AAOS AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS
AMERICAN ASSOCIATION OF ORTHOPAEDIC SURGEONS

Position Statement

Principles of Medicare Reform and Access to Specialty Care

This Position Statement was developed as an educational tool based on the opinion of the authors. It is not a product of a systematic review. Readers are encouraged to consider the information presented and reach their own conclusions.

Medicare is the Federal health insurance program for the nation's elderly. Part A of the program covers inpatient hospital services, inpatient care in skilled nursing facilities after hospitalization, home healthcare, and hospice care among other services. Part B of the program covers physician services, outpatient hospital care, diagnostic services, durable medical equipment, and ambulance services among other services. Part D provides coverage for prescription drugs.

Medicare continues to face both short-term and long-term fiscal challenges that impact both patients and providers. Factors causing the growth in Medicare costs include but are not limited to:

- a 50 percent increase in the number of beneficiaries since the start of the program;
- an increase in the life span of beneficiaries which increases the number of years that they use medical services;
- advances in medical science and technology that prolong and enhance the quality of life but may be costly;
- the addition of the part D prescription drug benefit;
- the increased prevalence of obese patients which is a significant factor in the growth of Medicare expenses associated with treating chronic diseases among seniors;[1]
- increased beneficiary demand for services due to many factors - first dollar coverage among Medigap plans, direct-to-consumer advertising, lower beneficiary cost-sharing requirements, the growth of chronic disease among seniors and a medical liability system that encourages inefficiencies including the practice of defensive medicine; and fraud and abuse.

The American Academy of Orthopaedic Surgeons (AA0S) believes that the Medicare program needs fundamental reform because of its impending financial crisis which threatens patient access to medical care. To achieve Medicare solvency, the AAOS believes that policymakers must undertake a thorough review of all program components, including health care delivery and benefits, payments to providers, and initiatives to contain costs.

I. Health Care Delivery and Benefits

Quality Initiatives

The AAOS has been engaged in quality initiatives to improve patient care and outcomes for several decades and maintains this as a top priority. The AAOS is actively involved in developing the quality measures for orthopaedic care. Through the Orthopaedic Quality Institute, the AAOS works with government and private stakeholders to define needs and expectations of quality measures. Using this input, orthopaedic surgeons and staff are producing metrics which better define and measure value in musculoskeletal health. These measures are anticipated to improve systems such as the Physician Quality Reporting System (PQRS) and evaluations by private payers.

To further enhance quality care in orthopaedics, the AAOS produces Evidence-Based Clinical Practice Guidelines, Systematic Reviews, Appropriate Use Criteria (AUC), and Clinical Performance Measures for the most common musculoskeletal conditions (e.g., management of hip fractures, anterior cruciate ligament injuries, etc.) These evidence-based quality products help drive care algorithms, supplement patient-clinician discussions and decision-making, improve efficiency, and add value to specialty care delivery and can be viewed via the OrthoGuidelines webpage (www.orthoguidelines.org). The AAOS believes it is important that orthopaedic surgeons have direct input into the development of quality standards and supports quality initiatives that demonstrate effectiveness in improving patient outcomes. It is important that quality and reporting initiatives are regularly re-evaluated to ensure that they continue to improve the quality of orthopaedic care.

II. Ensuring Patient Access to Specialty Services

While the initial passage of laws banning physician self-referral was well-intentioned, unintended consequences have placed continuity of patient care at risk. Responsible physician ownership of services and facilities has been demonstrated to improve patient safety, access, quality, efficiency and the delivery of cost-effective services and should not be prohibited.[2]

Integral to patient care, continuity of care, patient convenience, patient choice, and patient safety is the provision of in-office ancillary services as well as ensuring that patients continue to have the choice of receiving care in a specialty hospital setting. It is in this patient-centered context that physician owned services and physician self-referral must be examined and permitted. The AAOS believes that the well-being of the informed patient is paramount in any health care policy.

Guaranteeing Individuals the Right to Enroll in a Health Care Plan of Their Choice

Individuals should to be able to choose a health plan with the benefits, providers, and patient cost-sharing arrangements of their choice. It is important that policy makers ensure that health plans cover basic health care benefits, including access to specialty care, while avoiding the temptation to impose excessive mandates that drive up the cost of medical insurance. This will ensure that basic health care needs are met, while giving health plan enrollees greater choices and flexibility.

Some policy makers have proposed the creation of governmental agencies (i.e., a National Health Board) that may limit, directly or indirectly, the types of benefits and services that could be offered in private health care plans. Such objectionable limits could include:

- An outright ban on plans that provide additional services
- Excluding plans that provide such services from participating in health care exchanges
- Denying these plans the same tax treatment as the plans that meet the government's mandates

The AAOS believes that it is appropriate to establish a minimum benefit package for private health care plans - at the federal and/or state level - but would caution policy makers to ensure that such mandated benefits are basic to ensure that essential health care needs are met, including access to specialty care, and that the cost of a basic health care plan remains affordable.

The AAOS believes strongly that patients should be empowered to control and decide how their health care dollars are spent and thus opposes the establishment or use of a federal regulatory body that would impose on private insurance plans any limitations on benefits and services offered or provided under such plans. Furthermore, the AAOS opposes any policy that would impose such limitations directly or indirectly through tax policy, regulations, regulatory bodies, or other means.

III. Cost Containment and Solvency

In order to ensure the long-term sustainability of Medicare, policy makers must adopt new models of providing health care coverage for seniors and ensure that seniors have access to a wider range of choices that best meet their health care needs.

