



The Living Truth about “Death Panels”

By Scott Gottlieb, M.D., and Elizabeth DuPre

The controversy over aspects of the House health care legislation that have been inappropriately equated with “death panels” has obscured the real problems with these provisions. While equating these proposals with death panels is a careless exaggeration, the legislative language about end-of-life counseling is disturbing because of the intrusion it represents into patients’ discretion and the way doctors practice medicine. The provisions are needlessly prescriptive, and they invite the government into private and complex health matters. Proponents believe these policies can save substantial money, but this will not occur. Congress can fix the problem by simplifying the legislation and making the principal goal ensuring patients’ autonomy and providing high-quality care at the end of life.

Speaking before a joint session of Congress on September 9, President Barack Obama said the emotional charges that his health reform calls for the creation of “death panels” are “bogus claims” that are “cynical and irresponsible. It is a lie, plain and simple.”¹

The assertion is that Obama’s health care proposals, embodied in House bill HR 3200,² create government-sponsored committees to decide which patients are not appropriate candidates for life-saving but expensive medical treatments.³ The charges stem from a Medicare provision sponsored by Representative Earl Blumenauer (D-Ore.) that would pay doctors for voluntary counseling sessions that address end-of-life issues.⁴ The indictments are indeed false, but they have nonetheless framed the debate around the end-of-life provisions, obscuring the real problems with proposals actually included in the legislation.

This provision, under “Advance Care Planning Consultation” in Section 1233 of HR 3200, is highly prescriptive, outlining in pedantic

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Key points in this Outlook:

- The end-of-life provisions in HR 3200 were not an eleventh-hour endeavor, but the product of longstanding political concern over the costs to Medicare for patients with terminal illness.
- The accusations that the bill contains provisions to create money-saving “death panels” are factually incorrect. But the provisions are based on an economic premise that they can help save significant money on end-of-life care, which is also incorrect.
- The inclusion of these measures represents a troubling intrusion into medical practice.
- The provisions are unnecessary. Doctors can already receive compensation for providing end-of-life counseling. The provisions also usurp traditional state prerogatives and may actually discourage doctors from providing counseling.
- Congress can fix the end-of-life provisions by making them voluntary and general in scope.

legislative language what end-of-life issues doctors should “advocate” with patients, the specific medical advice they should offer, and even the sort of clinical circumstances (chronic illness, transfer to a nursing home, cancer diagnosis, severe injury) that should serve as a trigger for these discussions. Critics of similar state-level legislation on end-of-life care (on which HR 3200 is loosely modeled)⁵ argue that the way these provisions are structured requires doctors to offer “death as a valid medical option.”⁶ This is an emotional charge that only reinforces why these sensitive matters are best left to private discussions between patients and doctors without federal guidance.

The provisions themselves impose burdens on providers that obviate what should be the principal purpose: encouraging physicians to raise end-of-life issues with patients in order to promote patients’ autonomy and make sure medical care at the end of life reflects their individual preferences. The language of HR 3200 is too prescriptive, and it introduces federal rules to govern the details of how these discussions should occur in the privacy of routine clinical practice. In this respect, these provisions magnify larger concerns many people have about current health reform efforts—namely, that present proposals are built on a foundation of greater government control of, and intrusion into, people’s medical care.⁷

The Basis for Concern

Critics are viewing the end-of-life provisions through the prism of Obama’s call to “bend the cost curve” in health care and decrease overall medical spending. Deconstructing the genesis for the “lies” that the president spoke of starts with understanding how end-of-life provisions actually fit into the administration’s vision for reforming health care in the first place, and how they do not.

The central economic feature of the administration’s proposal is the premise that greater government responsibility for the provision and payment of health care will give federal agencies the leverage they need to eliminate “wasteful” tests and procedures. This thesis turns on a controversial premise that Americans receive only 55 percent of recommended care, and much of it—up to one-third—is unnecessary, even harmful. To arrive at this estimate, the administration relies on data from Medicare and studies from Dartmouth University that show wide variations in the costs of medical care in different regions of the United States, even for treatment of the same conditions.⁸ They also demonstrate that regions

that spend more on medical services do not necessarily have better health outcomes.⁹ If these findings are true, some claim that differences between low- and high-spending areas must represent dollars wasted.

