

**Coburn Amendment 2964: To ensure that government health care rationing does not harm, injure, or deny medically necessary care or endorse the taking of life as a form of health care.**

The Reid bill creates new government rationing programs and expands the ability of the federal government to deny or limit health care services—particularly to the elderly.

This amendment would strike or amend many of the provisions in this legislation that will lead to government-rationing of health care, as well as require a study by the Government Accountability Office (GAO) to determine the extent to which government programs are currently rationing care within government-run health care programs.

This amendment also ensures the federal government will not ration end of life care, and that no taxpayer dollars will be used to pay for assisted suicide and euthanasia.

Specifically this amendment:

- Prohibits comparative effectiveness research from being used by federal health programs to ration care;
- Strikes the Independent Medicare Advisory Board, which has been dubbed by the Wall Street Journal as a “rationing commission”<sup>1</sup>;
- Strikes provisions that empower the United States Preventive Services Task Force to ration, restrict, or deny care;
- Requires a GAO study to identify health care rationing currently happening in government run programs.

**This legislation fails to prohibit the government from rationing care based on comparative effectiveness research.**

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<sup>1</sup> Wall Street Journal, “The Rationing Commission,” November 15, 2009, <http://online.wsj.com/article/SB10001424052748703792304574504020025055040.html>

The Reid bill purposely does not prohibit government-run programs from using comparative effectiveness research to make payment, coverage, or treatment decisions. During the Health, Education, Labor, and Pensions (HELP) Committee debate, the majority party voted down a straightforward amendment to prohibit comparative effectiveness research from being used to ration care.

The amendment was a clear, up or down vote on government rationing. But it failed on a straight party-line vote, which is why it is now necessary to include this language in this amendment.

Supporters of the Reid bill will point to language in the bill that says *“Nothing in this section shall be construed to permit the Institute to mandate coverage, reimbursement, or other policies for any public or private payer;”*

Unfortunately, this language does not adequately protect patients. First, the concern is not that the Comparative Effectiveness Institute will ration care. The real concern is that Medicare and other government-run programs will use this research as the scientific rationalization to deny care to their patients.

Further, saying that *nothing shall be construed* is not the same as an express *prohibition*. Rationing by the Centers for Medicaid and Medicare Services (CMS) is a clear example. The original Medicare statute reads:

*“Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided...”*

Few would argue that CMS does not ration care. Recent examples include Medicare curtailing the use of virtual colonoscopies, certain wound-healing devices, and asthma medications.

**This legislation empowers unelected bureaucrats to restrict current and future seniors' Medicare benefits.**

The prohibition on using comparative effectiveness research to ration care is particularly important, given the creation of an “Independent Medicare Advisory Board” in section 3403. This amendment strikes this section in order to ensure that no unelected board can threaten and ration Medicare benefits.

The “Independent Medicare Advisory Board,” has been dubbed a “rationing commission” by the Wall Street Journal, because it would create a “global budget” for Medicare that would be required to recommend further cuts to Medicare to meet arbitrary spending targets.

**The Wall Street Journal quotes health care economist Alain Enthoven who likened a global budget to “*bombing from 35,000 feet, where you don’t see the faces of the people you kill.*”**

The Medicare Advisory Board would have the authority to set payment updates to Medicare providers and propose other payment reforms, subject only to presidential or congressional *disapproval*. These recommendations will come into effect without Congressional action.

The potential implications of creating this rationing commission are devastating. The commission is required to find “sources of excess cost growth.” What if we find an expensive treatment for Leukemia that would add significant new costs to the Medicare budget? Multiple Sclerosis? Alzheimer’s?

This again looks a lot like the rationing board developed in Great Britain to constrain health care costs. But it also looks like a similar rationing board in the state of Washington that has banned a number of important procedures and treatments based on costs instead of clinical importance.

