



**new york state
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TESTIMONY OF NEW YORK STATE RIGHT TO LIFE COMMITTEE

Delivered by Barbara Meara, Chairman

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Mr. Chairman, the New York State Right to Life Committee appreciates the opportunity to testify before you today concerning the crucial issue of the impact of current proposals for health care restructuring on our senior citizens.

Let me begin by emphasizing that as a pro-life organization New York Right to Life believes that all Americans should be able to obtain life-saving medical treatment, food and fluids, and that ensuring access to adequate health insurance for all is certainly compatible with that objective. Indeed, over two years ago our parent organization, National Right to Life, put forth proposals demonstrating how it would be possible to achieve universal health insurance without putting senior citizens and others at risk of rationing and denial of life-saving care, proposals available on its website at www.nrlc.org.ⁱ

In raising serious questions about H.R. 3200, the health care restructuring bill before the federal House of Representatives, we do not wish to be understood as opposing health care reform or extension of health insurance to those currently uninsured, but rather as emphasizing how important it is that health care reform be done in the right way. New York State Right to Life has always prided itself on its commitment to accuracy and fairness in its assessment of legislative proposals, a standard we intend to adhere to today. It would be very unfortunate if the de-bunking of exaggerated or inaccurate criticisms of H.R. 3200 were to obscure legitimate and accurate concerns about important aspects of the bill.

Advance Care Planning

One feature that has generated considerable controversy is Section 1233 and associated provisions that promote “advance care planning.” Specifically, Section 1233 provides for Medicare reimbursement for consultations about “advance care planning” between health care providers and their patients when they enter Medicare, every five years thereafter, and if they become seriously ill. Other provisions require private and public health care plans to give potential enrollees the option to establish advance directives and direct the Secretary of Health and Human Services to spearhead a public education campaign, toll-free telephone hotline, and clearinghouse to promote advance directives and other advance care planning.

New York Right to Life strongly encourages the execution of a pro-life advance directive, the Will to Live.ⁱⁱ The theoretical notion of providing objective and accurate assistance to patients to involve them in treatment decision-making, if truly directed to helping patients to understand and communicate their beliefs and preferences related to their treatment options, and to decide with their health care provider what treatments are best for them based on their treatment options, scientific evidence, circumstances, beliefs, and preferences is unobjectionable and even commendable.

The danger comes to the extent the proposed process in practice deviates from one that facilitates the articulation of patient preferences and values into the medical plan and becomes a means of subtly or overtly pressuring patients to agree to less treatment, or less expensive treatment. The emphasis many



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advocates place on the savings to be expected from implementation of such proposals heightens this concern. 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. . . ."ⁱⁱⁱ

Indeed, a medical journal article of which Prigerson was lead author concluded that the mean cost of care was 35.7% less for patients who reported having end-of-life discussions, compared with patients who did not.^{iv} A recent study published in the *Journal of the American Medical Association* similarly concluded, "[P]atients who reported having end-of-life discussions received less aggressive medical care and were more likely to receive hospice services for more than a week."^v

What is particularly disturbing about this "cost-savings" rationale for this provision of the bill is that it appears to follow President Obama's call this past spring for "a very difficult democratic conversation" about "those toward the end of their lives [who] are accounting for potentially 80 percent of the total health care bill out here."^{vi}

The author and blogger Lee Siegel, a strong advocate of universal health care coverage, points out the problem:

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.

. . . .

The section, on page 425 of the bill, 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 Obama's nominee for 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.^{vii}

Misuse of Comparative Effectiveness to Deny Treatment Based on Age or Disability

A second area of concern is the potential misuse of comparative effectiveness research. The House bill, as reported, allows comparative effectiveness research to be used in making coverage decisions, determining reimbursement rates, and in establishing incentive programs in ways that could discriminatorily deny or limit health care based on age, present or predicted disability, or expected length of life.

