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 Legislative analysis for citizens and media

## End-of-Life Consultations: Coercive Self-Rationing?

**8.28.2009.** Our nation is engaged in an important and vigorous debate on the common ground goal of reaching healthcare reform that increases accessibility and affordability.

This bill analysis is an educational resource that enables you to **read for yourself** the end-of-life language in [HR 3200](#) (“the bill”) so that you can articulate fully informed concerns, if any.

While this analysis addresses the language of the House healthcare bill (HR 3200), citizens are encouraged to be attentive about similar language making its way into other House or Senate bills, and most importantly into the final conference report.



### Advance Care Planning Consultations under HR 3200 Encouraging Medicare Patients to Decline Future Care?

- Section 1233 of HR 3200 would authorize Medicare to expand reimbursement for a benefit called an “**advance care planning consultation.**” (p. 424, lines 6-20).

This analysis seeks to bring clarity to the debate that has been overshadowed by “death panels” characterizations, or conversely as denying that the bill contains any end of life language. Our conclusion is that that HR 3200, if passed as currently worded, will foster a professional mentality favoring the rationing of care for Medicare patients. It will accomplish this by influencing seniors to:

- (1) sign advance directives; and/or
- (2) be subject to actionable medical orders

that decline future life-sustaining treatment years before that patient’s condition can be reasonably assessed.

This bill analysis aims to address 3 questions:



**1. How would “advance care planning consultations” result in an “actionable medical order” for future life-sustaining treatment?**



**2. Would the consultations be mandatory and/or incentivized?**



**3. Could the consultations coerce “self-rationing”?**

# Who Decides?

**An initial note:** The heart of the confusion and difficulty in getting solid answers about HR 3200 is very simple:

The bill gives the Secretary of Health and Human Services and other appointed Secretaries broad authority to promulgate rules which, under the guise of “implementing” the statute, could go far beyond it in creating requirements not set forth in the bill.

- A .pdf search of the term “by the Secretary” occurs **179** times in HR 3200 in language such as “deemed appropriate by the Secretary,” “developed by the Secretary,” “established by,” “prescribed by,” “defined by,” “required by,” etc.

## 1. How would “advance care planning consultations” result in an “actionable medical order” for future life-sustaining treatment?

- The definition of “**advance care planning consultation**” spans over three pages of HR 3200 (pp. 424-426). The term includes certain required information (“**shall include,**” p. 425, line 2) to be given during “a consultation between an individual and a **practitioner.** . . . regarding advance care planning if. . . the individual involved has not had such a consultation within the last 5 years.” (p. 424, line 21 to p. 425, line 1).



- The consultation “may be conducted more frequently” if there is a “significant change in the health condition of the individual.” That change is not limited to a terminal diagnosis. Rather, it also includes conditions such as a “diagnosis of a chronic, progressive, life-limiting disease” (**diabetes?**) or even a “life threatening injury” (**car accident?**). (p. 428, lines 19-25)

- The consultation “may include the formulation of an **order regarding life-sustaining treatment.**” (p. 429, lines 1-3) The **order** may indicate treatment ranging from “full treatment to an indication **to limit some or all** or specified interventions” including “**transfer to a hospital,**” “**the use of antibiotics**” and “**the use of artificially administered nutrition and hydration.**” (p. 430, lines 4-17).

- “Order regarding life-sustaining treatment” is defined as an “**actionable medical order**” that “is in a form that stays with the individual and [is] followed by health care professionals and providers across the continuum of care.” (p. 429, line 4-16).



### QUESTION:

*If I am temporarily unconscious, could antibiotics or nutrition/hydration be withheld based on a check-mark that I made on a document five years earlier?*

## 2. Would the consultations be mandatory and/or incentivized?

### A. HR 3200 creates incentives for Government regulated end-of-life consultations

- Section 1233 of HR 3200 would authorize Medicare to reimburse “**advance care planning consultations**” for all Medicare recipients. (p. 424, lines 6-20)
- At a minimum, this **creates incentives** with our tax dollars for providers to promote “advanced care planning consultations” to Medicare patients by making these sessions reimbursable under Medicare.



**While it is wise to discuss your wishes with your family and your providers, here is the DANGER of Government-regulated and incentivized consultations:**

- Once a Medicare recipient participates in these consultations by providers who would then profit from them, the **bill requires certain mandatory explanations**, (p. 425) including “the reasons why the development of such an order [regarding life-sustaining treatment] is **beneficial** to the individual and the individual’s family.” (p. 426, lines 4-8)
- The bill provides that the consultation “may include the **formulation of an order regarding life-sustaining treatment** or a similar order,” defining that term as “**an actionable medical order** relating to the treatment of that individual.” (p. 429, lines 1-7)
- The **order** may indicate treatment ranging from “full treatment to an indication to **limit some or all** or specified interventions” including “**the use of antibiotics**” and “**the use of artificially administered nutrition and hydration**.” (p. 430, lines 4-17)

