Analysts Predict Surge in Limited Insurance Policies

BY JOYCE FRIEDEN
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WASHINGTON — Expect more health plans to offer limited insurance policies for people who are currently uninsured, Robert Laszewski said at a press briefing sponsored by the Center for Studying Health System Change.

"Insurers are recognizing that the 45 million people who are uninsured are a market," said Mr. Laszewski, founder and president of Health Policy and Strategy Associates, a consulting firm. "Now, they're not a market for comprehensive major medical insurance, but … for very limited benefits programs, programs that cost perhaps $50-$100 per month."

He added that such plans—which typically include a wellness checkup every other year, a few visits to a primary care physician, and a drug benefit based on generic drugs—have come under criticism for not doing enough to help the uninsured. "I think that's a false set of arguments," he said. "Of course they're not going to solve the problems of the uninsured, but [they] do respond to the needs of people who cannot afford health insurance."

Most speakers at the conference also were upbeat about the future of consumer-driven health plans, such as health savings accounts (HSAs), although Christine Arnold, an executive director specializing in managed care at New York brokerage firm Morgan Stanley, noted that such plans are still a very small part of employers' health insurance offerings.

"Less than 5% of any HMO's total book of business is right now in any form of consumer-directed health care," she said. "We may be on the cusp of a product revolution, which I've been hoping for, but I don't think it's here yet."

Mr. Laszewski added that although consumer-driven health care "is a wonderful thing," it focuses on first-dollar benefits rather than on the real problem in health care spending: that 75% of the costs are incurred by the 15% of people who are very ill. "It's the sick people who blow through the deductibles and get to the out-of-pocket maximums," he said. "Sick people are the ones who control costs. Consumer-driven health care is a wonderful thing, but when the day is done, the incentives haven't fundamentally changed. In about another year or two, we're going to get this out of our system."

Efforts to measure physician quality also came in for much discussion. "While I think 'sabotage' is a strong word, I would say there has been resistance by the health plans because each of them is trying to use this initiative as a competitive advantage," said Ms. Arnold. "The tug of war is that employers want this on a macro basis—they want a Consumer Reports for providers."

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Two new initiatives could help consumers and employers compare health care quality, Ms. Arnold said. One is the Ambulatory Care Quality Alliance, a project of the American Academy of Family Physicians, the American College of Physicians, America's Health Insurance Plans, and the Agency for Healthcare Research and Quality (FAMILY PRACTICE NEWS, June 1, 2005, p. 1). "They are trying to put together an objective list of measures. How do we measure who is a good provider? As we think about ways to assess quality, I think we need a standard."

The second initiative involves a group of employers and consultants who are exploring "care-focused purchasing—that is, getting health plans to aggregate their provider data so that employers and consumers can see which are the highest quality providers. "Any one health plan can't give you a full picture of [a physician]," she said.

Frederic Martucci, a managing director specializing in not-for-profit companies at Fitch Ratings, a New York credit-rating firm, said that Medicare's efforts to measure provider quality are likely to have a big impact on the health care market.

"The biggest insurance company in the world is Medicare, and Medicare is into quality," he said. ■

Pharmacogenomics Thought to Be Influencing Clinical Practice Already

BY TIMOTHY F. KIRN
Sacramento Bureau

SAN FRANCISCO — Pharmacogenomics has already entered the practice of medicine, with several recent developments that went largely unnoticed, Richard M. Weinshilboum, M.D., said at the annual meeting of the American College of Physicians.

New guidelines on pharmacogenomics from the Food and Drug Administration that were first drafted in 2003 were finalized and published in March, noted Dr. Weinshilboum, professor of medicine and pharmacology at the Mayo Clinic, Rochester, Minn.

The guidelines state that when a company with an investigational new drug has pharmacogenomic information on the drug, it should be submitted with the rest of the approval data. Currently, the submission of these data is considered voluntary.

On the one hand, industry is embracing pharmacogenomics because it can provide essential information in the initial studies of an investigational drug about whether it is worth the effort to continue pursuing expensive development. But on the other hand, industry is being "dragged" unwillingly into pharmacogenomics by the FDA because information on patients who may not respond to a drug or who may have side effects could spell the end of blockbuster drugs, Dr. Weinshilboum said.

