently no corroborative evidence regarding the risk for PPHN following exposure to SSRIs in pregnancy; this is the first study that has investigated the potential risk. The study did not include enough cases with exposure to individual SSRIs to determine if all SSRIs posed similar levels of PPHN risk. When treating a pregnant woman with Lexapro during the third trimester, the physician should carefully consider both the potential risks and benefits of treatment (see **DOSE AND ADMINISTRATION**). Physicians should note that in a prospective longitudinal study of 201 women with a history of major depression who were euthymic at the beginning of pregnancy, women who discontinued antidepressant medication during pregnancy were more likely to experience a relapse of major depression than women who continued antidepressant medication. **Labor and Delivery** The effect of Lexapro on labor and delivery in humans is unknown. **Nursing Mothers** Racemic citalopram, like many other drugs, is excreted in human breast milk. There have been two reports of infants experiencing excessive somnolence, decreased feeding, and weight loss in association with breastfeeding from a citalopram-treated mother; in one case, the infant was reported to recover completely upon discontinuation of citalopram by its mother and, in the second case, no follow-up information was available. The decision whether to continue or discontinue either nursing or Lexapro therapy should take into account the risks of citalopram exposure for the infant and the benefits of Lexapro treatment for the mother. **Pediatric Use** Safety and effectiveness in the pediatric population have not been established (see **BOX WARNING and WARNINGS—Clinical Worsening and Suicide Risk**). One placebo-controlled trial in 264 pediatric patients with MDD has been conducted with Lexapro, and the data were not sufficient to support a claim for use in pediatric patients. Anyone considering the use of Lexapro in a child or adolescent must balance the potential risks with the clinical need. **Geriatric Use** Approximately 6% of the 1144 patients receiving escitalopram in controlled trials of Lexapro in major depressive disorder and GAD were 65 years of age or older; elderly patients in these trials received daily doses of Lexapro between 10 and 20 mg. The number of elderly patients in these trials was insufficient to adequately assess for possible differential efficacy and safety measures on the basis of age. Nevertheless, greater sensitivity of some elderly individuals to effects of Lexapro cannot be ruled out. In two pharmacokinetic studies, escitalopram half-life was increased by approximately 50% in elderly subjects as compared to young subjects and C_{max} was unchanged (see **CLINICAL PHARMACOLOGY**). 10 mg/day is the recommended dose for elderly patients (see **DOSE AND ADMINISTRATION**). Of 4222 patients in clinical studies of racemic citalopram, 1357 were 60 and over, 1034 were 65 and over, and 457 were 75 and over. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but again, greater sensitivity of some elderly individuals cannot be ruled out. **ADVERSE REACTIONS** Adverse event information for Lexapro was collected from 715 patients with major depressive disorder who were exposed to escitalopram and from 592 patients who were exposed to placebo in double-blind, placebo-controlled trials. An additional 284 patients with major depressive disorder were newly exposed to escitalopram in open-label trials. The adverse event information for Lexapro in patients with

LEXAPRO® (escitalopram oxalate) TABLETS/ORAL SOLUTION

GAD was collected from 429 patients exposed to escitalopram and from 427 patients exposed to placebo in double-blind, placebo-controlled trials. Adverse events during exposure were obtained primarily by general inquiry and recorded by clinical investigators using terminology of their own choosing. Consequently, it is not possible to provide a meaningful estimate of the proportion of individuals experiencing adverse events without first grouping similar types of events into a smaller number of standardized event categories. In the tables and tabulations that follow, standard World Health Organization (WHO) terminology has been used to classify reported adverse events. The stated frequencies of adverse events represent the proportion of individuals who experienced, at least once, a treatment-emergent adverse event of the type listed. An event was considered treatment-emergent if it occurred for the first time or worsened while receiving therapy following baseline evaluation.

Adverse Events Associated with Discontinuation of Treatment Major Depressive Disorder Among the 715 depressed patients who received Lexapro in placebo-controlled trials, 6% discontinued treatment due to an adverse event, as compared to 2% of 592 patients receiving placebo. In two fixed-dose studies, the rate of discontinuation for adverse events in patients receiving 10 mg/day Lexapro was not significantly different from the rate of discontinuation for adverse events in patients receiving placebo. The rate of discontinuation for adverse events in patients assigned to a fixed dose of 20 mg/day Lexapro was 10%, which was significantly different from the rate of discontinuation for adverse events in patients receiving 10 mg/day Lexapro (4%) and placebo (3%). Adverse events that were associated with the discontinuation of at least 1% of patients treated with Lexapro, and for which the rate was at least twice that of placebo, were nausea (2%) and ejaculation disorder (2% of male patients).

Generalized Anxiety Disorder Among the 429 GAD patients who received Lexapro, 10 mg/day in placebo-controlled trials, 8% discontinued treatment due to an adverse event, as compared to 4% of 427 patients receiving placebo. Adverse events that were associated with the discontinuation of at least 1% of patients treated with Lexapro, and for which the rate was at least twice the placebo rate, were nausea (2%), insomnia (1%), and fatigue (1%).

Incidence of Adverse Events in Placebo-Controlled Clinical Trials Major Depressive Disorder Table 2 enumerates the incidence, rounded to the nearest percent, of treatment-emergent adverse events that occurred among 715 depressed patients who received Lexapro at doses ranging from 10 to 20 mg/day in placebo-controlled trials. Events included are those occurring in 2% or more of patients treated with Lexapro and for which the incidence in patients treated with Lexapro was greater than the incidence in placebo-treated patients. The prescriber should be aware that these figures can not be used to predict the incidence of adverse events in the course of usual medical practice where patient characteristics and other factors differ from those which prevailed in the clinical trials. Similarly, the cited frequencies cannot be compared with figures obtained from other clinical investigations involving different treatments, uses, and investigators. The cited figures, however, do provide the prescribing physician with some basis for estimating the relative contribution of drug and non-drug factors to the adverse event incidence rate in the population studied. The most commonly observed adverse events in Lexapro patients (incidence of approximately 5% or greater and approximately twice the incidence in placebo patients) were insomnia, ejaculation disorder (primarily ejaculatory delay), nausea, sweating increased, fatigue, and somnolence (see TABLE 2).