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So the Obama team argues that bringing the highest-spending areas in line with the lowest-spending areas would save about 30 percent, or \$700 billion, each year by eliminating “waste.”¹⁰ The specific proposals the Obama team and HR 3200 offer to try to eliminate this waste, however, are limited to proposals that increase spending on health care information technology and comparative effectiveness research (CER) or that create an independent Medicare commission empowered to make binding cuts to the program. Whatever their individual merit, these proposals are little more than window dressing, and they will not wring any meaningful cost savings out of Medicare or health care generally. There is a reason the Congressional Budget Office (CBO) cannot attach a consequential score to any of these policy proposals and why CBO director Douglas Elmendorf said the House health care legislation would increase, not reduce, the government’s long-term health costs.¹¹ Proposals for more investment in health care information tools, or for spending on CER, all have broad appeal largely because they are politically safe ideas, not because they are particularly effective. These initiatives neither cut existing benefits nor threaten entrenched interests.

Because the administration’s cost-saving provisions are highly debatable, reasonable observers looking in on this incongruity argue that wringing savings out of Medicare and bending the cost curve will inevitably require the government to turn to the historic tools government health programs (principally Medicare) use to cut spending—coverage and coding decisions designed to constrain the use of certain high-cost technologies and procedures and price controls implemented through government schedules that are gradually tightened.¹²

R. Glenn Hubbard put it succinctly in a recent article in the *New York Times*. Obama's proposals for universal coverage and government insurance options are directly at odds with his emphasis on cost containment. A public option that reduces costs through public subsidies simply shifts the expense to taxpayers while increasing the share of health care the government would pay for with taxes.¹³ It further concentrates power and health care decision making in the hands of Washington politicians and federal agencies without addressing the real causes behind inefficient consumption or delivery of care.

Confronted with the charge that programs like Medicare will inevitably be forced to ration access to products and services using their coverage and coding process, Obama officials point to the decisions private insurers make daily to defend the idea of government agencies making these same choices. But big government health care programs like Medicare are not ordinary payers. Medicare's sheer size and its government imprimatur often mean that its rulings drive decisions made across the entire health care market. Moreover, when a private insurer chooses not to cover a specific service, patients presumably understood the service fell under a non-covered category when they chose that particular insurance plan. Patients also retain some latitude to appeal these decisions or change insurers. No such option exists with a government program. The Medicare appeals mechanism is virtually impenetrable to patients. Formal appeals to Medicare took patients an average of twenty-one months, according to a 2001 report from the U.S. Government Accountability Office. Delays in administrative processing due to "inefficiencies and incompatibility of their data systems" accounted for 70 percent of the time spent processing appeals.¹⁴ Nor do patients have the ability to switch out of a government program like Medicare—they are locked in.

The nexus between the concerns that Medicare will be compelled to make more rationing decisions as a method of addressing costs and the origin of congressional interest in tackling end-of-life issues has stoked fears about how these provisions will affect American medical care. These worries fuel the hyperbole Obama soundly rejected September 9. But the administration bears responsibility for emphasizing the tie between end-of-life care and Medicare's rising costs. The end-of-life provisions in HR 3200 were not a hasty, eleventh-hour endeavor, but the product of a longstanding political preoccupation over the costs to Medicare of caring for patients with terminal illness. Fully 25 percent

of Medicare's budget is spent on beneficiaries during their last year of life, and 40 percent of that is spent in the last month of life.¹⁵ These are statistics that have found their way into countless commentaries on Medicare's high costs as well as statements made by health advisers close to the president.¹⁶

