Policy & Practice

Rich and Educated Burn More

Wealthier and better-educated Americans get sunburn more often, according to a study published in the Journal of the American Academy of Dermatology. University of Pennsylvania researchers used data from the 2003 Behavioral Risk Factor Surveillance Survey, a random sample of 248,000 Americans conducted by the Centers for Disease Control and Prevention. About 85% of the respondents self-identified as white; overall, half were female, and the mean age was 47 years. Thirty-nine percent said they'd had at least one sunburn in the year before their interview; 26% said they'd had two or more burns, 15% had three or more, and 9% had four or more. Not surprisingly, sunburns were more prevalent in the 18- to 24-year-old age group, and decreased with age, becoming least prevalent in those over age 75. Prevalence was highest in those making more than $50,000 annually and who had a college degree, and decreased with less income and lower education. Adjusting for age and alcohol and tobacco use attenuated some of the income and wealth effect, but higher education and earnings were still positively associated with sunburn, said the researchers.

Report Faults Wound Payment

Medicare needs to improve the way it pays for wound management, according to a new report by AdvaMed, a trade association for medical device companies. "Coverage and reimbursement policies in the nation's Medicare system currently do not reflect technological advances in wound care management, are too comprehensive, and can cause disruptions in delivering appropriate care to patients," the report's authors said. "Medicare often focuses narrowly on a specific unit cost or the cost of wound care at a specific site, while not considering the long-term costs of caring for patients." AdvaMed urged the Centers for Medicare and Medicaid Services to increase the amount of money the agency pays for wound care supplies used by hospitals, nursing homes, and outpatient clinics. The recommendations also included prevention: AdvaMed suggested the agency provide coverage as part of Medicare's surgical dressing benefit for "preventive and early intervention technologies for tissue damage."

Fix the SGR, Delay Imaging Cuts

Rep. Michael Burgess (R-Tex.), an ob.gyn., has introduced legislation (H.R. 5866) that would put an end to physician fee cuts under Medicare by halting application of the sustainable growth rate by Jan. 1, 2007. Each year, the SGR has contributed to a decrease in payments; in 2007, that cut will be at least 4.6%. Rep. Burgess is proposing to tie physician fees to one factor only: the Medicare Economic Index minus 1%. According to Rep. Burgess, this places "more value on actual cost inputs." The bill also would establish a system of quality measures to give patients more information about Medicare providers, delay by 1 year proposed cuts in imaging services reimbursement, and require the Institute of Medicine to perform a study on the question of whether imaging saves money. The American Medical Association called the Medicare Physician Payment Reform Bill and Quality Improvement Act of 2006 an "important step toward replacing the flawed Medicare physician payment formula." Rep. Burgess' bill is the third in the House to delay or repeal the cuts in imaging fees. Rep. Joseph Pitts (R-Pa.) has called for a 2-year delay in H.R. 5704; a similar bill was recently introduced by Sen. Gordon Smith (R-Ore.) and Sen. Jay Rockefeller (D-W.Va.).

Senate Bill to Boost Drug Safety

After months of public discourse, Sen. Edward Kennedy (D-Mass.) and Sen. Mike Enzi (R-Wyo.) have introduced a bill that aims to increase assurances that drugs are safe before they reach the marketplace, or at least have a plan in place to more closely monitor when they need to be withdrawn. The Enhancing Drug Safety and Innovation Act would require pharmaceutical manufacturers to be more proactive about safety problems. Companies would have to establish risk evaluation and management strategies that will be agreed upon by the manufacturer and the Food and Drug Administration before the product is approved. The companies would have to submit adverse event reports every 15 days, quarterly, and annually. If a company knowingly does not comply with the agreed-upon strategy, the FDA can impose monetary penalties. The senators also proposed that manufacturers make clinical trial results public. Fuller disclosure "will help patients and their health care providers make better informed decisions about treatment," Sen. Kennedy said in a statement. Finally, the bill would overhaul the FDA's process for vetting outside advisory panel members, with a goal of minimizing conflicts of interest and then ensuring that they are fully disclosed.

