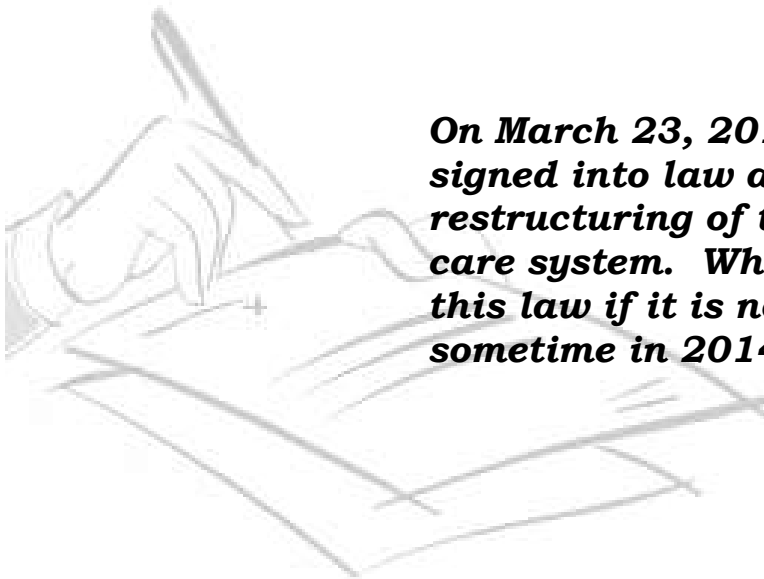


LIFE AT RISK:

How the Obama Health Care Plan Will Ration Your Family's Medical Treatment - A Factsheet



www.nrlc.org/healthcarerationing
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On March 23, 2010 President Obama signed into law a fundamental restructuring of the American health care system. What will happen under this law if it is not repealed by sometime in 2014?

FOUR ROUTES TO RATIONING

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1. HOW THE OBAMA HEALTH CARE LAW WILL LIMIT WHAT HEALTH CARE PROVIDERS CAN DO TO SAVE THE LIVES OF YOUR FAMILY MEMBERS

A Powerful Rationing Commission:

An 18-member “Independent Payment Advisory Board” is given the duty, on January 15, 2015 and every two years thereafter, with regard to *private* (not just governmentally funded) health care, to make “recommendations to slow the growth in national health expenditures” *below* the rate of medical inflation.¹

How the Federal Government Will Force Doctors to Limit Care:

The Commission’s recommendations are to be ones “that the Secretary [of Health and Human Services] or other Federal agencies can implement administratively.”² In turn, the Secretary of Health and Human Services is empowered to impose “quality and efficiency” measures on hospitals, requiring them to report on their compliance with them.³ Doctors will have to comply with quality measures in order to be able to contract with any qualified health insurance plan.⁴

What This Will Mean for Your Family’s Health Care:

Basically, doctors, hospitals, and other health care providers will be told by Washington just what diagnostic tests and medical care are considered to meet “quality and efficiency” standards – not only for federally funded programs like Medicare, but also for health care paid for by private citizens and their nongovernmental health insurance.

And these will be standards *specifically designed to limit what ordinary Americans may choose to spend on health care so that it is BELOW the rate of medical inflation.* Treatment that a doctor and patient deem needed or advisable to save that patient’s life or preserve or improve the patient’s health but which runs afoul of the imposed standards will be denied, *even if the patient is willing and able to pay for it.*

In effect, there will be one uniform national standard of care, established by Washington bureaucrats and set with a view to limiting what private citizens are allowed to spend on saving their own lives.

2. MEDICARE: HOW THE OBAMA HEALTH CARE LAW LIMITS SENIOR CITIZENS' RIGHT TO USE YOUR OWN MONEY TO SAVE YOUR OWN LIFE

Denying Senior Citizens the Right to Make Up Medicare Cuts With Your Own Money

According to an August 2010 Congressional Budget Office estimate, the Obama Health Care Law will cut \$555 billion from Medicare over the next ten years.⁵ Most senior citizens know that the law will significantly cut government funding for their Medicare. *Less widely known is the law's provision allowing Washington bureaucrats to prevent older Americans from making up the Medicare shortfall with their own funds—taking away their right to spend their own money to save their own lives.*

The Medicare Shortfall

Even before the Obamacare cuts, Medicare—the government program that provides health insurance to older people in the United States—faced 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 population that is retired will increase, while the proportion of the population that is working will decrease. The consequence will be that the amount of money available for each Medicare beneficiary, when adjusted for health care inflation, will shrink.