Obama has also talked about the economic impact of high-cost care at the end of life. He has referenced the hip replacement that his grandmother received while she was terminally ill with cancer as an example of spending near the end of life that may not be well directed or efficient. He has publicly wondered whether the country can afford those kinds of bills, even though he said he would have paid for his grandmother's hip replacement out of his own pocket.¹⁷ Moreover, the connection between cost control and the end-of-life provisions is fueled by the rhetoric of the architects of HR 3200 themselves and arguments that beneficiaries would opt to forgo expensive and sometimes extraordinary care if they had the opportunity to stipulate these things in advance of a serious illness.¹⁸ This may be so, although it is worth noting that studies cast doubt on whether wider adoption of advance directives would really produce any meaningful savings in the first place.¹⁹

In summary, the accusations that HR 3200 contains provisions to create money-saving death panels are factually incorrect and deliberately provocative. But the truth remains that the end-of-life provisions actually contained in HR 3200 are borne of a faulty economic premise that such measures can extract significant savings from end-of-life care. The critics of HR 3200 did not establish the link between the potential for cost savings and the end-of-life provisions in HR 3200; proponents of these provisions were the first to make that connection.

Does the Legislation Serve Its Purpose?

Even if wider adoption of advance directives would lead to significant savings—a debatable proposition—a fundamental question is whether provisions in HR 3200 would lead to wider adoption of end-of-life provisions. The balance of this essay will answer this question.

First, the actual text of HR 3200 is so prescriptive, and, at times, so out of sync with clinical routine, that it may actually discourage doctors and patients from considering the kinds of end-of-life services it seeks to promote. Second, the provisions ignore avenues currently available under Medicare to compensate doctors for end-of-life counseling. Moreover, there is nothing in the bill

to suggest doctors would be paid more for these services under HR 3200 than they are currently paid under the existing Medicare billing codes. Finally, the provisions in HR 3200 supersede state, local, and private efforts that already exist to encourage physicians to address end-of-life issues with patients.

The end-of-life provisions in HR 3200 are intended to give physicians a way to bill for providing patients with outpatient counseling on end-of-life planning. This includes things such as adoption of living wills and advance directives, in which patients stipulate the types of treatments they would like to have or forgo should they become critically ill and incapacitated.²⁰ By enabling doctors to bill Medicare for providing this counseling, one policy goal behind the provisions is to encourage more physicians to address these issues during office visits.

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On the surface, the advance-care planning provisions broadly mirror smoking-cessation provisions that the Bush administration implemented in March 2005 when Medicare Part B coverage was expanded to include smoking- and tobacco-cessation counseling.²¹ Both the end-of-life and smoking-cessation measures are aimed at providing physicians with a way to bill, and receive reimbursement, for providing prespecified counseling to patients. It is worth comparing the architecture of these two different measures.

The smoking-cessation provisions include requirements doctors must meet to qualify for reimbursement, but these conditions are far less prescriptive and intrusive than the constraints associated with the end-of-life provisions. For example, the smoking-cessation provisions specify the length of time that would have to be spent counseling patients in order for doctors to be able to bill under the new Medicare codes.²² The provisions also stipulate that doctors have to be qualified to provide the counseling, and patients have to have the cognitive capacity to receive the counseling.

The smoking-cessation decision, even at its most prescriptive point, merely states:

Medicare will cover 2 cessation attempts per year. Each attempt may include a maximum of 4 intermediate or intensive sessions, with the total annual benefit covering up to 8 sessions in a 12-month period. The practitioner and patient have flexibility to choose between intermediate or intensive cessation strategies for each attempt. . . . Intermediate and intensive smoking cessation counseling services will be covered for outpatient and hospitalized beneficiaries who are smokers and who qualify as above, as long as those services are furnished by qualified physicians and other Medicare-recognized practitioners.²³

