

THE
**AFFORDABLE CARE
ACT** AND
**HEALTH CARE
ACCESS**
IN THE UNITED STATES

MARCH 2014

The Affordable Care Act and Health Care Access in the United States

is a report issued by the Robert Powell Center for Medical Ethics at the National Right to Life Committee (NRLC). Founded in 1968, National Right to Life, the federation of 50 state right-to-life affiliates and more than 3,000 local chapters, is the nation's oldest and largest national grassroots pro-life organization. Recognized as the flagship of the pro-life movement, NRLC works through legislation and education to protect innocent human life from abortion, infanticide, assisted suicide and euthanasia.

Original Release: March 6, 2014

For further information or to arrange an interview with one of our experts, please contact the National Right to Life Communications Department.

NRLC Communications
(202) 626-8825
mediarelations@nrlc.org
www.nrlc.org/communications

"The Affordable Care Act and Health Care Access in the United States 2014" © 2014
National Right to Life Committee, Inc.
512 10th Street NW, Washington, D.C. 20004

TABLE OF CONTENTS

On March 23, 2010 President Obama signed into law a major health care initiative that fundamentally restructured the American health care system. This report describes how the "Patient Protection and Affordable Care Act" (commonly referred to as "Obamacare") is affecting health care access for Americans.

Introduction by NRLC President Carol Tobias	4
Summary: Obamacare's Impact on Health Care Access in the United States	5
The "Excess Benefits" Tax: How Obamacare's "Excess Benefits" Tax Will Prevent Health Insurance from Keeping Up with Medical Inflation	8
The Obamacare Exchanges: How the Insurance Exchanges Are Limiting the Ability to Use Private Funds to Receive Adequate Coverage	10
Medicare: How Obamacare Limits the Right of Senior Citizens to Use Private Funds to Receive Adequate Coverage	13
The Independent Payment Advisory Board: How Obamacare Will Limit the Level of Care and Treatment that Health Care Providers Can Provide	16
Endnotes	18
About National Right to Life	24



CAROL TOBIAS

National Right to Life President

In March 2010, the United States Congress gave final passage to the Patient Protection and Affordable Care Act, better known as Obamacare. Implementing health care reform in the United States was a hallmark of Barack Obama's campaign for the presidency in 2008. On March 21, 2010, President Obama signed the bill into law, marking the single greatest overhaul of America's health care system since Medicare was created.

For pro-life Americans concerned about its impact on innocent human life—both born and unborn—the policies of Obamacare couldn't be worse. As National Right to Life reported at the time of the law's passage, and in subsequent news stories since, Obamacare opens the door to federal funds, that is taxpayer dollars, being used to subsidize insurance coverage for elective abortion. The law created new pipelines of federal funding for health insurance plans that were not covered by, and which departed sharply from the principles of, the Hyde Amendment, which had prevented federal Medicaid funding of elective abortion since 1976.

In addition to the abortion-related policies woven into Obamacare, pro-life Americans are just as concerned with the law's impact on our own ability to access life-saving medical treatment for ourselves and our family members and loved ones.

Lost in the debate over Obamacare was the real consequence of this law: our ability to maintain access to health care will be continually and increasingly limited.

As our Robert Powell Center for Medical Ethics explains in these pages, Obamacare will restrict access to health care not just by limiting what we can spend to access health care, but also by limiting the growth of health care spending well below medical inflation. Taken altogether, these various policies will severely change the health care landscape in the United States if the law is allowed to reach full implementation.

Then-Speaker of the House Nancy Pelosi quipped during the House debate over Obamacare that "...we have to pass the bill so you can find out what's in it..." Well, now we know. Obamacare will not only limit what we can spend to access life-preserving health care, it will limit the care we can receive.

Obamacare is bad medicine for America.

OBAMACARE'S IMPACT ON HEALTH CARE ACCESS IN THE UNITED STATES

A Brief Summary



Since its inception, the National Right to Life Committee has been just as committed to protecting those who have been born, especially older people and people with disabilities, from euthanasia, as it has been committed to protecting unborn children from abortion.

Our efforts to protect the vulnerable from euthanasia have been directed at opposing not only direct killing such as assisting suicide but also denial of life-saving medical treatment, food and fluids necessary to sustain life. In particular, we have fought involuntary euthanasia—the denial of life-saving treatment and sustenance to patients against their will. This includes our opposition to government rationing of health care.

