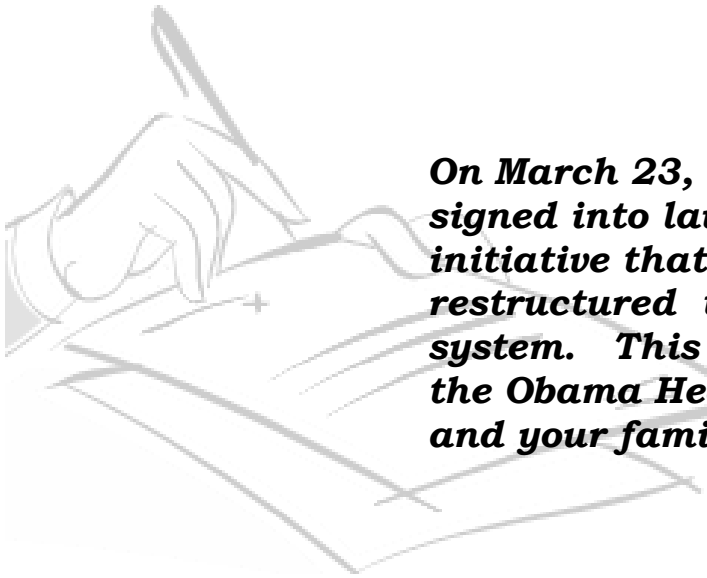
Obamacare Routes to Rationing

How the Obama Health Care Law Will Ration Your Family's Medical Treatment - A Factsheet

Revised January, 2014



On March 23, 2010 President Obama signed into law a major health care initiative that fundamentally restructured the American health care system. This document describes what the Obama Health Law means for you and your family.

