Collin County Republican Review

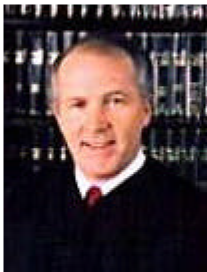
September 2009

Volume 2009, Issue 09
CCRMC

September Meeting:

Thursday, September 17, 2009

6:30 PM Social; 7:00 PM Meeting
Speaker : Judge Ray Wheless, Collin County Courts



Accomplishments

- Eight and a half years service as Judge of County Court at Law No. 4, Collin County, Texas. Appointed by the Collin County Republican Party in 2000. Elected twice without opposition.
- Local Administrative Judge for the County Courts at Law of Collin County, Texas (2009).
- Board Certified in Civil Trial Law (1990) and Personal Injury Trial Law (1989).
- Established Collin County's Official Drug Court Program in 2005.
- Vice-Chairman Collin County Republican Party (1998 to 2000).

Education

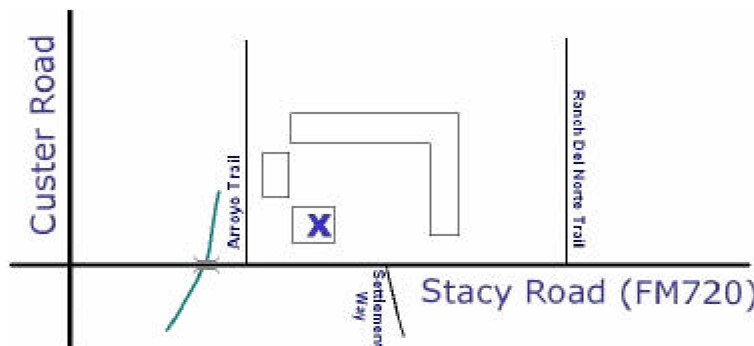
- J.D., University of Texas at Austin (1979).
- BBA, (Major in Management) California State College, San Bernardino, CA 1976.

Personal

- Married to Cynthia McCrann Wheless for 21 years. Two children, Ryan 15, Dylan 12.
- Hobbies include fly fishing, backpacking and hiking.

Directions to HQs @ 8416 Stacy Road, McKinney

From SH 121 -- go north on CUSTER RD to the second stop light -- Custer & Stacy Rd (aka FM720). There's a CVS Pharmacy on the SE corner of Custer & Stacy/FM720/3537. Turn east (right) onto STACY RD (aka FM720/3737). The shopping center where the office is located is approx. 1/2 mile on the left. You will pass the ASPCA on the right then cross a bridge. The shopping center immediately following is on the left. It's comprised of 5 buildings. The HQ office is in the building on the left closest to Stacy Rd. You may also get there from Alma Road too by going N from 121 and zigzagging around the ball fields to Stacy.



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No more lies

News Media Honeymoon Over? **7**

Upcoming Events:

- Sept. 17 —CCRMC Meeting

Judge Wheless, Collin County Court of Appeals

- Oct. 15—CCRMC Meeting

State Representative Jerry Madden

- Nov. 19—CCRMC Meeting

U.S. Congressman, Sam Johnson

- Dec. 17—CCRMC Meeting

Texas Senator, Florence Shapiro

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Roger Bolin

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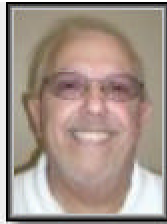
Roger Bolin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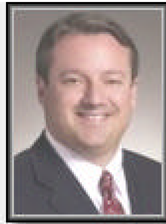
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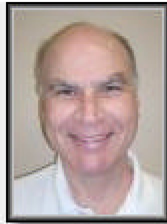
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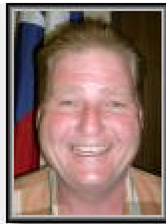
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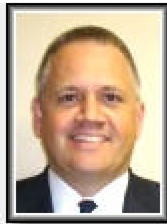
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Message FromVP Newsletter Jim Bortzfield

If this were baseball.....

This is really part II of last month's discussion on focusing on what is important. My email mailbox runneth over with conservative email. Notice, I didn't say good conservative email. There is such a stir, that my comrades will believe just about anything written that comes in after fifty previous forwardings. This is the ultimate pyramid marketing. Millions will read it, believe it, forward it and propagate a lie without the most minor hesitancy.

