Rules Issued for Use of Genetic Information by Insurers

BY MARY ELLEN SCHNEIDER

The federal government has issued new rules spelling out how it intends to police the use of genetic information by health plans.

The regulations bar health insurers from increasing premiums or denying enrollment based on genetic information. The regulations implement certain provisions in the Genetic Information Nondiscrimination Act (GINA), which was signed into law by President Bush in May 2008.

'Consumer confidence in genetic testing can now grow and help researchers get a better handle on the genetic basis of diseases.'

Beefing up consumer protections for genetic information should help accelerate progress in genetic testing and research, said Health and Human Services secretary Kathleen Sebelius.

"Consumer confidence in genetic testing can now grow and help researchers get a better handle on the genetic basis of diseases," Ms. Sebelius said in a statement.

"Genetic testing will encourage the early diagnosis and treatment of certain diseases while allowing scientists to develop new medicines, treatments, and therapies."

In an interim final rule, federal officials provide details on how health plans can obtain and use genetic information.

The regulation generally bars health plans from increasing premiums based on genetic information. They also cannot require, or even request, that individuals or family members undergo genetic testing. And health plans cannot request, require, or purchase genetic information at any time for underwriting purposes, or prior to or in connection with enrollment.

Although the rule bars insurers from charging its members more based on genetic information, it doesn't limit them from doing so because of the manifestation of a disease. However, a health plan can't use the manifestation of a disease in one of its members as genetic information for a family member and raise their premiums, according to the interim final rule.

The rule does allow plans to request limited genetic information if it's necessary to determine the "medical appropriateness" of a certain treatment. Plans also can request that individuals participate in research where genetic testing will be conducted. However, none of the genetic information collected during that research can be used for underwriting purposes.

The interim final rule goes into effect 60 days after publication in the Federal Register.

HHS officials also issued a proposed rule that would modify the Health Insurance Portability and Accountability Act (HIPAA) to comply with the provisions of GINA. Like the GINA rule, the HIPAA rule bars health plans from using and disclosing genetic information for underwriting purposes.

However, since HIPAA applies more broadly, the prohibition in the proposed rule also affects employee welfare benefit plans and long-term care policies. It would exclude nursing home fixed indemnity policies.

If the proposed rule is finalized, then plans would have 180 days to comply with the provisions. ■

Doctors to Test Single Portal For Insurance Information

BY MARY ELLEN SCHNEIDER

In November, physicians in Ohio and New Jersey will begin to test a single, online portal through which they can access health insurance eligibility and benefits information for most of their privately insured patients.

Physicians and their staffs in those states will have access to data on copayments, deductibles, in-network and out-of-network coverage, and the status of claims from multiple plans in one place. They will also be able to submit referrals, pre-authorization requests, and claims under a test project spearheaded nationally by America's Health Insurance Plans and the Blue Cross and Blue Shield Association.

Ultimately, the initiative will be rolled out across the country, AHIP President and CEO Karen Ignagni said at a press conference.

"It's a step that will ultimately transform our system to one that takes advantage of technology to the benefits of clinicians and their patients," she said.

The changes are significant, Ms. Ignagni said, and are akin to what the banks did when they first allowed consumers to withdraw money from any ATM worldwide.

The initiative is expected to decrease hassles for physicians and significantly reduce costs for both physicians and health plans. Ms. Ignagni estimated that the entire health system could see savings of hundreds of billions of dollars once these administrative simplification tools are available around the country, based on estimates of savings automating administrative tasks and implementing consistent business practices.

The insurers' announcement comes as Congress debates comprehensive health reform, including tighter regulation of the insurance industry. Ms. Ignagni said AHIP has been exploring projects to simplify insurance administration over the last year and has kept the Obama administration and congressional leaders apprised of their progress. Some simplifications are already part of health reform proposals circulating in Congress, she said.

"Most policy makers understand that health reform that doesn't address the cost of care will fail." She added that projects like the ones in Ohio and New Jersey have "great potential to slow the growth in the cost of care and contribute to savings needed nationally for reform."

Although this type of Web-based tool has been possible for years, the standards for sharing information across multiple health plans were only recently completed, Ms. Ignagni said. With the standards in place, the state-level pilot projects will focus on making sure the Web portal is user friendly for physicians and learning which functions are most helpful. The project will begin with physicians and will be extended to hospitals later, according to AHIP.

The initiative was praised by physician organizations that are working on the project in Ohio, where eight health plans representing 91% of privately insured residents will participate in the Web portal. Mark Jarvis, senior director of practice economics at the Ohio State Medical Association, said the ability to access insurance information through one online source will make administrative tasks easier, faster, and more accurate.

This type of tool is critical, he said, because it allows the physician's staff to let patients know up front what their coverage is and how much they will end up paying. "If you can have that conversation before the encounter, the transaction works much better and [is] less confusing than if you're trying to chase it after."

Mr. Jarvis estimated that the average physician spends 3-4 hours a week on administrative dealings with insurance companies, while his or her staff spends another 58 hours on insurance-related administration in a given week. Creating a one-stop shop for insurance information is a great "first step" to try to reduce the administrative burden on physician practices, he said. ■

One-Fifth of Meeting Presenters Are Mum on Disclosures

BY JOYCE FRIEDEN

Despite explicit requirements, a number of speakers at medical meetings do not disclose financial conflicts of interest, a study has found.

"Currently, disclosures by physicians are largely self-reported, but there is reason to suspect that this may change in the near future," Dr. Kanu Okike of Brigham and Women's Hospital and Massachusetts General Hospital and colleagues wrote. "Legislation requiring all drug and device manufacturers to publicly disclose payments to physicians is currently pending in the U.S. Congress and has been met with widespread support."

The authors analyzed payments made to physicians in 2007 by five makers of total hip and knee prostheses that together account for nearly 95% of the market. Payment listings were found on each company's website and included a wide range of direct and indirect expenditures (N. Engl. J. Med. 2009;361:1466-74).

The authors compared the payments with conflict-of-interest disclosures made by physicians who either presented at or served as board or committee members at the 2008 annual meeting of the American Academy of Orthopaedic Surgeons (AAOS).

A total of 1,347 payments were made to 1,162 physicians during 2007. Overall, 166 physicians received payments from multiple companies, and there were 282 payments that exceeded $100,000. Approximately one-fourth of the payments (344) were made to presenters or board/ committee members at the AAOS meeting.

In 70% of the 299 cases that could be evaluated for topic relatedness, the payment was directly related to the topic of the presentation at the meeting.

The overall disclosure rate for the payments was 71%, including 79% for directly related payments, 50% for indirectly related payments, and 49% for unrelated payments.

The researchers also surveyed 91 physicians who did not disclose payments; 36 physicians responded to the survey. Reasons for nondisclosure included the payment being unrelated to the presentation topic (39%) and misunderstanding the disclosure requirements (14%). In addition, 11% of respondents reported that the payment had been disclosed but was inaccurately printed in the program.

The authors cited the high rate of nondisclosure as the most notable finding of their study, saying that the disclosures didn't occur "despite instructions directing each participant to make a disclosure 'if he or she has received something of value from a commercial company or institution, which relates directly or indirectly to the subject of their presentation.' " They also noted that the 43 nondisclosed payments relating directly to the presentations totaled $4.3 million.

As for their own disclosures, the authors noted that co-authors Dr. Mininder Kocher, Dr. Charles Mehlman, and Dr. Mohit Bhandari have received grants from or consulted for a number of medical device firms, including several of those mentioned in the study. No other conflicts of interest were reported. ■