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Health Care Reform Bill H. R. 3200—America's Affordable Health Choices Act

What Is Missing?

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The House of Representatives recently introduced its Health Care Reform Bill that is labeled America's Affordable Health Choices Act. It seeks to provide affordable health care for all Americans and curb medical expense growth by offering coverage and choice, affordability, shared responsibility, prevention and wellness measures, and workforce investments. However, it fails to address the escalating threat of medical liability, the lack of patient accountability, and the absence of outcome measures in health care delivery that may jeopardize the cost and quality of accessible medical care.

The House of Representatives introduced its version of a health care reform bill, H.R. 3200, cited as "America's Affordable Health Choices Act of 2009," on July 14, 2009 (1). Chairman of the Committee on Energy and Commerce, Representative Henry A. Waxman, introduced it in his opening statement as a "landmark legislation" and a "defining moment for our country" (2). The stated objective of the 1,017-page document is "to provide affordable, quality health care for all Americans and reduce the growth in health care spending" (1).

The need for health care reform is evident and irrefutable and has been proposed since the early 1990s (3). There are 46 to 50 million uninsured people in this country, a number that threatens to rise to 54 million in the next few years. The current cost of such limited care is $2.5 trillion per year, which equates to 16% of the gross domestic product, and continues to grow (4). The urgency for reform is to broaden coverage, expand access, and improve the quality of health care while curbing the rising cost of health care (5). However, H.R. 3200 does not address key issues that escalate the cost of health care, including the threat of medical liability, lack of patient accountability, and the absence of performance measures in delivery of care.

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Medical Liability

The current medical liability system is costly and unproductive and requires revision as a critical component of any health system reform legislation. The inefficiencies of the tort system, escalating and unpredictable litigation awards, and the high cost of defending even frivolous lawsuits contribute to the increase in medical liability insurance premiums, which are near all-time highs (6). In Pennsylvania, the malpractice insurance premium for an interventional cardiologist is almost $4,500 upfront for retroactive coverage plus an additional $1,500 annually for prospective coverage. As insurance becomes unaffordable, physicians are forced to alter or limit their services due to liability concerns, which impede patient access to care. Furthermore, defensive medicine, with extraneous testing and procedures, triggered by concern about malpractice liability becomes a significant driver of growing health care costs. Although these costs are difficult to estimate, trimming even 1% of health care spending would save around $22 billion per year (7).

Medical liability reform has received little or no attention in the discussion of H.R. 3200. To address liability reform, several medical societies, including the American College of Cardiology (ACC) and the Society for Cardiovascular Angiography and Interventions (SCAI), have partnered to propose models based on California's Medical Injury Compensation Reform Act (MICRA), including a $250,000 cap on

noneconomic damages, sliding scale for attorney fees, collateral source rule reform, periodic payment for future damage awards, and requirements to file a certificate of merit in any medical liability lawsuit, along with expert witnesses (6). Other proposed alternatives are multifold: 1) health courts, which would provide a forum where medical liability actions could be heard by specially trained judges; 2) early disclosure and compensation programs, where providers would be required to notify a patient of an adverse event within a limited period of time; 3) administrative determination of compensation models, where a state entity would be charged with setting a compensation schedule and resolving claims based on the patient's net economic loss; 4) expert witness qualification, which would mandate standards and qualifications of those that serve as medical expert witnesses at trial; and 5) liability protections for use of evidence-based medicine guidelines, by which physicians would receive legal protection for using current guidelines and following consensus statements and appropriate use criteria (6).

Patient Accountability

Consequences of individual choice and lifestyle play an important role in the cost of overall health care and needs to be included in any health system reform legislation. It is not just accessibility to health care that makes a patient healthy but also the application of care received and personal choices thereafter. Lifetime medical costs, which average approximately $225,000 per person, have been clearly linked to health habits: smokers, despite their shorter lives, have higher lifetime costs than nonsmokers by approximately one-third; people at low risk based on health habits have average claims of $190, whereas those at high risk have claims averaging $1,550; people with 3 or more risk factors from a list including smoking, alcohol abuse, and obesity have claims costs that are double those of people who have no risk factors (8). Noncompliance has also been overlooked as a serious public health issue and has received little direct, systematic, or sustained intervention (9). Patients commonly fail to take their medications as directed, leading to unnecessary hospital admissions and even death, costing the health care system as much as $177 billion a year (10). For example, despite significant improvements in technology and stent deployment technique, stent thrombosis continues to burden the health care system, resulting in recurrent hospital admissions and, most important, increased patient morbidity and mortality. However, medical noncompliance, often involving premature cessation of optimal antiplatelet therapy, has been consistently identified as the strongest independent predictor of stent thrombosis (11).