My dad taught me how to play baseball. He would say that baseball is almost like life. Simple. All you have to do is master catching, throwing and hitting the ball. Don't make it complicated. Focus on the goal. Keep your eye on the ball. If the debate to stop socialism in America was baseball, we'd be beaned by now. Nobody keeps their eye on the ball with all the false trash being thrown at them.

Last month, Roger asked me to publish an email that was floating around about HR3200, the Obamacare plan. The email carefully detailed problems with page numbers and quotes. I had a copy of HR3200 but was reluctant to publish this email (again) without first checking it out. My warning signals were going off since the email carefully analyzed and found problems all the way to page 494. Then nothing. Could this bill be flawed for the first 494 pages and then perfect for the last 600 I thought.

There is even an empassioned three part YouTube video where a citizen expresses concern for this health care plan and quotes this mostly false email. That lump on my forehead was caused by the wall.

Well, I spent time, checked it out but will use FACTCHECK.ORG as the summary. I do not defend Obamacare. I do want to fight a real battle, not the electronic cartoon warrior-like video email game because there are no do-overs.

Obama says there are 30,000,000 (down from 46,000,000) uninsured people, we need mandatory insurance where everybody pays EXCEPT hardship exemptions and small business. Isn't that why we have 30,000,000 uninsured people? Exactly how do we pay for the uninsured hardship cases, taxes or premiums? Oh yeah, he said the efficiency of the Federal Government would save that money.................and that's how we know it isn't true. Government and Efficiency is a greater oxymoron than jumbo shrimp. Hey, but Medicare won't pay for motorized chairs anymore!

Obama delivered quite a good speech. When called a liar, his topic was whether illegal aliens would get "free healthcare." He said they were prohibited in the bill, as they are. However, there is no validation over WHO IS ILLEGAL because we can't fix immigration so go figure how he/we deny coverage. We can't keep them from working; how can we stop health care without some reform?

To me, there are REAL things that are critical to keep our eye on so we don't get beaned.

Anyway, back to the email with "facts" about the Obamacare HR3200 bill. Each of the claims in the email message:

> **Claim:** Page 22: Mandates audits of all employers that self-insure!

False: This section merely requires a study of "the large group insured and self-insured employer health care markets." There's no mention of auditing employers, only of studying "markets." The purpose of the study is to produce "recommendations" to make sure the new law "does not provide incentives for small and mid-size employers to self-insure."

> **Claim:** Page 29: Admission: your health care will be rationed!

False: This section says nothing whatsoever about "rationing" or anything of the sort. Actually, it's favorable to families and individuals, placing an annual cap on what they could pay out of pocket if covered by a basic, "essential benefits package." The limits would be $5,000 for an individual, $10,000 for a family.

> **Claim:** Page 30: A government committee will decide what treatments and benefits you get (and, unlike an insurer, there will be no appeals process)

False: Actually, the section starting on page 30 sets up a "private-public advisory committee" headed by the U.S. surgeon general and made up of mostly private sector "medical and other experts" selected by the president and the comptroller general. The advisory committee would have only the power "to recommend" what benefits are included in basic, enhanced and premium insurance plans. It would have no power to decide what treatments anybody will get. Its recommendations on benefits might or might not be adopted.

> **Claim:** Page 42: The "Health Choices Commissioner" will decide health benefits for you. You will have no choice. None.

False: The new Health Choices Commissioner will oversee a variety of choices to be offered through new insurance exchanges. The bill itself specifies the "minimum services to be covered" in a basic plan, including prescription drugs, mental health services, maternity and well-baby care and certain vaccines and preventive services (pages 27-28). We find nothing in the bill that prevents insurance companies from offering benefits that exceed the minimums. In fact, the legislation allows (page 84) any company that offers an approved basic plan to offer also an "enhanced" plan, a "premium" plan and even a "premium plus" plan that could include vision and dental benefits.

> **Claim:** Page 50: All non-US citizens, illegal or not, will be provided with free healthcare services.

False. That's simply not what the bill says at all. This page includes "SEC. 152. PROHIBITING DISCRIMINATION IN HEALTH CARE," which says that "[e]xcept as otherwise explicitly permitted by this Act and by subsequent regulations consistent with this Act, all health care and related services (including insurance coverage and public health activities) covered by this Act shall be provided without regard to personal characteristics extraneous to the provision of high quality health care or related services." However, the bill does explicitly say that illegal immigrants can't get any

government money to pay for health care. Page 143 states: "Nothing in this subtitle shall allow Federal payments for affordability credits on behalf of individuals who are not lawfully present in the United States." And as we've said before, current law prohibits illegal immigrants from participating in government health care programs.

