

CONTACT:

Sarah Little (202) 224-4774

Molly Haase (913) 451-9343

FOR IMMEDIATE RELEASE

September 23, 2010

Senator Roberts: American People Still Waiting to Learn of Dr. Berwick's Plans for CMS

WASHINGTON, DC – U.S. Senator Pat Roberts today joined Senators Chuck Grassley (R-IA) and Orrin Hatch (R-UT) at a public forum on the recess appointment of Dr. Donald Berwick to head the Centers for Medicare and Medicaid Services (CMS), the body controlling one-third of all health care spending in America.

Despite repeated requests from Republicans for Dr. Berwick to go on the record with the American people, he again chose not to attend and discuss the future of CMS under his leadership and Obamacare.

Senator Roberts made the following statement:

“It's a shame that Republicans have been forced to hold this ‘shadow’ hearing on the nomination of Dr. Donald Berwick to be the Administrator of probably the most important agency, at least as it relates to health care, in America- the Centers for Medicare and Medicaid Services, or CMS.

“The American people deserve to hear Dr. Berwick's plans for radically reforming the American health care system directly from the man himself. They deserve to hear him explain: His long history of support for rationing; How he plans on ‘bending the cost curve down’ now that it's clear that Obamacare will not; How he came to his conclusions on the amount of ‘waste’ in our current system; and finally, why he supports tightly restricted single-payer health care that only the very rich can circumvent.

“Unfortunately, this Administration has not made Dr. Berwick available to us and to the American people to answer these questions. We only have his long record of past statements to try and discern the plans he has for all of us.

“Dr. Berwick's affection for British National Health Service, calling it ‘not just a national treasure, [but] a global treasure’ is well known. He has advocated for the NHS to be an example for the U.S. health care system, and has characterized the NHS as ‘an example of a health system that is universal, accessible, excellent, and free at the point of care– a health system that is, at its core, like the world we wish we had: generous, hopeful, confident, joyous, and just.’

“For those who don't already know, the British National Health Service rations health care in order to contain costs. The way that NHS rations care is by assigning a dollar value to a treatment's benefit to a patients' life, and then making a bureaucratic calculation as to whether or not the treatment is worth the cost to the government relative to the value of the benefit. Typically, the NHS will pay a maximum of \$22,000 to extend a life by six months. Drugs and treatments that exceed these costs are deemed not cost-effective and are denied.

“Dr. Berwick has proposed similar rationing ideas for the American health care system saying: ‘It makes good sense to at least know the price of an added benefit, and at some point we might say that we wish we could afford it, but we can’t’; and: ‘the decision is not whether or not we will ration care– the decision is whether we will ration with our eyes open.’

“If Dr. Berwick were here today, I’d like to ask him whether he still thinks this is ‘a health system that is, at its core, like the world we wish we had: generous, hopeful, confident, joyous, and just.’ I’d also ask him how much he thinks a life is worth- \$44,000, \$5,800, \$3? And who should make care decisions- the doctor? The patient? Or the government? And finally, I’d ask Dr. Berwick which of these treatments, all commonly available to American patients, will he deny for Medicare and Medicaid patients?

“The recess appoint of this strong supporter of rationing is just one broad stroke in the continued over reach of government that Americans are sick and tired of.

“Most recently, it was the Secretary of Health and Human Services’ warnings to the insurance industry against ‘misinformation and unjustified rate increases.’ The Secretary’s letter demonstrates the need for the Administration to stifle any criticism of Obamacare.

“It shows how far the Administration will go to defy the economic reality that is more than obvious to the average American: if you expand benefits there will be a resulting cost increase.

“Time will show that Americans simply will not stand for this unprecedented expansion of government in the doctor-patient relationship – Which represents a continued erosion of the individual’s ability to make medical decision.

“Unfortunately, Dr. Berwick is not here to address his important role in the implementation of Obamacare and the consequences to our seniors and nation. I will have more questions for him and for our distinguished panelists later in this hearing.”

Senator Roberts submitted the following questions for the record:

QUESTION 1: BENDING THE COST CURVE AND THE FOUR RATIONERS

“I have often pointed out that Obamacare explicitly recognized the cost curve will bend upwards at an unsustainable rate, and enacted a sort of pre-emptive strike by including at least four rationing bodies in the law:

- the Patient Centered Outcomes Research Institute which will conduct comparative effectiveness research,
- the CMS Innovation Center which will ration care for the poor and elderly via payment policy,
- the U.S. Preventive Services Task Force which will have new powers over the private market, and
- the Independent Payment Advisory Board which will be empowered to cut future Medicare payments to ration care.

“Dr. Berwick has repeatedly advocated for ‘controlling the supply’ of health care technology and services and placing global caps on total spending. He is already trying to expand CMS’s powers to slow or prevent the entrance of new life-saving medical devices and drugs into the market.

“I am very concerned, for example, about a new proposal for a pilot program to allow CMS to conduct a premarket review of the comparable value of new medical devices parallel to the current FDA review of the products’ safety and efficacy. This is exactly the type of regulatory scheme that Dr. Berwick will use to ‘control supply’ and ration new lifesaving health care innovations.

“While this ‘parallel review’ scheme is being billed as voluntary, independent from FDA approval, and limited to medical devices, it won’t be long before it is mandatory, linked to FDA approval (and ultimately, availability to all patients), and expanded to drugs and all other health care innovations. I’d like to ask the panel about their reactions to this proposal. Isn’t this an unprecedented power grab by CMS? Are you concerned about CMS inserting itself and cost-effectiveness into the pre-market approval process for new drugs and devices? Shouldn’t these types of value and utility determinations be left to individual doctors and patients? Dr. Holtz-Eakin, are you familiar with this issue?

