
KEY TALKING POINTS ON HEALTH CARE RATIONING

NATIONAL RIGHT TO LIFE COMMITTEE – OCTOBER 2009

MEDICARE AND HEALTH CARE RATIONING

- A substantial part of health care subsidies, under current proposals, would be paid for by “robbing Peter to pay Paul” – **reducing Medicare funding for older people in order to cover the uninsured.**
- The proposals under serious consideration fail to ensure a sustainable method of financing subsidies. **Over-promising while under-funding health insurance for the uninsured will almost surely lead to rationing.**

THE “DEATH SPIRAL” PROVISION

- Under the Senate Finance Committee health care restructuring bill, doctors who authorize treatments for their Medicare patients that wind up in the top 10% of per capita cost for a year will lose 5% of their total Medicare reimbursements for that year.
- In the game of musical chairs, there is always one chair less than the number of players – so no matter how fast the contestants run, someone will always be the loser when the music stops. Similarly, under the penalty provision, a moving target is created – by definition, there will ALWAYS be a top 10%, no matter how far down the total amount of money spent on Medicare is driven.

COMPARATIVE EFFECTIVENESS AND HEALTH CARE RATIONING

- The language adopted by the Senate Finance Committee provides that the government cannot use “comparative effectiveness” research using “quality-adjusted life years” or other measures to compel or encourage denial of life-saving medical treatment, food or fluids based on the patient’s age, disability, terminal illness, or so-called “quality of life” as is routine in Great Britain. However, neither the House bill nor the bill reported from the Senate Health, Education, Labor, and Pensions Committee contains these protections.
- Moreover, the Secretary of Health and Human Services is given authority to improve “quality” measures on health care providers, and protective language needs to be applied to limit that authority.

PRESSURING PATIENTS TO FORGO TREATMENT AS A MEANS OF RATIONING

- Efforts to push patients and older people to prepare advance directives may, in practice, not center on respecting an individual’s wishes, but rather on persuading or **pressuring them to agree to less treatment as a means of saving money.**

FOR MORE INFORMATION:

See reverse side or visit www.nrlc.org/healthcarerationing as well as <http://powellcenterformedicaethics.blogspot.com/>

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KEY TALKING POINTS ON HEALTH CARE RATIONING

Inadequate Funding

- Unless there is sustainable, adequate financing, over-promising while under-funding health insurance for the uninsured will almost surely lead to rationing when, down the road, government has to face the shortfall. All versions of the health care restructuring bill provide for premium subsidies to help the uninsured obtain health insurance. The problem is that the proposals under serious consideration to date fail to ensure a sustainable method of financing these subsidies.
- A substantial part of the subsidies, under current proposals, would be paid for by “robbing Peter to pay Paul” – reducing Medicare funding for older people in order to cover the uninsured. The dangerous consequence is that in a few years, having over-promised and under-funded, the government will be faced with the choice of adding other means of revenue or else (and far more likely) in some way imposing rationing.

The “Death Spiral” Provision

- The Senate Finance version contains a provision that penalizes doctors based on how much medical treatment they direct for senior citizens on Medicare. It establishes that Medicare physicians who authorize treatments for their patients that wind up in the top 10% of per capita cost for a year will lose 5% of their total Medicare reimbursements for that year.
- This means that if doctors authorize enough treatment for their patients, however necessary and appropriate it may be, they are in danger of being one of the 1 in 10 doctors who will be penalized each year. Moreover, this penalty creates a moving target – by definition, there will ALWAYS be a top 10%, no matter how far down the total amount of money spent on Medicare is driven.
- It will create a constant sense of uncertainty in doctors, since none can know in advance precisely what the cutoff for a given year will be – resulting in ever-increasing pressure to limit treatment and diagnostic tests to the bare minimum.

Comparative Effectiveness

- The House bills and Senate Health Education, Labor and Pension (HELP) Committee bill, as reported, allow “comparative effectiveness” research to be used in making coverage decisions, determining reimbursement rates, and establishing incentive programs in ways that discriminatorily deny or limit health care based on age, present or predicted disability, or expected length of life. There is also no protection against the use of a QALY or “quality adjusted life year” (or any other name given to a standard that discounts the value of a period of life based on the patient’s present or predicted disability or quality of life) being employed as a mechanism to establish or recommend what health care is not cost-effective or not recommended.
- NRLC has been able to negotiate language that was included in the Senate Finance bill that forbid use of comparative effectiveness data to deny treatment discriminatorily based on disability, age, or terminal illness. This critical language needs to be contained in the final version, and also needs to be extended to cover other portions of the bill at risk for “quality of life” judgments.

Advance Planning

- NRLC opposes the H.R. 3200’s ‘Advance Care Planning’ Section 1233. ‘Advance Care Planning’ means, essentially, encouraging patients to fill out legal documents like living wills stating what treatment they would -- or would NOT -- get if no longer able to make health care decisions for themselves. The concern is that in practice, these sessions will not center on respecting an individual’s wishes, but rather on subtly or otherwise encouraging individuals to authorize withholding or withdrawal of life-saving medical treatment, food and fluids. For example, Holly Prigerson of Boston’s Dana-Farber Cancer Center says, “We refer to the end-of-life discussion as the multimillion-dollar conversation because it is associated with shifting costs away from expensive . . . care like being on a ventilator in an ICU, to less costly comfort care...” Data support Prigerson’s conclusion. Efforts to push patients and older people to prepare advance directives may in practice become a means of persuading or pressuring them to agree to less treatment as a means of saving money.
- This portion of the bill must not be included in the final version.