ROBERT POWELL CENTER for MEDICAL ETHICS
AT THE NATIONAL RIGHT TO LIFE COMMITTEE

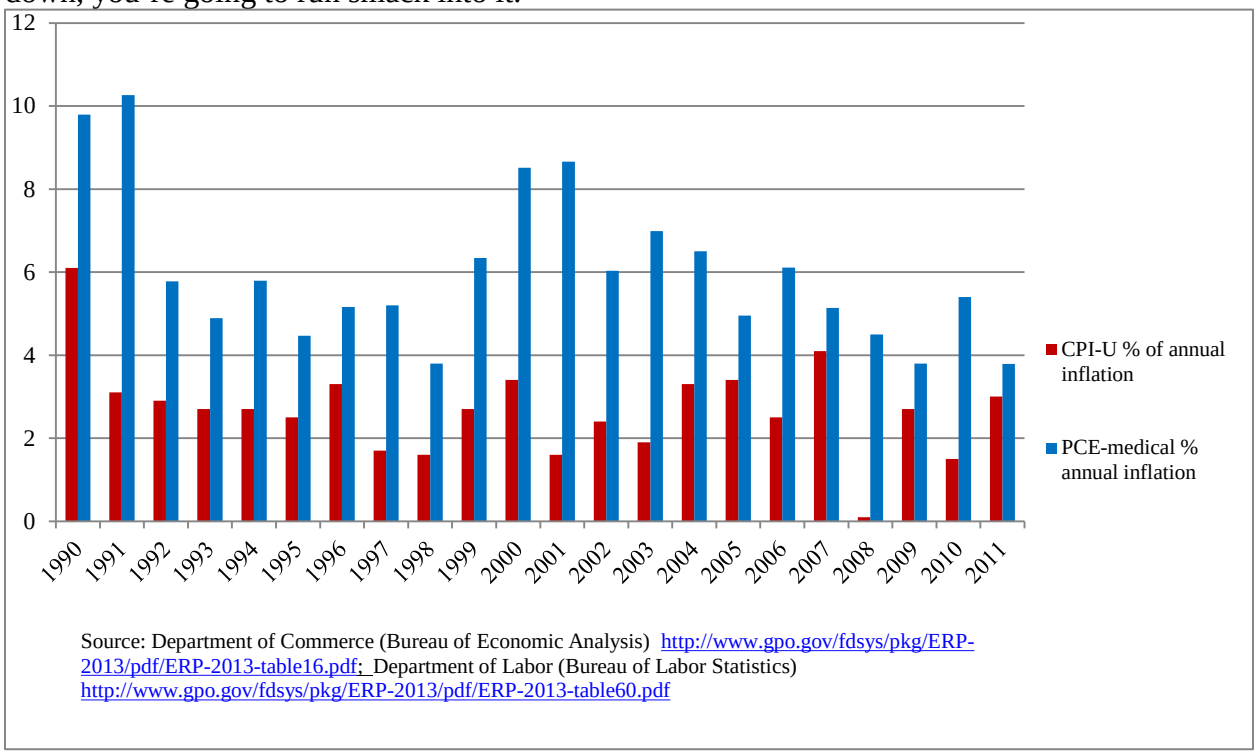
www.nrlc.org/healthcarerationing

OBAMACARE ROUTES TO RATIONING

1. How Obamacare's "Excess Benefits" tax will prevent health insurance from keeping up with medical inflation

The Excess Benefits Excise Tax

The Patient Protection and Affordable Care Act of 2010 (widely known among both proponents and opponents as "Obamacare") imposes a 40"% excise tax on "excess benefit" health insurance premiums, beginning in 2018. [1] It is designed to create a tax disincentive so as to suppress private, nongovernmental, health care spending beyond a governmentally imposed limit, and that limit is indexed to general rather than health care inflation. The problem with this approach is explained in a September 30, 2013 *Politico* article: "[The level at which taxes kick in will] be linked to the increase in the consumer price index, but medical inflation pretty much always rises faster than that. Think of the Cadillac tax as the slow-moving car in the right lane, chugging along at 45 miles per hour. It may be pretty far in the distance, but if you're . . . moving along at a reasonable clip in the same lane – say, 60 miles an hour—and you don't slow down, you're going to run smack into it."[2]



Source: Department of Commerce (Bureau of Economic Analysis) http://www.gpo.gov/fdsys/pkg/ERP-2013/pdf/ERP-2013-table16.pdf; Department of Labor (Bureau of Labor Statistics) http://www.gpo.gov/fdsys/pkg/ERP-2013/pdf/ERP-2013-table60.pdf

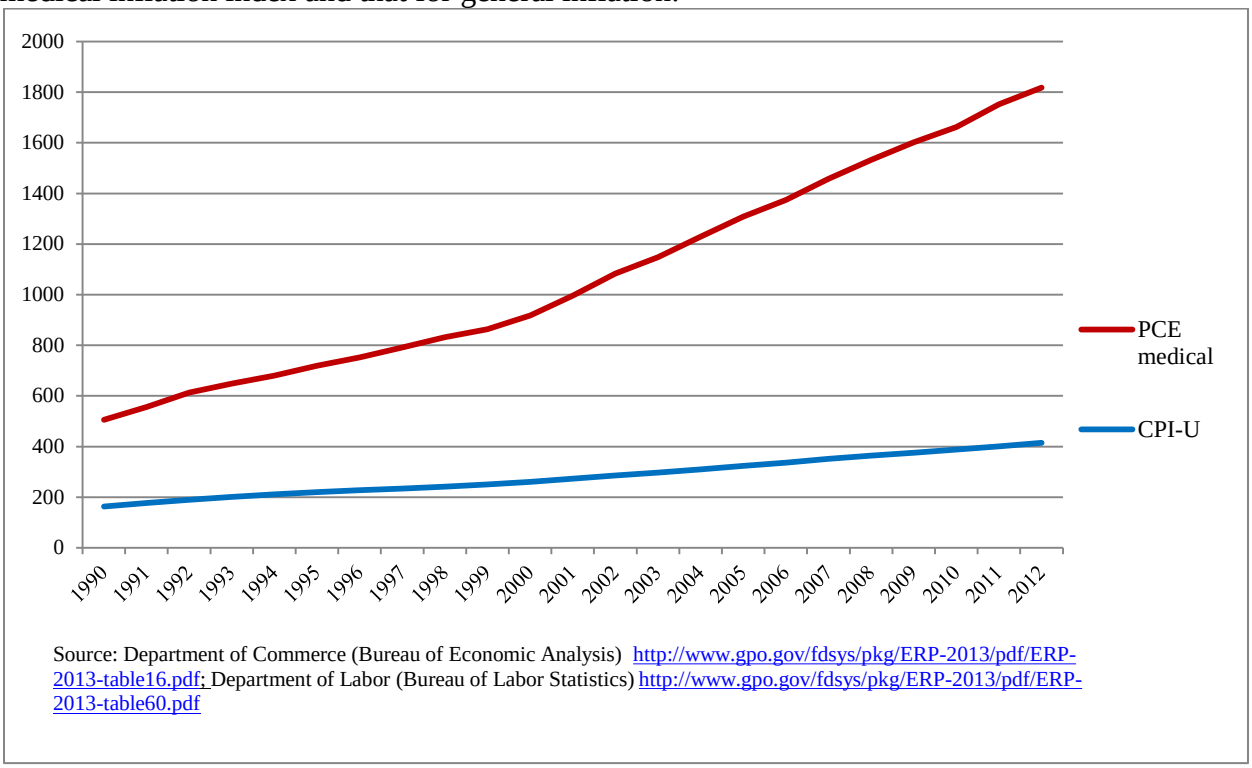
The Reality of Medical Inflation

It is important to recognize that the Consumer Price Index (CPI), to which Obamacare indexes the premium level above which the tax applies, is a weighted *average* of the change in prices of goods and services across the economy. As the chart above shows, from 1990 to 2011 medical inflation has outpaced the CPI by an average of 3.3% annually.[3]

It is as foolish to expect the prices of *all* goods and services exactly to track the CPI average measure as it would be to expect *all* students in a class to receive the "average" grade.

