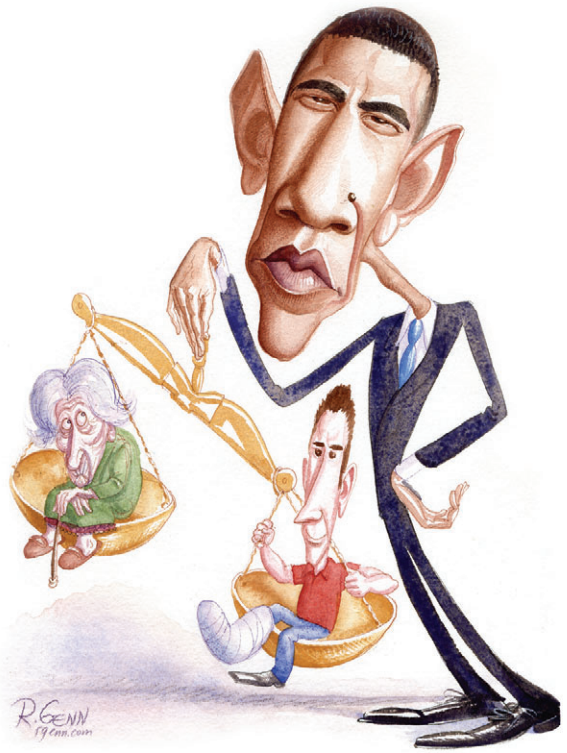

There Will Be Rationing

Sifting out what's right in Sarah Palin's 'death panels' hyperbole

BY JOHN C. GOODMAN

'Lies and distortions," said David Axelrod in an e-mail to 13 million of the Obama faithful plus an untold number of others who were spammed. He was referring to criticisms of the Obama health-care-reform plan—criticisms that are hitting the mark, to judge by opinion polls and the near-riotous responses members of Congress have gotten at town-hall meetings.

Chief among the White House's irritations is Sarah Palin's accusation that Obama would create "death panels" to decide who lives and who dies. It is true that none of the bills before Congress calls for the creation of such entities, but does Palin's statement, however hyperbolic, point toward legitimate concerns? Is there something we should be worried about? The answer is: Yes, we should be very worried.

Let's start with Obama's repeated insistence that health-care reform will be a failure if it doesn't control costs. Just how do you control costs? All over the developed world, the Left has done it in only two ways: squeezing the providers and denying care to patients.

Yes, I know: You never heard anything about this during the presidential campaign. Candidate Obama promised to control costs through coordinated care, preventive medicine, electronic medical records, and other innocuous measures. Yet at the same time, Congressional Budget Office director Peter Orszag—now head of the Office of Management and Budget and Obama's economic point man—had his staff study these proposals, and the conclusion was: None of them work. So now a new strategy has emerged.

The president let the cat out of the bag in a series of impromptu conversations. He pointed out that his grandmother had received a hip replacement shortly before she died and asked whether giving the terminally ill such treatments is a "sustainable model." "Maybe you're better off not having the surgery, but taking the painkiller," he told another audience.

President Obama was more explicit in his speech to the American Medical Association. We are performing too many tests, too many exams, and too many services of all types, he said. Referring to an article in *The New Yorker*, Obama said per capita Medicare spending in McAllen, Texas, is twice as high as it is in El Paso (both are border cities) but nonetheless fails to achieve better health outcomes. To emphasize this point, Orszag says that we could lower national average health-care spending by a third if all doctors practiced medicine as efficiently as those in the lowest-spending regions.

To make matters worse, the top White House health adviser is Ezekiel Emanuel, brother of chief of staff Rahm Emanuel. Zeke, as he is known in health-policy circles, has written rather extensively on how to ration care. In fact, he has mused that if government-controlled rationing is necessary, young adults should be given priority over senior citizens, because younger people have more years of life ahead of them.

What form will government rationing take? You won't find the answer by reading any bill before Congress. You won't find it by reading any act of parliament in Canada or Britain, either. Governments ration health care all over the world, but rarely do they admit it. (The state of Oregon is the only exception that I can think of.) Rationing Obama-style will be indirect and achieved through administrative decisions, all of them ostensibly made for the best of reasons: to eliminate futile and unnecessary care.

Here's how it will work. The administration is seeking authority for an independent commission to make decisions on reimbursing providers of services through the Medicare program. Currently, a similar commission recommends reimbursement rates, but Congress approves them. This will allow the federal government to use the power of the purse to force doctors to change the way they practice

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medicine. There will be fewer CAT scans, fewer MRI scans, fewer blood tests, and fewer operations, for the simple reason that Medicare will quit paying for procedures it considers questionable. Those who trust the government to make such determinations should remember: The rule-makers in Washington—far removed from doctors and patients—will be under constant pressure to keep spending down.

Medicaid (for the poor) could be used to pressure health-care providers in the same way as Medicare (for the elderly and disabled). But what about private health plans? Under Obamacare, everyone who does not get health insurance through his employer will be required to obtain it through a health-insurance exchange. Small businesses and (in the House bill) large businesses will be able to send their employees to the exchange. No one knows how many people we're talking about, but 100 million or more is not out of the question.

As currently envisioned, private health plans and at least one public plan would compete. The plans would be free to set their own premiums but would have to charge all enrollees the same price, regardless of their health status. Because some plans will attract a greater percentage of sick enrollees than others, a government administrator will have the power to "tax" plans with healthier enrollees in order to subsidize plans with sicker enrollees, through a process called risk adjustment. And it is through this process that the government will have enormous power to control what is done for the sick.

Suppose a plan attracts an above-average number of people whose doctors say they need hip replacements. The company asks the government risk adjuster for a subsidy to cover the cost. The risk adjuster may decide these hip replacements constitute "unnecessary care" or "futile care" and deny the request. In this way, the risk adjuster will effectively force doctors to deny people care.

The risk adjuster will be aided by a national health board, which will do "comparative effectiveness" analyses. If the health board decides that a hip replacement is "unnecessary" or "futile," it will offer cover for the risk adjuster to deny payment and for insurers to deny care.

Former senator Tom Daschle spelled out the idea behind a health board in his book *Critical: What We Can Do about the Health-Care Crisis*, which in many ways is the blueprint for all the congressional versions of Obamacare. According to Daschle, the model to follow is Britain's NICE (National Institute for Health and Clinical Excellence), which currently recommends against any treatment that costs more than about $45,000 to save a year of life. Because of NICE, British cancer patients are denied access to drugs that are routinely available in the U.S. and on the European continent, and thousands die prematurely.

It is impossible to predict the consequences of Obamacare in fine detail, but on one point all should agree: The burden of proof is on the Obama administration to demonstrate how it can reduce health-care spending without denying care. **NR**