TABLE 2: Treatment-Emergent Adverse Events: Incidence in Placebo-Controlled Clinical Trials for Generalized Anxiety Disorder* (Lexapro (N=429) and Placebo (N=427)); Autonomic Nervous System Disorders: Dry Mouth (9% and 5%); Sweating Increased (4% and 2%); Central & Peripheral Nervous System Disorders: Dizziness (5% and 3%); Gastrointestinal Disorders: Nausea (15% and 7%); Diarrhea (8% and 5%); Constipation (3% and 1%); Indigestion (3% and 1%); Abdominal Pain (2% and 1%); General: Influenza-like Symptoms (5% and 4%); Fatigue (5% and 2%); Psychiatric Disorders: Insomnia (9% and 4%); Somnolence (6% and 2%); Appetite Decreased (3% and 1%); Libido Decreased (3% and 1%); Respiratory System Disorders: Rhinitis (5% and 4%); Sinusitis (3% and 2%); Urogenital: Ejaculation Disorder† (9% and <1%); Impotence‡ (3% and <1%); Anorgasmia§ (2% and <1%). Events reported by at least 2% of patients treated with Lexapro are reported, except for the following events which had an incidence on placebo > Lexapro: headache, upper respiratory tract infection, back pain, pharyngitis, inflamed injury, anxiety. †Primarily ejaculatory delay. ‡Denominator used was for males only (N=225 Lexapro; N=188 placebo). §Denominator used was for females only (N=490 Lexapro; N=404 placebo).

Generalized Anxiety Disorder Table 3 enumerates the incidence, rounded to the nearest percent of treatment-emergent adverse events that occurred among 429 GAD patients who received Lexapro 10 to 20 mg/day in placebo-controlled trials. Events included are those occurring in 2% or more of patients treated with Lexapro and for which the incidence in patients treated with Lexapro was greater than the incidence in placebo-treated patients. The most commonly observed adverse events in Lexapro patients (incidence of approximately 5% or greater and approximately twice the incidence in placebo patients) were nausea, ejaculation disorder (primarily ejaculatory delay), insomnia, fatigue, decreased libido, and anorgasmia (see TABLE 3).

TABLE 3: Treatment-Emergent Adverse Events: Incidence in Placebo-Controlled Clinical Trials for Generalized Anxiety Disorder* (Lexapro (N=429) and Placebo (N=427)); Autonomic Nervous System Disorders: Dry Mouth (9% and 5%); Sweating Increased (4% and 2%); Central & Peripheral Nervous System Disorders: Headache (24% and 17%); Paresthesia (2% and 1%); Gastrointestinal Disorders: Nausea (18% and 8%); Diarrhea (8% and 6%); Constipation (5% and 4%); Indigestion (3% and 2%); Vomiting (3% and 1%); Abdominal Pain (2% and 1%); Flatulence (2% and 1%); Toothache (2% and 0%); General: Fatigue (8% and 2%); Influenza-like symptoms (5% and 4%); Musculoskeletal: Neck/Shoulder Pain (3% and 1%); Psychiatric Disorders: Somnolence (13% and 7%); Insomnia (12% and 6%); Libido Decreased (7% and 2%); Dreaming Abnormal (3% and 2%); Appetite Decreased (3% and 1%); Lethargy (3% and 1%); Yawning (2% and 1%); Urogenital: Ejaculation Disorder‡ (14% and 2%); Anorgasmia§ (6% and <1%); Menstrual Disorder (2% and 1%). Events reported by at least 2% of patients treated with Lexapro are reported, except for the following events which had an incidence on placebo > Lexapro: inflamed injury, dizziness, back pain, upper respiratory tract infection, rhinitis, pharyngitis. †Primarily ejaculatory delay. ‡Denominator used was for males only (N=182 Lexapro; N=195 placebo). §Denominator used was for females only (N=247 Lexapro; N=232 placebo).

Dose Dependency of Adverse Events The potential dose dependency of common adverse events (defined as an incidence rate of ≥5% in either the 10 mg or 20 mg Lexapro groups) was examined on the basis of the combined incidence of adverse events in two fixed-dose trials. The overall incidence rates of adverse events in 10 mg Lexapro-treated patients (66%) was similar to that of the placebo-treated patients (61%), while the incidence rate in 20 mg/day Lexapro-treated patients was greater (86%).

Table 4 shows common adverse events that occurred in the 20 mg/day Lexapro group with an incidence that was approximately twice that of the 10 mg/day Lexapro group and approximately twice that of the placebo group. **TABLE 4: Incidence of Common Adverse Events* in Patients with Major Depressive Disorder Receiving Placebo (N=511), 10 mg/day Lexapro (N=310), 20 mg/day Lexapro (N=125): Insomnia (4%, 7%, 14%); Diarrhea (5%, 6%, 14%); Dry Mouth (3%, 4%, 9%); Somnolence (1%, 4%, 9%); Dizziness (2%, 4%, 7%); Sweating Increased (<1%, 3%, 8%); Constipation (1%, 3%, 6%); Fatigue (2%, 2%, 6%); Indigestion (1%, 2%, 6%).** Adverse events with an incidence rate of at least 5% in either of the Lexapro groups and with an incidence rate in the 20 mg/day Lexapro group that was approximately twice that of the 10 mg/day Lexapro group and the placebo group.