Price increases for health care have consistently outpaced the "average" rate of inflation across the economy for a variety of reasons, among which is the inherent labor intensiveness of the health care sector.[4] It is neither realistic nor just to tie the trigger for the punishing "excess benefits" tax to a measure of inflation that is less than the real rate of medical inflation.

As the following graph demonstrates, because the difference between medical and average inflation "compounds" over time, two decades have brought a dramatic gap between the medical inflation index and that for general inflation:



Source: Department of Commerce (Bureau of Economic Analysis) http://www.gpo.gov/fdsys/pkg/ERP-2013/pdf/ERP-2013-table16.pdf; Department of Labor (Bureau of Labor Statistics) http://www.gpo.gov/fdsys/pkg/ERP-2013/pdf/ERP-2013-table60.pdf

Although the excess benefits tax does not apply until 2018, the *Politico* article reported, "[The consulting firm] Towers Watson found that more than six out of 10 employers said the fear of triggering [it] would influence their health care benefit strategies in 2014 and 2015. . . . For one thing, the thresholds were set in 2010, and even though the law has a method for raising them if there's a lot of growth in health care spending, employers are still concerned that they'll get busted for offering fairly standard plans."

2. HOW INSURANCE EXCHANGES ARE LIMITING YOUR RIGHT TO USE YOUR OWN MONEY TO SAVE YOUR FAMILY MEMBERS' LIVES

The Role of State-Based Health Insurance Exchanges

Under the Obama Health Care Law, there are state-based health insurance "exchanges." The exchanges were designed to be marketplaces through which individuals and employees of small businesses and, later, employees of large employers could select their health insurance plan for the next year. The original idea for exchanges was to allow comparison shopping among all insurance plans that provided basic benefits. Under Obamacare, however, consumers may only choose plans offered by insurers that do not allow their customers to spend more than what government bureaucrats deem an "excessive or unjustified" amount for their health insurance, as detailed below. This means that health insurance plans offered in the exchanges typically have narrow panels of available health care providers that exclude specialist doctors and healthcare centers with a high reputation for successfully offering effective life-saving medical treatment.

The Health Research Institute of the PricewaterhouseCoopers consulting company concluded that insurers passed over major medical centers when selecting providers in California, Illinois, Indiana, Kentucky, and Tennessee, as well as other states.[5] In an October 21, 2013, piece by Annika McGinnis entitled "Big insurers avoid many state health exchanges," *USA Today* reported

> In New Hampshire, the exchange has just Anthem Blue Cross and Blue Shield, which greatly reduces the number of hospital options, says State Sen. Andy Sanborn. Since more than 90% of doctors are affiliated with specific hospitals, the new plans will also exclude many doctors, he added. Plans don't include the capital's Concord Hospital, and the next-closest hospital uses Concord doctors, Sanborn said. So, he said, people will have to drive to a third hospital an hour away. They'll even have to call an ambulance from a far-away hospital to pick them up, he said.

A CNN story on October 29, 2013 by Jen Christensen entitled "Obamacare: Fewer options for many" noted:

> In New York, NYU will accept only a minority of the plans. In Los Angeles, UCLA medical centers will accept a couple. In Atlanta, Emory has limited the number of plans it will take. Academic medical centers are often pricier because they tackle the more complex cases. WellPoint, a Blue Cross Blue Shield insurer offering policies in 14 states, is narrowing its networks in many markets….
>
> Many other reports document the phenomenon.[6]

Exclusion of Health Insurers Who Allow Their Clients to Choose "Excessive" Insurance

The narrowing of access to health care providers in insurance plans offered on the exchanges has been widely reported, but few news accounts have clearly linked these limits to Obamacare's provision for suppressing the ability of consumers on the exchange who choose to do so to obtain policies priced to allow access to a wider selection of health care providers.

Provisions in Obamacare and its implementing regulations[7] have the effect of authorizing and requiring state bureaucrats to limit the value of the insurance policies that Americans using the exchanges may purchase. Under these provisions, state insurance commissioners are to recommend to their state exchanges the exclusion of "particular health insurance issuers ... based on a pattern or practice of excessive or unjustified premium increases."[8] Indeed, White House deputy assistant for health policy, Jeanne Lambrew, boasted on the White House blog, "[T]he review of premium increases of 10 percent or more helped 6.8 million Americans save an estimated $1.2 billion in 2012 after their insurers cut back on planned increases as a result of this process."[9] Essentially, this means that Americans able and desiring to do so were each denied the choice of spending an average of about $176 more to obtain policies that might them access to specialists and health care centers with the qualifications and experience to be more likely to save the lives of their family members.[*] The government made the decision that they wouldn't be allowed to spend that amount of their own money to increase the chance of saving their own lives or preserving their own health.