QUESTION 2: THE MISCONSTRUCTION OF THE DARTMOUTH STUDY

“If Dr. Berwick were here, I would ask him to explain the premise behind his support for centralized rationing of health care- i.e.; that there is an ‘oversupply’ of health care in America.

“Dr. Berwick has characterized American health care as having a waste level approaching 50 percent. He's said that ‘one of the drivers of low value in health care today is the continuous entrance of new technologies, devices, and drugs that add no value to care.’ And he's argued that ‘most people who have serious pain do not need advanced methods, they just need the morphine and counseling that have been available for centuries.’

“The argument that billions of dollars-- perhaps as much as \$700 billion a year according to Obama's former budget Director Peter Orszag-- of health care spending is pure waste that can be cut to not only improve our country's fiscal condition, but also make people healthier along the way, forms the rationale for much of the Obama health care reforms.

“Where did this idea originate? How did it become the conventional wisdom among Democrats in Congress and in this Administration?

“The premise that there exists an ‘oversupply’ of ‘wasteful’ health care in America is largely based on research compiled in the Dartmouth Atlas of Health Care, commonly referred to as the ‘Dartmouth Study’ here in Congress. Very basically, the Dartmouth study examined spending in hospitals across the country and displayed the varying costs of care by region.

“The results of this study have been used over and over again. Dr. Berwick has even referred to the Dartmouth study as ‘the most important research of its kind in the last quarter-century.’

“But there's just one big problem: in a recent New York Times article the authors of the study admitted that they ‘never asserted and never claimed that we judged the quality of care at a hospital– only the cost.’ As the Times pointed out: ‘the [Dartmouth] hospital rankings do not take into account care that prolongs or improves lives. If one hospital spends a lot on five patients and manages to keep four of them alive, while another spends less on each but all five die, the hospital that saved patients [lives] could rank lower because Dartmouth compares only costs.’

“It is clear that extrapolating the results of this study to support an argument of wasteful spending in health care is just plain wrong, if not immoral. How do we know whether the spending was wasteful if we have no indications of quality? How can one say that \$700 billion per year, or as much as 50 percent of all spending is wasteful based on a study that just looks at costs? What if that spending saved a life? Extended it by 6 months or a year or more? Allowed a person to walk without pain, or pick up their grandchild, or ride their bicycle again?

“One man's waste could be another man's salvation, and that's why the misconstruction of this study is so dangerous. If Dr. Berwick were here, I'd ask him to explain his assumptions in light of this recent revelation. In his absence I'm very interested to hear our panelists' reactions as well. Dr. Holtz-Eakin?

QUESTION 3: SINGLE PAYER HEALTH CARE FOR THEE, BUT NOT FOR ME

“Finally, Dr. Berwick has been outspoken about his preference for a government-run single-payer system of health care. He has said: ‘If I could wave a wand...health care [would be] a common good– single payer’, and as we have previously discussed, he has heaped praise upon the government-dominated health care system in the United Kingdom.

“Now the United Kingdom does not have a true single-payer system because they allow private care and insurance to exist, a situation which Dr. Berwick has criticized as the ‘development of a privileged private care market.’

“But it is important to understand the consequences of going outside of the system in the U.K.. It is very similar to the public v. private education system in the U.S. where those who choose the private market essentially pay twice, in addition to forfeiting all of their rights to advantage themselves of any feature of the public system along the way.

“Dr. Sarah Anderson, a British ophthalmologist, found this out the hard way when her father was diagnosed with cancer and the NHS refused to pay for the drug he needed. When her family tried to pay for the drug out of their own pockets, the NHS responded by threatening to withhold NHS funding for all of his care- blood tests, scans and doctors' visits included.

Dr. Anderson was shocked that the NHS would essentially ‘wash its hand’ of her father. In her words, ‘if dad should lose his life to cancer, it would be devastating, but to lose his life to bureaucracy would be far, far worse.’

“This penalizing feature of the British system makes circumventing the NHS's rationing decisions very cost-prohibitive for many patients and sets up a truly two-tiered system whereby only the very wealthy or perhaps the very politically-connected can go outside of the system.

“Canada has something closer to a true single-payer system, in that private care and insurance are even more marginalized. But that doesn't stop the very wealthy from getting around its rationing rules and long lines.

“Just ask Newfoundland and Labrador's Premier, Danny Williams. When the Premier, an ardent supporter of Canada's single-payer system and a millionaire, needed heart surgery that was not available in his home province, he simply hopped on a jet and headed south to the U.S. for the surgery. Forcing citizens to leave the country to circumvent the system is even more cost-prohibitive, making the gap between the haves and have-nots even wider.

“It seems that the logic behind the single-payer system is that if some can't have it, then no one can— unless you are extremely rich.

“If Dr. Berwick were here, I would ask him whether, given his \$600,000 annual salary at his previous non-profit employer, he would accept the rationing decisions of a government payer- decisions that denied care to Sarah Anderson's father, leukemia-patient and prospective father Jed Anderson, endocrine cancer patient Ian Bowers, and abnormal heartbeat sufferer Martin Harman? Or would he use his considerable wealth and political connections to ensure that he and his family had access to whatever treatment his doctor prescribed? I find it very hard to believe that he, like Canadian Premier Danny Williams, would not choose the latter.”

Senator Roberts is a member of the Senate Committee on Finance and a member of the Senate Health, Education, Labor and Pensions Committee.