President’s Message

Meaningful Reform

William T. Durkin, Jr., MD MBA FAAEM

As I write this column we are in the throes of a government shutdown and a looming debt-ceiling crisis, while Congress finds a way to pay for promised benefits with insufficient funds. Then there is the initiation of the ACA (aka Obamcare), with all the bureaucratic snafus that go along with most new government programs. There should be fewer uninsured once the computers and websites are fully operational. However, many health care systems are cutting back their work forces in anticipation of decreased reimbursements. Obscured by these stories are reports from states such as North Carolina, New Hampshire, and Massachusetts of new transparency laws — the first step to true health care reform.

Transparent hospital charges will allow patients to compare rates for different hospitals online, much the way they select airfares and hotels on Expedia. Presently, patients are blind to these charges. It is not uncommon for two hospitals in the same metropolitan area to charge radically different rates for similar emergency, inpatient, and outpatient services. Having that information at hand would be very valuable to any patient with a high deductible or limited insurance coverage. The other important piece of information is quality data. That would not be difficult to compile in the age of computerized records. Having cost and quality data on hospitals would greatly aid any patient in selecting a hospital. Institutions that are overpriced will either need to become more efficient or justify their higher price by demonstrating superior outcomes, better service, etc. As ACOs come into play, reimbursements will be further squeezed and hospitals and providers will need to improve efficiency and demonstrate better outcomes.

Of course, this works only if patients have some responsibility for their health care costs. Some “skin in the game,” if you will. Consumers become much more interested in the cost of services when they actually bear some of those costs. High-deductible policies and health savings accounts have become more popular in recent years. They are cheaper to buy but also place the consumer at some financial risk. We see this in practice, as when a patient inquires about the cost of a prescription versus those who want the Z-Pack for a URI because they are responsible only for a $5 co-pay, making cost no object for them. Patients tend to be more discriminating when they must bear some out of pocket costs.

The other piece of the puzzle that must be put into place is to make health insurance portable, available across state lines, and independent of employment — just as auto and other types of insurance are today. It is hardship enough to lose a job, but to lose your health insurance at the same time compounds the disaster. Sure, COBRA extensions are available, but they are very costly and have an end-date. If employers who provide health insurance instead provided an allowance, whereby employees could purchase their own policy based on their own needs and budget, things would be less complicated. The policy then belongs to the individual, who wouldn’t be tied to a particular job by the need to hang on to insurance. Currently, if you have auto, life, or disability insurance you can keep those policies no matter where you work or live. Health insurance should be the same way. To me it makes more sense than hiring only part-time employees to get around ACA rules.

Of course, the final reform I would like to see is comprehensive tort reform. Numerous studies have documented the unnecessary costs associated with defensive medicine. It is in the billions of dollars. Most physicians do their very best for their patients. We pride ourselves on the excellence of the care we provide. An unexpected outcome or less than perfect result should not mean a lawsuit costing tens of thousands of dollars just to defend, not to mention the associated time lost from work and the significant emotional distress that goes with being accused of negligence.

As shown by Studdert, et al., (N Engl J Med 2006;354:2024-33), 40% of malpractice claims involve either no injury at all or no error — not just no negligence, but no error — yet 16% of no injury claims and 28% of no error claims still result in a payment to the plaintiff. And for the latter, the average payment is over $313,000. What’s more, the average lawsuit takes over five years to resolve. I have seen several excellent emergency physicians leave the specialty, totally disillusioned after such an experience. This is a loss to their communities as well as the specialty, and this is one of the reasons AAEM favors tort reform beyond caps on noneconomic damage awards.*

In the state where I received my first medical license, in order to bring a malpractice suit a plaintiff had to have the case reviewed by a panel consisting of a physician, an attorney, and members of the community. If, after reviewing expert testimony, they thought the plaintiff had a good case, the case could proceed. If not, the plaintiff could still proceed but had to post a bond to cover defense costs in the event of defeat. Not a bad system — too bad it fell by the wayside! Some states have legislated meaningful tort reform. Texas recently passed a law that states there must be “willful and wanton” misconduct for a successful malpractice suit. That raises the bar significantly! Others have caps on pain and suffering awards. An interesting system is the one in New Zealand, where they have socialized medicine. When there is a claim of malpractice all parties are brought to the table, the case discussed, and an agreement made right there. Any monies paid are paid by the state. While I am not sure we would ever get to that point, I do think that malpractice claims should be taken out of the courts and reviewed by unbiased panels. Of course, this works only if patients have some responsibility for their health care costs. Some “skin in the game,” if you will. Consumers become much more interested in the cost of services when they actually bear some of those costs. High-deductible policies and health savings accounts have become more popular in recent years. They are cheaper to buy but also place the consumer at some financial risk. We see this in practice, as when a patient inquires about the cost of a prescription versus those who want the Z-Pack for a URI because they are responsible only for a $5 co-pay, making cost no object for them. Patients tend to be more discriminating when they must bear some out of pocket costs.

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AAEM Antitrust Compliance Plan:

As part of AAEM’s antitrust compliance plan, we invite all readers of Common Sense to report any AAEM publication or activity which may restrain trade or limit competition. You may confidentially file a report at info@aaem.org or by calling 800-884-AAEM.
course the devil is in the details, and the trial lawyers would block that as best they could, but the current situation is unbearable.

As we work our way through the present iteration of health care reform, we should bear in mind that true reform requires transparency in cost, quality, and outcomes; consumers must bear some responsibility for the cost of their health care; health insurance should not be linked to employment but rather owned by the insured, as is the case with other types of insurance; and tort reform must occur, so that physicians can practice to the best of their abilities without the fear of being hauled into court just because of an untoward outcome.

*A gross negligence standard for malpractice in emergency care is much more preferred than the currently, more common, ordinary negligence standard. See our White Paper on Tort Reform for more information. (http://www.aaem.org/em-resources/position-statements/tort-reform).*

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**AAEM/RSA Advocacy Day was a Success!**

On October 9, 2013, AAEM and AAEM/RSA members traveled to Capitol Hill to meet with congressional leaders, to learn about health care issues, and to advocate for emergency medicine.

(L-R) AAEM/RSA President Dr. Meaghan Mercer; Rep. Joe Heck (R-NV); and AAEM President Dr. William Durkin

(L-R) AAEM/RSA President Dr. Meaghan Mercer; Ganesh Nagaraj, RSA Advocacy Committee member; Rep. Eric Swalwell (D-CA); and AAEM President Dr. William Durkin

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