

Letter to the Editor

The Health Care Bill

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To the Editor:

On Christmas Eve, the Senate approved health care legislation, HR 3590, by a strict party-line vote of 60 to 39; just enough votes to prevent further debate or filibuster. The bill now heads for reconciliation with the house version with the President hopeful that he will have something to sign before the State of the Union message in January.

The Editors were constrained in their comments on health care¹ by their duty to remain true to their mission of promoting the dissemination of the scientific literature on orthopaedic arthroscopic surgery. As we have recently witnessed with the climate science literature scandal, scientific journals and politics should not be mixed and I applaud the Editors for their restraint.

As chair of the AANA Health Policy and Practice Committee and as our representative to the Coding, Coverage, and Reimbursement Committee, I have an obligation to share my thoughts on this bill with our membership. What follows is my opinion regarding the bill and its content.

Both the AAOS and AANA have joined a coalition of 13 other specialties in opposition to the bill through Physicians United for Patients (www.physiciansunitedforpatients.org). That our parent and specialty organizations have come out publicly against this bill speaks to its many deficiencies. They include:

- The creation of an Independent Payment Advisory Board that will have the power to determine coverage decisions. The Board will be made of unelected appointees that must submit coverage policy to the President and Congress. This will politicize treatment decisions best left to physician and patients. It may be hard fighting with insurance companies; imagine having to go to Congress to affect treatment decisions!
- New Comparative Effectiveness Research Programs (CER) similar to the NICE (National Institute for Health and Clinical Excellence) board in the United Kingdom that rations care and leads to as many as 15,000 premature cancer deaths in that country per year according to the National Cancer Intelligence Network.
- The bill depends on the recommendations of the U.S. Preventive Service Task Force in setting coverage and treatment policy. This is the same organization that recently caused such an uproar over advising woman under 50 not to undergo annual mammograms.
- The bill nationalizes insurance regulations including mandatory community rating and the prohibition of denial of

coverage based on previous medical conditions. This will drive up the cost of insurance in the majority of states that currently do not have such rules. New York has had such regulations since 1994 and our insurance costs are 2 to 3 times the costs in other states. Wellpoint, Inc., ran an actuarial analysis of its insurance programs and found that this will cause a significant increase (up to 168% in some instances) in premiums.

- There will be \$6.7 billion in new fees (taxes) on insurance companies to help fund the bill. Where do the Senators think the money for this new tax will come from? The bill also dictates insurance executive salaries and limits their profitability. I am no fan of the insurance companies but making them federally controlled utilities will not reform the perverse incentives created by the current third-party payer system.
- New payroll taxes for those earning over \$200,000.
- Failure to address reform of the SGR (Sustainable Growth Rate) of Medicare.
- For Medicare, there will be \$400 million in cuts over the next 10 years. Medicare will be insolvent in 7 years if unreformed. The bill's answer to that fact is this cut. It is also necessary to keep the overall cost of the bill under the arbitrary \$1 trillion cost set by the President. If history is any guide, these cuts will never materialize because Congress knows that the program is already underfunded and that making these cuts will limit seniors' access to health care as doctors flee the system. This is why they have voted every year to override the hated SGR and not cut provider fees.
- An expansion of Medicaid to those well above the poverty level. Medicaid is the largest line item in many state budgets. Increasing eligibility will place enormous stress on state budgets already crippled by the current economic climate. It will necessitate huge state tax increases, unless you live in Nebraska where Senator Ben Nelson was able to negotiate no increases for new Nebraskans in Medicaid in exchange for his yes vote. So all the rest of us get to pay for the Nebraskans and also those from Louisiana, since Senator Mary Landrieu also switched her vote to yes in exchange for \$300 million in Medicaid subsidies to her state. In addition, all these newly insured will find that 40% of doctors do not accept their new insurance so by definition they will be underinsured.
- The creation of government run exchanges that will subsidize insurance for those making up to 400% of the poverty level, or \$96,000 per year. Under the Senate bill, someone who earned \$42,000 would get \$5,749 from the current tax

exclusion for employer-sponsored coverage but \$12,750 in the exchange. An employee making \$60,000 would get \$3,758 in the current system and \$8,310 in the exchanges. This will significantly distort the labor market making much more attractive for small business to offload insurance costs to the exchanges or to make employee “contractors.” It also may significantly underestimate the government’s costs as more employers flee the private insurance market for the exchanges.

- The creation of the health care insurance mandate. All individuals will be forced to purchase some type of health insurance or face a fine of \$750 that will be levied by the IRS. Some may chose to pay the rather small fee and not get insurance. This would be especially attractive for young, healthy men since they will be able to purchase insurance anytime they have a medical problem under the guarantee issue part of the bill. Some legal experts believe that such a mandate is unconstitutional and it is likely to face protracted battles in the courts.
- New taxes of \$2 billion (increasing to \$3 billion in 2018) on medical device makers. Our specialty is technology and device intensive. Our collaboration with the device industry has been a resounding success with the benefits accruing to our patients in terms of less pain, scarring, and improved outcomes. It has also greatly facilitated the orthopaedic education initiatives sponsored by AANA. This tax represents a real threat to innovation, patient care, and education.
- Limitation and new taxes on Health Savings Accounts. These accounts are popular because they give patients more control over how they spend their health care dollars. In an era of rising copays and deductibles they are a great hedge against increased expenses and offer a way for patients to control their own costs. I know, I’ve had one for 5 years. They will be severely limited in this bill.
- Restrictions on Medicare Advantage. This popular program, which enrolls about 20% of Medicare recipients will be slowly abolished. Unless you live in Florida where Senator Bill Nelson negotiated a \$3 billion deal to exempt Florida seniors who currently have Medicare Advantage from losing their benefits.

- Severe limitation on physician-owned hospitals.
- No serious effort at tort reform as a potential health care cost saver.

This legislation will affect all of us as practicing surgeons, as employers, and as patients. We will face threats that will severely curtail our ability to care for our patients. We will be limited by central decision makers in Washington determining coverage and treatment options. We will be limited in our ability to order diagnostic tests and use new instruments and devices. What happens when the CER says that rotator cuff repair is ineffective? Think it can’t happen? Our patients will face increasing insurance costs and limitations of coverage; especially seniors who face rationing of their care. As employers we will see our insurance cost increase and will face the possible elimination of health care insurance from the benefits we offer our employees.

This bill is reckless and poorly constructed. The unintended consequences will be manifold. It does not lower or control costs, it increases them. It does not improve quality: quality will suffer. It does increase access of some, but not all, of those who currently lack insurance. Some, like those on Medicaid, will remain underinsured.

The debate on this bill is not over. It must be reconciled with the House bill, which contains a public option and an income tax surcharge on single fillers with an income of \$500,000 and couples making \$1 million that some Senators who voted for the Senate bill will not vote for. By the time this letter is published, we will know the final outcome. In the months that follow, the Health Policy and Practice Committee will strive to keep you all abreast of the changes ahead.

Louis F. McIntyre, M.D.

Chair, AANA Health Policy and Practice Committee

Reference

1. Lubowitz JH, Poehling GG. Access to arthroscopy: Ethical imperatives and economic challenges. *Arthroscopy* 2009;25:1363-1364.