Many “Living Will” forms contain default positions that decline future life-sustaining care. A “living will” (used to create “orders for life-sustaining treatment”) shifts control from its signer and gives decision-making authority to a physician. **It also gives a physician immunity from civil or criminal liability for his or her action or inactions.**

“Living Wills” are unnecessary under present law because there is nothing to prevent doctors from withholding or withdrawing life-sustaining medical treatment when all reasonable hope for recovery is gone. Patients already have the right to give their doctors and family instructions on how they want to be treated in the event of a terminal illness or grave injury. **Bioethics Defense Fund recommends that patients decline to sign advance directives, and that they instead sign a Healthcare Power of Attorney that assigns someone who understands you and your values to make decisions if you are unable to do so.**



#### **QUESTION:**

***Given that end-of-life decisions are highly dependent on each unique medical situation as it unfolds, is it wise to allow Government any role in the content and “quality” of such highly personal decisions?***

## B. Consultations are likely mandatory for Providers to participate in Medicare

**While Medicare coverage would unquestionably create incentives for government regulated advance care consultations, there has been much contention over whether the consultations would be mandatory:**

### ▪ **As to the PATIENT:**

While the consultations currently seem to be optional for the patient, there is no language in HR 3200 to prevent the Secretary of Health and Human Services from implementing a regulation providing that the consultations **shall be mandatory as a coverage condition for Medicare patients.**

### ▪ **As to the PROVIDER:**

Certain language in the bill supports the discretion of the Secretary to mandate advance care consultations as **a condition for providers to participate in Medicare.**

The most telling evidence in HR 3200 is the “**Expansion of Physician Quality Reporting Initiative for End of Life Care**” provisions (p.431, line 16 et seq.) that seem to make advance care planning a reportable pay for performance measure for every professional providing services to Medicare patients:

- “The Secretary shall include quality measures on end of life care and advance care planning that have been adopted or endorsed by a consensus-based organization, if appropriate.” (p. 432, lines 3-7)
- “Such measures shall measure both the creation of and adherence to orders for life-sustaining treatment.” (p. 432, lines 7-9)

What will these “quality measures” require? Again that is left to the discretion of the Secretary. However, in an August 2008 [DHH Report to Congress](#) entitled “**Advance Directives and Advance Care Planning: Report to Congress**,” there is support for the idea that the consultations will likely be mandated as a condition for participating as a Medicare provider: In Appendix H, Section 2.c, the report states:

- “One mechanism would be to **require** use of such protocols [such as Physicians Orders for Life-Sustaining Treatment] by providers accepting Medicare/Medicaid funds.”
- Other recommendations included: “**Link funding to facilitation of advance care planning and outcomes;**” and “**Recognize poor advance care planning as a medical errors that require remedy.**”



### **QUESTION:**

***What will happen to me or my doctor if either of us decline to participate in government regulated advance care planning consultations?***

### 3. Could the consultations coerce “self-rationing”?

- As discussed above, the end of life consultations may result in Medicare recipients signing **advance directives that decline certain treatment years before they know the nature of future illnesses.**
- The consultation may even result in the formulation of an **actionable medical order that declines life-sustaining treatment** – such as “transfer to a hospital,” the “use of antibiotics,” and “the use of artificially administered nutrition and hydration.” (p. 430, lines 9-17).
- As explained by end-of-life legal expert Wesley Smith on his [First Things blog](#):



The Medicare “mandatory counseling” controversy in the Obamacare debate laid bare a realistic fear that **compensated counseling under Medicare could easily become subtle (or not so subtle) persuasion to refuse treatment**—particularly since the primary point of the clause is to cut costs.

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In the wrong hands, end of life counseling could easily be subtly or overtly outcome directed, as studies have shown often happens with genetic counseling of pregnant women testing positive for a Down fetus. Thus, there is much about which to be concerned when Medicare pays practitioners to engage in counseling about end of life, and

indeed, **authorizes part of the counseling to consist of referrals to outside organizations** that might have ideological agendas (such as Compassion and Choices)[formerly known as the Hemlock Society].



#### QUESTION:

***Given the goal to reduce Medicare spending and costs, why would HR 3200’s provisions INCREASE spending on end of life consultations?***

***Isn’t it reasonable to conclude that such consultations will subtly encourage Medicare recipients to decline life-sustaining treatments for future illnesses – resulting in subtle self-rationing?***

**See the Appendix 1 to read the end-of-life provisions of HR 3200 in their entirety.**

- **To read about current dangers of end-of-life counseling provided by the Obama Veterans Administration, see the August 18, 2009 [Wall Street Journal](#) piece by Jim Towey.**

This educational resource was produced by the Bioethics Defense Fund, a public interest law firm that advocates against the human rights violations of abortion, human cloning/destructive human embryo experiments, and euthanasia through litigation, legislation and education.

