

The Reid Bill contains important elements that would greatly impact the ability of patients to receive unrationed medical care. These elements, combined with inadequate funding – a scheme of “robbing Peter to pay Paul” wherein half of the funding comes from cuts in Medicare spending, would result in rationing life-saving treatment for senior citizens.

**Limiting Senior Citizens’ Right to Use Their Own Money to Save Their Own Lives**

**Limiting Exchange Users’ Right to Use Their Own Money to Save Their Own Lives**

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**Notes**

**–Limiting Senior Citizens’ Right to Use Their Own Money to Save Their Own Lives**

The Reid bill duplicates the House bill provision that would effectively allow federal bureaucrats at the Centers for Medicaid and Medicare Services (CMS) to bar senior citizens from adding their own money, if they choose, to the government contribution in order to get private-fee-for-service Medicare Advantage (MA) plans less likely to ration life-saving treatment.

Medicare—the government program that provides health insurance to older people in the United States—faces grave fiscal problems as the baby boom generation ages. Medicare is financed by payroll taxes, which means that those now working are paying for the health care of those now retired. As the baby boom generation moves from middle into old age, the proportion of the retired population will increase, while the proportion of the working population will decrease. The consequence is that the amount of money available for each Medicare beneficiary, when adjusted for health care inflation, will shrink.

Three alternatives exist.

In theory, taxes could be increased dramatically to make up the shortfall – an unlikely and politically difficult proposition. The second alternative—to put it bluntly but accurately—is rationing. Less money available per senior citizen would mean less treatment, including less of the treatments necessary to prevent death. For want of treatment, many people whose lives could have been saved by medical treatment would perish against their will. The third alternative is that, as the government contribution decreases, the shortfall could be made up by payments from older people themselves, so that their Medicare health insurance premium could voluntarily be financed partly by the government and partly from their own income and savings. What most people do not realize is that, as a result of legislative changes in 1997 and 2003 undertaken at the instance of the National Right to Life Committee, this third alternative is now

law. Under the title of “private fee-for-service plans,” there is an option in Medicare under which senior citizens can choose health insurance whose value is not limited by what the government may pay toward it. These plans can set premiums and reimbursement rates for providers without upward limits imposed by government regulation.

This means that such plans will not be forced to ration treatment, as long as senior citizens are free to choose to pay more for them. For more on the background of this program see [here](#).

Medicare covers everyone of retirement age, regardless of income or assets. Yet, because of budget constraints, the Medicare reimbursement rates for health care providers tend to be below the cost of giving the care—a deficit that can only accelerate as cost pressures on Medicare increase with the retirement of the baby boomers. To cope with this, providers engage in “cost shifting” by using funds they receive in payment for treating privately insured working people to help make up for what the providers lose when treating retirees under Medicare. Thus, comparatively low-income workers often effectively subsidize higher-income retirees. However, when middle-income retirees are free voluntarily to add their own money on top of the government contribution, through a private fee-for-service plan, they stop being the beneficiaries of cost-shifting and become contributors to it.

This program faces potential elimination under the Reid substitute. Section 3209 indirectly amends the section in existing law allowing private fee-for-service plans to set their premiums without approval by CMS by adding, “Nothing in this section shall be construed as requiring the Secretary to accept any or every bid submitted by an MA organization under this subsection.” [1] This allows CMS to refuse to allow private-fee-for-service plans that charge what CMS regards as premiums that are too high – or, literally, allows CMS to refuse to allow private-fee-for-service plans (or any other MA plans) altogether, for any reason or no reason.

With this dangerous provision in the Reid bill could lead to elimination of the only way that seniors have to escape rationing - taking away their right to spend their own money to save their own lives.

### **–Limiting Exchange Users’ Right to Use Their Own Money to Save Their Own Lives**

In the Reid Substitute, a new provision –Section 1003 -- will effectively allow state bureaucrats to limit the right of Americans who are NOT on Medicare to use their own money to save their own lives.[2] With minor modifications, Section 1003 adopts the House bill provision allowing an exchange to exclude “particular health insurance issuers ... based on a pattern or practice of excessive or unjustified premium increases.”[3]

Originally, state-based “exchanges” were designed to allow comparison shopping among all insurance plans that provided the basic benefits. Under Section 1003, however, exchanges would be authorized, in effect, to limit the value of the insurance policies that Americans using the exchanges may purchase.

Not only will the exchanges be allowed to exclude policies when government authorities do not agree with the premiums, but they will be able to look at any increases plans charge, *outside*

the exchange – and remove those insurers from the exchange. This would create a “chilling effect,” deterring insurers who hope to be able to compete within the exchange from offering adequately funded plans even outside of it, limiting consumers’ access to adequate and unrationed health care.