Claim: Page 58: Every person will be issued a National ID Healthcard.

False. There is no mention of any "National ID Healthcard" anywhere in the bill. Page 58 says that government standards for electronic medical transactions "may include utilization of a machine-readable health plan beneficiary identification card," to show eligibility for services. Insurance companies typically issue such cards already, but if such a standard were issued the cards would need to be in a standard form readable by computers. The word "may" is used to permit such a standard, but it does not require one.

Claim: Page 59: The federal government will have direct, real-time access to all individual bank accounts for electronic funds transfer.

False. This section aims to simplify electronic payments for health services, the same sort of electronic payments that already are common for such things as utility bills or mortgage payments. The bill calls for the secretary of Health and Human Services to set standards for electronic administrative transactions that would "enable electronic funds transfers, in order to allow automated reconciliation with the related health care payment and remittance advice." There is no mention of "individual bank accounts" nor of any new government authority over them. Also, the section does not say that electronic payments from consumers is required.

Claim: Page 65: Taxpayers will subsidize all union retiree and community organizer health plans (read: SEIU, UAW and ACORN)

Misleading. Page 65 is the start of a section (SEC. 164. REINSURANCE PROGRAM FOR RETIREES) that would set up a new federal reinsurance plan to benefit retirees and spouses covered by *any* employer plan, not just those run by labor unions or nonprofit groups. Specifically, it covers "retirees and . . . spouses, surviving spouses and dependents of such retirees" who are covered by "employment-based plans" that provide health benefits. It's open to any "group health benefits plan that . . . is maintained by one or more employers, former employers or employee associations," as well as voluntary employees' beneficiary associations (page 66). Furthermore, the aim of the fund is to cut premiums, copays and deductibles for the retirees. Payment "shall not be used to reduce the costs of an employer."

Claim: Page 72: All private healthcare plans must conform to government rules to participate in a Healthcare Exchange.

True. This page begins a section setting up a new, national Health Insurance Exchange through which individuals and employers may choose from a variety of private insurance plans, much like the system that now covers millions of federal workers. Any private insurance plans offered through this exchange must meet new federal standards. For example, such plans can't deny coverage for preexisting medical conditions (page 19).

Claim: Page 84: All private healthcare plans must participate in the Health care Exchange (i.e., total government control of private plans)

Partly true. Nothing like this appears on page 84. No insurance company is required to sell plans through the exchange if it doesn't want to. Any employer may choose to buy coverage elsewhere. In fact, the vast majority of employers will still be buying private plans through the normal marketplace, because only employers with 10 or fewer employees are even allowed to buy through the exchange in the first year. The limit rises to 20 employees in the second year. However, new plans sold directly to individuals will only be sold through the exchange. Individuals who currently buy their own coverage can keep those plans if they wish, and if the insurance company continues to offer them.

Claim: Page 91: Government mandates linguistic infrastructure for services; translation: illegal aliens

Misleading. It's true that page 91 says that insurance companies selling plans through the new exchange "shall provide for culturally and linguistically appropriate communication and health services." The author's "translation," however, assumes that anyone speaking a foreign language or from another culture is an *illegal* immigrant, which is false.

Claim: Page 95: The Government will pay ACORN and Americorps to sign up individuals for Government-run Health Care plan.

False: This page is the start of "SEC. 205. OUTREACH AND ENROLLMENT OF EXCHANGE-ELIGIBLE INDIVIDUALS AND EMPLOYERS IN EXCHANGE-PARTICIPATING HEALTH BENEFITS PLAN." It says a newly established Health Choices Commissioner "shall conduct outreach activities" to get people covered by private or government health insurance plans. The section says on page 97 that the Commissioner "may work with other appropriate entities to facilitate … provision of information." But there is no authorization anywhere in the entire section for the Commissioner to pay money to any group to engage in outreach.

Claim: Page 102: Those eligible for Medicaid will be automatically enrolled: you have no choice in the matter.

