

Position Statement

Principles of Health Care Reform and 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.

Overview

Health care spending in the United States has increased from \$75 billion (7% of Gross Domestic Product [GDP]) in 1970 to more than \$2 trillion (16% of GDP). This is twice the rate of spending of other developed countries, yet for a number of health outcomes Americans trail behind other nations. In spite of this level of spending, tens of millions of Americans lack insurance. Uncompensated and under-compensated care are persistent problems and remain among the greatest concerns to physicians who consistently put patients first in our health care system.

Among the factors leading to increased and inefficient health care spending are:

- High administrative costs
- A broken liability system
- An increase prevalence of chronic disease
- A shift in cost from the uninsured to the insured
- A predominant third-party payer system
- Unnecessary patient care

The existing employer-based system of health care coverage poses unique problems with regard to portability and the availability of health care for all. The current health insurance and health care delivery system is not sustainable. The demand is infinite and must be checked through a variety of means (i.e., a defined basic benefit package and structured co-payments determined by an individual's ability to pay). Any health care reform must address these systemic problems.

Americans receive their health care coverage through a variety of public and private arrangements. As the Congress considers various initiatives to reform the existing health care system, it is important that policy makers avoid creating new unaffordable programs that repeat past mistakes. Existing government programs – Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) – face long-term sustainability challenges due to trillions of dollars in unfunded liabilities. The financial restraints of these programs lead policy makers to erect bureaucratic impediments to care and reimbursement rates that make it difficult for providers to cover the cost of care.

The demands upon physicians, providers, and payers is infinite but can be contained through incremental changes to the system. For example, altering the allocation of federal and state resources or increasing the portability and availability of health care coverage can increase the number of individuals with health insurance. However, significant changes to the system are necessary to overcome current challenges and to ensure tens of millions of uninsured Americans without health insurance are able to enroll in affordable insurance that provides access to high quality medical care, including unencumbered access to needed specialty care.

The American Association of Orthopaedic Surgeons (AAOS) believes that in any consideration of changes to the health care financing and delivery system in the United States, the well-being of the patient must be the highest priority. The AAOS strongly supports the reform measures and principles set forth in this statement as providing individuals consistent access to patient centered, timely, unencumbered, affordable and appropriate health care and universal coverage while maintaining physicians as an integral component to providing the highest quality treatment.

The AAOS believes that as policymakers consider health care reforms they should:

- ***Make certain that patients are empowered to control and decide how their own health care dollars are spent***
- ***Ensure unencumbered access to specialty care***
- ***Make health care coverage more affordable***
- ***Improve the quality of care***
- ***Extend both coverage and access for the uninsured and under-insured***
- ***Avoid establishing new unsustainable programs***

While the AAOS believes that expanding health care coverage and access should be implemented through a public-private partnership, we strongly oppose proposals that create a federal health care authority or move health care further in the direction of a single-payer health care system.

Improving Access to Medical Care and Affordable Coverage

While states can provide innovative initiatives to expand health care access and coverage, the federal government must take the lead to ensure access to health care for all. The individual has the right to select the health care coverage of his or her choice and the responsibility to enroll in coverage. At a minimum, individuals and families must have access to basic health care coverage, including catastrophic coverage, in order to avert not only personal financial ruin but also to avoid shifting the costs of their care to those who are insured.

The AAOS believes that everyone within the United States should receive access to health care coverage – including specialty care - without financial barriers or undue burdens placed on the patient or physician. The responsibility of financing appropriate health care services must be a shared public-private cooperative effort that advances a patient-centered model for choosing affordable health care options.

Benefit options for individually purchased coverage must align with employer-based coverage options. While individuals and families must have access to ample financing for the sole purchase of catastrophic health care coverage, a newly reformed health care system should allow individuals or employers to assert social responsibility when purchasing additional services or insurance as part of a structured or packaged offer. Open market approaches similar to the Federal Employees Health Benefits Program (FEHBP) can ensure portability and continuity of care.

The Uninsured

A large and growing number of uninsured and under-insured Americans constitute a major burden on the health care system. Among the factors contributing to the growing ranks of the uninsured are:

- Lack of access to affordable coverage
- Loss of employment and consequently insurance coverage
- Individuals simply choosing to go without insurance coverage
- Failure of eligible individuals to enroll in Medicaid or SCHIP
- Immigration status

In some states the cost of providing medical care to non-citizens has placed the local health care delivery system at risk.