Male and Female Sexual Dysfunction with SSRIs Although changes in sexual desire, sexual performance, and sexual satisfaction often occur as manifestations of a psychiatric disorder, they may also be a consequence of pharmacologic treatment. In particular, some evidence suggests that SSRIs can cause such untoward sexual experiences. Reliable estimates of the incidence and severity of untoward experiences involving sexual desire, performance, and satisfaction are difficult to obtain, however, in part because patients and physicians may be reluctant to discuss them. Accordingly, estimates of the incidence of untoward sexual experience and performance cited in product labeling are likely to underestimate their actual incidence. **Table 5** shows the incidence rates of sexual side effects in patients with major depressive disorder and GAD in placebo-controlled trials.

TABLE 5: Incidence of Sexual Side Effects in Placebo-Controlled Clinical Trials (In Males Only: Lexapro (N=407) and Placebo (N=383); Ejaculation Disorder (primarily ejaculatory delay) (12% and 1%); Libido Decreased (6% and 2%); Impotence (2% and <1%). (In Females Only: Lexapro (N=737) and Placebo (N=636): Libido Decreased (3% and 1%); Anorgasmia (3% and <1%) There are no adequately designed studies examining sexual dysfunction with escitalopram treatment. Priligam has been reported with all SSRIs. While it is difficult to know the precise risk of sexual dysfunction associated with the use of SSRIs, physicians should routinely inquire about such possible side effects.

Vital Sign Changes Lexapro and placebo groups were compared with respect to (1) mean change from baseline in vital signs (pulse, systolic blood pressure, and diastolic blood pressure) and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses did not reveal any clinically important changes in vital signs associated with Lexapro treatment. In addition, a comparison of supine and standing vital sign measures in subjects receiving Lexapro indicated that Lexapro treatment is not associated with orthostatic changes. **Weight Changes** Patients treated with Lexapro in controlled trials did not differ from placebo-treated patients with regard to clinically important change in body weight. **Laboratory Changes** Lexapro and placebo groups were compared with respect to (1) mean change from baseline in various serum chemistry, hematology, and urinalysis variables, and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses revealed no clinically important changes in laboratory test parameters associated with Lexapro treatment.

ECG Changes Electrocardiograms from Lexapro (N=625), racemic citalopram (N=351), and placebo (N=527) groups were compared with respect to (1) mean change from baseline in various ECG parameters and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses revealed (1) a decrease in heart rate of 2.2 bpm for Lexapro and 2.7 bpm for racemic citalopram, compared to an increase of 0.3 bpm for placebo and (2) an increase in QTc interval of 3.9 msec for Lexapro and 3.7 msec for racemic citalopram, compared to 0.5 msec for placebo. Neither Lexapro nor racemic citalopram were associated with the development of clinically significant ECG abnormalities.

Other Events Observed During the Premarketing Evaluation of Lexapro Following is a list of WHO terms that reflect treatment-emergent adverse events, as defined in the introduction to the ADVERSE REACTIONS section, reported by the 1428 patients treated with Lexapro for periods of up to one year in double-blind or open-label clinical trials during its premarketing evaluation. All reported events are included except those already listed in Tables 2 & 3, those occurring in only one patient, event terms that are so general as to be uninformative, and those that are unlikely to be drug related. It is important to emphasize that, although the events reported occurred during treatment with Lexapro, they were not necessarily caused by it. Events are further categorized by body system and listed in order of decreasing frequency according to the following definitions: frequent adverse events are those occurring on one or more occasions in at least 1/100 patients; infrequent adverse events are those occurring in less than 1/100 patients but at least 1/1000 patients.

Cardiovascular - Frequent: palpitation, hypertension. Infrequent: bradycardia, tachycardia, ECG abnormal, flushing, varicose vein. Central and Peripheral Nervous System Disorders - Frequent: light-headed feeling, migraine. Infrequent: tremor, vertigo, restless legs, shaking, twitching, dysequilibrium, tics, carpal tunnel syndrome, muscle contractions involuntary, sluggishness, coordination abnormal, faintness, hyperreflexia, muscular tone increased. Gastrointestinal Disorders - Frequent: heartburn, abdominal cramp, gastroenteritis. Infrequent: gastroesophageal reflux, bloating, abdominal discomfort, dyspepsia, increased stool frequency, belching, gastritis, hemorrhoids, gagging, polyposis gassy, swallowing difficulty. General - Frequent: allergy, pain in limb, fever, hot flashes, chest pain. Infrequent: edema of extremities, chills, tightness of chest, leg pain, asthenia, syncope, malaise, anaphylaxis, fall. Hemic and Lymphatic Disorders - Infrequent: bruise, anemia, nosebleed, hematoma, lymphadenopathy cervical. Metabolic and Nutritional Disorders - Frequent: increased weight. Infrequent: decreased weight, hyperglycemia, thirst, bilirubin increased, hepatic enzymes increased, gout, hypercholesterolemia. Musculoskeletal System Disorders - Frequent: arthralgia, myalgia. Infrequent: jaw stiffness, muscle cramp, muscle stiffness, arthritis, muscle weakness, back discomfort, arthropathy, jaw pain, joint stiffness. Psychiatric Disorders - Frequent: appetite increased, lethargy, irritability, concentration impaired. Infrequent: jetiriness, panic reaction, agitation, apathy, forgetfulness, depression aggravated, nervousness, restlessness aggravated, suicide attempt, amnesia, anxiety attack, bruxism, carbohydrate craving, confusion, depersonalization, disorientation, emotional lability, feeling unreal, tremulousness nervous, crying abnormal, depression, excitability, auditory hallucination, suicidal tendency, Reproductive Disorders/Female - Frequent: menstrual cramps, menstrual disorder. Infrequent: menorrhagia, breast neoplasm, pelvic inflammation, premenstrual syndrome, spotting between menses. *% based on female subjects only. N=905