Not only do the exchanges exclude *policies* from competing in an exchange when government authorities do not agree with their premiums,[+] but the exchanges even exclude *insurers* whose plans **outside** the exchange offer consumers the ability to reduce the danger of treatment denial by paying what those government authorities consider an "excessive or unjustified" amount. This creates a "chilling effect," deterring insurers who hope to be able to compete within the exchanges from offering adequately funded plans even outside of them, with the result that even outside the exchanges consumers will find it increasingly difficult to obtain health insurance that offers adequate and unrationed health care.

Limits on What You Are Permitted to Pay Restrict What You Are Allowed to Buy

When the government limits what can be charged for health insurance, it restricts what people are allowed to pay for medical treatment. While everyone would prefer to pay less – or nothing – for health care (or anything else), government price controls prevent access to lifesaving medical treatment that costs more to supply than the prices set by the government.

Dr. Marc Siegel explains the effect:

> For me and many of my colleagues, the real practice of medicine is

[*] While $176 may not seem like much, remember that insurance is designed to spread the risk of an unlikely but costly occurrence. So if 1 in 1000 people get a heart condition that can be most effectively treated by a $175,000 surgery, denying people the ability to pay the extra $176 in premiums might mean that a policyholder who gets that heart condition won't be able to get the surgery.

[+] Ironically, Section 1311(e)(1)(B)(ii), 124 Stat. at 178, [codified at 42 U.S.C.A. § 18031(e)(1)(B)(ii)], retains a provision barring an exchange from excluding health plans "through the imposition of premium price controls." Following standard norms of statutory construction, the two provisions would presumably be construed together to prevent state officials from imposing specific, explicit premium price controls on plans offered in an exchange while nevertheless allowing these officials to exclude insurers they deem to have a pattern or practice of what they consider "excessive or unjustified" premium increases.

supposed to involve an intimate encounter with each patient and a diagnosis of illness leading to a potential cure. In the future, however, a diagnosis of Lyme disease or the severity of a patient's depression may be missed because showing the photo or taking an extensive mental-health history doesn't fit squarely into the 10-minute visit authorized by insurance, along with mandatory computer documentation, insurance verifications and appointment scheduling.

. . . .

Unfortunately, the kind of insurance that is growing under ObamaCare's fertilizer is the exact kind that was jeopardizing the quality of health care in the first place: the kind that pays for seeing a doctor when you are well, but where guidelines and regulations predominate and choice is restricted when you are seriously ill.

How can quality of care not be affected if the antibiotic or statin drug or MRI scan I feel you need isn't covered under your plan?[10]

3. MEDICARE: HOW THE OBAMACARE LIMITS SENIOR CITIZENS' RIGHT TO USE YOUR OWN MONEY TO SAVE YOUR OWN LIVES

Denying Senior Citizens the Right to Make Up Medicare Cuts With Your Own Money

According to an August 2010 Congressional Budget Office estimate, the Obama Health Care Law will cut $555 billion from Medicare over the next ten years.[11] Most senior citizens know that the law will significantly cut government funding for their Medicare. Less widely known is the law's provision allowing Washington bureaucrats *to prevent older Americans from making up the Medicare shortfall with their own funds—taking away their right to spend their own money to save their own lives*.

The Medicare Shortfall

Even before the Obama Health Care Law's cuts, Medicare—the government program that provides health insurance to older people in the United States—faced grave fiscal problems as the baby boom generation aged. Medicare is financed by payroll taxes, which means that those currently working are paying for the health care of those now retired. As the baby boom generation moves from middle into old age, the proportion of the population that is retired will increase while the proportion of the population that is working will decrease. The result is that the amount of money available for each Medicare beneficiary, when adjusted for health care inflation, will shrink significantly.

The Alternatives: Increase Taxes, Ration, or Allow Seniors to Add Your Own Money

In theory, taxes could be increased dramatically to make up the shortfall; however, such a proposal would be unlikely to attract popular and political support. The second alternative is rationing. Less money available per senior citizen means less treatment, including those necessary to prevent death .Many people whose lives could have been saved by medical treatment would perish against their will. The third alternative is that, as the government

contribution decreases, the shortfall could be made up by voluntary payments by senior citizens. Thus, your Medicare health insurance premiums could be financed partly by the government and partly from your own income and savings.

Private Fee-for-Service Medicare Insurance

Through legislative changes in 1997 and 2003 successfully promoted by the National Right to Life Committee, this third alternative became law. A "private fee-for-service" option was created in Medicare under which senior citizens could choose health insurance whose value was not limited by what the government might pay toward it. These plans could set premiums and reimbursement rates for health care providers without upward limits imposed by government regulation.[12] Such plans would not be forced to ration treatment, as long as senior citizens were free to choose to pay more for them. For information on whether it would be possible to *afford* health care without rationing, see www.nrlc.org/MedEthics/AmericaCanAfford.pdf.