We do not believe that the government should limit the right of Americans, if they choose, to use even their own, private, funds for health care to save their lives and those of their family members. Although under-reported, that is what Obamacare does.

- **“Excess Benefits” Tax**

Obamacare imposes a 40% excise tax on employer-paid health insurance premiums above a governmentally imposed limit *that does not allow for medical inflation*. A September 30, 2013 *Politico* article explains: “[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.” [See: 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>]

The “excess benefits” tax will have the intended result of effectively imposing a price control on health insurance premiums that will not keep up with medical inflation. Consequently, insurance companies will be forced to impose increasingly severe restraints on policy-holders’ access to medical diagnosis and treatment—limits that will not prevent setting broken legs and giving flu shots, but will make it harder and harder to get the often-expensive medicines, surgery, and therapy essential to combat such life-threatening illnesses as cancer, heart disease, and organ failure.

OBAMACARE'S IMPACT ON HEALTH CARE ACCESS IN THE UNITED STATES

A Brief Summary

- **Exclusion of Adequate Health Insurance Plans from the “Exchanges”**

The Obamacare state-based health insurance “exchanges” are promoted as marketplaces through which gradually more and more of us will annually select our health insurance plan for the next year. Under Obamacare, however, consumers may only choose plans offered by insurers who do not allow their customers to spend what government bureaucrats deem an “excessive or unjustified” amount for their health insurance. As widely reported in the mainstream media, 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.

[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); Annika McGinnis, “Big insurers avoid many state health exchanges,” *USA Today* (October 21, 2013).]

- **Limits on Senior Citizens’ Ability to Use Their Own Money for Health Insurance**

According to an August 2010 Congressional Budget Office estimate, the Obama Health Care Law will cut \$555 billion from Medicare over ten years. (See *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) Most senior citizens know that the law will significantly cut government funding for their Medicare. *What many are not aware of is the law’s provision allowing Washington bureaucrats to prevent older Americans from making up the Medicare shortfall with their own funds—limiting their right to spend their own money to save their own lives.*

Before the enactment of Obamacare, under Medicare senior citizens could choose health insurance plans 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. (For information on the nature and history of this option, see <http://www.nrlc.org/medethics/medicare>). Such plans would not be forced to ration treatment, as long as senior citizens were free to choose to pay more for them.

Obamacare, however, enabled federal bureaucrats to refuse to allow senior citizens the choice of insurance plans that permit them to spend more than the bureaucrats think they should be allowed to devote to preserving their lives and health.

- **Federal Limits on the Health Care Doctors May Give Their Patients**

Obamacare creates an “Independent Payment Advisory Board” directed to recommend measures to limit *private, nongovernmental* spending on health care to a growth rate *below* medical inflation. (Although most news reports have focused on the Board’s authority to limit government spending in Medicare, little attention has been given to this more sweeping mission.) The federal Department of Health and Human Services, based on these recommendations or on its own initiative, is authorized to place limits on the treatments health care providers may give their patients, and under what circumstances. 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. 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, must be denied, *even if the patient is willing and able to pay for it*. Any doctor who dares to give a patient more or better treatment than the measures allow is made ineligible to contract with any qualified health insurance plan.