The Alternatives: Increase Taxes, Ration, or Allow Seniors to Add Your Own Money

In theory, taxes could be increased dramatically to make up the shortfall – a proposal unlikely to attract popular and political support. 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 voluntary payments from older people themselves, so that their Medicare health insurance premium could be financed partly by the government and partly from their own income and savings.

Private Fee-for-Service Medicare Insurance

As a result of legislative changes in 1997 and 2003 undertaken at the instance of the National Right to Life Committee, this third alternative became law. Under the title of “private fee-for-service plans,” an option was created in Medicare under which senior citizens could choose health insurance whose value was not limited by what the government might pay toward it. These plans could set premiums and reimbursement rates for providers without upward limits imposed by government regulation.⁶ Such plans would not be forced to ration treatment, as long

as senior citizens were free to choose to pay more for them. For information on whether it would be possible to *afford* health care without rationing, see www.nrlc.org/MedEthics/AmericaCanAfford.pdf.

What About Seniors Who Can't Afford to Add Your Own Money?

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.⁷ 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, those who take advantage of this opportunity stop being the beneficiaries of cost-shifting and become contributors to it. * This puts more money into the health care system, making it feasible for health care providers to offer more below-cost care to senior citizens of limited means.

The Obama Health Law's Assault on Seniors' Right to Add Your Own Money:

Section 3209⁸ of the Obama Health Care Law [codified at 42 USCS § 1395w-24(a)(5)(C)(i)] indirectly amended the section in existing law allowing private fee-for-service plans to set their premiums without CMS approval 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.” Therefore, CMS may now refuse to allow senior citizens the choice of private-fee-for-service plans that charge what CMS, in its standardless discretion, regards as premiums that are too high. Indeed, the provision literally authorizes CMS, if it decides to do so, to refuse to allow private-fee-for-service plans altogether.

With this dangerous provision the Obama Health Care Law could lead to elimination of the only way that seniors have to escape rationing - by taking away their right to spend their own money to save their own lives.

* It may seem strange to describe the ability to pay more as an “opportunity.” Obviously, senior citizens, like others, would prefer to pay less, not more, for health care— just as they would for *any* good or service. However, those who can afford to do so nevertheless frequently are willing to pay more for goods and services of higher quality. This is true of automobiles, houses, vacations, and restaurant meals. Since one can enjoy none of these if one is dead, it is entirely rational to pay more for health insurance when convinced that the higher price will give greater assurance of access to high-quality health care providers, and less likelihood that the insurance company will deny authorization or payment for treatments that are more costly but more likely to be effective and to carry less danger of deleterious side effects.

Reading the Obama Health Care Law:

What Is the Exact Language That Allows the Federal Government to Limit What Senior Citizens Can Choose to Spend for Health Insurance?

[Warning: To ordinary human beings trying to make sense out of the Obama Health Care Law’s language: it is written in extremely convoluted legalese. To figure out what is hidden in this law requires intense concentration – try not to let your head spin while you attempt to follow the explanation below (especially in the endnotes); unfortunately, it is the opposite of “plain language”!]

1. Under a provision in effect both before and after adoption of the Obama Health Care Law, the Secretary of Health and Human Services has authority to “negotiate” the premiums to be charged by private Medicare plans (“Medicare Advantage” health insurance plans) – meaning that the Centers for Medicare and Medicaid Services (CMS) can keep senior citizens from being able to choose a Medicare Advantage plan unless that plan agrees to charge a premium acceptable to CMS [42 U.S.C. §1395w-24 (a)(6)(B)⁹]. Importantly, however, this authority *did not apply to private fee-for-service plans* [42 U.S.C. § 1395w-24 (a)(6)(B)¹⁰] – meaning that CMS had no power to impose a premium price control on private fee-for-service plans, which senior citizens could be kept from choosing only if the plans failed to meet other applicable standards.