The flexible nature of the smoking-cessation provisions stands in stark contrast to the prescriptive terms of the end-of-life provisions contained in HR 3200, even though both measures have the same general purpose: to pay doctors for patient counseling sessions. While the smoking-cessation provisions provide a general framework, the end-of-life provisions provide detailed specifications on when, where, and how the prescribed counseling should occur. Among other conditions, HR 3200 stipulates in Section 1233 that end-of-life counseling should include:

1. "An explanation by the practitioner" of the full range of end-of-life options, and specifically, "advance directives, including living wills and durable powers of attorney, and their uses."
2. Counseling to the patient on the "benefits" as well as "the role and responsibilities of a health care proxy."
3. The provision by the practitioner of a list of "national and state-specific resources to assist consumers and their families" with advance-care planning, including the "national toll-free hotline, the advance-care planning clearinghouses, and State legal service organizations."
4. "[A]n explanation . . . of the continuum of end-of-life services," a requirement for practitioners. This gauzy and broad statement, at a minimum, is meant to include "supports available" that comprise

“palliative care and hospice, and benefits for such services and supports that are available under this title” according to the bill’s text.

The legislation goes beyond merely mandating what specific information should be provided to patients. The statutory language actually requires, in one section, that physicians present certain of these options as being in the patient’s clear interest, stating that an “explanation of orders regarding life sustaining treatment or similar orders . . . shall include: the reasons why the development of such an order is *beneficial* to the individual and the individual’s family and the reasons why such an order should be updated periodically as the health of the individual changes.”²⁴

The legislation describes no fewer than four broad medical conditions that should serve as a trigger for end-of-life planning. To wit, the advance-care planning provision states that a consultation may be conducted more frequently than once every five years “if there is a significant change in the health condition of the individual, including diagnosis of a chronic, progressive, life-limiting disease, a life-threatening or terminal diagnosis or life-threatening injury, or upon admission to a skilled nursing facility, a long-term care facility (as defined by the Secretary), or a hospice program.”²⁵ It follows that the congressional drafters saw conditions such as diagnosis of a “chronic, progressive, life-limiting disease”—a definition so broad it could encompass almost any chronic illness—as heralding onset of the end of life and triggering the need for consideration of living wills and similar measures.

HR 3200 also sets forth the specific medical interventions that doctors should ask their patients to weigh when deciding what treatments they would want to demand or forgo in an advance directive or living will. Some of these treatments are the core components of end-of-life planning, such as whether patients would want intubation should they become critically ill, cardiopulmonary resuscitation, or prolonged artificial nutrition.

Other treatments doctors are asked to consider in the legislation seem oddly out of place.²⁶ For example, the “indicated levels of treatment” that the legislation says patients should address in their advance directives include some of the core components of care that are typically addressed in advance directives, such as “the intensity of medical intervention if the patient is pulseless, apneic, or has serious cardiac or pulmonary problems” and the “individual’s desire regarding transfer to a hospital or remaining at the current care setting.” But it

also directs physicians to discuss elements that are not typically considered the core components of basic advance directives, such as “the use of antibiotics.”²⁷ Inclusion of this level of detail reflects a view among some that antibiotics are overused during the terminal stages of illness.²⁸ But is that really a matter for Congress to legislate? If the conduct of end-of-life counseling required this level of awkward specificity and direction to doctors, one would think that the actual provisions would have been left to regulation and guidance from expert agencies rather than being spelled out by Congress in proposed legislation.

Setting aside the political backlash the provision invited, the inclusion of end-of-life measures represents a troubling intrusion into medical practice that is of a piece with current efforts for health reform.

Is the Legislation More Harm Than Help?

Beyond the politics of this issue, there are compelling practical and clinical reasons Congress erred in including the “Advance Care Planning Consultation” provision in HR 3200, especially in its current form. Setting aside the political backlash the provision invited, the inclusion of end-of-life measures represents a troubling intrusion into medical practice that is of a piece with current efforts for health reform. Moreover, the provisions are wholly unnecessary, supersede state and local efforts, and may actually obviate their intended purpose—discouraging rather than promoting discussion of end-of-life issues with patients during private medical encounters.