What About Seniors Who Can't Afford to Add Their Own Money?

Medicare covers everyone of retirement age, regardless of income or assets. Yet, because of budget constraints, the Medicare reimbursement rates for health care providers tend to be below the cost of giving the care—a deficit that can only accelerate as cost pressures on Medicare increase with the retirement of the baby boomers. To cope with this, health care providers engage in "cost shifting"—using funds they receive in payment for treating privately insured working people to help make up for losses providers incur when treating retirees under Medicare.[13] As a result, comparatively low-income workers effectively subsidize higher-income retirees.

However, when middle-income retirees are free voluntarily to add their own money in addition to the government contribution through a private fee-for-service plan, those who take advantage of this opportunity stop being the beneficiaries of cost-shifting and become contributors to it.[*] This puts more money into the health care system, making it feasible for health care providers to offer more below-cost care to senior citizens with limited means.

The Obama Health Law's Assault on Seniors' Right to Add Your Own Money:

The Obama Health Care Law[14] indirectly amended the section in the pre-existing law allowing these plans to set their premiums without approval by the Centers for Medicare & Medicaid Services (CMS) by adding, "Nothing in this section shall be construed as requiring the Secretary to accept any or every bid submitted by an MA organization under this subsection." Therefore, CMS may now refuse to allow senior citizens the choice of private-fee-for-service plans that charge what CMS, in its standardless discretion, regards as premiums that are too high. Indeed, the provision literally authorizes CMS, if it decides to do so, to refuse to allow private-fee-for-service plans altogether.

Thus, this provision could eliminate the only avenue that senior citizen may use to escape rationing—using their own money to save their lives.

Reading the text of the Obama Health Care Law:

What Is the Exact Language That Allows the Federal Government to Limit What Senior Citizens Can Choose to Spend for Health Insurance?

[Warning: To ordinary human beings trying to make sense out of the Obama Health Care Law's language: it is written in extremely convoluted legalese. To figure out what is hidden in this law requires intense concentration – try not to let your head spin while you attempt to follow the explanation below (especially in the endnotes); unfortunately, it is the opposite of "plain language"!**]**

1. Under a provision in effect both before and after adoption of the Obama Health Care Law, the Secretary of Health and Human Services has authority to "negotiate" the premiums to be charged by private Medicare plans ("Medicare Advantage" health insurance plans)–meaning that CMS can keep senior citizens from being able to choose a Medicare Advantage plan unless that plan agrees to charge a premium acceptable to CMS [42 U.S.C. §1395w-24 (a)(6)(B)[15]]. Importantly, however, this authority *did not apply to private fee-for-service plans* [42 U.S.C.A. § 1395w-24 (a)(6)(B)[16]] – meaning that CMS had no power to impose a premium price control on private fee-for-service plans, which senior citizens could be kept from choosing only if the plans failed to meet other applicable standards.

Thus, under the law before Obamacare, senior citizens *could* choose, if they wished, to add extra money of their own on top of the government payment in order to get health insurance less likely to ration, and Washington bureaucrats could not limit their right to do this.

2. However, Section 3209 of the Obama Health Care Law, [codified at 42 USCS § 1395w-24(a)(5)(C)(i)[17]], indirectly amends the section allowing private fee-for-service plans to set their premiums without approval by CMS by adding, "Nothing in this section shall be construed as requiring the Secretary to accept any or every bid submitted by an MA organization under this subsection."

This means that the pre-existing law that effectively forbade the Secretary to exclude a private fee-for-service plan on the basis that CMS considers its premiums to be too high has been trumped by the new ability of the Secretary to reject "any or every" premium bid submitted by a private fee-for-service plan.

Thus, under Obamacare, Washington bureaucrats are given the authority to limit – or even eliminate – senior citizens' ability, if they choose, to spend their own money on health insurance less likely to ration.

4. How the Obamacare Will Limit What Health Care Providers Can Do to Save the Lives of Your Family Members

A Powerful Rationing Commission:

An 18-member "Independent Payment Advisory Board" is given the duty, on January 15, 2015 and every two years thereafter, with regard to *private* (not just governmentally funded) health care, to make "recommendations to slow the growth in national health expenditures" *below* the rate of medical inflation[18]:

IPAB Must Limit HC Spending Growth to the LESSER OF:

Year	Limit
2015	Halfway between medical and general inflation
2016	Same
2017	Same
Later Years	Nominal GDP per capita + 1% [President Obama has proposed lowering to Nominal GDP per capita + .5%]

Year	% below projected spending
2015	.5 %
2016	1%
2017	1.25%
2018	1.5%
Later Years	1.5%

How the Federal Government Can Force Doctors to Limit Care:

The Commission's recommendations are to be ones "that the Secretary [of Health and Human Services] or other Federal agencies can implement administratively."[19] In turn, the Secretary of Health and Human Services is empowered to impose "quality and efficiency" measures on hospitals, requiring them to report on their compliance with them.[20] Doctors will have to comply with quality measures in order to be able to contract with any qualified health insurance plans.[21]

What This Will Mean for Your Family's Health Care:

Essentially, doctors, hospitals, and other health care providers can be told by Washington

just what diagnostic tests and medical care are considered to meet "quality and efficiency" standards. These standards will be enforced not just for health care paid for by federally funded programs like Medicare, but also for health care paid for by private citizens and by the health insurance they or their employers purchase..