Thus, under the law before Obamacare, senior citizens *could* choose, if they wished, to add extra money of their own on top of the government payment in order to get health insurance less likely to ration, and Washington bureaucrats could not limit their right to do this.

2. However, Section 3209 of the Obama Health Care Law, [codified at 42 USCS § 1395w-24(a)(5)(C)(i)¹¹], indirectly amends the section 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.”

This means that the pre-existing law that effectively forbade the Secretary to exclude a private fee-for-service plan on the basis that CMS considers its premiums to be too high has been trumped by the new ability of the Secretary to reject “any or every” premium bid submitted by a private fee-for-service plan.

Thus, under Obamacare, Washington bureaucrats are given the authority to limit – or even eliminate – senior citizens’ ability, if they choose, to spend their own money on health insurance less likely to ration.

3. HOW INSURANCE EXCHANGES WILL LIMIT YOUR RIGHT TO USE YOUR OWN MONEY TO SAVE YOUR FAMILY MEMBERS' LIVES

The Role of State-Based Health Insurance Exchanges

Under the Obama Health Care Law, beginning in 2014 there are to be state-based health insurance “exchanges.” These are designed as marketplaces through which, initially, individuals and employees of small businesses and, later, employees of large employers as well, will on an annual basis choose their health insurance plan for the next year. Originally, state-based “exchanges” were designed to allow comparison shopping among all insurance plans that provided the basic benefits. Instead, however, consumers will be denied the choice of plans offered by insurers who allow their customers to spend what state bureaucrats deem an “excessive or unjustified” amount for their health insurance.

Exclusion of Health Insurers Who Allow Their Clients to Choose “Excessive” Insurance*

Section 1003 of the law,¹² codified at 42 USC § 300gg-94, together with Section 1311(e)(2),¹³ codified at 42 USC § 18031(e)(2), has the effect of instructing and authorizing state bureaucrats to limit the value of the insurance policies that Americans using the exchanges may purchase. Under it, state insurance commissioners are to recommend to their state exchanges the exclusion of “particular health insurance issuers ... based on a pattern or practice of excessive or unjustified premium increases.”¹⁴ Not only will the exchanges exclude *policies* from competing in an exchange when government authorities do not agree with their premiums,⁺ but the exchanges will even exclude *insurers* whose plans **outside** the exchange offer consumers the ability to reduce the danger of treatment denial by paying what those government authorities consider an “excessive or unjustified” amount. This will create a “chilling effect,” deterring insurers who hope to be able to compete within the exchanges from offering adequately funded plans even outside of them, with the result that even outside the exchanges consumers will find it difficult to obtain health insurance that offers adequate and unrationed health care.

Limits on What You Are Permitted to Pay Restrict What You Are Allowed to Buy

When the government limits what can be charged for health insurance, it restricts 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.

⁺ Ironically, Section 1311(e)(1)(B)(ii), 124 Stat. at 178, (codified at 42 U.S.C. § 18031(e)(1)(B)(ii)), retains a provision barring an exchange from excluding health plans “through the imposition of premium price controls.” Following standard norms of statutory construction, the two provisions would presumably be construed together to prevent state officials from imposing specific, explicit premium price controls on plans offered in an exchange while nevertheless allowing these officials to exclude insurers they deem to have a pattern or practice of what they consider “excessive or unjustified” premium increases.

4. “SHARED DECISIONMAKING”: HOW THE OBAMA HEALTH CARE LAW TRIES TO PERSUADE PATIENTS THEY’RE BETTER OFF WITHOUT TREATMENT

Patient “Decision Aids” and “Shared Decisionmaking Resource Centers”

The Obama Health Care Law includes a program called “Shared Decisionmaking”¹⁵ which provides funding to nongovernmental organizations 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.”¹⁶ These organizations will also receive funding to establish “Shared Decisionmaking Resource Centers . . . to provide technical assistance to providers and to develop and disseminate best practices”¹⁷

A Bias Against Treatment

In the creation of these materials and the “assistance” given health care providers, what point of view will the nongovernmental organizations awarded grants and contracts espouse?