Respiratory System Disorders - Frequent: bronchitis, sinus congestion, coughing, nasal congestion, sinus headache. Infrequent: asthma, breath shortness, laryngitis, pneumonia, tracheitis. Skin and Appendages Disorders - Frequent: rash. Infrequent: pruritus, acne, alopecia, eczema, dermatitis, dry skin, folliculitis, lipoma, furunculosis, dry lips, skin nodule. Special Senses - Frequent: vision blurred, tinnitus. Infrequent: taste alteration, earache, conjunctivitis, vision abnormal, dry eyes, eye irritation, visual disturbances, eye infection, pupils dilated, metallic taste. Urinary System Disorders - Frequent: urinary frequency, urinary tract infection. Infrequent: urinary urgency, kidney stone, dysuria, blood in urine. Events Reported Subsequent to the Marketing of Escitalopram - Although no causal relationship to escitalopram treatment has been found, the following adverse events have been reported to have occurred in patients and to be temporally associated with escitalopram treatment during post marketing experience and were not observed during the premarketing evaluation of escitalopram: abnormal gait, acute renal failure, aggression, akathisia, allergic reaction, anger, angioedema, atrial fibrillation, choreoathetosis, delirium, delusion, diplopia, dysarthria, dyskinesia, dystonia, echymosis, erythema multiforme, extrapyramidal disorders, fulminant hepatitis, hepatic failure, hypoesthesia, hypoglycemia, hypokalemia, IRR increased, gastrointestinal hemorrhage, glaucoma, grand mal seizures (or convulsions), hemolytic anemia, hepatic necrosis, hepatitis, hypotension, leucopenia, myocardial infarction, myoclonus, neuroleptic malignant syndrome, nightmare, nystagmus, orthostatic hypotension, pancreatitis, paranoia, photosensitivity reaction, prapris, prolactinemia, prothrombin decreased, pulmonary embolism, QT prolongation, rhabdomyolysis, seizures, serotonin syndrome, SIADH, spontaneous abortion, Stevens Johnson Syndrome, tardive dyskinesia, thrombocytopenia, thrombosis, torsade de pointes, toxic epidermal necrolysis, ventricular arrhythmia, ventricular tachycardia and visual hallucinations.

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Group at the Robert Wood Johnson Foundation.

Several studies have shown that Americans without health insurance live sicker and die earlier than their insured counterparts. Often lacking access to primary and preventive care, 18,000 uninsured individuals die from treatable conditions every year, according to an Institute of Medicine (IOM) report. They also end up taking more sick days from work, costing U.S. companies millions of dollars a year in lost productivity.

Confirming those previous findings, a recent study published in the *Journal of the American Medical Association* found that after being injured or experiencing the first symptoms of a chronic condition, uninsured individuals are less likely to go to a doctor than insured patients. When they do seek medical attention, they are less likely to go for follow-up visits or to fill prescriptions.

These findings are especially troubling given that about 15 million of the uninsured have a chronic illness, says Dr. Lumpkin.

“Of those 15 million, half delay their care and will tend to show up in the emergency department or elsewhere, requiring much more expensive care. We don’t have a system where those kinds of costs just disappear. They are borne by society,” he says.

Worsening Crisis

The trend over the past several decades has been a slow, steady decline in the number of people who are covered by private health insurance, either provided through an employer or purchased on the individual market. That decline has been accompanied by a gradual increase in the number of people without health insurance.

While the overall increase in the number of uninsured Americans has been somewhat mitigated by rising enrollment in public coverage—mainly the State Children’s Health Insurance Program (SCHIP)—adults have been hit hard by the shift in the economy.

“SCHIP has helped to reduce the number of uninsured children,” says Peter Cunningham, senior fellow with the Center for Studying Health System Change (HSC) in Washington, DC. “It has more than offset the decline in private insurance coverage. Of course, that has impacted children much more than adults. Most of the growth in the uninsured over the past ten years or so has been among adults.”

Several studies have shown that when parents are covered, they are more likely to access the healthcare system for their children. Even so, under current rules, eligibility requirements are usually stricter for parents than for their children; and recently, many states have been rolling back some expanded-access efforts as part of broader cost-control measures.

The Bush administration and many Republican lawmakers have opposed recent attempts to expand SCHIP. They argue Democrats are trying to use the program in a broader effort to shift more Americans into public coverage. SCHIP already covers most eligible children; and raising the income level will only result in switching children who already have private coverage into the program, Health and Human Services Secretary Mike Leavitt has stated.

Between 2000 and 2005, nearly 4.5 million Americans under age 65 lost employer-provided coverage. If coverage rates had remained at 2000 levels, as many as 8.2 million more people would have been expected to have employer-provided health insurance in 2005, according to an analysis by the Economic Policy Institute.

Employer-based health insurance constitutes the bulk of health coverage in this country. However, rising costs have forced many small employers to drop benefits and many large employers to raise the amount that workers must contribute, making the benefit too expensive for some low-income families.

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Uninsured Access

Despite those erosions in both public and private coverage, some physicians are still making efforts to provide access for the uninsured. According to a recent study, slightly fewer than half of uninsured patients are either seeing or know of a physician in their community who offers discounts or lower prices for patients paying cash. For the most part these were physicians

either in an office-based setting or working at a community health center. Only a small percentage of respondents named hospital outpatient or emergency departments as access points.

But such access is not consistent across communities, says HSC's Peter Cunningham. "Some communities have very well-developed safety nets where access is, I hate to say good, but relatively good, while other communities have very little available there in terms of an organized safety net," says Mr. Cunningham.

Despite that inconsistency, the safety net system remains a crucial component of access for the uninsured.

Over the past few years, much of the federal policy has focused on buoying the system through large boosts in funding for federally qualified health centers. More commonly referred to as community health centers, these serve large shares of the uninsured with the help of annual grants from the federal government and enhanced Medicaid payments from the states. There are currently more than 1,000 community health centers, and with many having multiple locations, they serve around 15 million patients a year in 5,000 communities. That is up from around 3,300 sites and a little over 10 million patients in 2001.

Despite that growth, there are still many communities in which uninsured patients have no access to health centers or other low-cost medical services. More than half of uninsured patients don't have a primary care provider. The situation is worse in some states than others. In Minnesota, for example, 18 percent of the uninsured don't have a primary care provider, while in Texas it's 60 percent, according to a report from the National Association of Community Health Centers.