Doctors Can Receive Compensation for Counseling Now.

Doctors currently have vehicles for billing and being reimbursed for this kind of counseling. In the inpatient hospital setting, doctors can bill under a Medicare code for “extended face time” when they provide detailed end-of-life planning, including implementation of advance directives. On the outpatient side, physicians presently classify end-of-life planning discussions under a billing code covering counseling. In addition to this

consultation billing code, Medicare and other payers have a code for a family meeting to discuss goals of care.²⁹

While there is presently no payment associated with the family meeting code, Medicare could expand the range of services that fall under it and simply attach a payment to the code, precluding the need for the entire provision in HR 3200. Congress could have directed Medicare to begin paying for this code with a single line of legislative text. Another point worth noting: Medicare reimbursement rates are set according to formulas that take into account the intensity of a physician's work (Medicare typically pays \$92.33 for a forty-minute consultation). There is no reason to believe that, under the unique coding provision called for in HR 3200, Medicare would eventually value these kinds of consultations any differently, or that the reimbursement would be more generous than existing rates for similar services.

The Bill's Provisions Supersede State and Local Efforts. Even if the end-of-life provisions in HR 3200 are intended only to encourage implementation of advance directives, they supersede state and local efforts aimed at addressing these same issues. Regulation of the practice of medicine historically has been left to states and professional groups. In the context of end-of-life planning, the provisions in HR 3200 usurp from state and local efforts the authority to regulate aspects of medical practice.

Under the "Right to Know End of Life Options Act," California requires physicians and health care organizations to provide "comprehensive information and counseling" on end-of-life care options and their legal framework to terminally ill patients upon request.³⁰ The act states that "[e]very medical school in California is required to include end-of-life care issues in its curriculum" and that "every physician in California is required to complete continuing education courses in end-of-life care."³¹

Under New York law, among other end-of-life measures, "hospitals and nursing homes are required to inform patients before admission about advance directives."³² In Maryland, health care facilities are required to provide patients, on admission, information concerning the rights of the individual to make decisions concerning health care, "including the right to accept or refuse treatment and the right to make an advance directive, including a living will."³³ Most states also have measures that make it easier for patients to create advance directives and appoint health care proxies. Idaho, Maryland, Vermont, and Washington (to name just a few examples)

have created "advance directive registries" that "allow people to create and file legally binding advance directives free of charge."³⁴

Beyond the purview of state decrees, a countless number of alliances involving hospitals, hospices, nurse and physician groups, law firms, foundations, advocacy groups, and even clergy are also promoting advance-care planning through local efforts. The Robert Wood Johnson Foundation, for example, recently awarded \$11.25 million to twenty-one multidisciplinary coalitions that seek to improve end-of-life care through practical policies, guidelines, and regulations at the state level.³⁵ Many of these initiatives are already underway or completed and are credited with successfully encouraging wider awareness of end-of-life planning.³⁶ The Foundation for Healthy Communities has partnered with hospitals, physicians, and health plans in New Hampshire to help residents "plan for their health care, talk about their choices and have them respected." Their efforts have used survey research, medical chart reviews, statewide educational campaigns, and advance directive revisions to enhance the public's understanding of, and participation in, advance-care planning.

These measures have not escaped the attention of federal agencies. A Department of Health and Human Services report commissioned by Congress to look at ways to promote the adoption of advance directives found that "interventions that used multi-component, longitudinal approaches have tended to be more successful. More intensive and community wide-interventions [sic] that involve collaborative advance-care planning mechanisms have demonstrated more positive effects."³⁷ These findings appear at odds with the provisions actually included in HR 3200. Congress, it seems, did not follow its own report.

