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IN ADDRESSING HEALTH CARE, FIRST, DO NO HARM

DAN LIPINSKI*

While the origins of the famous enjoinder to physicians, "[f]irst, do no harm," are somewhat murky, its call for sober consideration and recognition that good intentions do not ensure good outcomes is clear. Indeed, policymakers engaged in health care reform would be wise to heed this cautionary directive.

Of course, in legislating, as in medicine, few treatments carry zero risk, and the admonition to do no harm should not serve as a prescription for inaction. Instead, it furnishes a useful reminder—both to the physician and the legislator—that we must carefully weigh the negative consequences of a given effort to improve the lives of others. With this in mind, I have worked to reform our nation's health care system and have supported a number of measures that would promote this goal since I was first elected to Congress in 2004. However, I remain convinced that the health care reform bill Congress passed in March, 2010, the Patient Protection and Affordable Care Act (PPACA),¹ will do real harm, and that in many cases the harm was both avoidable and excessive. For that reason, I had to oppose it.

I do not wish to suggest that providing coverage for millions of uninsured Americans is not important. It most certainly is. But in its pursuit of that goal, the health care reform law will negatively impact significant segments of society.

Certainly, Congress committed a grave mistake when it allowed the bill to permit taxpayer money to subsidize insurance plans that include coverage for elective abortions and also opened the door for direct taxpayer funding of elective abortions.² There is no doubt in my mind that this violates the "do

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no harm" standard, as it would lead to the loss of innocent life. Indeed, the original text of the Hippocratic Oath included a specific admonition against doctors enabling abortions.\(^3\)

While some have claimed that the PPACA would not change the status quo regarding federal funding for abortion, the fact is that for many years federal law—in the form of the Hyde Amendment—has prohibited federal funding for both abortions and health plans that cover abortions. The amendment is as clear on the latter point as on the former, stating that no funds "shall be expended for health benefits coverage that includes coverage of abortion."\(^4\) Unfortunately, as is beyond dispute, PPACA's tax credits subsidize the purchase of insurance that includes abortion coverage. That clearly violates the Hyde Amendment. Meanwhile, as the result of an effort to obscure this fact by segregating funds within plans through an accounting mechanism, all plans covering abortion would require enrollees to make a separate payment to cover abortions. That means anyone wishing to purchase such a plan because it provides the best coverage for themselves or their family, notwithstanding the abortion coverage, would have to finance abortions for others with their own money, regardless of their moral convictions.

Moreover, nothing in the law or elsewhere would prohibit the $7 billion it directly appropriates for Community Health Centers from being used to pay for abortions. That is because historically, courts have only applied the Hyde Amendment to Health and Human Services appropriations legislation that Congress enacts on a yearly basis. Hyde does not cover appropriations made through the PPACA, and courts have repeatedly held that when Congress authorizes the provision of comprehensive health services, such a provision must include abortion unless Congress carves out a specific Hyde-like exclusion, which the health care law does not do. The Medicaid program from 1973–76 funded as many as 300,000 abortions per year until the Hyde Amendment was enacted in 1976 because, as the Sixth Circuit Court of Appeals stated in 1996, "abortion fits within many of the mandatory care categories, including 'family planning,' 'outpatient services,' 'inpatient services,' and 'physicians ser-

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3. **Hippocrates, The Oath** (400 B.C.), *reprinted in 38 Harvard Classics* 3 (1910) ("I will not give to a woman a pessary to produce abortion.").

services."

Similarly, Congress modified the Hyde Amendment in 1993 to allow funding for abortions in cases of rape or incest, in direct conflict with some state laws that restricted funding for abortion to those situations in which abortion was necessary to save the life of the mother. In these situations, Medicaid required all states participating in Medicaid to fund rape and incest abortions. The states appealed to the courts, but the courts ruled the states must fund such abortions unless Congress explicitly removes the obligation.6

Just how inadequately the PPACA protects the unborn became clear for all to see in July 2010, when the Obama Administration approved plans from several states to participate in the law's high-risk pool program, despite the fact that their proposals would have permitted taxpayer dollars to pay for elective abortion.7 Only after pro-life groups sounded the alarm did the Department of Health and Human Services issue a regulation prohibiting abortion funding in the program under the authority over the pools specifically granted to it by the law.8 In so doing, the administration tacitly admitted nothing prevented federal funding for abortion in the high-risk pools.

