Everyone Wants Electronic Medical Records, But Who Can Really Afford Them?

By Justo Mendez, J.D., M.H.A., LL.M. Candidate

Many healthcare providers may want electronic medical record ("EMR") systems, but recent surveys have found that only 17% of primary care physicians and fewer than 5% of all physicians have EMRs. If the technology is available, and if there is an overwhelming consensus over the benefits of adopting industry-standardized EMRs, why are they so rare? Although there is great potential in the EMR technology, it is still unaffordable for most hospitals, group practices, and definitely for solo-practitioners. Furthermore, every healthcare institution and physician is aware that, after taking on the sunk costs of acquiring EMR technology, there is no guarantee that it will not become the next laser disc or that a newer version will not eclipse the previous model every three months. Additionally, there are the opportunity costs: The amount of money a healthcare institution spends on EMR technology in order to improve healthcare is money that the institution will not have to acquire other resources to provide healthcare.

Expectations for EMRs run very high on the provider side. Medical associations and experts advocate EMRs as a way to connect doctors to patients’ histories, provide immediate information about the best practices, and simply cut the number of medical errors. The Institute of Medicine estimates that every year between 44,000 and 98,000 people die from medical errors while medication-related errors for hospitalized patients cost roughly $2 billion annually. These errors generate numerous civil suits across the nation every year. Reducing the medical errors that trigger these lawsuits would also cut the costs of malpractice insurance, boost consumer confidence, and relieve a highly congested judicial system.

The adoption of an industry-wide EMR system would improve administrative functions as well. Electronic records would decrease paperwork, speed billing, and streamline health transactions. This could significantly lower the amount of time, resources, and personnel needed to process healthcare claims and appeals. The U.S. Department of Health and Human Services ("HHS") has estimated that the adoption of EMR systems nationwide could lower the country’s annual $1.7 trillion health care bill by 10%.

Given these potential benefits, medical associations and healthcare institutions are calling for the federal government to take the lead in establishing industry-wide standards, and in fact HHS has taken the initiative in this area. For example, HHS in 2003 announced, “[W]e want to build a standardized platform on which physicians’ offices, insurance companies, hospitals and others can all communicate electronically, which will improve patient care while reducing the medical

---

1 Clement J. McDonald, The Barriers to Electronic Medical Record Systems and How to Overcome Them, 4 J. AM. MED. INFORMATICS ASS’N 213 (May/June 1997).
errors and the high costs plaguing our health care system.”⁵ Beyond setting industry-wide standards, many healthcare entities also hope – or even expect – the federal government to assume a considerable amount of the costs of launching the EMR system across the nation. While medical groups may be excited about moving toward electronic records, they generally want to avoid an “unfunded mandate.” Congress has held several debates over the possibility of offering some funding, but any commitments have been limited. The federal budget for fiscal year 2005 included $100 million to fund initiatives that foster interoperability of EMR systems.⁶ HHS has also proposed spending up to half of the $1.2 billion collected annually in fraud and abuse fines to provide grants to help providers automate.⁷ These amounts pale in comparison to the size of the task, however. Not surprisingly, funding of what experts consider will be “the next step in the evolution of health care delivery”⁸ has thus become a political issue.

There are multiple reasons for exerting great caution when demanding or accepting federal funding in the development of technology, or in establishing new services for the population, however. For starters, common sense dictates that the more that is taken from the government, the more control is given to the government. If the federal government finances and retains the production licenses for what is considered to be the next step in healthcare delivery, the federal government’s power over the health care system will only increase.

The second argument against accepting federal funding is that it will come attached to a political timeframe. By accepting federal funds, healthcare institutions and practitioners will be subjected to a timeframe determined by the White House, approved by Congress, and enforced by HHS. Outsiders to the healthcare industry, highly motivated by political gain, will establish the deadlines. There is a clear and present risk that deadlines will be set without taking the actual capabilities of the healthcare industry into consideration. This situation was evident in the 2004 presidential campaign. In response to President Bush’s 10-year proposal to develop a national EMR system, Senator John Kerry announced that he would have the system up and running in five years. The reality is that neither politician could then demonstrate that his proposal was in fact feasible. Even if the federal government had the capacity to purchase this technology for every healthcare provider in the United States, the industry would still need the time to train, familiarize the staff, and embrace this new way of doing business.

The federal government has several options separate from completely assuming all costs of establishing a national EMR system. A common strategy for stimulating change in business practices and industrial innovation is conceding tax breaks. The federal government has the option of granting tax breaks to healthcare providers that engage in implementing EMR technology in their practices. Tax breaks represent a great incentive for institutions and physicians that have the economic resources to implement new technology, but have been

---

holding back because of the inherent risks involved (obsolescence, compatibility, standardization, etc.).

The federal government might also consider amending the federal anti-kickback statute. Presently, a healthcare institution would be prosecuted for passing on or discounting EMR software or equipment to a physician that normally refers patients to the institution. This means that physicians must purchase software or equipment only at the full fair market value. To speed implementation of EMR systems, healthcare institutions should be allowed to transfer this technology free of charge or at a very low cost to referring physicians, but this cannot occur without changes to the anti-kickback statute.

Finally, the federal government should adjust the deadlines of the proposed rules and legislation to the economic and workforce capabilities of healthcare institutions. As of November 7, 2005, the Centers for Medicare & Medicaid Services approved the final rule for an electronic prescription drug program under Title I of the Medicare Prescription Drug, Modernization and Improvement Act of 2003. This final rule establishes electronic prescribing standards effective January 1, 2006. In turn, physicians are required to write electronic prescriptions for all Medicare patients starting in 2007, except in emergencies and other circumstances. The American Medical Association argues that the rigid implementation of this deadline creates an unfunded mandate for physicians, forcing them to purchase untested and expensive systems in order to comply. Even if uniform electronic prescribing standards may be helpful, it should be up to physicians to decide whether adopting this expensive technology is in the best interest of their patients and practices.

There are many more aspects and areas to cover in the discussion of financing and implementing a nationwide EMR system. Perhaps the financial involvement of the federal government would be more effective and efficient after a conscientious process of strategic planning, with the active participation of the healthcare industry, particularly physicians, and as far away as possible from the distractions of politics and the presidential race of 2008.

February 2006