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November 7, 2009

RE: House roll call on passage of H.R. 3962, as amended

Dear Member of Congress:

On behalf of the National Right to Life Committee (NRLC) and its affiliates in all 50 states, we are writing to advise you regarding our organization's views on passage of H.R. 3962 as amended earlier today by the House of Representatives.

The House has adopted the NRLC-backed Stupak-Pitts Amendment. The Stupak-Pitts Amendment removed two major pro-abortion components from H.R. 3962. Specifically, (1) the amendment would permanently prohibit the new federal government insurance program, the "public option," from paying for abortion, except to save the life of the mother, or in cases of rape or incest; and (2) the amendment would permanently prohibit the use of the new federal premium subsidies ("affordability credits") to purchase private insurance plans that cover abortion (except to save the life of the mother, or in cases of rape or incest).

In view of today's approval of this critical modification to the bill, NRLC will not "score" the imminent House roll call vote on initial passage of H.R. 3962. However, as we have advised in previous communications, NRLC has very serious concerns about aspects of H.R. 3962 as they relate to involuntary denial of lifesaving medical treatment. We will continue to work to correct provisions that we find objectionable in this area, both in the health care legislation that will come before the Senate, and in any conference committee on health care legislation. We reserve the right to score the roll call vote on the conference report, or on any Senate-passed bill, if these concerns are not adequately resolved. Moreover, NRLC would certainly score the roll call on any conference report that did not contain the Stupak-Pitts language.

Since its inception, the pro-life movement has been as concerned with protecting the lives of older people and people with disabilities from euthanasia, including the involuntary denial of treatment, food, and fluids necessary to prevent death, as it has been dedicated to protecting unborn children from abortion. H.R. 3962 contains provisions that threaten these lives. (Documentation of and further details concerning the points made below are available at <http://www.nrlc.org/HealthCareRationing/HouseLegislation.html>.)

For both those eligible to participate in the insurance exchange and older Americans covered by Medicare, H.R. 3962 limits their right to spend their own money to save their own lives.

– Section 104, as modified by the Managers' Amendment, empowers the Commissioner of the Health Insurance Exchange to exclude from the exchange plans offered by health insurance issuers whom the Commissioner considers have "excessive or unjustified premium increases." This essentially grants to one federal official the discretion to impose price controls on insurance

premiums. While no one *wants* to pay more for anything, including health care, being *prohibited* from paying what may be needed to obtain unrationed health insurance amounts to government-imposed health care rationing.

– Under current law, Medicare recipients have the legal option, if they choose, of adding their own money on top of the government contribution in order to obtain “private fee-for-service” Medicare Advantage plans that can use the additional premiums to ensure access by paying providers higher rates and to avoid “managed care” limitations on treatments and tests. Presently, the Medicare statute prevents the government from second-guessing or imposing limits on the premiums for private fee-for-service plans, allowing beneficiaries to balance cost, benefit, and affordability in making their own decisions whether to purchase such plans. Section 1175 amends that provision so as to empower the federal government to exclude from competing in Medicare Advantage those plans whose bids it does not like. The consequence is to give the Centers for Medicare and Medicaid Services (CMS) the discretion to deny older Americans the choice of plans whose premiums CMS deems too high. This amounts to the imposition of price controls, thus limiting what older Americans are permitted to spend for health insurance. Again, being *prohibited* from paying what may be needed to obtain unrationed health insurance amounts to government-imposed health care rationing.

– In addition, Section 1165 effectively ends the ability of unions and employers to offer such plans nationwide – or on anything other than a local basis. Since a given company’s or industry’s retirees are likely to be spread around the country, this greatly undermines, if it does not effectively eliminate, the ability of unions and business to offer to their retirees plans that allow them to add their own money to the government Medicare contribution in order to reduce the prospect of being denied needed treatment.

Provisions in H.R. 3962 could be used to establish standards that would result in the denial of lifesaving medical care based upon degree of disability, age, or “quality of life.”