This all begs the following questions: with so many efforts underway in states, inside hospitals, and by the medical and legal profession itself to encourage adoption of advance directives, do Medicare and Congress really need to address this issue? If it is a matter for federal legislation, does Congress need to advance such narrow provisions given all the efforts already underway? Physicians, patients, and patients' families have become far more attuned to the benefits of addressing end-of-life issues and more comfortable addressing alternatives to intensive treatment at the final stages of death.³⁸ So many Medicare beneficiaries are taking advantage of hospice and home health services at the end of their lives, for example, that Medicare is contemplating a new

payment system to cut reimbursement for hospice and home health care providers in order to contain ballooning expenditures.³⁹

Narrow Provisions May Discourage Doctors from Providing Care. The provisions in HR 3200 are so detailed they might actually discourage doctors from billing under the resulting code. Simply put, doctors might be reluctant to provide end-of-life counseling under the language of the new law, fearing that their patients do not meet the detailed criteria Congress has prescribed in legislation. Ambiguity about the criteria established in the legislation for when end-of-life counseling should occur compounds this. It is not clear if these are requirements or merely suggestions. The resulting confusion could leave doctors worried about billing under the resulting codes out of concern that their patients would not meet all of the resulting regulatory criteria. Such fears are not without ample precedent. Earlier studies of end-of-life issues have reported that physicians have sometimes been encouraged not to refer certain patients to hospice care out of “fear that they will be charged with fraud if the referred patients do not die within six months.”⁴⁰

Can Congress Fix the End-of-Life Measures?

The legislation could have been written to create the same pathway for doctors to be reimbursed for offering counseling, without generating ambiguity about the prescribed counseling or creating new intrusions into private clinical matters. In the final analysis, however, for both political and practical reasons, the provisions should not have been included at all.

If these provisions do go forward, Congress should add legislative language stating that the counseling is entirely voluntary. Physicians should not be compelled to provide counseling, and patients should not have to stipulate whether they receive it. In that way, the corresponding regulations that will be developed by the Centers for Medicare and Medicaid Services will not be able to require counseling. Health care providers could never be pressured to discuss end-of-life planning for cost-reduction purposes that may conflict with their patients’ best interests or their own clinical considerations.

One has to assume congressional drafters who worked on the provision did not intend to require that end-of-life counseling take place or to coerce providers into cajoling their patients to adopt measures like living wills. Under this accommodating view, the current legislation,

with its ambiguous intentions, is merely a product of poor drafting. But the plain language of the proposed statute has opened congressional architects of the legislation up to appropriate criticism and doubts about their motives.

The legislation should also explicitly allow patients to refuse counseling and the implementation of an advance directive with no consequence to their coverage. Likewise, physicians should not be penalized if they decide not to offer counseling, if their patients do not accept counseling, or if their patients choose not to pursue advanced planning. Right now, the legislation seems to do the opposite, especially in its requirement that Medicare create quality measures to assess providers according to their implementation of advance directives.

Advance directives were developed to ensure patients’ autonomy and to provide high-quality care at the end of life; compassion and dignity—not economics—were justification for their initial use. The end-of-life provisions Congress is promoting are born of a more muddled purpose.

Language in HR 3200, for example, couples quality reporting measures to the end-of-life counseling provisions. It requires Medicare to collect “measures on end-of-life care and advance-care planning that have been adopted or endorsed by a consensus-based organization” for tracking the “quality” of care delivered by providers. “Such measures shall measure both the creation of and adherence to orders for life-sustaining treatment.” These measures create the possibility that—under a scheme in which physician pay is eventually tied to performance measures—providers could be penalized if, for example, they did not hit certain targets with respect to the number of patients they provided counseling to or if they had a large number of patients under their care opting to forgo advance directives.