These standards are *specifically designed to limit the funds that Americans may choose to spend on health care so that they cannot keep up with the rate of medical inflation.* Treatment that a doctor and patient deem needed or advisable to save the patient's life or preserve or improve the patient's health but which runs afoul of the imposed standards can be denied, *even if the patient is willing and able to pay for it.*

In effect, Washington bureaucrats can create one uniform, national standard of care, established by Washington bureaucrats, that is designed to limit what private citizens are allowed to spend to save their own lives.

On its face, the law maintains that this limitation does not amount to "rationing." Indeed, the statute states, "The proposal [by the Independent Advisory Board] shall not include any recommendation to ration health care..."[22] However, the law never actually defines what it means by the word "ration." If the "quality" standards limiting treatment are challenged, the law's administrators and supporters will claim they are simply "cost-effective" means of assuring patients get "appropriate" care. *Consequently, the prohibition on a "recommendation to ration" will not be an enforceable restraint courts could use to protect Americans from denial of medical care.* Rather than a shield against treatment denial, it is no more than a rhetorical sword to ward off the law's critics.

The Britannica Concise Encyclopedia describes rationing as "Government allocation of scarce resources and consumer goods, usually adopted during wars, famines, or other national emergencies." Whether health care actually need be "scarce" is open to debate.[23] However, when government bureaucrats tell you what treatments, paid for with your own money, you can and can't have – that is certainly "government allocation" of health care.

The Obama Health Care Law authorizes federal bureaucrats to impose limits on what life-saving medical treatments Americans are allowed to get. It may not *call* this "rationing." But that doesn't mean that it isn't.

ENDNOTES:

[1] P.L.111-148, §9001, 128 Stat. 119, 847-53, *codified at* 26 USC 4980I.

[2] David Nather, "How Obamacare affects businesses—large and small" (September 30, 2013), http://www.politico.com/story/2013/09/how-obamacare-affects-businesses-large-and-small-97460.html

[3] Table: Difference between Medical Inflation (PCE) and CPI-U Inflation Rate

Year	CPI-U Inflation Rate	Medical Inflation (PCE)	Difference
1990	6.1	9.79	3.69
1991	3.1	10.26	7.15
1992	2.9	5.78	2.88
1993	2.7	4.89	2.19
1994	2.7	5.79	3.09
1995	2.5	4.47	1.97
1996	3.3	5.16	1.86
1997	1.7	5.2	3.5
1998	1.6	3.8	2.2
1999	2.7	6.34	3.64
2000	3.4	8.51	5.11
2001	1.6	8.66	7.06
2002	2.4	6.03	3.63
2003	1.9	6.99	5.09
2004	3.3	6.5	3.2
2005	3.4	4.95	1.55
2006	2.5	6.11	3.6
2007	4.1	5.14	1.04
2008	0.1	4.5	4.4
2009	2.7	3.8	1.1
2010	1.5	5.40	3.9
2011	3.0	3.79	.79
Average	2.7	6.0	3.3

Source: Department of Commerce (Bureau of Economic Analysis) http://www.gpo.gov/fdsys/pkg/ERP-2013/pdf/ERP-2013-table16.pdf; Department of Labor (Bureau of Labor Statistics) http://www.gpo.gov/fdsys/pkg/ERP-2013/pdf/ERP-2013-table60.pdf

[4] See esp. William J. Baumol, "Health Care, Education and the Cost Disease: A looming crisis for public choice," *Public Choice* 77:1 (September 1993):17-28.

[5] Health Research Institute of PricewaterhouseCoopers. (2013*)* Health Exchanges: Open for Business. Retrieved from http://www.pwc.com/us/hix.

[6] See, e.g., Timothy W. Martin, "Shrinking Hospital Networks Greet Health-Care Shoppers on Exchanges," Wall Street Journal (December 13, 2013); Stephanie Kirchgaessner, "New Affordable Care US health plans will exclude top hospitals," Financial Times (December 8, 2013); Megan McArdle, " 'Doc Shock' On Deck in Obamacare Wars," Bloomberg (December 5, 2013).

[7] Patient Protection and Affordable Care Act, § 1003, Pub. L. No. 111-148, 124 Stat. 119, 139-40 (2010), codified at 42 U.S.C.A. § 300gg-94(b), provides:

> (b) Continuing premium review process.
> (1) . . . As a condition of receiving a grant under subsection (c)(1), a State, through its

Commissioner of Insurance, shall--

. . . .