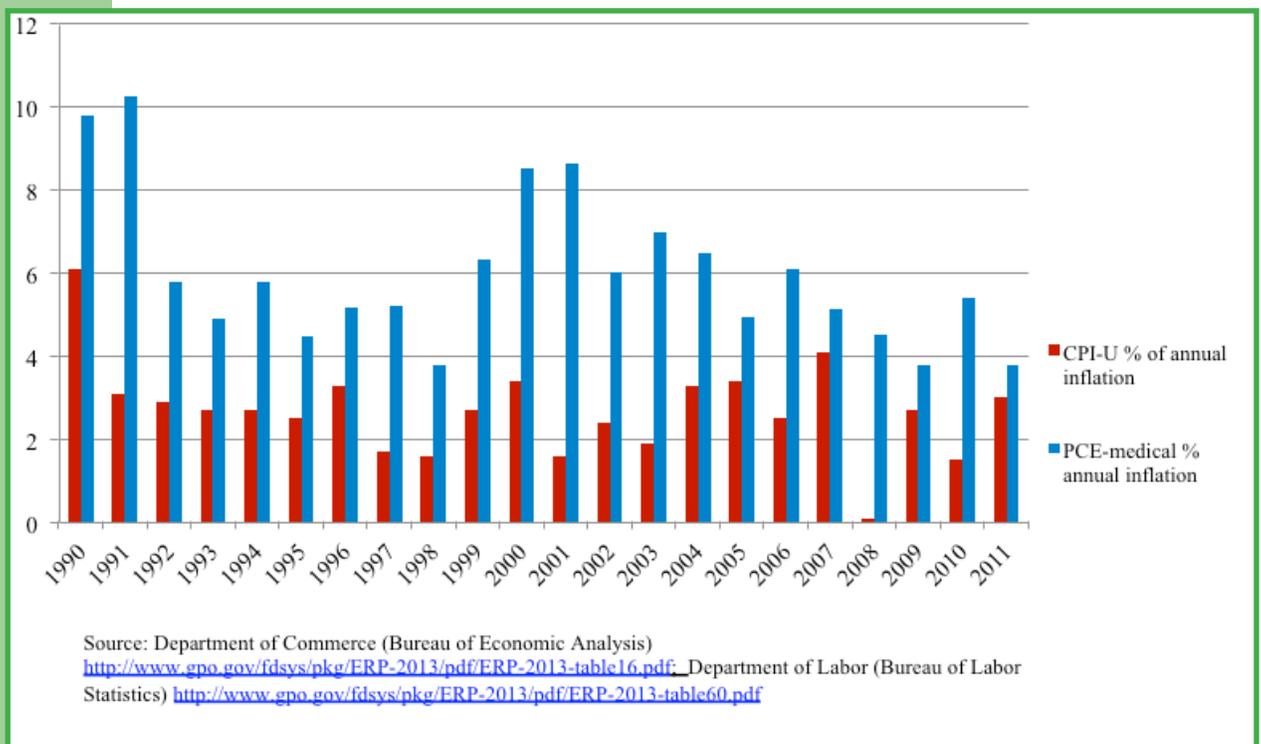
In effect, Obamacare authorizes Washington bureaucrats to create one uniform, national standard of care that is designed to limit what private citizens are allowed to spend to save their own lives.

The “Excess Benefits” Tax

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 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