When the government limits by law what can be charged for health insurance, it limits what people are allowed to pay for medical treatment. While everyone would prefer to pay less – or nothing – for health care (as for anything else), government price controls in fact prevent access to lifesaving medical treatment that costs more to supply than the price set by the government.

Under a scheme of premium price controls, health insurance companies will ration lifesaving medical treatment as they are squeezed more and more tightly each year by the declining “real” (that is, adjusted for health care inflation ) value of the premiums they take in. These day-to-day rationing decisions will have the most direct and visible impact on the lives – and deaths – of people with a poor “quality of life.”

#### **--“Shared Decisionmaking” – Advance Care Planning By Another Name?**

The Reid bill does not include provisions paralleling those in the House bill designed to create incentives for “advance care planning.”[4] Instead, Section 3506 provides funding to develop “patient decision aids” that are supposed to help “patients, caregivers or authorized representatives . . . to decide with their health care provider what treatments are best for them based on their treatment options, scientific evidence, circumstances, beliefs, and preferences.”

Under the Reid bill, the Department of Health and Human Services would contract with an “entity” that is to “develop and identify consensus-based standards to evaluate patient decision aids for preference sensitive care . . . and develop a certification process” for these “patient decision aids.” [6] Additional grants and contracts would be awarded to develop such “patient decision aids” which are to include “relative cost of treatment or, where appropriate, palliative care options” and to “educate providers on the use of such materials, including through academic curricula.”[7] Money would be awarded to establish “Shared Decisionmaking Resource Centers . . . to provide technical assistance to providers and to develop and disseminate best practices . . .”[8]

While there is language stating the materials are to be “balanced” to help patients and their representatives “understand and communicate their beliefs and preferences related to their treatment options,”[9] the concern, is the same as that with the promotion of advance care planning: Given the strong views many in the medical community have about poor quality of life and the considerable emphasis on saving costs, these measures will in fact subtly or otherwise “nudge” in the direction of rejecting costly life-saving treatment {NOTE TO KAREN: PLEASE HYPERLINK UNDERLINED TEXT TO <http://powellcenterformedicalethics.blogspot.com/2009/08/advanced-care-planning-provisions-must.html> }.

#### **--The Medicare Commission**

The Reid bill provides for an “Independent Medicare Advisory Board,” given the task of ensuring senior’s Medicare meets budget goals (that will tighten each year).

For fiscal years 2015 through 2019, the bill sets a target rate of growth for Medicare midway between medical inflation and average inflation; for subsequent years the target is the growth in Gross Domestic Product per capita plus 1%.<sup>[10]</sup>

To the extent the Center for Medicare and Medicaid Services (CMS) project that Medicare growth rates would exceed these targets, the Board would have to act to reduce the gap by specified percentages varying by year. This gap-reducing would likely come at the expense of reduction of Medicare Advantage benefits, and reductions in payments to doctors and so forth.

The Congressional Budget Office notes, “The provision would place a number of limitations on the actions available to the board, including a prohibition against modifying eligibility or benefits, so its recommendations probably would focus on [r]eductions in subsidies for non-Medicare benefits offered by Medicare Advantage plans; and [c]hanges to payment rates or methodologies for services furnished in the fee-for-service sector by providers other than hospitals [but hospitals would be included beginning in 2020], physicians, hospices [but hospices would be included beginning in 2020], and suppliers of durable medical equipment that is offered through competitive bidding.<sup>[11]</sup>

The recommendations of the Board would automatically go into effect unless Congress, through an expedited procedure, adopted another means resulting in the same reductions; to waive this would require a 3/5 vote. It would also require a 3/5 vote to repeal or amend the provisions of the Reid bill establishing the Board and its duties and authority; in 2017 there would be an expedited procedure essentially guaranteeing a vote on a proposal to repeal the Board, but this vote would require 3/5 of each House to pass.