The Washington board has banned knee arthroscopy for osteoarthritis, discography for chronic back pain, and implantable infusion pumps for non-cancer related pain. That same board is currently targeting knee replacements, spinal cord stimulation, autism therapy and MRIs on the abdomen, pelvis, or breasts for cancer. It will also issue a decision on routine ultrasounds for pregnancy—which are highly beneficial, but costly.<sup>2</sup>

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<sup>2</sup> Wall Street Journal, “The Rationing Commission,” November 15, 2009, <http://online.wsj.com/article/SB10001424052748703792304574504020025055040.html>

**This legislation fails to protect patients from morally-reprehensible denials of care based on life expectancy or age.**

Some countries, such as Great Britain, have developed government formulas to determine whether a patient can get the care their doctor prescribes. Tragically, government bureaucrats puts a price on people's lives—they decide how much money a quality life year is worth to decide if a particular treatment or medication is worthwhile.

During the Help, Education, Labor, and Pensions (HELP) Committee debate, Sen. Enzi offered a common-sense amendment to prohibit the federal government from developing “Quality-Adjusted Life Year” measurements akin to the ones in Great Britain. His amendment was defeated on a 13-10 party-line vote.

This amendment includes similar language to *prohibit* the government from developing quality of life year measurements or other government formulas that would lead to the rationing of care.

**This legislation relies on government bureaucrats—such as the Preventive Services Task Force—to make health care decisions for individual patients.**

Doctors and their patients should make decisions about proper preventive care—not government bureaucrats. Unfortunately, this legislation empowers unelected bureaucrats to ration the preventive care Americans can receive.

As is now well known, the U.S. Preventive Services Task Force recently released a recommendation that women ages 40-49 are no longer encouraged to get routine mammograms. Further, the Task Force now recommends that doctors do not teach patients how to do a self breast exam—stating that self-breast exams are not an evidenced-based preventive service.

The majority's government-run health care bill would allow the Secretary seemingly unlimited authority to modify benefits under Medicare, or even

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the government-run public plan, if they are consistent with Task Force recommendations. In the case of mammograms, this means charging more for routine mammograms for women between the ages of 40-49. It also means potentially denying coverage for doctors to teach women how to conduct self-breast exams.

Steven Pearlstein recently authored a telling article in the Washington Post in which he chided Health and Human Services Secretary Kathleen Sebelius for “undermining the move toward evidence-based medicine with her hasty and cowardly disavowal of a recommendation from her department’s own task force that women under 50 are probably better off not getting routine annual mammograms.” Pearlstein concluded that, “in the end, [the task force] found that while some lives might be saved each year, the benefits of annual screening of women in their 40s were outweighed by the costs...”<sup>3</sup>

**This legislation exasperates the rationing, wait times, care restrictions, and poor health outcomes experienced in government-run health care plans.**

Government-run programs are known for substandard care, fraud and waste, waiting lines, and a lack of access to high-quality care.

Patients covered under the government run program Medicaid have worse health outcomes and lack access to 40 percent of the doctors in this country. Medicare is one the verge of bankruptcy which threatens the health care security of seniors and future retirees. Both programs are plagued with fraud and abuse.

The Indian Health Service (IHS) is known for its waiting lines and poor health outcomes. There’s even a saying in Indian country, “don’t get sick after June,” because most clinics manage their dollars poorly and must ration care to cut costs.

Many of the veterans that I talk to bemoan the driving past 3 or 4 well-renowned hospitals before arriving at the VA hospital hundreds of miles

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<sup>3</sup> Steven Pearlstein, “Sebelius’s cave-in on mammograms is a setback for health-care reform,” Washington Post, November 20, 2009, <http://www.washingtonpost.com/wp-dyn/content/article/2009/11/19/AR2009111904053.html>.

from their home. After the disclosure of the substandard conditions of the Walter Reed Army Medical Center, the VA did an audit of its 1,400 health clinics and hospitals and found numerous maintenance problems, including mold, leaking roofs, and even a colony of bats.

This amendment would require GAO to conduct a study of current federal health care programs (Medicare, Medicaid, IHS, VA) that would include the following:

- (1) any restrictions or limitations regarding access to health care providers (including the percentage of health care providers willing or permitted to care for patients insured by each program);
- (2) any restrictions, denials, or rationing relating to the provision of health care, including medical procedures, tests (including mammograms and cervical cancer screenings), and prescription drug formularies;
- (3) average wait times to see a primary care doctor;
- (4) average wait times for medically necessary surgeries and medical procedures; and
- (5) the estimated waste, fraud, and abuse (including improper payments) in each program.