(B) make recommendations, as appropriate, to the State Exchange about whether particular health insurance issuers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified premium increases.

(2) Monitoring by Secretary of premium increases.

(A) In general. Beginning with plan years beginning in 2014, the Secretary, in conjunction with the States and consistent with the provisions of subsection (a)(2), shall monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange.

Id., § 1311(e)(2), 124 Stat. at 178, codified at 42 U.S.C.A. § 18031(e)(2), provides:

The Exchange shall require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. Such plans shall prominently post such information on their websites. The Exchange may take this information, and the information and the recommendations provided to the Exchange by the State under section 2794(b)(1) of the Public Health Service Act (relating to patterns or practices of excessive or unjustified premium increases)[this is the provision quoted just above above], into consideration when determining whether to make such health plan available through the Exchange. The Exchange shall take into account any excess of premium growth outside the Exchange as compared to the rate of such growth inside the Exchange, including information reported by the States.

Implementing regulations for these provisions are at 45 C.F.R. §§154.101 through 154.301.

[8] 42 U.S.C.A. § 300gg-94(b)(1)(B) (see n. 7 above for text).

[9] http://www.whitehouse.gov/blog/2014/01/06/new-report-shows-2012-continued-trend-slow-growth-health-care-spending

[10] Marc Siegel, "The Death of the Bedside Manner [:] Obamacare is speeding the decline in the quality of medical practice", *Wall Street Journal* (December 26, 2013).

[11] *The Budget and Economic Outlook: An Update*, CONGRESSIONAL BUDGET OFFICE (Aug. 2010) www.cbo.gov/sites/default/files/cbofiles/ftpdocs/117xx/doc11705/08-18-update.pdf

[12] For more information on this alternative (entitled "private fee-for-service") and its history, see www.nrlc.org/MedEthics/RationinginMedicare.html.

[13] Allen Dobson, Joan DaVanzo, & Namrata Sen, *The Cost-Shift Payment 'Hydraulic': Foundation, History, And Implications*, 25 HEALTH AFF. 22 (2006).

[14] Patient Protection and Affordable Care Act, § 3209, Pub. L. No. 111-148, 124 Stat. 119, 460 (2010) codified at 42 U.S.C.A. § 1395w-24(a)(5)(C)(i).

[15] 42 U.S.C.A. § 1395w-24 (a)(6)(B) reads, in relevant part (emphasis supplied):

(B) Acceptance and negotiation of bid amounts.

(i) Authority. *Subject to clauses* (iii) and *(iv)*, the Secretary has the authority to negotiate regarding monthly bid amounts submitted under subparagraph (A) . . . . [I]n exercising such authority the Secretary shall have authority similar to the authority of the Director of the Office of Personnel Management with respect to health benefits plans under chapter 89 of title 5, United States Code [5 U.S.C.A. §§ 8901 et seq.].
(ii) Application of FEHBP standard. *Subject to clause (iv*), the Secretary may only accept such a bid amount or proportion if the Secretary determines that such amount and proportions are supported by the actuarial bases provided under subparagraph (A) and reasonably and equitably reflects the revenue requirements (as used for purposes of section 1302(8) of the Public Health Service Act [42 U.S.C.A. § 300e-1(8)][relating to the standards for setting different rates for individuals and families and for individuals, small groups, and large groups]) of benefits provided under that plan.

(Clause iv is quoted in the next endnote.)

[16] 42 U.S.C.A. § 1395w-24 (a)(6)(B) provides:

(iv) Exception. In the case of a [private fee-for-service] plan described in section 1851(a)(2)(C) [42 U.S.C.A. § 1395w-21(a)(2)(C)], the provisions of clauses (i) and (ii) [quoted in the previous endnote] shall not apply and the provisions of paragraph (5)(B), prohibiting the review, approval, or disapproval of amounts described in such paragraph, shall apply to the negotiation and rejection of the monthly bid amounts and the proportions referred to in subparagraph (A).

The "provisions of paragraph (5)(B)" incorporated by reference are:

(B) Exception. The Secretary shall not review, approve, or disapprove the amounts submitted under paragraph (3) or, in the case of an MA private fee-for service plan, subparagraphs (A)(ii) and (B) of paragraph (4).

Paragraph (4), subparagraph (A)(ii) reads:
"the amount of the Medicare + Choice [now called Medicare Advantage] monthly basic beneficiary premium";

Paragraph (4), subparagraph (B) reads:
"Supplemental benefits. For benefits described in section 1852(a)(3) [42 U.S.C.A. § 1395w-22(a)(3)], the amount of the Medicare + Choice monthly supplemental beneficiary premium (as defined in subsection (b)(2)(B))."