However, perhaps the biggest problem for uninsured patients is getting access to specialty care. Uninsured patients who do receive care from primary care physicians and are referred for specialty care often have a lot of difficulty finding a specialist who will see them in a timely manner. They also tend to have difficulty getting tests, procedures, or even treatments that are requested by their physician.

"There is a severe problem in terms of their ability to get needed services," Mr. Cunningham explains. "A lot of times there are just certain medical groups or certain specialists who don't provide any charity care in the community. [For those who

Sharing the Burden

Many Americans with health insurance are finding it easier these days to identify with the plight of the uninsured. Pressured by rising healthcare costs, more companies are encouraging employees to switch to high-deductible health plans, which generally feature lower premiums but more out-of-pocket expenses.

Between January 2005 and January 2006, enrollment in so-called consumer-directed health plans jumped from 3 million to between 5 and 6 million, according to the Government Accountability Office (GAO). The GAO concludes that it is too early to determine whether these plans reduce overall healthcare spending, but other studies suggest they may contribute to an epidemic of medical debt.

According to Harvard researchers, nearly half of bankruptcies in the United States are due at least in part to unpaid medical bills. And researchers at the Commonwealth Fund estimate that, in 2003, nearly one in three Americans (estimated 61 million people) reported having problems paying medical bills. One in five had been contacted by a collection agency about these bills, and one in seven had “changed their life significantly” in order to pay medical bills.

The problem seems to be getting worse, says Carol Pryor, a senior policy analyst for the Access Project, a Boston-based group that studies the situations of the uninsured and under-insured.

Based on interviews conducted by the Project and researchers from Brandeis University, many insured patients are feeling the pain of an increasingly unaffordable healthcare system. “Even when people are paying for health insurance, paying their premiums, they still seem unable to afford care,” she says.

While many of the out-of-pocket costs associated with these plans seem relatively modest, they can add up over time for those with chronic illness.

While there are anecdotal reports that physicians are seeing more unpaid bills, a recent study by the Center for Studying Health System Change (HSC), a policy research organization funded by the Robert Wood Johnson Foundation, found that only about 40 percent consider patients’ out-of-pocket costs when recommending diagnostic tests. However, 80 percent of physicians consider co-pays when prescribing medicines.

“Most physicians reported routinely considering insured patients’ out-of-pocket costs in clinically straightforward prescribing decisions,

but only half or fewer do so in more complex situations that allow greater clinical discretion,” says Hoangmai Pham, MD, MPH, a senior health researcher at HSC.

The out-of-pocket costs that result from the latter can cause a rift in the physician’s relationship with patients, says Ms. Pryor. “When people were left with these bills that the insurance wouldn’t cover, they were...often really outraged at the prices for services and felt abused by the providers. They may have felt that they received very good care, but also really felt that they were being inappropriately charged,” she says. The uninsured often get charged much more than the discounted prices negotiated by insurance companies, but even those with insurance often feel that prices are too high. “These policies are not good for consumers, but they are a real problem for doctors as well, both in terms of their ability to be reimbursed for services and in terms of their relationship with their patients,” Ms. Pryor says.

Even middle-income households are increasingly feeling the pain of rising costs due to increasingly common cost-shifting mechanisms such as higher deductibles and caps on coverage.

“Those can really be a problem for somebody who experiences some kind of catastrophic medical event. The people we spoke to with those kinds of problems often owed \$100,000 or more,” she says. Many patients also reported receiving bills for services they thought were covered or should have been covered.

“A very common problem that we saw was that people who had higher co-payments for out-of-network fees were careful to go to a hospital that was in their network, but nobody told them that the doctors were out of network,” she says.

New restrictions, rules, and deductibles have made it harder for people to figure out what is and isn’t covered, and explanations of benefits are so confusing that they are often of little help.

“There are a myriad of ways for people to get caught in the middle between confusing insurance policies and practice and difficult-to-understand provider billing and collection practices that leave people at risk,” Ms. Pryor says.

When faced with doctor’s bills they can’t pay, insured patients tend to behave like the uninsured. Almost 30 percent of both uninsured people and privately insured people with medical debt postpone care due to cost. That compares with only 6 percent of the privately insured who don’t have any medical debt.

do provide care], there is a long queue of patients waiting to see them, so it may take a lot longer” to get an appointment, he says.

There are also signs that access to primary care is also beginning to degrade, he says. “Piecing together information both from studies that we do, as well as from talking to people out in the communities, there is a sense that it is getting harder for the uninsured,” Mr. Cunningham says.

Although traditionally, physicians were the main source of charity care in their communities, this is changing. For many physicians, payment rates are holding steady or even dropping while their practice operating costs continue to rise.

“These days there are very few physicians who can set their own fees because their fees are set by Medicare and Medicaid. And today virtually all private insurers negotiate discounted fees with physicians,” Mr. Cunningham says. This makes it more difficult for physicians to build into their fees extra income that helps pay for charity care. “It is much more difficult today for physicians to do those cross-subsidies,” he says.

Shifting Perspectives

The rising cost of health coverage means that middle-class families are increasingly being affected. More middle-class families are being hit with out-of-pocket costs that effectively diminish their access to the healthcare system.

“It’s not just an issue of the uninsured, although certainly people feel frustration that we can’t get on top of that problem as a nation, but it’s also frustration with the fact that they are paying more and more for health insurance and getting less and less for it,” says Kathleen Stoll, JD, director of health policy for FamiliesUSA, a nonprofit healthcare advocacy organization based in Washington, DC.

An annual poll conducted by the Robert Wood Johnson Foundation suggests that concerns about paying more for health care have quickly given way to concerns about having health care at all, says Dr. Lumpkin. “The political environment is in the process of shifting,” he says.

People are getting more concerned about the stability and adequacy of employer-based coverage, says Judith Feder, PhD, Dean of Georgetown University’s Public Policy Institute.

