MANAGER'S AMENDMENT INTENSIFIES RATIONING

The Manager's Amendment to the Senate health care restructuring bill offered by Majority Leader Harry Reid (D-NV) on December 19 contains two provisions that intensify the rationing already present in the Reid Substitute. See http://www.nrlc.org/HealthCareRationing/ReidSubstitute.html .

– Taking a significant step closer to the powerful Federal-Reserve-Board-like Federal Health Board envisioned by former Senator Tom Daschle, Obama's original nominee for health czar, the Manager's Amendment renames and expands the authority of what the Reid Substitute called the "Independent Medicare Advisory Board." Its new title is the "Independent Payment Advisory Board" [Section 10320(b), p. 189] and it is directed to make recommendations to "slow the growth" in PRIVATE (non-federal) "health expenditures . . . that the Secretary [of Health and Human Services] or other Federal agencies can implement administratively." Section 10320(a)(5), adding Section 1899A (o)(1)(A) of the Social Security Act, p. 188. To the extent these are effective, they will limit the ability of private citizens to spend their own money to protect their own lives, by obtaining health care or health insurance that is not rationed.

– Section 10304 (p. 152) empowers the Secretary of Health and Human Services to impose "efficiency measures," in addition to the "quality measures" already provided for under the Reid Substitute, on health care providers. Much of the professional literature advocates the use of "quality of life" standards that devalue the lives of older people and people with disabilities in such measures. While there are limits on the use of comparative effectiveness research to justify denial of treatment based on quality of life criteria under Section 6301(c) of the Reid Substitute, the quality and efficiency measures are not made subject to these critically important anti-discrimination protections.

A more detailed analysis of these rationing-promoting elements of the Manager's Amendment follows:

INDEPENDENT PAYMENT ADVISORY BOARD AUTHORITY TO RECOMMEND, AND HHS SECRETARY TO LIMIT, RIGHT TO USE ONE'S OWN MONEY TO SAVE ONE'S OWN LIFE

Under the Reid Substitute's Section 3403 (pp. 1000- 1053) as modified by the Manager's Amendment Section 10320 (pp. 180-90), the "Independent Payment Advisory Board" will have sweeping powers.

As originally set forth in the Reid Substitute, the Board was called the "Medicare" Advisory Board, and its mission was focused on cutting Medicare reimbursement rates (see below) – a duty it retains. However, the Manager's Amendment dramatically expands its authority, so as to work to limit nonfederal health care spending, as well. Starting in 2014, "and at least once every two years thereafter," the Board is to make recommendations "to slow the growth in national health expenditures" *other* than Federal health care programs – recommendations "that the Secretary or other Federal agencies can implement administratively," as well as recommendations for legislative action. To the extent these are effective, they will limit the ability of private citizens to spend their own money to protect their own lives, by obtaining health care, or health insurance, that is not rationed.

For 2015, unless Medicare spending is projected NOT to keep up with the rate of medical inflation (specifically, unless it is projected to come in at or below a "target" set at the midway point between medical inflation and the average inflation rate for all goods and services , the "Consumer Price Index-Urban"), the Board is to specify how to cut Medicare payments by either the difference from the target or half a percent, whichever is less.

For 2016, the Board is to specify how to cut Medicare by the lesser of the difference from the target for that year or 1 percent, and for 2017 by the lesser of the difference from the target for that year or 1.25 percent.

For 2018 and subsequent years, the target shifts to the growth in Gross Domestic Product (GDP) per capita, and the Board must specify how to cut Medicare payments by the lesser of the difference from that target and 1.5 percent.

Each year, the Secretary of Health and Human Services must implement the Board's directives unless Congress, within a given deadline, legislates an alternative set of restrictions to accomplish the same result. However, Congress could not reduce the net of the targeted cuts unless three-fifths of both chambers voted to do so. The bill goes so far as to forbid a future Congress from repealing these provisions, except for a one-time opportunity in 2017! Section 3403, adding Social Security Act Section 1899A(d)(3)(C), p. 1020.

How is the Board to bring about these Medicare reductions? On its face the bill instructs the Board not "to ration health care, raise revenues or Medicare beneficiary premiums . . . , increase Medicare beneficiary cost-sharing . . . , or otherwise restrict benefits or modify eligibility criteria." Section 3403, creating Social Security Act Section 1899A(c)(2)(A)(ii) , p. 1004. Predominately, the reductions will have to come in reimbursement rates for health care providers.

This is likely to have either – or, more likely, both– of two rationing effects. First, an increasing number of Medicare providers, being paid further and further below their costs of providing care, would stop accepting new Medicare patients. Second, the Board could change the way reimbursement rates are structured, away from a fee-for-service model toward a "capitated" model, for example, under which practitioners are paid a set annual amount per patient, or toward an "episode" model somewhat similar to the DRG payment system for hospitals, under which a set amount is paid per illness or injury. In either of these cases, the physician or other health care provider would have a strong financial incentive to limit treatment, especially if it is costly. So, in compliance with the statute, the Board itself would not be "rationing" treatment – instead, it would be compelling health care providers to do so.

"EFFICIENCY" MEASURES THAT MAY LEAD TO DISCRIMINATORY DENIAL OF TREATMENT BASED ON DISABILITY, AGE, AND OTHER QUALITY OF LIFE CRITERIA

Section 10304 (p. 152) empowers the Secretary of Health and Human Services to impose "efficiency measures," in addition to the "quality measures" provided for under the Reid Substitute, on health care providers. These measures are to be incorporated "in workforce programs, training curricula, and any other means of dissemination determined appropriate by the Secretary." Section 3014(b) adding Social Security Act Section 1890A(b)(1)(A) (p. 709). They are to be used in the calculation of value-based purchasing from hospitals, and renal dialysis services must abide by them or be penalized. Health care providers, including hospices,

ambulatory surgical centers, rehabilitation facilities, home health agencies, physicians and hospitals must provide reports, generally made publicly available, based on these measures. Consequently, they exercise considerable influence on how health care providers practice medicine, and consequently on what treatment patients do – and do not – receive.

In the medical and bioethical literature, quality and efficiency measures are often based on "quality of life" standards that discriminate on the basis of age and disability. See http://www.nrlc.org/news/2009/NRL07-08/CompEff.html . Accordingly, during the period when the group of six Senators were negotiating in an attempt to achieve a bipartisan health care bill, agreement was reached to make anti-discrimination language applicable to the results of comparative effectiveness research. See note 1 at http://www.nrlc.org/HealthCareRationing/SenFinCommBill.html . This language remains in the Reid Substitute, Section 6301(c), adding Social Security Act Section 1182 (c), (d) and (e) , pp. 1685-87.

However, the quality and efficiency measures are NOT made subject to the same limits on employment of quality of life criteria that are applied to the use of comparative effectiveness research under Section 6301(c) of the Reid Substitute. Consequently, the Secretary is free to formulate such measures in a way that has the effect of rationing treatment on the basis of disability, age, or other "quality of life" criteria, as advocated by many mainstream bioethicists.