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MEMORANDUM
TO:
FROM: David N. O'Steen, Ph.D., Executive Director
Darla St. Martin, Co-Executive Director
Jennifer Popik, J.D., Director, Powell Center for Medical Ethics
DATED: December 2016
RE: Rationing Concerns In Upcoming Health Care Reform Efforts

Background

Since its inception, the National Right to Life Committee has been just as concerned with protecting older people and people with disabilities from euthanasia as with protecting unborn children from abortion.[1] Our efforts to protect the vulnerable from euthanasia have been directed at opposing not only direct killing such as assisting suicide but also denial of life-saving medical treatment, food and fluids necessary to sustain life. In particular, we have fought involuntary euthanasia–the denial of life-saving treatment to patients against their will. This year, our prolife opposition to government rationing of health care is one of the most important messages we have for Congress.

As Congress moves forward crafting an alternative plan, we have several areas of concern which we wish to raise. The argument for the repeal of Obamacare that most resonated with grassroots Americans, especially those who are prolife, is that it will ration health care. So many working-class families worked hard for their high-quality healthcare plans and many without such plans certainly seek to access them. Any alternatives that Congress crafts must keep these constituencies in mind.

Both the original Clinton Health Care Plan and Obamacare were proposed by people who do not share our respect for life, so of course they do not believe that quality life-saving health care is something to be valued rather than reduced and rationed more each year by the government. And since many in the press do not respect life either, journalists and politicos alike are constantly telling us *we spend too much on our health care*. Of course it stands to reason that if you don't believe in the sanctity of human life you won't believe in spending much on health care to protect life.

While we have commented on the many alternatives proposed over the last two Congresses in detail, we will lay out several repeating concerns that we believe can lead to the rationing of health care, as well as a few items that ought to be considered.

[1] This memorandum does not deal with abortion-related aspects of the plan.

Keep employer-paid health insurance fully untaxed:

Significant numbers of lawmakers from both parties are openly criticizing the "Cadillac" Tax's 40% levy on employer-paid health insurance premiums above a governmentally imposed limit. What alternative plans cannot do is fall into the trap of enacting a similar concept of taxing health care benefits. Taxing healthcare plans would strike at the quality plans that so many across the country, including those in the rust belt, fought hard to obtain. Both the "Cadillac tax" as well as plans to tax employer-provided health insurance are designed to create a tax disincentive to suppress private, nongovernmental, health care spending beyond a governmentally imposed limit.

What Americans cannot afford to do is to create a tax disincentive that will suppress private health care spending. In short, if health benefits lose their full deductibility, the tax free amount you can spend will shrink yearly, if indexed for general inflation, and rather than putting the burden of additional costs on their employees, employers could offer healthcare plans that are stingier and more likely to ration.

In fact, it is highly probable, with additional taxes, that many employers may stop offering health insurance tied to employment altogether. According to an analysis from one of the chief Obamacare architects Jonathan Gruber, "Repealing or capping the exclusion could result in significant increases in government revenues and an increase in the progressivity of the tax system. Yet it would also lead to a significant reduction in insurance coverage."[1] Americans, who rejected Obamacare at the polls, want access to plans less likely to restrict or reduce access to care for themselves and their loved ones – not more rationing.

The Trump Plan

President-elect Donald Trump has proposed several new approaches to make sure Americans have quality health care access. Donald Trump's plan states:

> *Allow individuals to fully deduct health insurance premium payments from their tax returns under the current tax system. Businesses are allowed to take these deductions so why wouldn't Congress allow individuals the same exemptions?*[ii]

We applaud President-elect Trump's plan to keep employer-paid health insurance as an untaxed benefit to workers.

Allowing full deductibility, as the Trump plan proposes, will mean the continuation and growth of plans that are less likely to restrict and reduce treatment.

Additional Concerns:

If The "Exchanges" Remain, Lift the Exclusion on Adequate Health Insurance

One of the regulations in the beleaguered exchanges has required that consumers may only choose plans offered by insurers who do not allow their customers to spend what government bureaucrats deem an "excessive or unjustified" amount for their health insurance.

As widely reported in the mainstream media, this exclusion has created a situation where health insurance plans offered in the exchanges typically have narrow panels of available health care providers that exclude specialist doctors and healthcare centers with a high reputation for successfully offering effective life-saving medical treatment. [See, e.g., Timothy W. Martin, "Shrinking Hospital Networks Greet HealthCare Shoppers on Exchanges," Wall Street Journal (December 13, 2013); Stephanie Kirchgaessner, "New Affordable Care US health plans will exclude top hospitals," Financial Times (December 8, 2013); Megan McArdle, " 'Doc Shock' On Deck in Obamacare Wars," Bloomberg (December 5, 2013); Annika McGinnis, "Big insurers avoid many state health exchanges," USA Today (October 21, 2013).]

We hope that should the exchanges continue for a period of time or in an altered form, that this exclusion could be lifted.

Remove Limits on Senior Citizens' Ability to Use Their Own Money for Health Insurance

Most senior citizens know that the current law is slated to significantly cut government funding for their Medicare. What many are not aware of is the law's provision eliminating new private fee for service plans which previously were structured to allow older Americans to make up the Medicare shortfall with their own funds.

Before the enactment of Obamacare, under Medicare Advantage senior citizens could choose private fee for service (PFFS) health insurance plans in Medicare Advantage whose value was not limited by what the government might pay toward it. These plans could set premiums and reimbursement rates for health care providers without upward limits imposed by government regulation. (For information on the nature and history of this option, see http://www.nrlc.org/medethics/medicare). Such plans would not be forced to ration treatment, as long as senior citizens were free to choose to pay more for them.