Partly true. Page 102 says certain Medicaid-eligible persons will be "automatically enrolled" in Medicaid (which is the state-federal program to provide insurance to low-income workers and families) IF they are not already covered by private insurance. That would happen only if they had "not elected to enroll" in one of the private plans offered through the new insurance exchanges, however. So on paper at least, they would have a choice. Also, it's estimated that one in four persons who lacks health insurance is already eligible for Medicaid or its offshoot, the state Children's Health Insurance Program, but simply haven't signed up or been enrolled by their parents.

Claim: Page 124: No company can sue the government for price-fixing. No "judicial review" is permitted against the government monopoly. Put simply, private insurers will be crushed.

Half true. It's true that page 124 forbids any review by the courts of rates the government would pay to doctors and hospitals under the new "public option" insurance plan. But there's no mention of "price fixing" in the

bill; that's the e-mail author's phrase. It also remains to be seen if the "public option" plan would grow to become a "government monopoly," as the author predicts.

> **Claim:** Page 127: The AMA sold doctors out: the government will set wages.

Misleading. Nothing in the bill would "set wages" for doctors in general. Page 127 says the government would ask doctors to accept below-market rates set by the government for their patients who are covered by a new "public health insurance option," just as they now are asked to do so for patients covered by Medicare. Physicians would still be free to charge what they wish for other patients, and free not to accept patients covered by the new program just as they are now free to refuse Medicare patients. That's not a choice many doctors make, however, so as a practical matter the government would be setting rates (not "wages") for many patients. On the other hand, the new "public" plan is aimed mainly at covering people who have no insurance now and can afford to pay doctors little if anything.

> **Claim:** Page 145: An employer MUST auto-enroll employees into the government-run public plan. No alternatives.

False. It's true that employers would be required to sign up their workers for coverage automatically, but it doesn't have to be the "public plan." It would be the employer-offered plan "with the lowest applicable employee premium" (pages 147- 148). This would only be the "public option" if the employer was eligible to buy coverage through the Health Insurance Exchange (not likely, at least during the first two years when only small businesses would have access), and the "public option" was the cheapest plan (which would be likely). Furthermore, while the employer isn't given an alternative, the workers are. They may reject auto-enrollment under an opt-out provision (page 148).

> **Claim:** Page 146: Employers MUST pay healthcare bills for part-time employees AND their families.

Half true. There's nothing in this section about part-time employees' families, but this provision does call for employers to contribute toward part-time employees' health insurance. The bill says that "for an employee who is not a full-time employee … the amount of the minimum employer contribution" will be a proportion of the minimum contribution for full-time employees. This proportion will depend on the average weekly hours of part-time employees compared with the minimum weekly hours required to be a full-time employee, as specified by the Health Choices Commissioner. (For a point of reference: The minimum contribution for individual plans of full-time employees is not less than 72.5 percent of the premium of the cheapest plan the employer offers.)

> **Claim:** Page 149: Any employer with a payroll of $400K or more, who does not offer the public option, pays an 8% tax on payroll **Claim:** Page 150: Any employer with a payroll of $250K-400K or more, who does not offer the public option, pays a 2 to 6% tax on payroll.

Both Partly True. The bill requires employers either to offer private health insurance coverage or pay a percentage of their payroll expenses to help finance a public plan. The 8 percent payment would indeed apply to employers with payrolls over $400,000 in the previous year, and lesser amounts would apply to smaller firms. Those with payrolls of $250,000 or less would pay nothing. But the penalty isn't incurred if an employer "does not offer the public option," as the e-mail claims. Rather, it's a penalty for not offering health insurance to employees.

> **Claim:** Page 167: Any individual who doesn't have acceptable health care (according to the government) will be taxed 2.5% of income.

True. This is the mechanism in the bill to enforce the individual mandate requiring everyone to have insurance. A person who doesn't have insurance that meets minimum benefit standards (or other acceptable coverage, such as a plan that was grandfathered in) would pay a penalty of 2.5 percent of modified adjusted gross income for the year. The total penalty can't exceed a national average premium for individual coverage, or family coverage if applicable.

> **Claim:** Page 170: Any NON-RESIDENT alien is exempt from individual taxes (Americans will pay for them).

