
HOW THE OBAMA HEALTH LAW WILL RATION YOUR FAMILY'S MEDICAL TREATMENT



On March 23, 2010 President Obama signed into law a fundamental restructuring of the American health care system. What will happen under this law if it is not repealed by sometime in 2014?

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.¹

How the Federal Government Will 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.”² 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.³ Doctors will have to comply with such quality measures in order to be able to contract with any qualified insurance plan.⁴

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

Basically, doctors, hospitals, and other health care providers will be told by Washington just what diagnostic tests and medical care are considered to meet “quality and efficiency” standards – not only for federally funded programs like Medicare, but also for health care paid for by private citizens and their nongovernmental health insurance.

And these will be standards *specifically designed to limit what ordinary Americans may choose to spend on health care so that it is BELOW the rate of medical inflation*. Treatment that a doctor and patient deem needed or advisable to save that patient’s life or preserve or improve the patient’s health but which runs afoul of the imposed standards will be denied, *even if the patient is willing and able to pay for it*.

In effect, there will be one uniform national standard of care, established by Washington bureaucrats and set with a view to limiting what private citizens are allowed to spend on saving their own lives.

Documenting Endnotes

1. Understanding the legislative language that sets the required target below the rate of medical inflation requires following a very convoluted path:

42 USCS § 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 title 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 is to 42 USCS § 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 USCS § 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 USCS §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” [42USCS §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 USCS § 1395kkk(c)(7)(C)(I)].

2. This provision is quoted at the beginning of endnote1 above.
3. 42 USCS § 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]
4. 42 USCS § 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.”