Finally, congressional drafters could have modeled their provision after the smoking-cessation policy implemented by Medicare and simply directed the Medicare program to create a new billing code for end-of-life counseling. Alternatively, it would have been programmatically

easier, and even more obvious, simply to start paying for end-of-life counseling under an expansion of the existing Medicare code that already corresponds to this service.⁴¹

Advance directives were developed to ensure patients' autonomy and to provide high-quality care at the end of life; compassion and dignity—not economics—were justification for their initial use.⁴² The end-of-life provisions Congress is promoting are born of a more muddled purpose. As currently written, their aim is to generate wider adoption of advance directives rather than to ensure patient preferences are reflected at the end of life. Their motivation notwithstanding, the measures in HR 3200 remain needlessly prescriptive. They invite the federal government into private and complex health matters, needlessly co-opt matters of patient preference, and needlessly subordinate medical discretion to legislative meddling. They are a symptom of the flawed spirit of the entire House bill and are emblematic of what plagues the administration's approach to health reform.

Notes

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5. California bill AB2747 requires doctors to tell terminally ill patients about their end-of-life options. See Assembly Bill No. 2747: An Act to Add Part 1.8 (commencing with Section 442) to Division 1 of the Health and Safety Code, Relating to End-of-Life Care (September 30, 2008), *California Legislature—2007–2008 Regular Session*, available at www.assembly.ca.gov/acs/acsframeset2text.htm (accessed September 24, 2009).
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9. Jerome Groopman and Pamela Hartzband, "Sorting Fact from Fiction on Health Care," *Wall Street Journal*, August 30, 2009.
10. *Wall Street Journal*, "Obama's Health Cost Illusion," June 8, 2009.
11. According to the Congressional Budget Office (CBO), HR 3200 would add \$239 billion over ten years to the federal deficit. See Douglas W. Elmendorf to Rep. Charles B. Rangel, Washington, DC, July 17, 2009, available at <http://cbo.gov/ftpdocs/104xx/doc10464/hr3200.pdf> (accessed September 24, 2009). The Senate bill would add \$597 billion over ten years. See Douglas W. Elmendorf to Senator Edward Kennedy, Washington, DC, July 2, 2009, available at www.cbo.gov/ftpdocs/104xx/doc10431/07-02-HELPltr.pdf (accessed September 24, 2009); and Scott Gottlieb, M.D., "The Elmendorf in the Room," *Politico's The Arena*, July 18, 2009, available at www.aei.org/article/100784.
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Robert M. Wachter, M.D. (Washington, DC: Agency for Healthcare Research and Quality, July 2001), available at www.ahrq.gov/clinic/ptsafety/chap49.htm (accessed September 24, 2009).

20. According to Alan Meisel, a Hastings Center Fellow and director of the Center for Bioethics and Health Law at the University of Pittsburgh, "only about 15–20 percent of Americans have written advance directives such as living wills, and their usefulness has long been questioned by the physicians who must draw guidance from them. Advance directives tend to be either too general or too specific to shed light on the issue to be decided. For now, the best directives seem to be those that designate a health care proxy, but even their effectiveness is open to question. Studies show that close family members do not always have a good reading of what a patient really wants." See Alan Meisel, "End of Life Care," *The Hastings Center*, available at www.thehastingscenter.org/Publications/BriefingBook/Detail.aspx?id=2270 (accessed September 24, 2009). See also Angela Fagerlin and Carl E. Schneider, "Enough: The Failure of the Living Will," *Hastings Center Report* (March/April 2004), available at www.thehastingscenter.org/pdf/publications/hcr_mar_apr_2004_enough.pdf (accessed September 24, 2009).

21. Centers for Medicare and Medicaid Services (CMS), "Decision Memo for Smoking and Tobacco Use Cessation Counseling," March 22, 2005, available at www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=130 (accessed September 24, 2009); and RAND Corporation, *Evidence Report and Evidence-Based Recommendations: Interventions to Promote Smoking Cessation in the Medicare Population* (Santa Monica, CA: RAND, September 2003), available at www.rand.org/pubs/reprints/2007/RAND_RP1224.pdf (accessed September 25, 2009).

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25. *Ibid.*, § 1233, (3)(B).

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(Washington, DC, 2007), available at www.gao.gov/new.items/d0866.pdf (accessed September 24, 2009).