### **--Assisted Suicide?**

On assisted suicide, the language agreed to unanimously by the Senate Finance Committee that specifically said that federal dollars “shall not pay for or reimburse” any health entity for assisted suicide does NOT appear in the Reid bill. The Reid bill only retains the provision preventing discrimination against those who refuse to participate in assisting suicide.<sup>[12]</sup>

Why was the prohibition on funding assisted suicide stripped? The argument may be it is “unnecessary” because the Assisted Suicide Funding Restriction Act of 1997 (ASFRA) bars such funding by any “funds appropriated by Congress for the purpose of paying (directly or indirectly) for the provision of health care services ,”<sup>[42 U.S.C. Sec. 14402(a)]</sup> and it states, “The provisions of this Act supersede other Federal laws (including laws enacted after the date of the enactment of this Act [enacted April 30, 1997]) except to the extent such laws specifically supersede the provisions of this Act.” <sup>[13]</sup>

However, the provision was adopted unanimously in the Finance committee, emphatically affirming federal policy of no funding for assisted suicide, and removes any danger that some administrator or court might say the broad benefit mandates in the health care bill repealed the ASFRA limits by implication. What possible purpose was served by stripping it out?

### **--The Secretary and Quality Discretion**

There is language in the Reid bill that protects against discriminatory use of comparative effectiveness research on the basis of age, disability or terminal illness.[14] However, this important language has not been made applicable to the multiple provisions under which the Secretary can impose “quality” measures. [15]

Section 1559 [16] states that on the basis of race, age, sex or disability, [17] “an individual shall not . . . be excluded from participation in, be denied the benefits of, or be subjected to discrimination under,” health programs or activities receiving Federal financial assistance. Perhaps ominously, however, this anti-discrimination language is preceded by “Except as otherwise provided for in this title (or an amendment made by this title) . . . .” That is why it is critical to apply the anti-discrimination language from the Comparative Effectiveness provisions to the indicated provisions in note 15.

### **NOTES**

[1] At page 920

[2] Section 1003 creates a new Section 2794 of the Public Health Service Act (pp. 37-40)

[3] Ironically, Section 1311(e)(B)(ii) (p.143) retains the provision, added in the HELP committee, barring an exchange from excluding health plans “through the imposition of premium price controls.” Presumably the two provisions would be construed together to prevent the imposition of specific, explicit premium price control while allowing exclusion of insurers whose premiums the exchange deems to have a “pattern or practice” of being too high.

In addition, Section 1001, creating Section 2718(b) of the Public Health Service Act (pp. 31-32), mandates that group plans spend no more than 20%, and individual plans no more than 25% of their premium revenue on non-claims costs, limiting what can be used for administration,

marketing, and profit. (The individual plan percentage may be increased in a state if the HHS Secretary determines that it would “destabilize” the individual market there.)

[4] Note: The Reid bill provides for encouraging minors in foster care to prepare advance directives- in the same manner as the house bill.

[5] Sec. 3506, pp. 1105 -13

[6] At p. 1108

[7] At p. 1110

[8] At p. 1110

[9] At p. 1109

[10] Section 3403, beginning on page 1000.

[11] Letter from Douglas Elmendorf, Director, Congressional Budget Office to Senate Majority Leader Harry Reid (November 18, 2009), p. 11.

[12]Section 1553, p. 364.

[13] 42 U.S.C. Sec. 14408.

[14] Section 6301( c) of the bill [adding Section 1182 ( c), (d) and (e)] to the Social Security Act), pp. 1685-87.

[15] Places in the Reid bill where anti-discrimination language would be necessary

(a) Those described in Section 1890(b)(7) (B)(i) of the Social Security Act; [p. 710]

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- (b) Any quality measure developed, and, in its improved, updated, or expanded form, any quality measure improved, updated, or expanded under subsection ( c ) ; [pp. 703-707]
- (c) Strategy under Section 1311(g)(1); [p. 146]
- (d) Guidelines under Section 1311(g)(2); [p. 147]
- (e) Regulations under Section 1311(h)(1)(B); [p. 148]
- (f) The Secretarys application of recommendations under Section 1323(d)(3); [p. 193]
- (g) Requirements developed under Section 2717(a) of title XXVII of the Public Health Service Act; [pp. 26-27]
- (h) Measures under Section 3006(a)(2)(A) and (b)(2)(A); [pp. 676, 679]
- (i) Appropriateness criteria under Section 1115A(b)(2)(B)(vi) of the Social Security Act; [p. 727]
- (j) Guidelines under Section 1115A(b)(2)(B)(xii) of the Social Security Act; [p. 729]
- (k) Best practices and proven care methods under Section 1115A(b)(2)(B)(xv) of the Social Security Act; and
- (l) The measurement of patient-level outcomes and patient-centeredness criteria under Section 1115A(b)(4)(A) of the Social Security Act. [p. 734]

[16] At. p. 368

[17] Referencing the Civil Rights Act of 1964 (race), title IX of the Education Amendments of 1972 (sex), the Age Discrimination Act of 1975 (age), and section 504 of the Rehabilitation Act of 1973 (disability) ["handicap"].