False. "Non-resident aliens" are generally those who have spent less than 31 days in the U.S. during the year. The claim that "Americans will pay for them" assumes that such visitors would somehow be getting federal benefits that would cost taxpayers money. In any case, they are not "exempt from individual taxes" at all. Under current law, the Internal Revenue Service says: "If you are a nonresident alien, you must file Form 1040NR (PDF) or Form 1040NR-EZ (PDF) if you are engaged in a trade or business in the United States, or have any other U.S. source income on which the tax was not fully paid by the amount withheld." All that page 170 says is that non-resident aliens who don't obtain health coverage don't have to pay an additional 2.5 percent federal tax that would apply to U.S. workers who fail to get coverage, or to immigrants who are working here legally under green cards and who fail to obtain coverage. The tax is spelled out in subsection (a) starting on page 167.

> **Claim:** Page 195: Officers and employees of Government Health care Bureaucracy will have access to ALL American financial and personal records.

False. This section of the bill discusses "Disclosures To Carry Out Health Insurance Exchange Subsidies." It says that government employees of the health insurance exchange will have access to federal tax information for purposes of determining eligibility for affordability credits available for low- and moderate-income Americans. In other words, in order to qualify for a government subsidy to purchase health insurance, the government needs to confirm your income. And, no surprise, the government already has access to your federal tax information. The bill also says nothing about "ALL … financial and personal records." Instead it says "Such return information shall be limited to—(i) taxpayer identity information with respect to such taxpayer, (ii) the filing status of such taxpayer, (iii) the modified adjusted gross income of such taxpayer (as defined in section 59B(e)(5)), (iv) the number of dependents of the taxpayer, (v) such other information as is prescribed by the Secretary by regulation as might indicate whether the taxpayer is eligible for such affordability credits (and the amount thereof)." The bill goes on to limit use of this information "only for the purposes of, and to the extent necessary in, establishing and verifying the appropriate amount of any affordability credit … and providing for the repayment of any such credit which was in excess of such appropriate amount."

> **Claim:** Page 203: "The tax imposed under this section shall not be treated as tax." Yes, it really says that.

Misleading. What this actually says is: "The tax imposed under this section shall not be treated as tax imposed by this chapter *for purposes of determining the amount of any credit under this chapter or for purposes of section 55*," which deals with the Alternative Minimum Tax. It would limit the ripple effects of the new taxes the bill would impose on individuals making over $350,000 a year.

> **Claim:** Page 239: Bill will reduce physician services for Medicaid. Seniors and the poor most affected. **Claim:** Page 241: Doctors: no matter what specialty you have,

you'll all be paid the same (thanks, AMA!)

Both False. Both of these claims pertain to Section 1121, which updates the physician fee schedule for 2010 for Medicare. It doesn't "reduce physician services for Medicaid" (which wouldn't pertain to seniors anyway); instead it modifies a section of the Social Security Act that defines physicians' services. The section also doesn't say that doctors will be paid the same "no matter what specialty you have." Instead it sets up two categories of physician services with different growth rates for fees under those categories. As the Kaiser Family Foundation says of this section of the bill: "Allows the revised formula to be updated by the gross domestic product (GDP) plus 2% for evaluation and management services and GDP plus 1% for all other services." The measure will cost $228.5 billion over 10 years, according to the Congressional Budget Office and Joint Committee on Taxation.

> **Claim:** Page 253: Government sets value of doctors' time, their professional judgment, etc.

Misleading. It's true that page 253 refers to "relative value units" to be used when determining payment rates for doctor's services, and that such RVUs would weigh factors "such as time, mental effort and professional judgment, technical skill and physical effort, and stress due to risk." But this is nothing new; the government already uses RVUs when setting rates it will pay under Medicare. For example, the RVUs assigned to a colonoscopy are currently double the RVUs assigned to an intermediate office visit. In fact, page 253 is part of a section (Sec. 1122) that sets up a process for correcting existing but "potentially misvalued" rates.

> **Claim:** Page 265: Government mandates and controls productivity for private healthcare industries.

Misleading. This claim doesn't even make sense. How can anyone "mandate" that somebody else be productive, or "control" how productive they are? The author has simply misunderstood what this controversial item would do. In fact, page 265 is the start of a section (Sec. 1131) that is among several designed to slow future growth of Medicare payments to help offset the cost of the bill. It would require that "productivity improvements" be taken into account when setting annual "market basket" updates to Medicare rates for hospital-based services. The hospital industry has estimated this would translate into a 1.3 percent cut next year and a total of $150 billion in reduced payments over 10 years, and is opposed to it.