[17] The new subparagraph (C) is added to 42 U.S.C.A. § 1395w-24 (a)(5). Since the language of subparagraph (a)(6)(B) that prevents the Secretary from "negotiating" private fee-for-service plan premiums is based on incorporating by reference subparagraph (a)(5)(B), as explained in the previous endnote, and because clause (i) of (a)(5)'s new subparagraph (C) would prevent subparagraph (B) from being construed to limit the Secretary's authority to reject bids, it effectively makes meaningless the premium negotiation prohibition of subparagraph (a)(6)(B).

[18] Obama proposal (cited in chart) to lower post-2017 limit to nominal rate of GDP + .5% : Office of Management and Budget, "The President's Plan for Economic Growth and Deficit Reduction," September 2011, p. 39 (available at http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/jointcommitteereport.pdf).

Understanding the legislative language in the Obama Health Care Law (Patient Protection and Affordable Care Act, § 3209, Pub. L. No. 111-148, 124 Stat. 119, 460 [2010]) that sets the required target below the rate of medical inflation requires following a very convoluted path:

42 U.S.C. A. § 1395kkk(o) states:

> Advisory recommendations for non-Federal health care programs. (1) In general. Not later than January 15, 2015, and at least once every two years thereafter, the Board shall submit to Congress and the President recommendations to slow the growth in national health expenditures (excluding expenditures under this subchapter and in other Federal health care programs)… such as recommendations-- (A) that the Secretary or other Federal agencies can implement administratively;…(2) Coordination. In making recommendations under paragraph (1), the Board shall coordinate such recommendations with recommendations contained in proposals and advisory reports produced by the Board under subsection (c).

The reference to "subsection (c)" is to 42 U.S.C.A. § 1395kkk(c)(2)(A)(i), which provides for Board reports with recommendations that "will result in a net reduction in total Medicare program spending in the implementation year that is at least equal to the applicable savings target established under paragraph (7)(B) for such implementation year."

The "applicable savings target" is whatever is the lesser of two alternative targets. 42 U.S.C.A. § 1395kkk(c)(7)(B).

> **First alternative**: 2015 through 2017: The reduction necessary to limit the growth in medical spending to equal a percentage *halfway between* medical inflation and general inflation (using 5-year averages). 42 U.S.C.A. §1395kkk(c)(6)(C)(I).
>
> In 2018 and later years: The reduction necessary to limit the growth in medical spending to "the nominal gross domestic product per capita plus 1.0 percentage point." 42 U.S.C.A. §1395kkk(c)(6)(C)(ii).
>
> **Second alternative:** The reduction necessary to force actual spending below projected spending by a specified percentage of projected medical spending; the specified percentage differs by year (in 2015, .5%; in 2016, 1%; in 2017, 1.25%; in 2018 and in subsequent years, 1.5%).42 U.S.C.A. § 1395kkk(c)(7)(C)(I).

[19] 42 U.S.C.A. § 1395kkk(o)(1)(A).

[20] 42 U.S.C.A. § 1395l (t)(17) ["Each subsection (d) hospital shall submit data on measures selected under this paragraph to the Secretary in a form and manner, and at a time, specified by the Secretary for purposes of this paragraph"….and "(A) Reduction in update for failure to report. (i) In general . . . a subsection (d) hospital …that does not submit, to the Secretary in accordance with this paragraph, data required to be submitted on measures selected under this paragraph with respect to such a year, the . . . fee schedule increase factor . . . for such year shall be reduced by 2.0 percentage points."], 1395l(i)(7) [similar language applicable to ambulatory surgical centers], 1395cc(k)(3) [similar language applicable to certain cancer hospitals], 1395rr(h)(2)(A)(iii) [similar language applicable to end-stage renal disease programs], 1395ww(b)(3)(B)(viii) [similar language otherwise applicable to hospitals], (j)(7)(D) [similar language applicable to inpatient rehabilitation hospitals], (m)(5)(D) [similar language applicable to long-term care hospitals], (s)(4)(D) [similar language applicable to psychiatric hospitals], and 1395fff(b)(3)(B)(v) [similar language applicable to skilled nursing facilities], 1395(i)(5)(D) [similar

language applicable to hospice care], and (o)(2) [applicable to the way in which value-based incentives are paid].

[21] 42 U.S.C.A. § 18031(h)(1) provides, "Beginning on January 1, 2015, a qualified health plan may contract with…(B) a health care provider only if such provider implements such mechanisms to improve health care quality as the Secretary may by regulation require."

[22] 42 U.S.C. A. § 1395kkk (c)(2)(A)(ii) states:

> The proposal shall not include any recommendation to ration health care, raise revenues or Medicare beneficiary premiums under section 1818, 1818A, or 1839 [42 USCS § 1395i-2, 1395i-2a, or 1395r], increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria.

[23] See http://www.nrlc.org/MedEthics/AmericaCanAfford.pdf