Initiative Offers Coverage for Obesity Prevention Visits

BY MARY ELLEN SCHNEIDER

Nearly a million children would gain health insurance coverage for weight-management counseling under an obesity prevention initiative spearheaded by former President Bill Clinton.

As part of the initiative, a group of health insurers and employers have agreed to pay for at least four follow-up visits to a child's primary care physician and four visits with a registered dietitian for children aged 3-18 years whose body mass index is in the 85th percentile or above for their age.

Participating insurers include Aetna Inc., Blue Cross and Blue Shield of North Carolina, Blue Cross Blue Shield of Massachusetts, and WellPoint Inc. Also, PepsiCo. Inc., Houston Independent School District, Owens Corning, and Paychex Inc. will offer these benefits to their employees. President Clinton announced the agreement in New York last month at a press conference.

The initiative is the latest obesity prevention effort from the Alliance for a Healthier Generation, an organization launched jointly in 2005 by the William J. Clinton Foundation and the American Heart Association. "This landmark agreement will allow children and their families to have access to important preventive medical services in most regions of the country," said Dr. Tim J. Gardner, AHA president.

Research shows that overweight and obese children have up to an 80% chance of being so as adults, putting them at higher risk for conditions such as diabetes, heart disease, stroke, and even certain types of cancer, he said.

As part of the agreement reached with insurers and employers, nearly a million children are expected to gain access to new obesity prevention and treatment benefits during the first year of the initiative. But the long-term goal is to reach 6.2 million children—about a quarter of all overweight and obese children in the United States—within 3 years as more insurers and employers agree to participate.

During the first year of the initiative, insurers will collect health outcomes information and cost data to help determine the cost-effectiveness of certain approaches and identify best practices. "We need to know what really works here," President Clinton said.

This agreement will allow families 'to have access to important preventative medical services.'

DR. GARDNER

This new initiative takes the important step of removing the barriers that limit insurance payment for obesity prevention in the primary care setting, said Dr. David T. Tayloe Jr., president of the American Academy of Pediatrics, adding that it can be difficult for pediatricians to bill insurers for obesity counseling, and there has been a lot of confusion about what is covered.

Obesity can be successfully treated in the office, but pediatricians can't do it by themselves, Dr. Tayloe said. For example, physicians in his rural North Carolina practice work with registered dietitians and partner with community organizations like the YMCA to give obese patients and their families a comprehensive program of nutrition and fitness advice, and health assessments.

"To see successful long-term results, there must be an ongoing relationship involving patient, family, pediatrician, dietitian, and widespread community support," Dr. Tayloe said. ■

Off-Label Drug Use in ICU Lacks Supporting Evidence

BY MICHELE G. SULLIVAN

NASHVILLE — Almost half of the patients in the intensive care unit received medications for off-label indications, with little or no supporting evidence for that use, according to a retrospective review.

Patients received a mean of six approved and five nonapproved medications. Three drug classes accounted for most of the off-label orders: endocrine/metabolic, respiratory, and gastrointestinal. The most frequently prescribed off-label drugs were regular insulin for hyperglycemia; fentanyl for analgesia in critically ill, mechanically ventilated patients; and esomeprazole for the prophylaxis of stress ulcers.

"The use of off-label medications for critically ill patients is very common, and there appears to be a correlation between how sick the patients are and how many off-label drugs they receive," Ishaq Lat, Pharm.D., said at the annual congress of the Society of Critical Care Medicine. "We extrapolate a lot of what we do in the ICU from other areas of medical treatment, without a great deal of evidence in this patient population."

Dr. Lat, a pharmacist at the University of Chicago Medical Center, and his colleagues, reviewed all the medication orders in 37 U.S. intensive care units during the same 24-hour period. The study captured data on 414 patients, for whom 4,535 medications were ordered. Of these, 1,805 (40%) were for an off-label use.

Most medications given off label had little evidence supporting their use, Dr. Lat said in an interview. "When the off-label medication orders were evaluated by level of evidence and strength of recommendation, 829 (46%) had grade C or no evidence, and 718 (40%) had a grade 3 or indeterminate rating."