Patient accountability, however, has been ignored in the discussion of H.R. 3200. In a society where insurance premiums are inversely integrated with risky behavior—auto insurance that becomes increasingly expensive with history of accidents and traffic violations, disability insurance that is nearly always denied by participation in hazardous sports such as skydiving and white water rafting, life insurance that gets progressively more complicated with a history of obesity and substance abuse—there is little or no accountability on the patient for health insurance premiums despite known damaging lifestyle patterns. The federal Health Insurance Portability and Accountability Act (HIPAA) sets boundaries on the use of financial incentives for behavior change or biometric outcomes by requiring all workers covered under a particular employer-sponsored health plan to pay the same premiums regardless of their health status, with some exceptions to certain wellness programs (12). There have been reports to suggest that direct financial incentives can effectively motivate employees to change their health behavior and have been integrated by major corporations, including Dell, Scott's Miracle-Gro, and Clarian Health (12). The primary justification for such programs must rest on the economic harms imposed on others by engaging in unhealthy behavior, thereby promoting responsibility for habits that lead to poor health and increased costs and encouraging positive changes in lifestyle (12). Although there are enthusiastic government programs to support trade-ins of environment-polluting automobiles and prevalent insurance incentives to maintain a safe driving record, there is little incentive targeting the epidemic of obesity, tobacco use, and noncompliance. Patient education and responsibility need to be incorporated into any broad health care initiative aimed at reducing expenses and improving clinical outcomes.

Performance Measures

Health care reform requires incentives for delivery of high-quality patient-centered care that meets the practice guidelines of disease management and satisfies the expectations of patients and peers (5): that is, fee for performance rather than fee for service. Various performance metrics have been proposed including the 30-day readmission measure following percutaneous coronary interventions (PCI). However, it remains unclear whether a 30-day timeframe is an appropriate measurement when evaluating PCI performance. Some of the top 100 procedure codes associated with PCI readmissions include laparoscopic cholecystectomy, partial hip replacement, and implantation of an automatic implantable cardioverter-defibrillator (13), which are clearly unrelated to the quality of the PCI procedure.

The major concern elicited in the discussion of H.R. 3200 has been cost containment, whereas the key issue of performance of the health care plan has been disregarded. To this end, the ACC, under its program of "Quality First" using current guidelines, consensus statements, appropriate use criteria, performance measures, and process measures, has led efforts to create a new standard of health care centered on increasing the quality of care and ensuring greater patient value (14). However, further optimization and validation of current metrics need to occur before defining measures of payment

reform that reward quality of care and best practices, including reduced hospitalization and stabilization of disease processes.

Summary

The need for a major overhaul of the U.S. health care system is vital: uncontrolled health care costs, inequitable access to care, concerns about quality, and bureaucratic chaos in administration of health insurance programs have evoked widespread interest in restructuring the health care system (3). The proposed health care reform bill H.R. 3200, however, fails to acknowledge certain critical issues that lead to escalating health care costs, including medical liability reform, patient accountability, and performance measures. Yet, after its introduction in the House of Representatives on July 14, 2009, 3 House committees have passed this health care reform legislation in its current form: the Committee on Ways and Means passed this measure on July 17 with a vote of 23 to 18, and the Committee on Education and Labor cleared it on the same day with a vote of 26 to 22; the Committee on Energy and Commerce after much deliberation passed it on July 31 with a vote of 31 to 28. At the time of writing of this article, the bill, H.R. 3200, awaits to be considered on the floor of the U.S. House of Representatives when the House returns from its recess in September.

The ACC and its partners across the cardiology community continue to lead an aggressive campaign to prevent implementation of policies that further burden the patient under the current medical system, and to promote health care reform that is centered around improving quality of patient care. Additional information regarding these critical issues that face the cardiovascular community and opportunities for members to participate can be obtained at the ACC/CardioAdvocacy Network website (15).

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