Obamacare, however, enabled federal bureaucrats to refuse to allow senior citizens the choice of insurance plans that permit them to spend more than the bureaucrats think they should be allowed to devote to preserving their lives and health. We would want to see the PFFS option restored in Medicare Advantage.

Eliminate the IPAB and Do Not Include Any Similar Entity

We are grateful to the efforts in the last two Congresses to attempt to repeal the "Independent Payment Advisory Board." A hidden mechanism of the never-seated panel (note: the panel's power was reserved for the federal Department of Health & Human Services (HHS) in the event that the IPAB did not act) is to recommend measures to limit spending on health care to a growth rate below medical inflation - not just for Medicare, but also for all private, nongovernmental health care spending. HHS is then authorized to implement (and in fact has started creating such

measures due to the lack of a seated board) these measures places limits on the treatments providers may give their patients by requiring them to abide by so-called "quality and efficiency standards" imposed by HHS. These quality and efficiency measures have been applied to relatively minor procedures right now, but that cannot be expected to last.

Under such rules, treatment that a doctor and patient deem needed or advisable to save the patient's life or preserve or improve the patient's health, but which runs afoul of the imposed standards, must be denied, even if the patient is willing and able to pay for it. Any doctor who dares to give a patient more or better treatment than the measures allow is made ineligible to contract with any qualified health insurance plan. It is critical that no boards be created, nor further HHS discretion be granted, that have any similar unchecked ability to create treatment standards (i.e. comparative effectiveness).

Make Clear that Malpractice Reform Limitations Do Not Apply to Deliberate Involuntary Denial of Life-Preserving Treatment with Intent to Cause or Hasten Death

Many of the Republican plans have proposed a national cap on non-economic damages for medical malpractice. The attribution of cost-saving features to malpractice reform is based on the conclusion that the threat of malpractice actions causes medical providers to practice "defensive medicine," ordering costly unnecessary tests and the like. Our concern arises when damages caps are applied so broadly that they encompass not merely negligence, but also circumstances in which a doctor or hospital **deliberately** denies life-saving medical treatment in order **intentionally** to bring about the death of a patient who is felt to have an inadequate "quality of life" *against the express wishes of the patient or the patient's representatives*. This is a growing and increasingly blatant practice.

According to Dr. Lachlan Forrow, director of ethics programs at Boston's Beth Israel Deaconess Medical Center, "About 15 years ago, at least 80 percent of the cases [dealt with by the hospital ethics committee] were right-to-die kinds of cases. Today, it's more like at least 80 percent of the cases are the other direction: family members who are pushing for continued or more aggressive life support and doctors and nurses who think that's wrong."

These are not cases in which there is any dispute or doubt about the intent on the part of the health care provider to "allow" the patient to die by depriving the patient of treatment that, if provided, would sustain the patient's life. Rather, the treatment is involuntarily denied with the express purpose of hastening the patient's death.

We believe that applying the non-economic damages limits to *these* types of cases would preclude an important deterrent to involuntary euthanasia without advancing the stated objectives of malpractice reform. We simply ask for language ensuring that the claims subject to the non-economic damages cap are not deemed to include those based on deliberate and involuntary denial of medical treatment with the *intention* of causing or hastening the patient's death.

Punitive damages are most appropriately awarded to a victim who has suffered because of intentional and discriminatory actions. This form of damages exists to punish and deter particularly egregious violations of a person's rights. The intentional denial of life-saving

medical treatment against the patient's expressed wishes is certainly such a violation. Imposing a cap on punitive damages in this specific situation would significantly limit the ability to deter this form of involuntary euthanasia.

Allow for the Purchase of Health Insurance Across State Lines

We approve the proposal to allow Americans to obtain health plans licensed in states in which they do not reside. By fostering more alternatives and competition, it helps offset the reality that in a number of states one can now only pick from among a small number of insurers who dominate the geographic market. Allowing expanded options and greater competition increases the likelihood that people who choose to do so will at least have the opportunity to spend their own money for more expensive plans that are less likely to deny life-saving medical treatment, less likely to have narrow networks that exclude cutting-edge facilities and leading physicians, and less likely to deny innovative treatments and new pharmaceuticals.

Apply Strong Non-Discrimination Language to Relevant Portions of Any New Proposals

Such a provision was adopted during the short time when the so-called 'gang of six' was still working on health reform together. That provision was adopted as strong anti-discrimination language in several areas of the law. Under current law, thanks to this protective language, the government is prohibited from making coverage decisions, determining reimbursement rates, establishing incentive programs, designing benefits, or using comparative effectiveness research "in a manner that treats extending the life of an elderly, disabled, or terminally ill individual as of lower value than extending the life of an individual who is younger, nondisabled, or not terminally ill" [42 USCS § 1320e-1(c) (1)& (d)(1)] or "in a manner that precludes, or with the intent to discourage, an individual from choosing a health care treatment based on how the individual values the tradeoff between extending the length of their life and the risk of disability" [42 USCS § 1320e-1(c) (1)& (d)(1)]. This language has also, in turn, been adopted in several state codes both in the context of treatment decisions and conscience protection. We would urge, where appropriate, that this language be retained.

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[i] https://www.ntanet.org/NTJ/64/2/ntj-v64n02p511-30-tax-exclusion-for-employer.pdf

[ii] https://assets.donaldjtrump.com/HCReformPaper.pdf