As policy makers consider legislation to expand health care coverage access, it is important that they bear in mind that the demographics of the 45 million uninsured people in the United States vary widely. Among the facts to consider:

- 12 million are currently eligible to enroll in an existing government program
- 12 million are uninsured for less than one year
- 18 million earn more than \$50,000/year- including 5 million single adults earning more than \$80,000/year
- 10 million uninsured are non-citizens
- 25 million are childless adults
- 14 million have incomes below 200% of the poverty level (\$41,000/family of four) but are not eligible for a public program
- 70% are in families where there is at least one full-time worker

Physicians and health care facilities provide care to all, but they alone cannot and should not bear the burden and assume the costs of providing care to those who are uninsured or who have inadequate coverage. The problem of the uninsured demands a federal solution that recognizes that there are a variety of factors contributing to the lack of insurance and that a multifaceted approach is needed to expand both health care coverage and access for the uninsured.

Existing Health Care Programs

The federal government established, in conjunction with the states, both Medicaid and SCHIP to provide lower income Americans and children with health care coverage. Yet, millions of Americans that are eligible for these programs are not currently enrolled and are among the ranks of the uninsured. Additionally, some policy makers have proposed expanding Medicare enrollment eligibility to those under age 65 to help address the problem of the uninsured.

The AAOS believes that the states should make it a priority to enroll in Medicaid and SCHIP those who are currently eligible but who are not already enrolled. In addition, states should make it a priority to provide physician payments in Medicaid and SCHIP at parity to Medicare rates. Given Medicare's short-term and long-term insolvency, the AAOS is opposed to proposals that would expand eligibility for enrollment in Medicare.

(See AAOS Position Statement 1174 on Medicaid and State Children's Health Insurance Program (SCHIP) and Position Statement 1175 on Principles of Medicare Reform for a more thorough discussion.)

Financing Issues in Health Care

Health care financing reform should engage all stakeholders:

- Patients
- Insurers
- Hospitals
- Health care professionals
- Employers
- Governments
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Consistent with the concept of patient-centered care, the patient's basic medical needs must be the first priority in any payment/financing system.

The AAOS supports efforts to ensure that physicians are adequately compensated for providing medical care to the uninsured. In the absence of universal coverage and adequate reimbursement, the AAOS supports providing physicians with tax initiatives to defray the cost of uncompensated care. The AAOS believes it should be a priority for the federal and state governments to provide adequate long-term sustainable funding for existing government health care programs to ensure that these programs are sustainable and enrollees retain access to medical care. The AAOS opposes the use of any tax on health care professionals to finance changes to the health care delivery system. The AAOS also believes that administrative expenses in private health care plans should more closely mirror those of public programs, ensuring that a more significant portion of spending is dedicated to medical care.

Empowering Individuals to Access Affordable Coverage

Individuals should be able to choose the type of health care coverage that they want and that best fits their needs. Today's tax laws disadvantage individuals and those employed by small businesses. Employees who do not have access to health insurance through their employers are not able to benefit from the more than \$125 billion in tax subsidies the federal government provides through employer-provided health benefits.

The AAOS supports a number of tax initiatives as components of health care reform that will level the playing field and help make health care coverage more affordable. The health care marketplace, which has suffered from the lack of competition, should be strengthened by adoption of policies that restore equity and enhance market competition. Among the reforms that policy makers should consider are:

- ***Tax credits, vouchers and tax deductions for individuals and families for the purchase health care coverage, including refundable tax credits and vouchers to assist lower-income Americans in purchasing health insurance***
- ***Additional subsidies for those with higher than average health care costs will help keep overall premium costs lower***
- ***Extension of tax-favorable Health Savings Accounts (HSAs)***
- ***Open markets that permit individuals and families to purchase health insurance across state lines***

Patient Empowerment and Personal Responsibilities

Individuals have a personal responsibility and a right to choose and select the health care plan and benefits of their choice. There are significant existing federal and state structural barriers that make the current marketplace less competitive and impede the current market resulting in limited choices and higher costs. Individual choices should be expanded beyond those developed by government bureaucracies or employers. Individuals who make healthy life-style choices should be able to benefit from those choices by paying lower premiums or receiving other financial rewards.

