

Question and Answer: Government-Rationed Health Care

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In light of the inclusion of \$1.1 billion in the Democrat “stimulus” legislation for the Agency for Healthcare Research and Quality (AHRQ) to undertake comparative effectiveness research, the Republican Conference has compiled background on the issue and its larger implications about the federal government’s role in rationing health care.

“We won’t be able to make a significant dent in health-care spending without getting into the nitty-gritty of which treatments are the most clinically valuable and cost-effective....The federal government could exert tremendous leverage with its decisions...In choosing what it will cover and how much it will pay, it could steer providers to the services that are the most clinically valuable and cost-effective, and dissuade them from wasting time and money on those that are neither.”

— Former Sen. Tom Daschle, writing in *Critical: What We Can Do about the Health Care Crisis*¹

What is comparative effectiveness research?

Broadly speaking, comparative effectiveness research evaluates the relative merits of two or more forms of medical treatment, in the hopes of arriving at a best practice or set of best practices for treatment of a certain condition. Of critical importance is the distinction between *clinical effectiveness*—i.e., which treatments work best irrespective of cost—and *cost effectiveness*—where the most effective treatments could be considered inappropriate because their costs outweigh the perceived benefits in the eyes of the government.

Could the funding in the “stimulus” lead to government rationing of health care?

Yes. In fact, the draft report issued by the House Appropriations Committee on the “stimulus” promised as much:

By knowing what works best and presenting this information more broadly to patients and healthcare professionals, those items, procedures, and interventions that are most effective to prevent, control, and treat health conditions will be utilized, while those that are found to be less effective and in some cases, more expensive, will no longer be prescribed.

Former Health and Human Services Secretary-designee Tom Daschle has laid out the argument for the federal government to end coverage of treatments not deemed cost-effective, admitting that “doctors and patients might resent any encroachment on their ability to choose certain treatments.”²

¹ Tom Daschle, Scott Greenberger, and Jeanne Lambrew, *Critical: What We Can Do About the Health Care Crisis* (St. Martin's Press, 2008), pp. 171-72, 158.

What are other potential implications of using comparative effectiveness research to determine health coverage?

If comparative effectiveness research is used to determine coverage of particular therapies within government health programs (i.e. Medicare, Medicaid, etc.), two questions follow: Will individuals be permitted to pay for the treatments using their own funds? Some Members may be concerned by the implications of such a policy to deny coverage for certain treatments, regardless of whether or not “top-up” payments are permitted. If patients may supplement their Medicare or other government coverage with private funds, Members may be concerned that this “two-tier” health system would have a disproportionate impact on poorer individuals, who will not have the resources to purchase supplemental care. Conversely, if “top-up” payments are prohibited, Members may strongly oppose an effective ban on patients using their own money to obtain care. Therefore, some Members may oppose the federal efforts to take the unprecedented step of denying care based on cost grounds.

Why is this funding in the “stimulus” legislation?

Some Members may question this need for this provision’s inclusion, and believe that this significant expansion of funding for research that could lead to government-rationed health care should be debated through the usual appropriations process, rather than in a rushed setting, particularly as this government spending will have little effect in hastening economic recovery.

Will the \$1.1 billion in the “stimulus” for comparative effectiveness research be well spent?

No. A December 2007 CBO analysis notes that “it is not at all clear that such sums could be spent in an effective way in the near term.”³ Given that AHRQ’s entire budget in recent years has hovered around \$300 million, with only \$15 million per year of that sum devoted to clinical effectiveness (not cost effectiveness) research, some Members may question whether AHRQ could spend an additional \$300 million in “stimulus” funding—a doubling of its entire budget—effectively.⁴

Will comparative effectiveness research generate significant budgetary savings?

Former CBO Director Peter Orszag admitted that “the big kick” in savings associated with comparative effectiveness research would stem from insurers—and likely the federal government—implementing “changes in financial incentives tied to the research.”⁵ However, the CBO report admits that such decisions “could be difficult and controversial,” and further concedes studies suggesting that “patients who might benefit from more-expensive treatments might be made worse off” as a result of changes in reimbursement patterns.⁶

For further information on this issue see:

- [CBO Report on an Expanded Federal Role in Comparative Effectiveness Research](#)

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² Ibid., p. 199.

³ CBO, *Comparative Effectiveness*, p. 28.

⁴ Ibid., pp. 10-11.

⁵ Quoted in Fawn Johnson, “Bills Pushed to Gauge Effectiveness of Medical Treatments,” *CongressDaily* 17 March 2008, available online at <http://nationaljournal.com/pubs/congressdaily/dj080317.htm#5> (accessed March 18, 2008).

⁶ CBO, *Comparative Effectiveness*, pp. 30, 15.