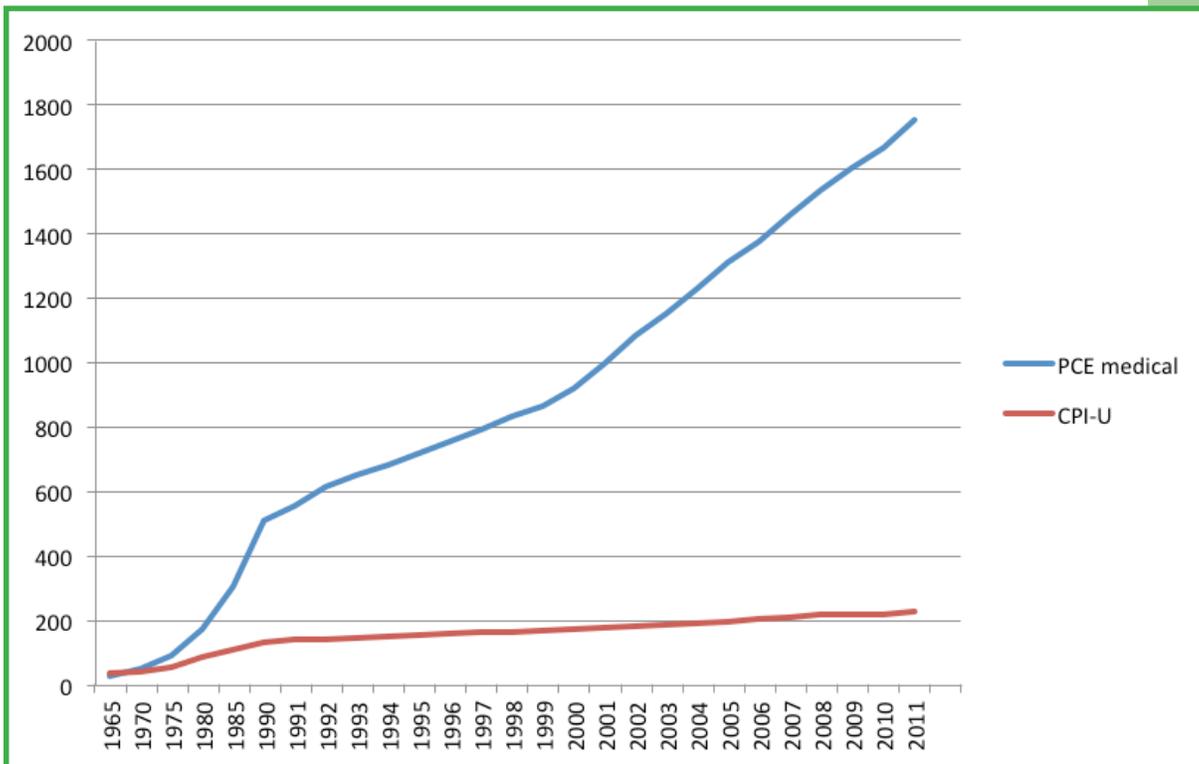


The Reality of Medical Inflation

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:



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.”

The Obamacare Exchanges

How the Insurance Exchanges Are Limiting the Ability to Use Private Funds to Receive Adequate Coverage

The Role of State-Based Health Insurance Exchanges

Under Obamacare, 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 regulations⁷ 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 give 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.

*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. 178, (codified at 42 U.S.C. § 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.

The Obamacare Exchanges

How the Insurance Exchanges Are Limiting the Ability to Use Private Funds to Receive Adequate Coverage

continued

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 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

Medicare

How Obamacare Limits Right of Senior Citizens to Use Private Funds to Receive Adequate Coverage

Denying Senior Citizens the Right to Make Up Medicare Cuts with Private Funds

According to an August 2010 Congressional Budget Office estimate, Obamacare 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 Obamacare'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 Private Funds

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, Medicare health insurance premiums could be financed partly by the government and partly from a senior's own income and savings.

Medicare

How Obamacare Limits Right of Senior Citizens to Use Private Funds to Receive Adequate Coverage

Private Fee-for-Service Medicare Insurance

As a result of legislative changes in 1997 and 2003 undertaken at the instance of the National Right to Life Committee, this third alternative became law. Under the title of “private fee-for-service plans,” an 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/uploads/medethics/AmericaCanAfford.pdf.

What About Seniors Who Cannot 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.

Obamacare’s Assault on the Right of Seniors to Add Their Own Money

Section 3209¹⁴ of the Affordable Care Act [codified at 42 U.S.C. § 1395w-24(a)(5)(C)(i)] indirectly amended the section in existing law allowing private fee-for-service 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

*It may seem strange to describe the ability to pay more as an “opportunity.” Senior citizens, like others, would prefer to pay less, not more, for health care—just as they would for any good or service. However, those who can afford to do so nevertheless frequently are willing to pay more for goods and services of higher quality, e.g., automobiles, houses, vacations, or restaurant meals. Because one cannot enjoy these goods or services after death, it is entirely rational to pay more for health insurance when convinced that paying a higher price will offer greater assurance of gaining access to high-quality health care, and will reduce the likelihood that the insurance company will deny authorization or payment for treatments that are more costly, but are more likely to be effective and are less likely to have deleterious side effects.

For the facts showing America as a whole can continue to increase health care spending, see: <http://www.nrlc.org/uploads/medethics/AmericaCanAfford.pdf>.

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 AFFORDABLE CARE ACT:

What is the exact language that allows the federal government to limit what senior citizens can choose to spend for health insurance?

1. Under a provision in effect both before and after adoption of the Affordable Care Act, 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. § 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 U.S.C. § 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.

The Independent Payment Advisory Board:

How Obamacare Will Limit the Level of Care and Treatment that Health Care Providers Can Provide

A Powerful 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	Year	% below projected spending
2015	Halfway between medical and general inflation	2015	.5 %
2016	Same	2016	1%
2017	Same	2017	1.25%
Later Years	Nominal GDP per capita + 1% [President Obama has proposed lowering to Nominal GDP per capita + .5%]	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 such measures.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 Individual 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 Payment 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.

