

Feds Use Bonus Payments to Urge E-Prescribing

BY MARY ELLEN SCHNEIDER
New York Bureau

Federal officials are urging physicians to begin electronic prescribing as soon as possible now that Congress has authorized bonus payments for use of the technology.

Under the recently enacted Medicare Improvements for Patients and Providers Act (H.R. 6331)—the same law that eliminated the 10.6% Medicare physician pay cut—Congress also outlined plans to ramp up e-prescribing beginning next year. Under the law, bonus payments will gradually decrease and eventually physicians will be penalized if they don't transmit prescriptions electronically.

"We expect this will have a profound effect on the adoption and use of e-prescribing," Health and Human Services Secretary Mike Leavitt said during a press conference to explain the details of the new initiative.

The widespread use of e-prescribing will create benefits for patients and the health system as a whole by allowing for real-time cross-checking for drug-drug interactions and providing automatic error screening of prescriptions, Mr. Leavitt said.

Medicare could also save up to \$156 mil-

lion over a 5-year period by avoiding adverse drug events, according to the Centers for Medicare and Medicaid Services.

The incentive payments will be awarded through the Physician Quality Reporting Initiative, Medicare's voluntary program that provides incentives to physicians who successfully report on certain quality measures. CMS officials have developed measures specific to e-prescribing



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MR. LEAVITT

and will be releasing guidance on how they define the routine use of e-prescribing. They also plan to host a conference on the technical details of the plan this fall.

The e-prescribing bonuses will be in addition to the current bonuses.

During 2009 and 2010, physicians who successfully report on e-prescribing measures will be eligible to earn 2% of total allowed Medicare charges. In 2011 and

2012, the incentive payment will drop to 1% and then to 0.5% in 2013.

Beginning in 2012, eligible physicians who do not e-prescribe will see their total allowed Medicare charges cut by 1% with that amount increasing to 2% by 2014, according to the provisions of H.R. 6331.

The law grants an exemption for those providers for whom the requirement would be a "significant hardship," such as a physician practicing in a rural area without sufficient Internet access.

CMS officials already have laid the groundwork for the increased use of e-prescribing by issuing standards around the transmission of electronic prescriptions, Mr. Leavitt said. With the authorization of bonus payments, the government will be able ease some of the costs of adopting e-prescribing technology.

According to CMS estimates, the average cost of acquiring and setting up an e-prescribing system is about \$3,000 per prescriber, with ongoing maintenance costs of \$80-\$400 per month.

Dr. James King, a family physician in Selmer, Tenn., and president of the American Academy of Family Physicians, estimated that he spent about \$10,000 to implement an e-prescribing system in his practice. But, even with the technology in

place, he is able to e-prescribe only some of the time. For example, not all pharmacies in his area are able to receive electronic prescriptions, he can't prescribe some narcotic drugs electronically, and he cannot prescribe medications electronically across state lines for his patients who live in Mississippi.

That's why Dr. King said he is pleased that Congress chose to proceed first with payment incentives, so policy makers have time to remove some of these barriers.

He urged physicians to adopt the technology. In addition to improving quality and safety for patients, it allows the physicians to engage in more "two-way communication," he said. For example, e-prescriptions generally allow physicians access to information about whether the patient has filled the prescription. And e-prescribing should improve efficiency, allowing physicians to devote more time to patient care, he said.

A significant number of family physicians are likely to be ready to begin e-prescribing in January, Dr. King said. The AAFP estimates that about half of their members either have electronic health records (EHRs) with e-prescribing capabilities or plan to implement them by the end of the year. ■

Genetic Nondiscrimination Law to Impact Insurers, Researchers

BY MARY ELLEN SCHNEIDER
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Patients will soon be able to undergo genetic testing without fear of discrimination from either their health insurers or their employers, thanks to a new law signed by President Bush.

The Genetic Information Nondiscrimination Act (H.R. 493), which passed both houses of Congress by wide margins, prohibits health insurers from using genetic information in determining eligibility or setting premiums and forbids employers from using that information for decisions about hiring, firing, job assignments, or promotions. The law also prohibits health insurers and employers from requesting or requiring that individuals take a genetic test. The health insurance provisions in the law will go into effect in 12 months, and the employment provisions will take effect in 18 months.