> **Claim:** Page 268: Government regulates rental and purchase of power-driven wheelchairs.

Misleading. What page 268 does is to stop Medicare for paying for "mobility scooters," which have been widely marketed as a Medicare-financed benefit, leading to ballooning costs to the program. They would no longer qualify as a "power-driven wheelchair." Only a "complex rehabilitative power-driven wheel chair recognized by the Secretary" would be covered. The Congressional Budget Office estimates this will save the government $800 million over 10 years (see page 2).

> **Claim:** Page 272: Cancer patients: welcome to the wonderful world of rationing!

False. This page merely calls for a study of whether a certain class of hospitals incur higher costs than some others for the cancer care they deliver. It also says the secretary of HHS "shall provide for an appropriate adjustment" in payments "to reflect those higher costs." It's hardly "rationing" to pay hospitals more to compensate for higher costs.

> **Claim:** Page 280: Hospitals will be penalized for what the government deems preventable re-admissions.

True: This does say that "the Secretary shall reduce the payments" to hospitals with too many "potentially preventable" readmissions of patients that they previously had discharged.

> **Claim:** Page 298: Doctors: if you treat a patient during an initial admission that results in a readmission, you will be penalized by the government.

False. That section is part of a list of *potential* physician-centered approaches to reducing excess hospital readmissions. The bill states that the secretary of Health and Human Services will conduct a study on the best ways to enforce readmissions policies with physicians. One of the approaches the secretary must consider is the option to reduce payments to physicians whose treatment results in a hospital readmission. Another is the option to *increase* payments to physicians who check up on recently released patients. Neither of these approaches is mandated in the bill – what's mandated is that the secretary consider them, among others.

> **Claim:** Page 317: Doctors: you are now prohibited for owning and investing in healthcare companies!

False. It's already illegal, with certain exceptions, for doctors to refer Medicare patients to hospitals, labs, medical imaging facilities or other such medical businesses in which they hold a financial interest. Page 317 would modify an exception to that "self-referral prohibition" for rural providers, and says doctors can't increase their stake in an exempt hospital after the bill becomes law.

> **Claim:** Page 318: Prohibition on hospital expansion. Hospitals cannot expand without government approval.

False. Expansion is forbidden only for rural, doctor-owned hospitals that have been given a waiver from the general prohibition on self-referral. It does not apply to hospitals in general. The bill provides for exceptions to even this limited expansion ban (page 321).

> **Claim:** Page 321: Hospital expansion hinges on "community" input: in other words, yet another payoff for ACORN.

False. Page 321 says rural, doctor-owned hospitals that are exempt from the Medicaid self-referral prohibition can ask to be allowed to expand under rules that must allow "input" from "persons or entities in the community." Under that language, anybody in the community could offer their opinion, but nobody – not ACORN or anybody else – would be paid for it.

> **Claim:** Page 335: Government mandates establishment of outcome-based measures: i.e., rationing.

Misleading. This section does deal with establishing quality measures for Medicare. It does not make any recommendations for treatment, or empower anyone to make treatment recommendations based on those measures. The only effect of these outcome-based measures established in the bill would be ranking and potential disqualification of underperforming Medicare Advantage plans – that's disqualification of the plans, not of any medical procedures.

> **Claim:** Page 341: Government has authority to disqualify Medicare Advantage Plans, HMOs, etc.

True. The bill allows for the possibility of disqualifying underperforming Medicare Advantage plans, which include Medicare HMOs. Medicare Advantage plans are private health plans that provide Medicare benefits. Under the bill, the secretary of Health and Human Services has the authority

to disallow plans that are providing low-quality care under the new quality measures (which include evaluations of patient health, mortality, safety and quality of life). If a plan is disqualified, this will not leave seniors without care. The Kaiser Family Foundation reports that "virtually all" Medicare beneficiaries have access to at least two Medicare Advantage plans, and most have access to three or more. In 2008, 82 percent of beneficiaries had access to six or more private fee-for-service plans, one type of Medicare Advantage plan (along with HMOs, PPOs and medical spending accounts). Beneficiaries are also always free to return to the regular Medicare fee-for-service program.

> **Claim:** Page 354: Government will restrict enrollment of SPECIAL NEEDS individuals.