An Oklahoma bill whose text closely resembled this part of the federal law gives a clue.¹⁸ That bill, which failed to pass the state legislature, actually named specific national groups which were to be consulted in the creation of the protocols and patient decision aids: the Foundation for Informed Medical Decision Making, the Center for Information Therapy, and Healthwise.[#]

If you go to the website of the Foundation for Informed Medical Decision Making (www.informedmedicaldecisions.org), you immediately come across a little box titled “Did You Know?” And in that box flash statements like these: “About 25% of Medicare dollars are spent on people in their last 60 days of life.” “Whether or not they receive active treatment, most men diagnosed with early stage prostate cancer will die of something else.” “Back patients in Idaho Falls, Idaho are 20 times more likely to have lumbar fusion surgery than those in Bangor, Maine, with no clear difference in . . . quality of life.” “For at least 70% of people who have heart bypass surgery, the survival rate is no better than if they had chosen to take medication alone.” “More care does not equal better outcomes.” “In many people with stable heart disease, medications are just as good as stents or bypass surgery.”

[#] Like the federal law, shared decisionmaking legislation enacted in Washington State did not specifically mention the groups who would be contracted to formulate the decision aids. WASH. REV. CODE § 41.05.033 (2010). When the law was implemented, the local Group Health Center for Health Studies consulted the Foundation for Informed Decisionmaking : <http://www.informedmedicaldecisions.org/forum-summaries/D.ArterburnForumSummary2010-2.pdf> .

In 2009, the Vermont State Legislature passed Act 49 to fund a “shared decisionmaking” pilot program. 2009 VT. ACTS & RESOLVES 49. (Significantly, its subtitle was “an act relating to containing health care costs.”) When the program was implemented, InformedMedicalDecisions.org was listed among the sources of patient decision aids to be used. (www.leg.state.vt.us/reports/2010ExternalReports/252637.pdf).

Notice a pattern? Clearly, this is a group that wants to *discourage* patients from choosing treatment that may be extensive or costly.

The Center for Information Therapy's website is now password protected but when it was publicly accessible it included the statement: "Toward the end of life, too many people receive ineffective, expensive medical treatments." What about "Healthwise"? Its website (www.healthwise.org/a_solutions.aspx) proclaims that health plan and benefit providers can "avoid unnecessary care with Healthwise consumer health information."

There are significant indications that under the guise of giving accurate and unbiased information to guide patients' informed consent, these groups will develop materials designed to push and persuade us to agree to forego intensive medical treatment.

Discouraging Veterans From Seeking Treatment: "Your Life, Your Choices"

A precedent on the federal level is a Veterans Affairs patient decision-making aid, a 53-page production entitled "Your Life, Your Choices."¹⁹

Under the heading, "What are the key things to think about?" on page 29, this document asks, "If you had severe dementia and then became ill with a reversible illness, such as pneumonia, would you want treatment even though the treatment would not help your memory problems? What if treatment included going to the hospital?"

On page 12, it certainly seems to discourage assisted feeding for someone with Alzheimer's disease. Using a fictional case, here's what it says: "Lily Chen, an elderly widow, was diagnosed 4 years ago with Alzheimer's Disease . . . Now she doesn't remember where she is and she can no longer recognize her daughter . . . Her daughter . . . has to decide whether to have a long-term feeding tube surgically placed into her mother's stomach. The surgery is quick and won't cause much pain, but the real issue is guessing how Mrs. Chen would value her current life. If they place the feeding tube, Mrs. Chen could live for many more years in the same or worse condition. If they don't she will die in about 2 weeks or less, and probably won't feel hungry or thirsty."^{*}

* This attitude is on full display in a recent *New England Journal of Medicine* article entitled "The Clinical Course of Advanced Dementia." The article [Susan L. Mitchell, M.D., et al., "The Clinical Course of Advanced Dementia," *New England Journal of Medicine* 361 (2009): 1529-1538, www.nejm.org/doi/full/10.1056/NEJMoa0902234] lamented that, "Distressing symptoms and burdensome interventions are . . . common among such patients." It stated that in the last three months of life 49.7% of those in the study underwent at least one instance of what the authors chose to classify as "burdensome intervention." These included hospitalization, visits to the Emergency Room, an injection or infusion, or tube feeding. The authors regretted that patients with advanced dementia received treatment for pneumonia, fever, and eating problems -- complications frequently experienced by such patients, which are generally addressed by measures that are quite low-tech and hardly "extraordinary."