Supporters of the law are hailing it as the first civil rights legislation of the new millennium. The law will have a positive impact on neurologists and their patients as soon as it goes into effect, said Dr. Bruce Sigsbee, a member of the legislative affairs committee of the American Academy of Neurology. Most neurologists already do at least some genetic testing and counseling for diseases such as Huntington's, he said, and that is likely to increase over time.

For many patients, the first barrier to genetic testing is whether they want to know their risk, but the potential for discrimination is one of the important factors in their decision, Dr. Sigsbee said. "It complicates their own medical decision making substantially," he said.

"Genetic testing holds great promise for improving public health, and patients must be able to trust that their genetic information will be protected from inappropriate and discriminatory uses," said Dr. Edward Langston, board chair of the American Medical Association. It "will allow patients to take advantage of scientific advances in genetics, such as screenings and therapies, without worrying that their personal health information could be used against them."

Some patients who would be good candidates for ge-

netic testing have been refusing the tests, or in some cases taking them under an assumed name, said Sharon Terry, president of the Coalition for Genetic Fairness, and CEO of the Genetic Alliance.

The frequency of genetic discrimination has been difficult to document, but it's clear that fear of discrimination has been a barrier to genetic services for some patients, said Dr. Matthew Taylor, director of adult clinical genetics at the University of Colorado in Denver. For example, last year the Genetics and Public Policy Center at Johns Hopkins University, Baltimore, conducted a survey of 1,199 U.S. adults on genetic testing and discrimination. The researchers found that 92% of respondents expressed concern that the results of a genetic test for disease risk could be used against them in some way.

One of the biggest impacts of the law may be its potential to alleviate concerns about genetic discrimination among both patients and physicians, Dr. Taylor said.

Another area where the law is likely to have a significant impact is in research. Many informed consent forms for clinical trials include statements warning participants that they could be discriminated against on the basis of their genetic information, according to Ms. Terry. The Coalition for Genetic Fairness plans to mount an educational campaign to make patients and physicians aware of the new protections in the law in the hopes of increasing participation in research, she said.

The new federal law is essential to help to "close the gaps in protection" among the various state laws, according to Naomi Senkeeto, a health policy analyst for the American College of Physicians. The new law is similar to policy positions outlined in an ACP monograph issued earlier this year. In fact, the law includes all of the provisions that the ACP monograph recommended. The law also adds a specific prohibition against issuers of Medicaid policies using genetic information to adjust price or condition eligibility.

The law was a long time coming, according to supporters. Legislation on genetic nondiscrimination was first introduced in 1995. The bill has had broad support in Congress for many years but couldn't get to the House floor under the Republican leadership, according to Susannah Baruch, associate director of the Genetics and Public Policy Center at Johns Hopkins University. The other change that propelled the legislation forward was the explosion in the number of genetic tests available, she said.

About 1,200 genetic tests can be used to identify thousands of health conditions, according to the Coalition for Genetic Fairness. Only about 100 genetic tests were available a decade ago.

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Over time, the legislation has garnered support from a broad coalition of groups, including the health insurance industry. "With this landmark bipartisan legislation, Congress and the president have taken strong action to prohibit discrimination based on a person's genetic makeup and to protect patients' privacy as they pursue genetic evaluations," Karen Ignagni, president and CEO of America's Health Insurance Plans, said in a statement. "This legislation also ensures that patients can continue to benefit from health plans' innovative early detection and care coordination programs that improve the safety and quality of care."

But more work needs to be done, Ms. Terry said. The Coalition for Genetic Fairness has been working with Sen. Edward Kennedy (D-Mass.) and Sen. Barack Obama (D-Ill.) on better oversight for genetic testing in general. And the Agency for Healthcare Research and Quality recently called for improvements to public health surveillance databases and health information technology used to monitor the tests.

Potential discrimination in life insurance and disability insurance also must be addressed in the future, Ms. Terry said. "This is a first-step bill for sure." ■