Misleading. Insurance companies already restrict enrollment in so-called "special needs" plans, a special category of Medicare Advantage plans that were created in 2003. Page 354 merely extends the authority to do that beyond the end of next year, when it was set to expire. Furthermore, what's being restricted isn't the number of patients, but the type of patients. Plans can be restricted to accepting only those patients who fall into in one or more special categories. These include those who are institutionalized (think, nursing homes), those who qualify both for Medicare and Medicaid (think, both low-income and over age 65) and those with severe or disabling chronic conditions such as diabetes, emphysema, chronic heart failure or dementia. And of course, this has nothing to do with children with learning problems.

> **Claim:** Page 379: More bureaucracy: Telehealth Advisory Committee (healthcare by phone).

Misleading. The advisory committee would not be a "bureaucracy" or have any administrative functions, but instead would bring together experts from the private sector to give advice on how Medicare and Medicaid should treat the practice of medicine via telecommunication, something used in rural hospitals and such places as cruise ships, battlefield settings and even on NASA space missions. Pages 380-381 call for the committee to consist of five "practicing physicians," two "practicing non-physician health care workers" and two "administrators of telehealth programs."

> **Claim:** Page 425: More bureaucracy: Advance Care Planning Consult: Senior Citizens, assisted suicide, euthanasia? **Claim:** Page 425: Government will instruct and consult regarding living wills, durable powers of attorney, etc. Mandatory. Appears to lock in estate taxes ahead of time. **Claim:** Page 425: Government provides approved list of end-of-life resources, guiding you in death **Claim:** Page 427: Government mandates program that orders end-of-life treatment; government dictates how your life ends. **Claim:** Page 429: Advance Care Planning Consult will be used to dictate treatment as patient's health deteriorates. This can include an ORDER for end-of-life plans. An ORDER from the GOVERNMENT. **Claim:** Page 430: Government will decide what level of treatments you may have at end-of-life.

All False. These six claims are a twisted interpretation of a provision in the bill that says Medicare will cover *voluntary* counseling sessions between seniors and their doctors to discuss end-of-life care. Medicare doesn't pay for such sessions now; it would under the bill. End-of-life care discussions include talking about a living will, hospice care, designating a health care proxy and making decisions on what care you want to receive at the end of your life. Doctors do the consulting, not the "government" or a "bureaucracy." The e-mail author's assertion that the bill calls for "an ORDER from the GOVERNMENT" for end-of-life plans rests on language about *a patient* drawing up such an order stipulating their wishes, and having that order signed by a physician. There's nothing about "an order from the government." The bill defines an order for life-sustaining treatment as a document that "is signed and dated by a physician …[and] effectively communicates the individual's preferences regarding life sustaining treatment." See our article "False Euthanasia Claims" for more on such assertions.

> **Claim:** Page 469: Community-based Home Medical Services: more payoffs for ACORN.

False. This section defines the term "community-based medical home" as a "nonprofit community-based or State-based organization" that "provides beneficiaries with medical home services." ACORN does not provide medical home services. The section goes on to say such a medical service is one that "employs community health workers, including nurses or other non-physician practitioners, lay health workers, or other persons as determined appropriate by the Secretary, that assist the primary or principal care physician or nurse practitioner in chronic care management activities." The only thing ACORN has in common with that description is the word "community." It's a community organization that offers services such as free tax preparation help and first-time home buyer counseling for low- and moderate-income people. It also works to register people to vote, and a few of its canvassers have been investigated for registration fraud, a point of concern during the presidential campaign.

> **Claim:** Page 472: Payments to Community-based organizations: more payoffs for ACORN.

False. This section is referring to community-based medical homes.

> **Claim:** Page 489: Government will cover marriage and family therapy. Government intervenes in your marriage.

Half true. It's true that pages 489 and 490 make state-licensed "marriage and family therapist" services a covered expense "for the diagnosis and treatment of mental illnesses." But the therapists wouldn't be employed by the government, and there's no requirement for anybody to receive their help. So the claim that this would mean that "government intervenes in your marriage" is false.

> **Claim:** Page 494: Government will cover mental health services: defining, creating and rationing those services.

Misleading. The provision amends Section 1861 of the Social Security Act laying out what services Medicare will cover. It expands coverage for mental health services, stipulating that a "mental health counselor" who can perform mental health counseling is someone with a master's or doctorate degree, a state license, and two years of practice as a counselor. Is this the government "defining" mental health services? Well, it's certainly the government defining what government programs will cover.

News Media Honeymoon Over?