The AAOS strongly believes that patient empowerment and individual responsibility are necessary components of health care reform. Healthy choices should be recognized and preventive care should be promoted.

Health Care Marketplace, Administrative, and Structural Reforms

Ensuring Continuity of Care and Coverage

Employer-based health care poses unique problems, since large group purchasers are favored under the current health care insurance delivery system. The current system must be changed so that individuals no longer lose their access to health insurance because they lose or change jobs. By linking health care to the individual rather than the place of employment, individuals will have more choices. Those who wish to remain in an employer-based insurance plan should be permitted to retain that choice.

The AAOS believes that all health care options should be linked to the patient (not the employer). All insurance coverage options must be portable and affordable to provide optimal access and continuity of quality health care.

Finding Alternatives to the “Medical Home” Concept

Formal legislative proposals and suggestions that outline the importance of a physician coordinator or overseer of all patient care may be appropriate in some circumstances when it is in the best interest of the patient. However, policy makers must avoid the creation of new health care delivery models that impede, delay, withhold, or deny access to necessary specialty care. As the practice of medicine has become increasingly specialized, it is important to ensure that patients have access to timely, high quality, affordable specialty care, including the physician of their choice.

The AAOS supports timely, unencumbered, affordable access to appropriate specialty care as it is paramount to achieving quality health care for all patients. Patients must have access to the right treatment, by the right health care professional, at the right time. For some conditions, the most efficient and effective entry point into the health care system is through appropriate specialty access. More specifically, the AAOS believes that access to essential musculoskeletal services must not be impeded – including access to preventive care, pediatric musculoskeletal care, trauma treatment, emergency room care, and disaster preparedness. In certain situations, an orthopaedic practice could serve as the medical home.

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 it should not be prohibited.

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 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.

Emergency Room Care

Throughout the nation, patients are finding it difficult and sometimes impossible to obtain emergency care services in a timely manner because of:

- An ever-increasing patient population seeking emergency care
- A decrease in the number of hospital emergency departments
- A shortage of specialists available to take call
- Shortages of other hospital resources to support emergency care services
- An increasing volume of uninsured or underinsured patients
- A challenging liability environment

The AAOS believes that all stakeholders must work together to address emergency department coverage issues. A solution to this problem must include solutions to the unfunded mandate of EMTALA in order to ensure the success of any health care reform proposal. Participation by a patient in a particular health care plan should not restrict access or reimbursement to any and all emergency rooms and necessary providers.

(Please see the AAOS Position Statement 1172 on Emergency Orthopaedic Care for more information.)

ERISA Reform

While states are able to pass strong patient protection legislation, the laws apply to few health plans since most insurers are exempt from state law by the Employee Retirement Income Security Act (ERISA). ERISA currently impedes the ability of states to improve the quality of medical care provided in their states.

The AAOS believes that ERISA should be amended to allow states to enact laws that affect all insurance plans when consistent with federal policy objectives of improving patient care.

Antitrust Relief Must Level the Playing Field

Under existing law, insurance companies, health plans, and hospitals have an unfair advantage in setting prices. The playing field should be leveled, and physicians should be allowed to share information and negotiate collectively with health plans. The current “third party messenger” model has proven an ineffective, cumbersome and costly attempt at addressing this situation. Moreover, the McCarran-Ferguson Act effectively exempts insurance companies from the very antitrust laws which physicians are required to follow.

The AAOS believes that the antitrust laws should be changed to allow physicians to collectively negotiate with health plans and insurers without the necessity of joining a labor union. The McCarran-Ferguson Act needs to be amended to change the anti-competitive practices of insurance companies and establish equity among health plans, insurers, and physicians.

Providing Efficient Care and Coverage (Cost/Efficiency vs. Quality/Value/Safety)

In recent years, several initiatives have been introduced to either control costs or improve quality:

- “Pay-for-performance”
- Gainsharing
- Value-based purchasing

Patients deserve the highest quality treatment and any cost-control mechanism must be implemented in a manner that is in the best interest of the patient. Patient safety and the well-being of the patient must always be the first consideration.

The AAOS supports efforts by stakeholders to control costs to attain a workable, affordable, and sustainable health care system that is based upon high levels of evidence-based medical research. However, any cost-containment mechanism must be balanced with quality in order to provide patients with the most valuable care.