The article went on to claim, "Patients with health care proxies [that is, surrogate decision-makers] who have an understanding of the prognosis and clinical course are likely to receive less aggressive care near the end of life." In those cases, many of the patients did not die from the underlying dementia, but from starvation that a feeding tube could have avoided or an infection that antibiotic could have treated. The phrase (continued-)

The booklet has worksheets to fill out for “Current Health,” “Permanent Coma,” “Severe Dementia,” “Severe Stroke” and “A future situation of concern when I might not be able to express my wishes.” For each of these there is a section on “quality of life.” Only for current health is there a choice to affirm that life is worth living without reservation. For all of the others, the choices are “Life like this would be difficult, but acceptable,” “Life like this would be worth living, but just barely,” and “Life like this would not” – the “not” is underlined – “be worth living.” In each circumstance except current health a negative picture is given. For example, “Terminal Illness” is described as a state in which you “have a lot of discomfort that requires medication[,], are in bed most of the time due to weakness[, and] need help with getting dressed, bathing, and bowel and bladder functions.”

Of course, what people experience when terminally ill varies widely depending on the particular illness and many other factors, but this booklet seemed designed to lead people to believe that life with terminal illness will be almost unremittingly bleak.⁺⁺

In the words of Paul Malley, President of the national non-profit organization Aging with Dignity, “Your Life, Your Choices” encourages our nation’s service men and women to look at illness and disability as things that render life not worth living.”²⁰

The Payoff—Less Money for Health Care

The motivation for nudging patients to reject life-saving medical treatment is clear. 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. . . .”²¹ 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.²² A recent JAMA study reaches a similar conclusion that, “On the other hand, patients 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.”²³

This perspective is certainly in line with President Obama’s call in Spring 2009 for “a very difficult democratic conversation” about treating “those toward the end of their lives [who] are accounting for potentially 80 percent of the total health care bill out here.”²⁴

(-continued) “burdensome interventions” is a conclusion based on a very subjective determination. It employs a value judgment that a person with dementia lacks dignity or an adequate quality of life.

⁺⁺ The lead author was Dr. Robert Pearlman, the chief of Ethics Evaluation for the VA’s National Center for Ethics in Healthcare. Given the excerpts, it should come as little surprise that Dr. Pearlman was one of a group who filed a brief before the Supreme Court in 1996 urging the Court to recognize “physician-assisted suicide . . . as a fundamental right.” Brief of *Amicus Curiae* Bioethicists Supporting Respondents, at 1 (Pearlman listed in Appendix A), *Washington v. Glucksberg*, 521 U.S. 702 (1997) & *Vacco v. Quill*, 521 U.S. 793 (1997).

CONCLUSION

In short, not only will the Obama Health Care Law limit our ability to use our own money to save the lives of our family members, it will also fund propaganda to convince us this is all for the best.

ENDNOTES:

1. Understanding the legislative language that sets the required target below the rate of medical inflation requires following a very convoluted path:

42 USCS § 1395kkk(o) states,

“Advisory recommendations for non-Federal health care programs. (1) In general. Not later than January 15, 2015, and at least once every two years thereafter, the Board shall submit to Congress and the President recommendations to slow the growth in national health expenditures (excluding expenditures under this title and in other Federal health care programs) ... such as recommendations-- (A) that the Secretary or other Federal agencies can implement administratively;...(2) Coordination. In making recommendations under paragraph (1), the Board shall coordinate such recommendations with recommendations contained in proposals and advisory reports produced by the Board under subsection (c).”

The reference is to 42 USCS § 1395kkk(c)(2)(A)(i), which provides for Board reports with recommendations that “will result in a net reduction in total Medicare program spending in the implementation year that is at least equal to the applicable savings target established under paragraph (7)(B) for such implementation year.”

