

Childbirth Is a Top Expense for Illegal Immigrants

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WASHINGTON — The first study of emergency Medicaid expenditures for illegal immigrants shows that childbirth is the most expensive component. However, at least in North Carolina, that expense amounted to less than 1% of the state's Medicaid budget, showing that state and federal authorities are not pouring huge amounts of dollars into providing care for

undocumented immigrants, Dr. C. Annette DuBard, the study's lead author, said at a media briefing presented by the Journal of the American Medical Association.

With debate growing over whether states should pay for illegal immigrants' health care, Dr. DuBard, a research associate at the University of North Carolina at Chapel Hill and Dr. Mark W. Massing of the Carolinas Center for Medical Excellence in Cary, N.C., set out to document the expenditures. They published

their results in a special issue of JAMA devoted to access to care issues (JAMA 2007;297:1085-92).

North Carolina experienced a 274% increase in its foreign-born population during the 1990s. From 2001 to 2004, 48,000 undocumented immigrants received emergency Medicaid services in North Carolina. Overall, spending rose from \$41 million in 2001 to \$53 million in 2004.

Childbirth and complications of pregnancy accounted for 86% of total expen-

ditures in 2001, dropping to 82% in 2004. Given that most children born to illegal immigrants are granted citizenship, it "calls into question the rationale of excluding this population from comprehensive contraceptive and prenatal care coverage," the authors said.

Eight states provide coverage for prenatal care under the State Children's Health Insurance Program and five other states cover prenatal care regardless of immigration status, according to the authors. ■

IMPORTANT SAFETY INFORMATION

Patients taking Coreg CR™ (carvedilol phosphate) Extended-release Capsules or Coreg® (carvedilol) should avoid abrupt cessation of therapy. Following abrupt cessation of therapy with certain β-blocking agents, exacerbation of angina pectoris and, in some cases, MI and ventricular arrhythmias have occurred. The dosage should be reduced gradually over a 1- to 2-week period and the patient should be carefully monitored.

COREG CR and COREG are contraindicated in patients with bronchial asthma or related bronchospastic conditions, second- or third-degree AV block, sick sinus syndrome, or severe bradycardia (unless a permanent pacemaker is in place), in patients with cardiogenic shock or decompensated heart failure (HF) requiring the use of intravenous inotropic therapy (such patients should first be weaned from intravenous therapy before initiating COREG CR or COREG), in patients with clinically manifest hepatic impairment and in patients who are hypersensitive to any component of this product.

Like other β-blockers, COREG CR and COREG should be used with caution in patients with peripheral vascular disease, thyrotoxicosis, or who are undergoing major surgery. Caution should also be used in diabetic patients as β-blockers may mask some of the manifestations of hypoglycemia, particularly tachycardia. Worsening heart failure or fluid retention may occur during up-titration of COREG CR or COREG.

The most common side effects reported in the controlled trials in HF (reported in 10% of patients [both the mild-to-moderate and the severe populations studied] and more frequently on COREG) were dizziness, fatigue, weight increase, hypotension, and bradycardia. Worsening HF symptoms were also reported, but with equal or greater frequency in placebo-treated patients.

The most common side effects reported with COREG in the CAPRICORN trial were consistent with the profile of the drug in the US HF trials and the COPERNICUS trial, as well as the health status of patients. The only additional adverse events reported in >3% of patients and more frequently on COREG in CAPRICORN were dyspnea, lung edema and anemia.

The most common side effects in hypertension trials with carvedilol were nasopharyngitis (COREG CR) and dizziness and fatigue (COREG) and were generally mild.

INDICATIONS AND DOSING

Hypertension: COREG CR and COREG are indicated for the management of essential hypertension. COREG CR and COREG can be used alone or in combination with other antihypertensive agents, especially thiazide-type diuretics. Starting dose for COREG CR: 20 mg QD. Uptitrate to 40 mg QD after 1 to 2 weeks, as needed for blood pressure control. The maximum/target dose is 80 mg QD, if required.

Left Ventricular Dysfunction Following Myocardial Infarction: COREG CR and COREG are indicated to reduce cardiovascular mortality in clinically stable patients who have survived the acute phase of an MI and have a left ventricular ejection fraction (LVEF) ≥40% (with or without symptomatic heart failure [HF]). Starting dose for COREG CR: 20 mg QD. Uptitrate to 40 mg QD after 3-10 days as tolerated. The maximum/target dose is 80 mg QD. If clinically indicated, start at 10 mg QD and/or uptitrate more slowly. Patients should be maintained on lower doses if higher doses are not tolerated. No dosing alteration needed when started after IV or oral β-blocker MI treatment.

Heart Failure: COREG CR and COREG are indicated for the treatment of mild to severe HF of ischemic or cardiomyopathic origin, usually in addition to diuretics, angiotensin-converting enzyme (ACE) inhibitor, and digitalis, to increase survival and, also, to reduce the risk of hospitalization. Starting dose for COREG CR: 10 mg QD for 2 weeks. Uptitration to 20, 40, and 80 mg QD should occur over successive intervals of at least 2 weeks, based on tolerability. The maximum/target dose is 80 mg QD. Patients should be maintained on lower doses if higher doses are not tolerated.

Please see brief summary of Prescribing Information on the following page.

References: 1. Wetzels GE, Nelemans P, Schouten JS, et al. Facts and fiction of poor compliance as a cause of inadequate blood pressure control: a systematic review. *J Hypertens.* 2004;22:1849-1855. 2. Prescribing Information for COREG CR. GlaxoSmithKline.



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