– Section 2401 creates a “Center for Quality Improvement” which is to promote “best practices” in health care by doing *four* things: 1) identify existing best practices, 2) develop new ones, 3) evaluate both, and 4) implement them. It contains a provision that states that the Center “shall not *develop* quality-adjusted life year measures or any other methodologies that can be used to deny benefits to a beneficiary against the beneficiary’s wishes on the basis of the beneficiary’s age, life expectancy, present or predicted disability, or expected quality of life.” (Emphasis added.) As far as this goes, it provides a critically important protection against the widespread emphasis in the comparative effectiveness scholarly literature on the use of discriminatory criteria in standards of medical practice, an approach unapologetically employed in Great Britain by that nation’s National Institute for Health and Clinical Excellence (NICE). Unfortunately, this protection applies only to *one* of the Center’s *four* missions – the *development* of “best practices.” It leaves a gaping loophole with regard to the Center’s identification, evaluation, and implementation of *existing* “best practices.”

– Anything like this anti-discriminatory protective language is missing entirely from Section 1401, which creates a Center for Comparative Effectiveness Research, and from Section 1159's provisions commissioning the Institute of Medicine to develop new Medicare reimbursement standards to create incentives for “high value care” which will be implemented automatically unless vetoed by Congress.

Advance care planning provisions could be used to “nudge” patients toward accepting denial of treatment as a means of cost control, and despite *apparent* prohibitions, could include assisted suicide.

– Section 240 requires health insurers participating in the exchange to provide beneficiaries with the option to establish advance directives and disseminate information about “end-of-life” planning, while Section 1233 reimburses Medicare providers for “advance care planning consultations” with senior citizens. While the National Right to Life Committee recognizes the legal right to execute advance directives and promotes its own version, the “Will to Live,” the author and blogger Lee Siegel, a strong advocate of universal health care coverage, points out an important danger in these provisions:

For those of us who believe that the absence of universal health care is America's burning shame, the spectacle of opposition to Obama's health-care plan is Alice-in-Wonderland bewildering and also enraging but on one point the plan's critics are absolutely correct. One of the key ideas under end-of-life care is morally revolting.

[Section 1233] . . . offers to pay once every five years for a voluntary, not mandatory, consultation with a doctor, who will not blatantly tell the patient how to end his or her life sooner, but will explain to the patient the set of options available at the end of life, including living wills, palliative care and hospice, life sustaining treatment, and all aspects of advance care planning, including, presumably, the decision to end one's life.

The shading in of human particulars is what makes this so unsettling. A doctor guided by a panel of experts who have decided that some treatments are futile will, in subtle ways, advance that point of view. Cass Sunstein [who is the Obama Administration's regulatory czar] calls this “nudging,” which he characterizes as using various types of reinforcement techniques to “nudge” people's behavior in one direction or another. An elderly or sick person would be especially vulnerable to the sophisticated nudging of an authority figure like a doctor. Bad enough for such people who are lucky enough to be supported by family and friends. But what about the dying person who is all alone in the world and who has only the “consultant” to turn to and rely on? The heartlessness of such a scene is chilling.

What gives weight to Siegel's concerns is the focus by advocates on the money such "nudging" is expected to save. For example, Holly Prigerson of Boston's Dana Farber Cancer Institute has been quoted as saying, "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....."

Moreover, these provisions could lead to federal facilitation of direct killing. While both sections state that they do not authorize "promotion" of "suicide" or "assisted suicide," providing information about its availability in states where it is legal could well be described as not "promoting" it, only making patients aware of legal options. Section 240 states that it does not require health insurers participating in the exchange to inform beneficiaries about advance directives that include assisted suicide in states where it is legal. However, Section 1233 contains no express limitation on including advance directives that direct assisted suicide as part of the federally funded "advance care planning consultations" with Medicare patients.

What is more, a section in the statutes of both Oregon and Washington State pertaining to what most people recognize as the legalization of assisted suicide explicitly provides that what these state laws authorize "shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law." In light of this, it is troubling that the final drafters of Sections 240 and 1233 rejected the inclusion of a federal definition of "suicide" and "assisted suicide" based the existing federal Assisted Suicide Funding Restriction Act, opening the possibility that provision of information about the option of obtaining lethal prescriptions in these states would be construed *not* to constitute the excluded provision of information about "suicide" or "assisted suicide."

Thank you for your consideration of NRLC's objections to these provisions of H.R. 3962.

Sincerely,



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