Medical Liability Reform

Patients who suffer an injury because of the negligence of a health care professional should be justly compensated. Yet the high cost of defensive medicine in today's punitive and adversarial environment has a detrimental effect on affordability and access for all patients.

The AAOS strongly maintains that meaningful medical liability reform at the federal level and/or constitutionally sustainable state medical liability reforms are a necessary component of any viable health care reform proposal. Absent liability reforms, billions of dollars will continue to be wasted on defensive medicine, driving up the cost of health insurance. (See the AAOS Position Statement 1118 on Professional Liability: Tort Reform for greater detail.)

Reduction of Administrative Costs in the Health Care System

In the United States, the proportion of total health care expenditures diverted to administrative expenses is far too high. In some plans, administrative costs can be as high as 50 percent. In addition, individual physician practices continue to face undue regulatory and administrative burdens.

The AAOS believes that the burden of administrative cost of private health care plans should mirror the costs in the public sector and that the great preponderance of all health care expenditures should be spent on actual delivery of health care.

Health Information Technology (HIT)

Efficient administrative systems, including comprehensive HIT infrastructure and implementation, are essential to maximize funding available for actual patient care. Adoption of HIT may reduce costly inefficiencies by enhancing physicians' access to medical tests and reducing the need for duplicative services. It is critical that interoperable standards be established in a timely manner to ensure more rapid adoption of HIT. Given the failure of Medicare reimbursements to keep pace with inflation, the growing cost of providing care to the uninsured and underinsured and other financial pressures on physician practices, it is unreasonable to expect the physician community to bear the cost of HIT implementation.

The AAOS believes that health information technology has the potential to enhance the quality of care for musculoskeletal patients. Adequate funding for interoperable HIT must be allocated by the federal government, subsidized by cooperation-based state grants, or supported by other private insurer financing mechanisms. The cost of implementing HIT must not be borne by the physician community. AAOS also believes that HIT must accord with preset standards as long as the highest quality patient care is delivered.

Professionalism

Recently, there has been a focus of attention in the public arena on conflicts-of-interest with industry, direct-to-consumer marketing, and advertising by physicians. The AAOS has addressed these issues in other documents which can be accessed at www.aaos.org/profcomp.

AAOS maintains among the highest standards of professionalism and has developed a *Code of Ethics and Professionalism for Orthopaedic Surgeons*. The best interest of the patient is the cornerstone of physician conduct and should direct all physician activities.

Workforce and Graduate Medical Education

The federal government, through Medicare, is the largest financial supporter of graduate medical education. The private sector contributes to graduate medical education by paying the higher charges of teaching hospitals. In recent years, however, the private sector has become less willing to pay these higher charges. If the Medicare program involves more managed care and/or privatizes, support for graduate medical education may decrease significantly, threatening quality and access to care for all Americans. In addition, Medicare's current funding formulas for graduate medical education have led to increases in the number of trainees in fields which may not be consistent with the nation's current and anticipated needs.

The AAOS believes that all payers should contribute equitably to graduate medical education funding. A mechanism should be developed to ensure that the number of residency positions funded through Medicare and other payers actually reflects the nation's health care needs. More specifically, policy makers must ensure that additional resources and residency slots are provided for orthopaedic surgeons and other specialists involved in providing trauma care. In addition, loan repayment programs should be expanded and loan deferment programs should be extended to the full length of residency.

Medical Care and Non-Citizens

Over the past several years, policy makers have debated the impact of immigration on the Medicaid and SCHIP programs. One focal point of the immigration debate has been citizenship documentation. In this and other areas, federal policy makers should delegate immigration issues to those who are best-situated to deal with those issues: immigration and homeland security experts.

The AAOS believes that physicians should not be required to act as immigration agents by restricting care only to citizens and that they should be appropriately reimbursed for all medically necessary care that they deliver to all individuals.

Conclusion

As we approach the great public debate on health care reform in America, the AAOS believes preservation of the autonomy of the physician-patient relationship to be of the highest priority. Though challenges and opportunities are many, each part of the solution must ensure patient-directed physician empowerment to deliver individual value, overall quality and systemic efficiency. All Americans are or will become patients. Implementing a reformed public-private partnership health care system that reflects the principles addressed will serve this and future generations with meaningful universal coverage and real access for all.

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