Poll: Live Unhealthy, Pay the Price

More than half of respondents to a Wall Street Journal/Harris Interactive poll say that people who smoke or choose not to wear seat belts should pay a higher health insurance premium, but most did not feel the same way about people who were overweight or didn't exercise enough. Only 27% of the poll's 2,200 respondents thought that overweight people should pay more for insurance than slimmer people; the same percentage favored having people who did not exercise regularly pay more. The amount of education the respondent had affected the responses given: Those with some college education were more likely to agree that those with unhealthy lifestyles should pay higher premiums, compared with respondents with a high school education or less. The poll had a 3.3% margin of error.

—Alicia Ault

New Federal Regs Aim to Speed Technology Adoption

Regulations are positive first step; ACP will ask Congress for add-on payments to speed adoption.

BY MARY ELLEN SCHNEIDER
New York Bureau

Hospitals, health plans, and other health care organizations will soon be able to assist physicians in obtaining health information technology without running afoul of federal fraud laws under regulations issued last month by the Department of Health and Human Services.

In two final regulations published in the Federal Register on August 8, the Centers for Medicare and Medicaid Services and the HHS Office of Inspector General carved out new exceptions to the Stark physician self-referral law and the federal antikickback statute. Under these new exceptions, certain health care entities will be able to donate interoperable electronic health record (EHR) software and training. And hospitals and other health care organizations will also be able to provide hardware, software, and training services that are "necessary and used solely" for electronic prescribing.

The regulations were praised by physician organizations and health IT industry groups for breaking down barriers to physician adoption.

The regulations did not cap the donations to physicians for electronic prescribing technology, but the government is requiring physicians to share some of the costs of donated electronic health record technology. Under the rules, physicians will be required to pay 15% of the donor's cost of the EHR technology and services.

The regulations go into effect in early October (60 days after publication in the Federal Register). The provisions related to EHR arrangements are slated to sunset on Dec. 31, 2013.

The regulations were widely praised by physician organizations and health IT industry groups for breaking down barriers to physician adoption. But Patrick Hope, legislative counsel for the American College of Physicians, said the changes aren't likely to do a whole lot to speed physician adoption of the technologies since few hospitals will be able to afford to donate the expensive technology to physicians.

"They are operating at the margins just as physician offices are," Mr. Hope said.

ACP officials are urging members of Congress to establish an add-on payment to the Medicare reimbursement for an office visit to help offset the ongoing costs of an electronic health record system, Mr. Hope said. While the regulations are helpful in removing some barriers, he said, an add-on payment would create a better business case for physician adoption of health IT.

The jury is still out as to what impact these regulations will have on physician adoption, said Chantal Worzala, senior associate director for policy at the American Hospital Association. Not all hospitals will have the financial resources to donate IT services, she said, since only about a third of U.S. hospitals are making a profit.

But the regulations will give hospital administrators more options. "Hospitals really should have flexibility in working with community physicians," she said.

While some health plans may be interested in offering electronic prescribing products, Ms. Worzala said, hospitals are likely to want to help physicians acquire more comprehensive EHR systems.

The relaxation of the Stark physician self-referral law and the antikickback statute is a good thing, said Dr. Steven E. Waldren, assistant director of the American Academy of Family Physicians' Center for Health Information Technology, since the changes will allow more health IT resources to flow to physicians. However, he cautioned physicians not to count on getting this support.

This type of support won't be available to all physicians and in some cases may not be appropriate, he said. For example, Dr. Waldren said that some hospital electronic health record systems are not designed for the ambulatory environment and may end up costing physicians more money in the long run. The bottom line is that physicians need to continue to do their "due diligence" in researching systems, he said.

The Medicare Modernization Act of 2003 mandated that the HHS Secretary create exemptions that would allow for certain health care organizations to help furnish physician practices with electronic prescribing technology. The changes were originally outlined in a proposed rule issued last October.

Under the provisions related to electronic prescribing technology, hospitals can donate hardware, software, and services to members of their medical staffs; group practices can donate to physician members; and Medicare prescription drug plan sponsors and Medicare Advantage plans can donate to pharmacies and prescribing physicians. The Stark law exemption and antikickback safe harbors have slightly different definitions of who can donate the comprehensive electronic health record system software and training.

The electronic prescribing safe harbors and exemptions allow organizations to donate hardware, software, Internet connectivity, and training and support services. The provisions for electronic health records are slightly different and do not include hardware. For EHRs, organizations can donate software, which must include an electronic prescribing component. Also, organizations can donate information technology and training services, which can include Internet connectivity. ■