That paragraph, 42 USCS § 1395kkk(c)(7)(B), defines the applicable savings target through 2017 as reducing projected spending by either a percentage *halfway between* medical inflation and general inflation [42 USCS §1395kkk(c)(6)(C)(i)], or a specified percentage differing with each year (in 2015, .5%; in 2016, 1%; in 2017, 1.25%; in 2018 and in subsequent years, 1.5%), whichever is less. In 2018 and later years, “the nominal gross domestic product per capita plus 1.0 percentage point” is substituted for the percentage halfway between medical and general inflation in this formula [42USCS §1395kkk(c)(6)(C)(ii)].

What this means is that the Board’s target for reduction in *private* (nongovernmental) health care spending must be “coordinated” with its target for reduction of Medicare spending; in turn, for 2015 through 2017 that target is a varying percentage below projected medical inflation, or halfway between projected general and medical inflation, whichever is less. For 2018 on, it is the difference between projected medical inflation and either projected GDP per capita plus 1%, or 1.5%, whichever is less. In all years (after 2015), the target is below projected medical inflation.

2. This provision is quoted at the beginning of endnote 1 above.
3. 42 USCS § 1395l (t)(17) [“Each subsection (d) hospital shall submit data on measures selected under this paragraph to the Secretary in a form and manner, and at a time, specified by the Secretary for purposes of this paragraph”....and “(A) Reduction in update for failure to report. (i) In general....a subsection (d) hospital ...that does not submit, to the

Secretary in accordance with this paragraph, data required to be submitted on measures selected under this paragraph with respect to such a year, the . . . fee schedule increase factor . . . for such year shall be reduced by 2.0 percentage points.”], 1395l(i)(7) [similar language applicable to ambulatory surgical centers], 1395cc(k)(3) [similar language applicable to certain cancer hospitals], 1395rr(h)(2)(A)(iii) [similar language applicable to end-stage renal disease programs], 1395ww(b)(3)(B)(viii) [similar language otherwise applicable to hospitals], (j)(7)(D) [similar language applicable to inpatient rehabilitation hospitals], (m)(5)(D) [similar language applicable to long-term care hospitals], (s)(4)(D) [similar language applicable to psychiatric hospitals], and 1395fff(b)(3)(B)(v) [similar language applicable to skilled nursing facilities], 1395(i)(5)(D) [similar language applicable to hospice care], and (o)(2) [applicable to the way in which value-based incentives are paid].

4. 42 USCS § 18031(h)(1) provides, “Beginning on January 1, 2015, a qualified health plan may contract with . . . (B) a health care provider only if such provider implements such mechanisms to improve health care quality as the Secretary may by regulation require.”
5. Congressional Budget Office, “The Budget and Economic Outlook: an Update,” August 2010, at www.cbo.gov/ftpdocs/117xx/doc11705/08-18-Update.pdf. (October 26, 2010).
6. For more information on the private fee-for-service alternative and its history, see www.nrlc.org/MedEthics/RationinginMedicare.html.
7. Dobson, Allen, Joan DaVanzo, and Namrata Sen, "The Cost-Shift Payment 'Hydraulic': Foundation, History, And Implications," *Health Affairs* 25, no. 1 (2006): 22-33.
8. Patient Protection and Affordable Care Act, § 3209, Pub. L. No. 111-148, 124 Stat. 119, 460 (2010).
9. 42 U.S.C. § 1395w-24 (a)(6)(B) reads, in relevant part (emphasis supplied):

(B) Acceptance and negotiation of bid amounts.

(i) Authority. *Subject to clauses (iii) and (iv)*, the Secretary has the authority to negotiate regarding monthly bid amounts submitted under subparagraph (A) [I]n exercising such authority the Secretary shall have authority similar to the authority of the Director of the Office of Personnel Management with respect to health benefits plans under chapter 89 of title 5, United States Code [5 USCS §§ 8901 et seq.].

(ii) Application of FEHBP standard. *Subject to clause (iv)*, the Secretary may only accept such a bid amount or proportion if the Secretary determines that such amount and proportions are supported by the actuarial bases provided under subparagraph (A) and reasonably and equitably reflects the revenue requirements (as used for purposes of section 1302(8) of the Public Health Service Act [42 USCS § 300e-1(8)]) [relating to the standards for setting different

rates for individuals and families and for individuals, small groups, and large groups]) of benefits provided under that plan.

