Rules Issued for Use of Genetic Information by Insurers

BY MARY ELLEN SCHNEIDER

The federal government has is- 

sued new rules spelling out the way 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 infor-

mation. The regulations implement cer- 

tain provisions in the Genetic Information Nondiscrimination Act (GINA), which was signed into law by President Bush in May 2008.

Beefing up consumer protections for genetic infor-

mation should help ac-

celerate progress in genetic testing and research, said Health and Human Services secretary Kathleen Sebelius.

“Consumer confidence in genetic testing can now grow and help re-

searchers get a better handle on the genetic basis of diseases,” Ms. Sebe-

lius said in a statement.

“Genetic testing will encourage the early diagnosis and treatment of cer-

tain diseases while allowing scientists to develop new medicines, treat-

ments, and therapies.”

In an interim final rule, federal of-

ficials 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 can-

not require, or even request, that in-

dividuals or family members undergo genetic testing. And health plans can-

not request, require, or purchase ge-

netic information at any time for un-

derwriting 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 be-

cause of the manifestation of a dis-

ease. However, a health plan can’t use the manifestation of a disease in one of its members as genetic infor-

mation for a family member and raise their premiums, ac-

cording to the inter-

im final rule.

The rule does al-

low plans to request limited genetic in-

formation if it’s nec-

essary to determine the “medical appro-

priateness” of a cer-

tain treatment. Plans also can request that individuals partici-

pate in research where genetic testing will be conducted. However, none of the genetic information collected dur-

ing that research can be used for under-

writing purposes.

The interim final rule goes into ef-

fect 60 days after publication in the Federal Register.

HHS officials also issued a pro-

posed rule that would modify the Health Insurance Portability and Ac-

countability 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.

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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 ben-

efits information for most of their pri-

vately insured patients.

Physicians and their staffs in those states will have access to data on copayments, deductibles, in-network and out-of-net-

work coverage, and the status of claims from multiple plans in one place. They will also be able to submit referrals, pre-au-

thorization 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 with-

draw money from any ATM worldwide.

The initiative is expected to decrease has-

les 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 bil-

lions of dollars once these administrative simplification tools are available around the country, based on estimates of savings au-

tomating administrative tasks and imple-

menting consistent business practices.

The insurers’ announcement comes as Congress debates comprehensive health re-

form, including tighter regulation of the insurance industry. Ms. Ignagni said AHIP has been exploring projects to simplify in-

surance 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 doesn’t address the cost of care will fail.” She added that pro-

jects like the ones in Ohio and New Jersey have “great potential to slow the growth in the cost of care and contribute to sav-

ings 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 fo-

cus 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 extend-

ed 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 res-

idents will participate in the Web portal. Mark Jarvis, senior director of practice economics at the Ohio State Medical As-

sociation, said the ability to access insur-

ance information through one online source will make administrative tasks easi-

ier, faster, and more accurate.

“This type of tool is critical, he said, be-

cause it allows the physician’s staff to let patients know up front what their cover-

age is and how much they will end up pay-

ing. “If you can have that conversation be-

fore 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 ad-

ministrative dealings with insurance com-

panies, while his or her staff spends an-

other 58 hours on insurance-related admin-

istration 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 prac-

tices, he said.

One-Fifth of Meeting Presenters Are Mum on Disclosures

BY JOYCE FRIEDEN

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epite explicit requirements, a num-

ber of speakers at medical meetings do not disclose financial conflicts of in-

terest, a study has found.

“Currently, disclosures by physicians are largely self-reported, but there is rea-

son 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. Con-

gress and has been met with widespread support.”

The authors analyzed payments made to physicians in 2007 by five makers of to-
tal hip and knee prostheses that togeth-

er 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 pay-

ments that exceeded $100,000. Approxi-

mately one-fourth of the payments (344) were made to presenters or board/ com-

mittee members at the AAOS meeting.

In 70% of the 299 cases that could be evaluated, presentation-related payments were unrelated to the presentation at the meeting. The overall disclosure rate for the pay-

ments was 71%, including 79% for di-

rectly related payments, 50% for indi-

rectly related payments, and 49% for unre-

lated payments.

The researchers also surveyed 91 physi-

icians who did not disclose payments; 36 physicians responded to the survey. Rea-

sons for nondisclosure included the pay-

ment being unrelated to the presentation topic, not knowing if the payment was required, and misunderstanding the disclosure requirements (14%). In addi-

tion, 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 find-

ing of their study. They added that disclo-

sures didn’t occur “despite instructions directing each participant to make a disclo-

sure ‘if he or she has received something of value from a commercial com-

pany or institution, which relates directly to the content or conclusions 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 au-

thors noted that co-authors Dr. Mininder Kocher, Dr. Charles Methylman, and Dr. Mohit Bhandari have received grants from or consulted for a number of med-

ical device firms, including several of those mentioned in the study. No other conflicts of interest were reported.