Obamacare 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

The Affordable Care Act and Health Care Access in the United States 2014

1. P.L.111-148, §9001, 128 Stat. 119, 847-53, codified at 26 U.S.C. 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 1: 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> For a technical explanation of why the health care component of personal consumption expenditures (PCE) is the preferred measure of medical inflation, see <http://www.nrlc.org/uploads/medethics/MeasuringMedicalInflation.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. § 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. § 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.

ENDNOTES

The Affordable Care Act and Health Care Access in the United States 2014

8. 42 U.S.C. § 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 (August 2010) www.cbo.gov/sites/default/files/cbofiles/ftpdocs/117xx/doc11705/08-18-update.pdf

12. For more information on the private fee-for-service alternative and its history, see www.nrlc.org/medethics/medicare.

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).

15. 42 U.S.C. § 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. §§ 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. § 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. § 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. § 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. § 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).

ENDNOTES

The Affordable Care Act and Health Care Access in the United States 2014

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. § 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. § 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. § 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. §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. § 1395kkk(c)(7)(C)(I).

19. 42 U.S.C. § 1395kkk(o)(1)(A).

20. 42 U.S.C. § 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], (i)(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. § 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. § 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 U.S.C. § 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/uploads/medethics/AmericaCanAfford.pdf>



Founded in 1968, National Right to Life is the nation's oldest and largest national pro-life group. National Right to Life works to protect innocent human life threatened by abortion, infanticide, assisted suicide, euthanasia and embryo-killing research. National Right to Life is a non-partisan, non-sectarian federation of 50 state affiliates and more than 3,000 local chapters. National Right to Life is governed by a representative board of directors with a delegate from each state affiliate, as well as eight directors elected at-large.

National Right to Life's efforts center around the following policy areas:

Abortion: Abortion stops a beating heart more than 3,000 times a day. National Right to Life works to educate Americans on the facts of fetal development and the truth about abortion; works to enact legislation protecting unborn children and providing abortion alternatives in Congress and state legislatures; and supports activities which help women choose life-affirming alternatives to abortion.

Infanticide: National Right to Life works to protect newborn and young children whose lives are threatened and who are discriminated against simply because they have a disability.

Euthanasia: Through the work of the Robert Powell Center for Medical Ethics, National Right to Life fights rationing of health care on a national level, such as in the context of Medicare legislation or more general health care reform. National Right to Life speaks out against efforts by the pro-death movement to legalize assisting suicide and euthanasia based on an ethic which says that certain persons do not deserve to live because of a perceived "low quality of life." National Right to Life also makes available to individuals the Will to Live, a pro-life alternative to the living will.

National Right to Life works to restore protection for human life through the work of:

- the **National Right to Life Committee (NRLC)**, which provides leadership, communications, organizational lobbying and legislative work on both the federal and state levels.
- the **National Right to Life Political Action Committee (NRL PAC)**, founded in 1979 and the nation's largest non-partisan, pro-life political action committee, which works to elect, on the state and federal level, officials who respect democracy's most precious right, the right to life.
- the **National Right to Life Victory Fund**, an independent expenditure political action committee established in 2012 with the express purpose of electing a pro-life president and electing pro-life majorities in the U.S. House of Representatives and U.S. Senate.
- the **National Right to Life Educational Trust Fund** and the **National Right to Life Educational Foundation, Inc.** which prepare and distribute a wide range of educational materials and advertisements.
- various **outreach efforts** to groups affected by society's lack of respect for human life: the disability rights community; the post-abortion community; the Hispanic and African-American communities; the community of faith; and the *Roe* generation – young people who are missing brothers, sisters, classmates and friends.
- **National Right to Life NEWS** – published daily Monday-Saturday and available at www.nationalrighttolifenews.org, is the pro-life news source of record providing a variety of news stories and commentaries about right-to-life issues in Washington and around the country.
- the **National Right to Life website**, www.nrlc.org, which provides visitors the latest, most up-to-date information affecting the pro-life movement, as well as the most extensive online library of resource materials on the life issues.

This report may be downloaded from the National Right to Life website at:
www.nrlc.org/uploads/communications/healthcarereport2014.pdf



512 10th Street NW | Washington, DC 20004
(202) 626-8825 | www.nrlc.org | mediarelations@nrlc.org

