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# IPAB: The Controversial Consequences for Medicare and Seniors

While the title of this hearing focuses on the implications that the Independent Payment Advisory Board (IPAB) will have for senior citizens in the Medicare program, it is equally important to understand IPAB's critical role in limiting the ability of Americans of all ages to obtain unrationed health care. The Obama Health Care Law requires IPAB to make recommendations, which the federal Department of Health and Human Services is given coercive power to

[1]Founded in 1968, the National Right to Life Committee, the federation of 50 state right-to-life affiliates and more than 3,000 local chapters, is the nation's oldest and largest 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.

Since its inception, the National Right to Life Committee has been equally concerned with protecting older people and people with disabilities from euthanasia as with protecting the unborn from abortion. We have recognized that involuntary denial of lifesaving medical treatment is a form of involuntary euthanasia, and therefore have opposed government rationing of health care.

implement, effectively to limit what resources Americans are allowed to devote to health care for their family so that they cannot even keep up with the rate of medical inflation. In short, IPAB will play a crucial role in limiting the ability of Americans of all ages to spend their own money to save their own lives.

IPAB is given the duty, on January 15, 2015 and every two years thereafter, to make "recommendations to slow the growth in national health expenditures" *below* the rate of medical inflation with regard to *private* (not just governmentally funded) health care.[1]

Under the law, 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 "quality" measures in order to be able to contract with any qualified health insurance plan.[4]

This will have grave effects on every 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.

It is critically important that the devastating impact of the Independent Payment Advisory Board on the right and ability of Americans of all ages to spend their own money as they judge best to preserve their lives and the lives of their family members be made more widely known. It is among the most dangerous rationing provisions of the Obama Health Care Law. We urge its repeal before it is too late.

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. 42 USCS § 1395kkk(o)(1)(A).

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], 13 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."