The following story is a copyright story from Newsweek. Interesting. Not that far left support of Obama we have seen. Worth the read.

We cannot, it seems, have a candid national conversation on health care. President Obama's speech the other night was a brilliant performance, and it may improve prospects for congressional passage of his "reform." But no possible plan will fix the "health care problem" for all time. When Obama says that "I am not the first president to take up this cause, but I am determined to be the last," he is indulging his ambition for a special place in history and illustrating why Americans don't discuss health care honestly.

The political problem was simple: Support for "reform" was collapsing. In April, 43 percent felt they'd be better off with his "reform" and only 14 percent didn't, according to a Kaiser Family Foundation poll. By August, it was 36 percent to 31 percent. To restore momentum, Obama needed to convince more people that his program would help them.

Americans generally want three things from their health-care system. First, they think that everyone has a moral right to needed care; that suggests universal insurance. Second, they want choice; they want to select their doctors—and want doctors to determine treatment. Finally, people want costs controlled; health care shouldn't consume all private compensation or taxes.

Appealing to these expectations, Obama told Americans what they want to hear. People with insurance won't be required to change plans or doctors; they'll enjoy more security because insurance companies won't be permitted to deny coverage based on "pre-existing conditions" or cancel policies when people get sick. All Americans will be required to have insurance, but those who can't afford it will get subsidies.

As for costs, not to worry. "Reducing the waste and inefficiency in Medicare and Medicaid will pay for most of this plan," Obama said. He pledged to "not sign a plan that adds one dime to our [budget] deficits—either now or in the future." If you believe Obama, what's not to like? Universal insurance. Continued choice. Lower costs.

The problem is that you can't entirely believe Obama. If he were candid—if we were candid— we'd all acknowledge that the goals of our ideal health-care system collide. Perhaps we can have any two, but not all three.

If we want universal insurance and unlimited patient and doctor choice, costs will continually spiral upward, because there will be no reason or no one to stop them. We have a variant of that today—a cost-plus system, with widespread insurance and open-ended reimbursement. Higher costs push up premiums and taxes. That's one reason health spending has gone from 5 percent of gross domestic product in 1960 to 16 percent in 2007. (Other reasons: new technologies, rising incomes.) But controlling spending requires limits on patients and doctors.

Studies of various health proposals conclude that their long-term costs exceed their long-term financing. In its second decade (2020-29), H.R. 3200—the main House bill—would increase federal budget deficits by $1 trillion, estimates the Lewin Group, a consulting firm that is owned by one of the nation's largest health-care insurers, UnitedHealth Group. Total health spending would reach 28 percent of GDP by 2029. How can Obama claim to control costs and never add to the deficit? Well, he'd adopt a provision requiring "more spending cuts if the savings we promised don't materialize." Sound convincing?

It isn't. Congress often enacts automatic triggers to control spending. The triggers usually don't work. When they might bite, Congress delays or modifies them. Consider one trigger: the "sustainable growth rate" (SGR) that Congress created in 1997 to control doctors' spending under Medicare. Since 2002, the SGR formula has consistently called for annual cuts in doctors' reimbursements. Congress has routinely overridden the formula. Now, there's pressure to scrap the whole SGR.

Obama's selling of "reform" qualifies as high-class hucksterism, but in fairness, many conservative opponents match or exceed his exaggerations and distortions with low-class fear-mongering.

These critics charge that Obama would curtail Medicare benefits or create "death panels" to deprive ill seniors of desirable care. Not only are these charges mainly false (as Obama says), but they wrongly suggest that we put some important subjects off-limits. Medicare represents one-fifth of personal health spending. Why shouldn't we debate what should be covered and who should pay? Similarly, doctors, patients and families should discuss end-of-life care. It's not just that 25 to 30 percent of Medicare spending occurs in patients' last year. Expensive, heroic care often compounds suffering.

The candor gap reflects a common condescension. One side believes it must fool Americans into thinking "reform" will do more than it will; the other thinks it must frighten Americans into believing that it will harm them in ways that it won't. Given Americans' contradictory expectations, any health-care proposal can be criticized for offending some popular goal. We refuse to face unavoidable—and unpleasant—choices.

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If George W. Bush had been the first President to need a teleprompter installed to be able to get through a press conference, would you have laughed and said this is more proof of how inept he is on his own and is really controlled by "smarter" men behind the scenes?