The premise of comparative effectiveness research is that determinations can be made about whether certain treatments are more effective than others in treating a given diagnosed condition. The problem lies in the standards used to determine what counts as "more effective." In the scholarly literature on such research, heavy reliance is placed on what are known as "quality-adjusted life years." As one medical journal article describes it, "The basic idea underlying the QALY [Quality-Adjusted-Life-Year] is simple: it assumes that a year of life lived in perfect health is worth 1 QALY (1 Year of Life × 1 Utility = 1 QALY) and that a year of life lived in a state of less than this perfect health is worth less than 1. . . . By moving away from a purely biological model . . . a need arises to focus on areas such as the individual's ability to operate in society [and] disability."^{viii} Some measures have "negative . . . scores for health states perceived as being worse than death."^{ix}

In a featured piece in the July 19 *New York Times Magazine*, Princeton bioethicist Peter Singer openly advocated government rationing of health care, using QALYs. He made it clear that society should be more willing to withhold treatment from those who are old and those with disabilities.

“The death of a teenager is a greater tragedy than the death of an 85-year-old, and this should be reflected in our priorities,” he wrote. “[S]aving one teenager is equivalent to saving 14 85-year-olds.” Similarly, “If most would . . . choose 6 years of nondisabled life over 10 with quadriplegia, but have difficulty deciding between 5 years of nondisabled life over 10 with quadriplegia, then they are, in effect assessing life with quadriplegia as half as good as nondisabled life.”

In one example in the medical literature, an attempt was made to assess different quality adjusted life year scores for each of the following: “no physical disability, limp, walk with crutches, and need a wheelchair.”^x In another, the authors wrote, “[I]t may be judged that one year of life with a moderate disability is equivalent to 0.75 years of life at optimal health.”^{xi}

The assumptions built into such a use of quality-adjusted life years are often inaccurate. As Hayden Bosworth of the Duke University Medical Center documents, “Patients who have not experienced a stroke . . . or individuals at risk for future stroke . . . respond with low [quality of life] estimates for physical impairments. Yet it is clear that patients who actually experience a high level of impairment as a result of a stroke provide high estimates of their quality of life.”^{xii}

As part of the ongoing negotiations over the bill that may come out of the Senate Finance Committee, agreement has been reached on language to prevent discriminatory denial of treatment based on age or disability through the use of comparative effectiveness research.^{xiii} We strongly urge that this language be added to the House bill.

Over-Promising and Under-Funding

As I indicated at the beginning of my testimony, we are convinced that there are ways of ensuring adequate funding to cover extension of health insurance to the uninsured. Unfortunately, instead the House bill relies heavily on cuts in Medicare to fund this extension, effectively robbing Peter to pay Paul. It includes a net cut of \$200 billion over ten years.^{xiv}

In the words of Bruce Yarwood, President and CEO of the American Health Care Association, “The bottom line is that U.S. seniors’ Medicare-funded nursing care will be substantially undermined by the pending health reform bill in the U.S. House of Representatives Arguments being made that seniors’ benefits will not be reduced by the House bill ignore the fact that when Medicare cuts provider reimbursement, providers, in turn,

are forced to cut staff because labor expenses comprise 70 percent of facility costs. Cutting staff within a facility, has a direct, immediate, negative impact on patients and their care – and that is what the House bill will do.”^{xv}

New York faces Medicare cuts in nursing care alone of 2.87 billion over ten years under the House bill.^{xvi}

The difficulty goes beyond the way the House bill relies on Medicare cuts to finance a large portion of funding health insurance for the uninsured. The revenue sources the House bill uses to make up the difference between the cost of the program and the cuts in Medicare, Medicaid, and the CHIP program will not cover the full cost in the future. Economist David Leonhardt points out the basic problem: “Over time, general taxes — taxes on income, for instance — don’t rise as quickly as health costs do. General taxes generally rise with economic growth, and these are the kind of taxes the House would use to pay for health reform. But health spending is growing much more quickly than the economy is.”^{xvii}

The dangerous consequence is that not too many years in the future, having over-promised and under-funded, the government will be faced with the choice of adding other means of revenue or, far more likely, in some way imposing rationing.

Thank you for the opportunity to present the views of the New York State Right to Life Committee on the House of Representatives health care reform bill.

