

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.

Comparative Effectiveness

- The House bills and Senate HELP Committee bill, as reported, allow “comparative effectiveness” research to be used in making coverage decisions, determining reimbursement rates, and in 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.
- While a critically important amendment to prevent “comparative effectiveness” research from being used for rationing was defeated in the Senate HELP committee, NRLC has been able to negotiate language to be included the comparative effectiveness portion of the bill planned to be brought before the Senate Finance Committee in September that would forbid use of comparative effectiveness data to deny treatment discriminatorily based on disability, age, or terminal illness. Since no such language is included in the Kennedy bill or House legislation, there is no guarantee that this protective provision will be included in any bill finally passed by Congress. Moreover, if the bipartisan group of six Senators does not agree on a compromise bill, Democratic Senate leaders have warned they may bring the Kennedy bill to the Senate floor under reconciliation, which would permit many portions of it to pass with only 51 votes.

Advanced Planning

- NRLC opposes the H.R. 3200’s ‘Advance Care Planning’ Section 1233 and two related amendments (Baldwin and Hill amendments) as written. ‘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.