That includes the President's much-publicized Executive Order, which was designed to allay the concerns of pro-life Members of Congress.9 Though I wish it were otherwise, the President's order does not guarantee protection for the unborn. Under the Constitution, the President is not free to rewrite legislation Congress passes or reinterpret such legislation in a way contrary to that of our courts. To the extent the Order departs from the law as written by Congress and construed by the courts, any action based on it almost certainly would not survive a legal challenge. And to the extent it does not depart from the law, it does nothing to prevent taxpayer-funded abortion.

6. See id. at 641–42.
8. Pre-Existing Condition Insurance Plan Program, 75 Fed Reg. 45,014, 45,031 (July 30, 2010) (to be codified at 45 C.F.R. § 152.19(b)). See id. at 45,018, for a discussion of the reasoning behind the regulation, citing to President Obama's Executive Order.
Congress can still right this wrong. The Protect Life Act, introduced by Rep. Joe Pitts and myself, would insert the needed controls on federal funding into the PPACA and assure that no taxpayer funds will subsidize abortions.\(^{10}\) Moreover, there would be strong public support for such a measure, as recent polls have found Americans overwhelmingly oppose public funding for abortion, by as large as a three to one margin.\(^{11}\) This bill would undo the harm caused to the unborn in PPACA.

Seniors also face harm under PPACA. In order to pass a bill that Congress could deem budget neutral, hundreds of billions of dollars in reductions to future Medicare payments were included in PPACA to offset the costs of new programs and coverage.\(^{12}\) Undoubtedly, we must work to address the growing costs of health care to the government, and Medicare is the largest governmental health care program. Yet the Chief Actuary of the Center for Medicare and Medicaid Services, the agency that manages Medicare, has forecast the cuts could lead doctors, hospitals, and other medical providers to stop serving seniors on Medicare or to greatly reduce the amount of service they provide to this population.\(^{13}\) In particular, the Chief Actuary forecast that payment reductions could result in Medicare participation becoming unprofitable for fifteen percent of Medicare Part A providers, leading them to abandon the program.\(^{14}\) Thus, in an effort to expand coverage and improve insurance standards, health care reform threatens to harm access to medical coverage for millions of Americans. These cuts to Medicare are of great concern to me and we must address them before any seniors face rejection by their doctors or other health providers whom they have come to trust and rely upon.

It is not just seniors and the unborn who face harm under the new law. All Americans stand to lose as a result of the threat it poses to our nation’s fiscal stability. While ostensibly reducing

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14. Id. at 9.
the deficit over the next decade according to the Congressional Budget Office (CBO), there are reasons to believe the reality is quite different. For instance, there is ample evidence that, during the second decade and after, costs will increase dramatically. The Community Living Assistance Services and Support (CLASS) Act, a component of the PPACA that provides long-term disability care, is structured so that it begins raising funds years before it starts providing benefits. As a result, it demonstrates an initial savings to the government, via increased revenue, of $70 billion. But because people can opt out of the program, adverse selection is likely to occur, meaning that sick people will enroll, healthy people will opt out and pay no premiums, and the program’s costs will grow while its revenues decline. This will lead to a major imbalance and cost the taxpayers hundreds of billions of dollars. As the Chief Actuary of the Centers for Medicare and Medicaid Services reported, the program faces “a very serious risk” of being unsustainable and entering an “insurance death spiral.”

The National Commission on Fiscal Responsibility and Reform recently agreed, observing that CLASS is “viewed by many experts as financially unsound” and threatens to “collapse under its own weight.” Notably, Health and Human Services Secretary Kathleen Sebelius in February conceded that the CLASS Act faces extraordinary problems, telling the Senate Finance Committee that it is “totally unsustainable” as written.

Having warned about the unsustainability of the CLASS Act for more than a year, I recently joined with Reps. Charles Boustany Jr. (R-La.) and Phil Gingrey (R-Ga.) to introduce H.R. 1173 to end the program before the federal government begins to make promises it cannot keep. In the context of today’s budget difficulties, and in the absence of a viable plan to reform the program, I believe we have no choice but to repeal the CLASS Act. Failure to do so would simply shift the burden of paying for the program to future generations.