27. *America's Affordable Health Choices Act of 2009*, § 1233, (5) (B) (iii).

28. Nicholas Bakalar, "Antibiotics Questioned in Care at Life's End," *New York Times*, March 4, 2008.

29. The specific codes for this are 99367–99368; these codes correlate to "team conference, no direct patient and/or family contact."

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31. James O'Brien, "About the Right to Know End-of-Life Options Act," EHow.com, available at www.ehow.com/about_5148668_right-endoflife-options-act.html (accessed September 25, 2009).

32. Barbara Bell, "New York State's End-of-Life Laws: Empire State Follows Its Own Path on Patients' Right to Die," Suite101.com, October 15, 2008, available at http://seniors-health-medicare.suite101.com/article.cfm/new_york_states_endoflife_laws (accessed September 25, 2009).

33. Health Care Decisions Act, *The Annotated Code of the Public General Laws of Maryland*, available at www.marylandadvancedirectives.com/pdf/HCDAtext.pdf (accessed September 25, 2009).

34. Maggie Datiles, "The Rising Role of Advance Directives in Protecting the Sanctity of Human Life," Americans United for Life, available at www.aul.org/Advance_Directives (accessed September 25, 2009).

35. Center for Practical Bioethics, "Community-State Partnerships to Improve End-of-Life Care," available at www.practicalbioethics.org/cpb.aspx?pgID=932 (accessed September 25, 2009).

36. Robert Wood Johnson Foundation, "Community-State Partnerships to Improve End-of-Life Care" (October 2004), available at www.rwjf.org/reports/npreports/csp.htm (accessed September 25, 2009).

37. U.S. Department of Health and Human Services, "Advance Directives and Advance Care Planning," *Report to Congress, Office of the Assistant Secretary for Planning and Evaluation*,

110th Cong., 2nd sess. (Washington, DC, August 2008), available at <http://aspe.hhs.gov/daltcp/reports/2008/ADCongRpt.htm> (accessed September 25, 2009).

38. Jody M. Jackson, Sharon J. Rolnick, Stephen E. Asche, Richard L. Heinrich, "Knowledge, Attitudes, and Preferences Regarding Advance Directives among Patients of a Managed Care Organization," *American Journal of Managed Care* 15, no. 3 (March 2009): 177–86, abstract available at www.ncbi.nlm.nih.gov/pubmed/19298099 (accessed September 25, 2009).

39. Patients using hospice care save Medicare close to \$2,400 per beneficiary, researchers from Duke University concluded in a 2007 study. See Donald H. Taylor Jr., Jan Ostermann, Courtney H. Van Houtven, James A. Tulsky, and Karen Steinhauer, "What Length of Hospice Use Maximizes Reduction in Medical Expenditures Near Death in the U.S. Medicare Program?" *Social Science and Medicine* 65 (October 2007): 1466–78. Meanwhile, research has found that hospice patients lived an average of twenty-nine days longer than similar patients who did not enroll in hospice. See Stephen R. Connor, Bruce Pyenson, Kathryn Fitch, Carol Spence, and Kosuke Iwasaki, "Comparing Hospice and Nonhospice Patient Survival among Patients Who Die within a Three-Year Window," *Journal of Pain and Symptom Management* 33, no. 3 (March 2007). See also Newt Gingrich and Nancy Desmond, "Home Care Patients Could See Aid Cut," *Sun-Sentinel*, August 29, 2009, available at www.aei.org/article/100964.

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41. It is worth noting that the end-of-life counseling provisions in HR 3200 seem to reflect inappropriately the same spirit of the smoking-cessation counseling provisions. The goal behind the latter provisions is to help patients make the decision to stop smoking and then encourage them to follow through with it. The intent of end-of-life related counseling should be to ensure the resulting decisions reflect patient preferences, not to achieve a specific outcome.

42. Ezekiel J. Emanuel, M.D., and Linda L. Emanuel, "The Economics of Dying—The Illusion of Cost Savings at the End of Life."