Many employers confronted with the exploding price of health insurance have reduced benefits, increased cost sharing, or both. This has hit low-income workers the hardest, but many middle-income families are also feeling squeezed. “They really are concerned, not only about money taken out of their paycheck, but what they are paying out of pocket. They’re also concerned about the way their benefits are structured. There is a lot more fine print in policies, in plan, out of plan; they don’t know which doctor is covered, whether the doctor will see them,” says Dr. Feder.

The difference between the insured and uninsured has become less like a dichotomy and more like a continuum—instead of breaking down to the have’s and the have-not’s, there’s a realization that all health insurance is not created equal. There is a growing awareness even

“It’s not just an issue of the uninsured, although certainly people feel frustration that we can’t get on top of that problem as a nation, but it’s also frustration with the fact that they are paying more and more for health insurance and getting less and less for it,” says Kathleen Stoll, JD, director of health policy for FamiliesUSA.

among the insured about what their health insurance doesn’t cover, says Ms. Stoll. “This is not just an issue of altruism for those of us who have health insurance. It’s an issue that hits every voter in the pocketbook. Even for those with health insurance, there is a growing sense of health insecurity...that their insurance won’t cover the care they need and that there is more and more that they have to pay out of their own pockets,” she says.

Those concerns continue to raise the political profile of the uninsured. Experts expect that the debate over what to do about the uninsured will play a major role in the presidential elections next year. Already, several presidential hopefuls have laid out detailed health-reform proposals. (See “Campaign Promises.”)

While many policy experts believe that a single-payer system is still not politically realistic, more and more people are talking about universal coverage. The idea that building a better system includes providing access for virtually everyone has gained a lot of ground, says Dr. Feder. “When you talk about universal coverage, you are talking about securing coverage for people who feel they are losing it, but you’re also talking about getting it for

Campaign Promises

Healthcare access is a rising concern among voters and is expected to play a prominent role in the 2008 presidential race. While the conventional wisdom is that major reforms will not happen in a presidential election year, several of the hopefuls have already revealed broad proposals meant to address concerns about the cost and accessibility of the U.S. healthcare system. Throughout this chapter we highlight some of the major points of candidates who had released healthcare positions at press time.

Democratic Sen. Hillary Clinton of New York

Plan would

- create a national benefit program in which both the currently insured and the uninsured could participate.
- offer health-insurance tax credits to help individuals, families and small businesses.
- require insurers to provide benefits at a reasonable price for anyone who applies and pays their premiums.
- offer physicians financial incentives to adopt health information technology.
- promote prevention services and chronic-care coordination models and management programs.
- establish a “Best-Practices” Institute to produce treatment comparisons.
- streamline approval of generic drugs and biologics.
- reduce pay to Medicare Advantage plans.

Democratic Sen. John Edwards from North Carolina

Plan would

- create state-run Regional Health Markets subsidized by the federal government.
- require companies to offer comprehensive benefits or pay into regional health markets.
- provide refundable tax credits for low-income families on a slide-scale basis.
- expand Medicaid and SCHIP.
- mandate guaranteed issue with fair rates.
- require insurers to offer coverage for preventive and chronic-care services with limits on cost-sharing arrangements.
- create a “Consumer Reports” for health care.

those who don't have it," she says.

The sense that people are increasingly at risk of losing their health insurance and access to the healthcare system makes it much harder to convincingly say "no" when someone proposes coverage for all. "It's a much iffier world for folks," says Dr. Feder. "What has always been in the way of moving toward universal coverage is that when a particular plan or proposal is on the table and gets resoundingly and aggressively attacked by stakeholders, as it often does, it's very easy to scare people who have health insurance that they are going to be worse off. But now those people are starting to question whether the status quo is acceptable."

Strange Bedfellows

Workers are not the only ones worried about this. Employers are becoming increasingly concerned that the rising price of health care is an unsustainable trend. Not only have they been hit by rising premiums, but they have to deal with the economic impact of lost work time when employees get sick and cannot see a doctor.

Those worries have helped to motivate them and other stakeholders to form a spate of new and surprising partnerships that bring together the shared concerns, but often differing points of view, of patient advocates and corporate interests. These so-called "strange bedfellows alliances" are fused with the simple acknowledgment that while everyone has a first choice, the second choice may be better than the status quo.

"Too often, particularly around the issue of the uninsured, we have seen the perfect acting as the enemy of the good. Because no solution is perfect, we end up doing nothing. Now, the only option that is not workable is doing nothing," says Dr. Lumpkin.

That is one more sign that there is a new impetus for reform. While this is not the first time that diverse groups have come together, they are more motivated than ever before, says Ms. Stoll. "FamiliesUSA worked with the insurance industry and the hospitals six or seven years ago to develop a proposal that, at that time, did not move, but was a proposal that we could all agree to," she says.

However, the coalitions may be even stranger this time, she

Campaign Promises

Republican Rudolph Giuliani, former Mayor of New York City

Plan would

- allow a tax exclusion of up to \$15,000 for the purchase of health insurance for individuals without employer-based coverage.
- create a tax credit for the purchase of health insurance for low-income individuals.
- give states block grants to devise approaches for reducing costs and finding coverage for the uninsured.
- allow individuals to purchase health insurance across state lines if affordable coverage isn't available locally.
- lower the regulatory barriers for setting up a health savings account.
- launch an initiative designed to promote healthy lifestyles and preventive care programs.

Democratic Sen. Barack Obama from Illinois

Plan would

- create a national health plan with guaranteed issue, comprehensive benefits, and affordable rates.
- subsidize health insurance for low-income workers.
- establish a National Health Insurance Exchange to act as a watchdog over private insurers.
- require companies that don't offer health benefits to contribute to the national health plan.
- expand Medicaid and SCHIP.