The possibility that Medicare payment reductions will be eliminated offers another reason to doubt the PPACA will reduce

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15. PPACA § 8002, 124 Stat. at 828-47.
deficits. While undoing those reductions will likely be necessary to save seniors from harm, it will also undermine the fiscal sustainability of the PPACA. Similarly, the deficit-reduction claim assumes that in later years, the growth in federal subsidies for the purchase of insurance will suddenly be allowed to decline. There is also the fact that the passage of time and further examination seems likely to reveal that the bill—which is of almost unprecedented size and complexity—is more expensive than it initially appeared. In fact, less than two months after the measure passed, the CBO doubled its estimate of discretionary spending in the law to more than $115 billion over ten years, pushing its total price tag past $1 trillion.20 I doubt that is the last unpleasant budgetary surprise the law has in store for us.

For all of these reasons, the PPACA threatens to undermine numerous national priorities, health care included. We must show the foresight and leadership to avoid overextending our limited budget resources for one priority at the expense of many others.

No doubt any substantive health care reform bill would have included some tradeoffs and contained some bitter pills. But I had hoped that in return the legislation would have a serious impact on the biggest problem with America’s medical system: the soaring cost of care. As I stated after voting against enactment of the PPACA, I have grave concerns about the growth of health care spending in this nation:21

Since 1980, overall spending on health care has risen on average at almost twice the rate of inflation, and per capita health care spending is nearly double what it was 10 years ago. Unless we address these increases, health care will continue to gobble up more and more of people’s income, and more and more of our tax dollars, until we reach a breaking point. Government subsidies alone cannot solve


the problem of the increasing burden that skyrocketing health care costs impose on middle-class Americans.\textsuperscript{22}

Yet, according to the CBO, PPACA gives little help to those who currently receive health care coverage through their employers. Because this is the case, and because employer-based health care insurance makes up eighty-three percent of the market,\textsuperscript{23} PPACA does not sufficiently reduce costs for a large majority of working families. Thus, in attempting to create a new health care system to expand coverage to the uninsured, the system for those currently insured has been unsettled, the long-term health care outlook remains cloudy, and the risk to our nation continues to grow.

Despite these many problems, I would not claim that the PPACA's effects are uniformly negative. The law made a number of important changes to our existing health care framework, including eliminating discrimination based on pre-existing conditions, banning lifetime and annual limits on coverage, and extending coverage for dependents on their parents' health plans. For that reason, I do not believe a wholesale repeal of the health care law is wise.

Prior to last year's election, Republicans promised to offer legislation to "repeal and replace" the health care law. Unfortunately, they only fulfilled the first part of their pledge. A repeal that does nothing to preserve the good parts of the law would put us right back where we started, with a health care system in dire need of improvement and the odds in Congress stacked against any changes. Our choice should not be all-or-nothing, take-it-or-leave-it, between the prior status quo and the health care law exactly as written. Even proponents of the law admit it is not perfect, and even its biggest detractors concede the system we had in place previously needed serious improvement. That is why I voted against repeal earlier this year,\textsuperscript{24} and in favor of a resolution directing various committees to draft health care reform measures.\textsuperscript{25} While the resolution is non-binding, it does provide a path toward making much-needed changes, such as

\textsuperscript{25} H.R. Res. 9, 112th Cong. (2011).
lowering costs through increased competition and choice, as well as prohibiting taxpayer funding for abortion.

Improving our health care system ought to be a bipartisan effort. And while this would seem to be a tall order given all the acrimony in Washington, there is evidence both parties can agree on the need to change certain aspects of the health care law. One example is the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011,\textsuperscript{26} which I cosponsored and which passed the House and Senate with bipartisan support and was recently signed into law by President Obama.\textsuperscript{27} This measure repeals a provision of the health care law that imposes a burdensome tax-reporting requirement on small businesses; especially during this time of high unemployment, we should be helping small businesses create jobs rather than hampering them with more paperwork.

In the end, fixing the health care law and improving our health care system will require both parties to listen to the American people, work together, and develop a solution that is viable over the long term. When we do this, we will be able to expand coverage to more Americans and rein in costs without threatening coverage for seniors, without bankrupting taxpayers, and without changing the status quo prohibiting the federal funding of abortion.