Enhanced Beneficiary Cost-Sharing

The way in which Medicare is financed will also have serious consequences for patient access to quality care. Currently, Medicare Part A is supported by a 2.9 percent payroll tax on annual wages. Part B is financed through general revenues. Both parts are also funded through contributions from beneficiaries in the form of premiums (Part B), deductibles (Parts A and B) and co-payments (Parts A and B).

When Medicare began in 1966, Part B premiums paid 50 percent of program costs and Part B deductibles paid about 45 percent of the average charges for medical services. Today, Part B premiums pay only 25 percent of program costs and deductibles pay less than 5 percent of average charges. In 2003 Congress acted to increase Part B premiums for higher income seniors, in 2015, individual seniors with income under 85,000 paid $104.90 per month while individuals with incomes between $85,000 and $107,000 paid $146.90 and those with income between 107,000 and $160,000 paid $209.80. The highest premium was paid by individuals with incomes over $214,000 who paid $335.70 per month.

While this step was taken to decrease the subsidy to higher income seniors, other Medicare cost-sharing provisions have failed to keep pace with inflation. Consumer prices increased more than seven-fold between 1966 and 2008, but the Part B deductible has only increased from $50 to $147 per year as of 2015 - less than one third the increase in the consumer price index. Yet growth in Part B costs averaged 9.6% annually from 2002 through 2007. Furthermore, there is no premium for Medicare Part A, and there is no co-payment required for home health, clinical laboratory, pathology or skilled nursing facility services.

As contributions from beneficiaries have decreased in relation to costs, the financial burden of Medicare has been covered, increasingly, by working people under age 65 through higher general revenue taxes. This financial burden on younger working people is compounded by the fact that the number of workers is shrinking in proportion to the growing number of Medicare beneficiaries. Moreover, many young workers are not able to afford their own health insurance yet must contribute their taxes to Medicare coverage for seniors.

The AAOS believes that most beneficiaries should assume greater cost-sharing responsibility for the Medicare program, with protections for low income beneficiaries, in order to preserve their access to quality care. There are a broad range of options that policy makers could consider for enhancing beneficiary cost-sharing, among them are:

- Indexing Part B premiums to gradually raise the overall beneficiary proportion of Part B expenditures above 25%.
- Further reducing the subsidy for Medicare Part B premiums for high-income beneficiaries so that they assume a greater share of program costs.
- Increasing Part B deductibles and indexing them to better reflect the cost growth in the program.
- Replacing the complex set of cost-sharing arrangements with a single standardized coinsurance rate.
- Restructuring Part A financing, including establishing a Part A premium.
- Establishing a co-payment for home health, clinical laboratory, pathology and skilled nursing facility services.
- Raising the eligibility age for Medicare beneficiaries to be consistent with the Social Security program.
- Eliminating the costs generated by the increased utilization of services due to Medigap first dollar coverage.
- Enacting liability reform to lower the costs of liability insurance and the practice of defensive medicine.
- Establishing a basic benefit package for every Medicare patient; the projected cost of which, is within the budget and would be expected to cover all basic health care needs. Then allowing supplemental insurance to be offered by private companies to enhance an individual's coverage if they choose.

IV. Access to Specialty Care

As Alternative Payment Models (APMs) evolve under Medicare payment reform, creative solutions are expanding for patient care. Some of these models such as such as Accountable Care Organizations or Patient Centered Medical Homes offer ways for primary care and specialists to work together. However, the models can also place primary care providers in a gate-keeper role, limiting the access of their patients to direct specialty care.

The AAOS encourages and supports Alternative Payment Models (APMs) which allow creative delivery and reimbursement models. However, access to specialty care must remain an option for our patients.

V. Payments to Providers

Limiting access to services and cuts in payments to providers have been the traditional means by which government policy makers have sought to curb Medicare spending. For more than two decades Medicare payments to physicians and hospitals have been cut by tens of billions of dollars. Payment to physicians, which account for 23% of Medicare expenditures, have been cut due to a number of factors including reimbursement freezes, fee reductions, limits on balance billing, implementation of the "resource-based" payment system, and a flawed Medicare reimbursement formula. If allowed to continue this will result in significant access and quality problems as providers struggle to deliver care below their actual costs.

Balance Billing

The ban on balance billing under the Medicare program has further impacted the ability of providers to cover the widening gap between inadequate Medicare payments and the cost of providing services. The AAOS believes that, in the absence of reimbursement that reflects the full costs of care for Medicare beneficiaries, the federal rules prohibiting balance billing should be repealed and insurers should be forbidden from including balance billing prohibitions in physician-insurer contracts.

The AAOS believes that repeal of the ban on balance billing will help providers close the gap between inadequate Medicare payments and the cost of providing services to seniors.

References:

Footnotes

1. Finkelstein EA, Fiebelkorn IC, Wang G: National medical spending attributable to overweight and obesity: How much, and who's paying. *Health Affairs,* May 13, 2003.
2. Medicare's Financial Condition: Beyond Actuarial Balance. Issue Brief American Academy of Actuaries, March 2008.

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3. Physical Therapy: Self-Referring Providers Generally Referred More Beneficiaries but Fewer Services per Beneficiary. GAO-14-270: Published: Apr 30, 2014. Publicly Released: Jun 2, 2014 http://www.gao.gov/products/GAO-14-270
   Status of the Social Security and Medicare Programs, 2008 Annual Report.

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Position Statement 1175

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