Democrat Bill Richardson, Governor of New Mexico

Plan would

- allow individuals to enter the Medicare program ten years earlier, at age 55.
- allow young adults, up to age 25, to stay on their parents' health insurance.
- eliminate health insurers' use of pre-existing-conditions clauses to deny coverage.
- require insurers to use at least 85 percent of premiums on health services.
- create incentives for preventive health care.
- create new tax breaks for companies and individuals for the purchase of health coverage.

says. This time around, FamiliesUSA has joined a group that includes health insurers, pharmaceutical companies, business groups, consumer advocates, doctors, and hospitals.

“Many of us have thought the situation was at the crisis breaking point for many years. But I think this is really a different time in history, she says. “I have been working in healthcare policy for more years than I would like to admit, but I feel that the proliferation of ‘strange-bedfellow’ groups coming together and having really good, honest dialogue and trusting relationships around crafting solutions that involve compromise, no matter what side of the ideological spectrum you are coming from, is different from what we have seen before. There is a different tone; it’s less adversarial,” says Ms. Stoll.

“The diverse players are all very sincere about wanting to address the problem of the 45 million [as of 2005] uninsured in the country. There is a point where ideological differences about how to do that come into play, but there are also ways to bridge those differences,” says Ms. Stoll.

Another group includes the highly unlikely partnerships between the mega-retailer Wal-Mart and one of the largest labor groups in the world, the Service Employees International Union (SEIU).

“What unites us to be here today, and will continue to hold us together, is our belief that it will be a far greater America when we finally get health care for every man, woman, and child,” Andy Stern, president of SEIU, said in a statement.

Elements of Compromise

The various stakeholders appear unlikely to agree on what an ideal system would look like, but there is a growing consensus over which elements are absolutely necessary. “Instead of focusing on where we may have some differences—and there certainly are differences, no question about it—we tried to focus on where we had commonality,” says Ms. Stoll.

“The diverse players are all very sincere about wanting to address the problem of the 45 million [as of 2005] uninsured in the country. There is a point where ideological differences about how to do that come into play, but there are also ways to bridge

those differences,” she says.

The basic difference is whether to cover the uninsured through public programs, such as Medicare and Medicaid, or to rely on private industry to provide access to health care. However, these groups have discovered that the stakeholders may be able to agree on an approach that balances the two.

“Whether you want to rely on the government, public pro-

Campaign Promises

Republican Mitt Romney, former Governor of Massachusetts

Plan would

- encourage states to reduce the number of regulations imposed on the private health insurance market and implement other reforms designed to foster low-price options.
- redirect healthcare dollars that currently subsidize free or low-cost care for the uninsured into programs that help low-income families purchase private health insurance.
- expand access to health savings accounts and tax benefits to individuals and families that purchase health insurance in the private market. Both HSA and tax deductions for health coverage are currently available only to individuals who receive health coverage through an employer.
- allow Americans to deduct the full cost of their health insurance and out-of-pocket medical expenses if they are covered by an indemnity plan.
- convert Medicaid to a block-grant system so that states have more flexibility and incentive to innovate how they run the program. (States currently receive federal matching dollars for any money they spend on the program. Under a block-grant, they would receive a lump sum each year, likely based on how many low-income families lived in the state.)

Republican Tommy Thompson, former Secretary of Health and Human Services

Plan would

- build a system that focuses more energy on disease prevention than on treatment.
- use information technology to cut costs and reduce medical errors.
- require states to form purchasing pools to negotiate prices for health insurance for those who cannot otherwise obtain coverage.

gram-type approaches, or go with more of a private-sector, unregulated, competitive model, we felt that there were ways to have both of those elements of ideology wedded together in a hybrid plan that would advance coverage for the uninsured and break the ideological gridlock," she says.

Early this year, FamiliesUSA along with its partners in the Health Coverage Coalition for the Uninsured published an agreement that includes a two-phased approach. Phase one is to cover all children; and phase two, adults. The approach represents a seemingly straightforward compromise, but one that has been hard won, given the strong and often opposed forces that have had to come together to reach it.

Once SCHIP reauthorization is taken care of, the group intends to begin working on the much larger problem of uninsured adults. That may be difficult to achieve in 2008, as the conventional wisdom is that major reforms are never passed in a presidential election year.

"The challenge is going to be keeping those relationships with diverse folks strong and moving forward. That is an important focus for next year, but I don't think you will see legislative action in 2008. I think you could see it happen very quickly in 2009," she says.

With growing public support for change, the elements for reform are already beginning to fall in place. "There are a lot of ideas floating around. Congress won't have to go very far or look very hard to find a solution. They just have to want to do it," says Dr. Lumpkin.

Everyone seems to agree that whatever that solution involves, it will have to include all parties to be successful. "The ballgame here is getting everybody in a system," says Dr. Feder.

That is fundamental, agreed Ms. Stoll. "Ultimately that is what insurance is," she says. "As a concept, it is a system where you share risk. I pay into the system now so that when I am older or sicker and need health care, I won't have to be bankrupted by that," she says.

That has important implications for policy, especially in terms of establishing good pooling mechanisms, which very likely will require regulation of insurance rates.

Reform efforts will inevitably include some cost controls, says

Dr. Feder. “We’re talking value for the dollar, which means making sure doctors have the information they need in ways they can use it about what works and what doesn’t,” she says. That could include an agency responsible for conducting comparative effectiveness reviews, something that has recently gained support within the research community.

“And then you have to talk about how you put in incentives,” she says. That could include pay-for-performance programs or some other mechanism for rewarding physicians for better outcomes.

Counting the Uninsured

Last March, the Census Bureau released a revised estimate of the number of Americans who went without health insurance in 2005. The new statistic, 44.8 million people—or just over 15 percent of the population—was about 1.8 million lower than the Bureau had reported in August 2006. The revised estimate differs by less than one percent from the original 2005 estimate of 46.6 million, or just under 16 percent of the population.

“We are committed to ensuring that the nation has the most accurate numbers we can provide in a timely manner,” says Howard Hogan, Census Bureau associate director for demographic programs.