The guidelines identify two pharmacogenomic biomarkers that the FDA will consider valid biomarkers. They are cytochrome P450 2D6 and thiopurine S-methyltransferase (TPMT). Information on other markers that identify possible genetic variation of response to a new drug should be submitted also, but the information needs to include background data on the biomarker.

TPMT is an enzyme known to be involved specifically in the metabolism of mercaptopurine, which is commonly used for childhood acute lymphoblastic leukemia, and the immunosuppressant azathioprine (Imuran). It has been shown that individuals have wide variation in TPMT activity. There are three important mutations in the TPMT gene, and individuals with low TPMT activity build up high drug levels leading to myelosuppression that is sometimes severe.

Cytochrome P450 2D6 is one of the isoforms of the cytochrome P450 enzyme family. It has been shown that individuals can have more than one copy of the gene for cytochrome P450 2D6, and that persons with more copies are high metabolizers of the affected drugs. At least 41 different drugs are known to be metabolized through cytochrome P450 2D6; an important one is codeine, which cytochrome P450 2D6 transforms to morphine.

Dentists already know about cytochrome P450 2D6, because just this year Roche Diagnostics received approval for its AmpliChip CYP450 test, a microarray test for clinical use. Patients are coming in armed with information from the Internet, demanding to have their cytochrome P450 2D6 status checked to see if they are among those who do not respond to codeine, he said.

Pharmacogenomics also has recently been an issue in the approval of the new "smart" cancer drug gefitinib (Iressa), which is used for non–small cell lung cancer. The drug was given accelerated approval in 2003, based on preliminary data on a response in some end-stage patients. But a new, placebo-controlled trial of the drug was recently halted because gefitinib failed to show any survival benefit.

The study may have failed to show a benefit because the investigators did not obtain genetic profiles of the patients. It now appears that gefitinib can produce a marked response, but only in those patients with a particular mutation of the epidermal growth factor receptor gene—about 10% of all patients, he said.

AstraZeneca, manufacturer of Iressa, has recently announced that it will begin cancer biomarker studies of the drug. ■

Parent Factors Can Predict Noncompliance With Well Child Visits, Study Shows

NEW ORLEANS — Older parents and those with private insurance were more likely to miss well child visits, according to a study in a family practice clinic that treats both parents and children, Dwenda Gjerdingen, M.D., said at the annual conference of the Society of Teachers of Family Medicine.

Children younger than 18 years comprise one-fifth of all visits to primary care physicians. Well child visits are the sixth most common reason for seeing a family physician, and the No. 1 reason for seeing a pediatrician.

"Despite their importance, many well child visits are missed," said Dr. Gjerdingen, professor in the department of family medicine and community health at the University of Minnesota, Minneapolis.

Dr. Gjerdingen and her associates conducted a telephone survey of parents at the university's Bethesda Clinic in St. Paul who missed an appointment between January and December 2002. Respondents were 90% female, 61% married, and 50% employed. Fifty-seven percent were insured through public assistance. Mean age of parents was 26 years and mean age of children was 5.4 months. Parents were 65% Southeast Asian, 15% African American, 14% white, and 6% other. Almost half (48%) had less than a 12th-grade education; 86% kept well child visits. Among the 14% who were noncompliant, "I forgot" was the No. 1 reason cited. Most parents, 77%, said they like telephone reminders.

All respondents said they believed well child visits are important, citing vaccinations as the No. 1 reason. Therefore, Dr. Gjerdingen said, "We can use that for encouraging parents to come to visits."

A minority of parents, 20%, said they were "often" or "always" stressed. Financial or employment concerns were most often cited.

Contrary to other compliance studies, younger parents were more likely to keep visits, Dr. Gjerdingen found. "I was surprised by age, that the older they were the more likely they were to miss the appointment," she said.

Another unexpected finding was parents with private insurance were more likely to miss appointments compared with those who had public insurance. "I was wondering if it was a co-pay differential," she said.

Small sample size and single center setting were limitations of the study.

—Damian McNamara