NOTES

- i. <http://www.nrlc.org/MedEthics/SaveNotRation.html>
- ii. It is available on our website at <http://www.nysrighttolife.org/willtolive.htm> .
- iii. <http://www.oncologynursingnews.com/end-of-life-care-talks-better-for-patients-and-budgets/article/137327/>
- iv. "Health Care Costs in the Last Week of Life Associations With End-of-Life Conversations," *Arch Intern Med.* 2009;169(5):480-488.
- v. Wright AA, Zhang B, et al. Associations Between End-of-Life Discussions, Patient Mental Health, Medical Care Near Death, and Caregiver Bereavement Adjustment. *JAMA.* 2008;300(14):1665-1673.
- vi. April 14 interview, published in the *New York Times Magazine* April 29, 2009 <Available at <http://www.nytimes.com/2009/05/03/magazine/03Obama-t.html?pagewanted=all> >
- vii. www.thedailybeast.com/blogs-and-stories/2009-08-11/obamas-euthanasia-mistake/
- viii. Prieto, L, & Sacristan, J (2003). Problems and solutions in calculating quality-adjusted life years (QALYs). *Health and Quality of Life Outcomes*, 1, Retrieved June 17, 2009, from <http://hqlo.com/content/1/1/80>.
- ix. Vetter, T (2007). A primer on health-related quality of life in chronic pain medicine . *Anesthesia & Analgesia*, 104, 703, 711.
- x. Duru, G, Auray, J P, Beresniak, A, Lamure, M, Paine, A, & Nicoloyannis, N (2002). Limitations of the methods used for calculating quality-adjusted-life-year values. *Pharmacoeconomics*, 20, 463-73.
- xi. A. Atherly, S.D. Cutler, E.R. Becker. "The Role of Cost Effectiveness Analysis in Health Care Evaluation," *The Quarterly Journal of Nuclear Medicine* 2000 June; 44 (2): 112-120.
- xii. Bosworth, H (2001). Health-related quality of life after stroke: a comprehensive review. *Stroke*, 972.
- xiii. The agreed language is:
“(1)The Secretary [of Health and Human Services] shall not use comparative effectiveness evidence in determining coverage, reimbursement or incentive programs for a treatment in ways that treat extending the life of an elderly, disabled, or terminally ill patient as of lower value than extending the life of a person who is younger, non-disabled, or not terminally ill.

“Rule of construction: This limitation shall not be construed to prevent the Secretary from using comparative effectiveness evidence in determining coverage, reimbursement or incentive programs based upon comparing the difference in the effectiveness of alternative treatments in extending a patient's life due to that patient's age, disability, or terminal illness.

“(2) The Secretary shall not use comparative effectiveness evidence in determining coverage, reimbursement, or incentive programs in ways that preclude, or with an intent to discourage, patients from choosing treatments based on how they value the tradeoffs between extending the length of their life and the risk of disability.

“Rule of Construction: This limitation shall not be construed to limit the application of differential copayments based on factors such as cost or type of service. Nothing in this legislation shall be construed to limit comparative effectiveness research or any other research, evaluation, or dissemination of information concerning the likelihood that a treatment will result in disability. In addition, this limitation shall not be construed to prevent the Secretary from using CE evidence in determining coverage, reimbursement or incentive programs based upon comparing the difference in the effectiveness of alternative treatments in extending a patient's life due to that patient's age, disability, or terminal illness.

“(3) The Institute shall not develop or employ a dollars per quality adjusted life year (or similar measure that discounts the value of a life because of a person's disability) as a threshold to establish what healthcare is cost-effective or recommended. The Center for Medicare and Medicaid Services shall not utilize a dollars per quality

adjusted life year (or similar measure that discounts the value of a life because of a person's disability) as a threshold to determine coverage, reimbursement, or incentives programs.”

xiv. http://www.msnbc.msn.com/id/32225671/ns/politics-capitol_hill/

xv. Quoted in “New Study: State-by-state Impact of Proposed Medicare Cuts to Skilled Nursing Facility Care for Seniors”, August 20, 2009 press release available at

http://www.ahcancal.org/News/news_releases/Pages/StatebystateImpactofProposedSNFMedicareCuts.aspx .

xvi. Id.

xvii. David Leonhardt, “Health Care Reform: Beyond the First Decade” ; blog available at

<http://economix.blogs.nytimes.com/2009/08/06/health-care-reform-beyond-the-first-decade/> . As he points out,

“[T]he way to pay for an expansion of health insurance, over the long term, is to reduce health spending or to tax health spending.” The first means rationing; the second is the alternative that would work, as explained at

<http://www.nrlc.org/MedEthics/SaveNotRation.html> and in the webinar at

<http://nrlcomm.wordpress.com/2009/06/13/hcrwebinar/> .