The accuracy is welcome, but what the new number doesn’t change is the scale of the problem, says Karen Davis, president of the Commonwealth Fund, a private foundation that supports research on healthcare issues and provides grants for projects designed to improve healthcare practice and policy. “Few could argue that 44.8 million people living without insurance are an acceptable number, particularly in a nation that spends nearly twice as much per capita on health care as any other country,” she said in a statement.

The new number also does not change the rate at which the ranks of the uninsured grew. According to the bureau, the correction would likely be relatively constant over the previous years.

This is not the first time that the process for counting the uninsured has been the subject of debate. Although designed to determine how many people have no insurance for the entire year, the Census’s statistics are generally considered more an estimate of the number of Americans who are without insurance at a single point in time during the year.

Some experts have suggested that a more telling gauge of the uninsured population would be to look at how many people go without

Incremental Reform

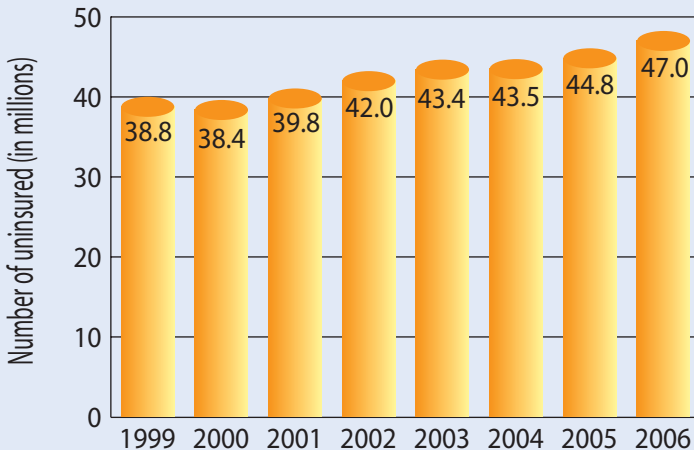
The goals are ambitious, but change may not come all at once. There are a number of policy options that are being discussed, and most experts expect that changes to the healthcare system will be incremental.

While the overall impact has been modest, the most significant reform of the past couple of years has been the creation of Health Savings Accounts (HSAs) as part of the 2003 passage of the Medicare Modernization Act. HSAs allow companies and their employees to establish an account from which the worker

coverage at any point during the year. That would push the number much higher, with possibly as many as 70 million people going without insurance at some point each year.

In fact, another argument is that many people go without insurance temporarily, perhaps for a month or two, when changing jobs or going through some other transition. Based on that, the more relevant statistic would be how many people are uninsured for an entire year. That, of course, gives a much lower estimate: around 30 million without insurance.

How Many Uninsured



Source: U.S. Census Bureau.

can draw money to pay for medical services. By law, they must be attached to a conventional, high-deductible insurance policy.

As of the beginning of the year, enrollment—which includes individuals or families—was up to about 4.5 million. Of the 1.1 million plans established in the individual market, a little more

Tax credits are one more policy proposal that has a number of supporters, including some physicians and public advocacy groups. This idea would make the tax treatment of health insurance within the individual market more like what it is in the group market, where employers receive a tax break for health benefits.

than a quarter (27 percent) were set up by people who were previously uninsured, according to America's Health Insurance Plans, a Washington-based trade group for private health insurers.

However, estimates on the overall impact on the market suggest that because HSAs are more attractive to healthier individuals, they could actually hasten premium increases and

ultimately push the number of uninsured higher.

Despite those concerns, the White House and some in Congress have been pushing to expand the HSA initiative by making the accounts more attractive through tax deductions or credits and lessening restrictions on contributions to them.

Another proposal that has been hotly debated in Washington is the idea of Association Health Plans, also known as Small-Business Health Plans. Over the past several years, several pieces of legislation have been introduced that would allow nationally recognized associations to set up health plans across state lines but regulated under federal rules, not unlike the way many large companies are set up. This would allow associations to pool their members and give them not only better economy of scale but more negotiating power over insurers, proponents say.

However, opponents of these proposals argue that, by removing oversight of state regulators, association health plans are more susceptible to insolvency and scams that ultimately will leave workers without any coverage.

Tax credits are one more policy proposal that has a number of supporters, including some physicians and public advocacy groups. This idea would make the tax treatment of health insurance within the individual market more like what it is in the

group market, where employers receive a tax break for the cost of health benefits. By making it refundable and advanceable, a tax credit would also enable more low-income families to purchase health insurance.

There are also several proposals to expand access to public coverage through Medicaid and SCHIP by increasing financial support and providing the states with more flexibility in how they run the programs. Most experts believe that, ultimately, coverage expansion efforts will bubble up from the states.

Laboratories for Reform

While partisan politics has largely stood in the way of federal action on the uninsured, legislatures in a lot of states have had more success moving forward with some bold reforms.

“A lot of the states are moving ahead because they see that the federal government is really kind of paralyzed politically,” says Mr. Cunningham. “The debate is very polarized [in Washington] in terms of how to reform health care. There is a lot of interest in the government, but there is no consensus.”

State lawmakers are also closer to the problem, he points out. “They see the effects that it has, not only on the people in the state, but on healthcare providers who have to eat a lot of bad debt,” he says.

It is much easier for states to make changes and adjustments to reform plans, but financing them is more difficult. “What they are running into is that it is going to be hard to do that without a national solution, without looking at how we’re going to fund the coverage of the 45 million Americans [as of 2005] who have no health insurance,” says Dr. Lumpkin.

States will not be able to support these efforts on their own, but they have shown that reform is possible. “Through state experimentation, the nation is learning about what types of reforms work and what types don’t work,” he says.

State efforts are already helping to answer questions such as how much individuals can be expected to contribute financially toward their own coverage and how willing they may be to participate without mandates of some kind. “All of those are important components that will need to be debated if we ever go to a national solution,” says Dr. Lumpkin.