The analysis found an association between the increasing severity of illness and the use of off-label medications. Patients who received off-label drugs had significantly higher APACHE II (Acute Physiology and Chronic Health Evaluation II) and SOFA (Sepsis-Related Organ Failure) scores than did those who did not receive these drugs.

Off-label use varied significantly with the type of ICU, Dr. Lat noted. Cardiothoracic, surgical, trauma, and bone marrow transplant units had more off-label than on-label medication usages. Medical, coronary, and neurologic ICUs used more on-label medications, he added.

The high rate of off-label prescribing in ICUs may reflect a lack of adequate pharmaceutical research in critically ill patients, Dr. Lat said. "It's very difficult to perform drug studies on patients who are this sick, and there is not much funding available for these studies. So, we're applying what we know from other areas of medicine… without much good evidence."

A follow-up study will explore the possible relationship between off-label prescribing in the ICU and patient outcomes, he added. ■

Analysts Predict Big Jump in Health Care Share of GDP

BY ALICIA AULT

WASHINGTON — As the economic downturn slows private health spending public sector health spending is rising, according to a federal analysis.

An estimated 3.4 million people may lose private health insurance coverage in 2009, and another 2.6 million may lose coverage in 2010, said Sean Keehan of the Center for Medicare and Medicaid Services' Office of the Actuary.

Total U.S. health care spending was an estimated $2.4 trillion in 2008—an increase of 6.1% over 2007, according to the annual projection of spending trends published online in the journal Health Affairs. This year, spending is expected to grow by only 5.5%.

That growth rate is expected to far outpace the nation's gross domestic product in 2009. Economists for the CMS said they predict the GDP will shrink by 0.2% this year. Meanwhile, the health care share of the GDP is expected to grow 1.4%—the biggest annual jump as a portion of GDP since economists first started tracking this indicator in 1960, said Christopher Truffer, a CMS actuary. Health spending will account for 17.6% of the GDP in 2009, the report says (Health Affairs 2009 Feb. 24 [doi:10.1377/hlthaff.28.2.w346]).

Absent any policy changes, health care is on track to gobble up one-fifth of the nation's dollar by 2018, Mr. Truffer and his colleagues said.

The economists projected that overall health spending will rise by only 4.6% in 2010, thanks largely to the mandated 21% reduction in physician payments required under the Sustainable Growth Rate target set by Medicare.

However, since Congress usually eliminates the cuts or grants a fee increase every year, the CMS economists calculated some alternative scenarios. If payments were kept constant, Medicare spending would rise 6.4%, or 3.9% faster than if the cuts went into effect. Overall national health spending would rise 5.4%, or 0.8% more.

Medicaid spending will grow 9.6% in 2009, up from 6.9% in 2008. Private health insurance benefits spending grew an estimated 5.8% in 2008, but will rise only 4.1% in 2009.

The CMS projections make it seem like cost-containment efforts are having a negligible effect on restraining overall health spending. The economists said the Medicare fee cuts would make a difference, but that they lacked the data to calculate whether other cost-containment efforts in the private sector in particular were having any effect on restraining health spending.

However, prescription drug spending has dropped as a result of insurers successfully driving an increase in the use of generic drugs, said John Poisal, deputy director of the Office of the Actuary. Overall, the public and private sector spent 3.5% more on drugs in 2008, compared with a 4.9% increase the previous year. The nation spent $235 billion on prescriptions in 2008. The analysts expected a 4% rise in 2009.

Hospital spending is expected to grow only 5.7% in 2009, compared with a 7.2% increase in 2008, as cash-strapped Americans put off elective procedures and insurers continue to clamp down, the actuaries said.

The analysts projected spending trends to 2018, but said their assumptions would change if the recession ran beyond early 2010. Their macroeconomic assumptions are based on the Blue Chip Consensus forecast, an amalgamation of the views of expert economists that predicts positive economic growth beginning in the second half of 2009.

The CMS analysts said that jobs—and insurance coverage—tend to lag behind initial growth, hence their prediction for slowing health spending through 2011.

The assumptions could also change if any significant health care reform occurs. CMS Chief Actuary Rick Foster said he did not expect to see significant health reform proposals in the 2010 budget. ■