(Clause iv is quoted in the next endnote.)

10. 42 U.S.C. § 1395w-24 (a)(6)(B) provides:
(iv) Exception. In the case of a [private fee-for-service] plan described in section 1851(a)(2)(C) [42 USCS § 1395w-21(a)(2)(C)], the provisions of clauses (i) and (ii) [quoted in the previous endnote] shall not apply and the provisions of paragraph (5)(B), prohibiting the review, approval, or disapproval of amounts described in such paragraph, shall apply to the negotiation and rejection of the monthly bid amounts and the proportions referred to in subparagraph (A).

The “provisions of paragraph (5)(B)” incorporated by reference are:

(B) Exception. The Secretary shall not review, approve, or disapprove the amounts submitted under paragraph (3) or, in the case of an MA private fee-for service plan, subparagraphs (A)(ii) and (B) of paragraph (4).

Paragraph (4), subparagraph (A)(ii) reads:

“the amount of the Medicare + Choice [now called Medicare Advantage] monthly basic beneficiary premium”;

Paragraph (4), subparagraph (B) reads:

“Supplemental benefits. For benefits described in section 1852(a)(3) [42 USCS § 1395w-22(a)(3)], the amount of the Medicare + Choice monthly supplemental beneficiary premium (as defined in subsection (b)(2)(B)).”

11. The new subparagraph (C) is added to 42 U.S.C. § 1395w-24 (a)(5). Since the language of subparagraph (a)(6)(B) that prevents the Secretary from “negotiating” private fee-for-service plan premiums is based on incorporating by reference subparagraph (a)(5)(B), as explained in the previous endnote, and because clause (i) of (a)(5)’s new subparagraph (C) would prevent subparagraph (B) from being construed to limit the Secretary’s authority to reject bids, it effectively makes meaningless the premium negotiation prohibition of subparagraph (a)(6)(B).
12. Patient Protection and Affordable Care Act, § 1003, Pub. L. No. 111-148, 124 Stat. 119, 139-40 (2010).
13. *Id.*, § 1311(e)(2), 124 Stat. at 178. It provides:

The Exchange shall require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. Such plans shall prominently post such information on their websites. The Exchange may take this information, and the information and the recommendations provided to the Exchange by the State under section 2794(b)(1)

of the Public Health Service Act (relating to patterns or practices of excessive or unjustified premium increases)[this is the section cited in endnote 1 above], into consideration when determining whether to make such health plan available through the Exchange. The Exchange shall take into account any excess of premium growth outside the Exchange as compared to the rate of such growth inside the Exchange, including information reported by the States.

14. *Id.*
15. 42 USC § 299b-36.
16. 42 USC § 299b-36(b)(1).
17. 42 USCS § 299b-36(e)(2)(a). The “decision aids” are to include “relative cost of treatment or, where appropriate, palliative care options.”
18. Sec. 3A, S.B. 1395, 52nd Leg., 2d Sess. (Ok. 2010), accessible through <http://webserver1.lsb.state.ok.us/WebBillStatus/main.html>.
19. For further information see www.nrlc.org/News_and_Views/Aug09/nv082409.html and www.nationalreview.com/articles/228199/your-life-not-worth-living/jim-towey.
20. www.news-medical.net/news/20090819/Veterans-deserve-better-than-the-Department-of-Veterans-Affairs-current-advance-care-planning-tool.aspx.
21. <http://www.empowher.com/cancer/content/end-life-talks-between-cancer-patients-and-doctors-lead-better-less-costly-care>.
22. “Health Care Costs in the Last Week of Life Associations With End-of-Life Conversations,” *Arch Intern Med.* 2009; 169(5):480-488.
23. 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.
24. April 14, 2009 interview, published in David Leonhart, “After the Great Recession,” *New York Times Magazine*, April 29, 2009, <http://www.nytimes.com/2009/05/03/magazine/03Obama-t.html?pagewanted=all>.