For More Information contact:

**Dorinda C. Bordlee**  
**Vice President, Senior Counsel**  
**Bioethics Defense Fund**  
[www.BDFund.org](http://www.BDFund.org)

[dbordlee@bdfund.org](mailto:dbordlee@bdfund.org)  
(504) 231-7234



# Appendix 1: The text of pages 424-434 of [H.R. 3200](#)

## SEC. 1233. ADVANCE CARE PLANNING CONSULTATION.

(a) Medicare-

(1) IN GENERAL- Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended

(A) in subsection (s)(2)—

(i) by striking `and' at the end of subparagraph (DD);

(ii) by adding `and' at the end of subparagraph (EE); and

(iii) by adding at the end the following new subparagraph: `(FF) advance care planning consultation (as defined in subsection (hhh)(1));'; and (B) by adding at the end the following new subsection:

`Advance Care Planning Consultation

(hhh)(1) Subject to paragraphs (3) and (4), the term **`advance care planning consultation' means a consultation between the individual and a practitioner described in paragraph (2)** regarding advance care planning, if, subject to paragraph (3), the individual involved has not had such a consultation within the last 5 years. Such consultation **shall** include the following:

`(A) An explanation by the practitioner of advance care planning, including key questions and considerations, important steps, and suggested people to talk to./p>

`(B) An explanation by the practitioner of advance directives, including living wills and durable powers of attorney, and their uses./p>

`(C) An explanation by the practitioner of the role and responsibilities of a health care proxy./p>

`(D) **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 (including those funded through the Older Americans Act of 1965)./p>

`(E) An explanation by the practitioner of the continuum of end-of-life services and supports available, including palliative care and hospice, and **benefits for such services and supports that are available under this title.**

`(F)(i) Subject to clause (ii), an explanation of orders regarding life-sustaining treatment or similar orders, which shall include—

**(I) 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;

(II) the information needed for an individual or legal surrogate to make informed decisions regarding the completion of such an order; and

(III) the identification of resources that an individual may use to determine the requirements of the State in which such individual resides so that the treatment wishes of that individual will be

carried out if the individual is unable to communicate those wishes, including requirements regarding the designation of a surrogate decision maker (also known as a health care proxy).

(ii) The Secretary shall limit the requirement for explanations under clause (i) to consultations furnished in a State—

(I) in which all legal barriers have been addressed for enabling orders for life-sustaining treatment to constitute a set of medical orders respected across all care settings; and

(II) that has in effect a program for orders for life-sustaining treatment described in clause (iii).

(iii) A program for orders for life-sustaining treatment for a States described in this clause is a program that—

(I) ensures such orders are standardized and uniquely identifiable throughout the State;

(II) distributes or makes accessible such orders to physicians and other health professionals that (acting within the scope of the professional's authority under State law) may sign orders for life-sustaining treatment;

(III) provides training for health care professionals across the continuum of care about the goals and use of orders for life-sustaining treatment; and

(IV) is guided by a coalition of stakeholders includes representatives from emergency medical services, emergency department physicians or nurses, state long-term care association, state medical association, state surveyors, agency responsible for senior services, state department of health, state hospital association, home health association, state bar association, and state hospice association.

(2) A practitioner described in this paragraph is--(A) a physician (as defined in subsection (r)(1)); and (B) a nurse practitioner or physician's assistant who has the authority under State law to sign orders for life-sustaining treatments.

(3)(A) An initial preventive physical examination under subsection (WW), including any related discussion during such examination, shall not be considered an advance care planning consultation for purposes of applying the 5-year limitation under paragraph (1). (B) An advance care planning consultation with respect to an individual may be conducted more frequently than provided under paragraph (1) 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.

(4) A consultation under this subsection may include the formulation of an order regarding life-sustaining treatment or a similar order.

(5)(A) For purposes of this section, the term **'order regarding life-sustaining treatment' means, with respect to an individual, an actionable medical order relating to the treatment of that individual that—**

(i) is signed and dated by a physician (as defined in subsection (r)(1)) or another health care professional (as specified by the Secretary and who is acting within the scope of the professional's authority under State law in signing such an order, including a nurse practitioner or physician assistant) and is in a form that permits it to stay with the individual and be followed by health care professionals and providers across the continuum of care;

(ii) effectively communicates the individual's preferences regarding life-sustaining treatment, including an indication of the treatment and care desired by the individual;

`(iii) is uniquely identifiable and standardized within a given locality, region, or State (as identified by the Secretary); and

`(iv) may incorporate any advance directive (as defined in section 1866(f)(3)) if executed by the individual.

`(B) The level of treatment indicated under subparagraph (A)(ii) may range from an indication for full treatment to an indication to limit some or all or specified interventions. Such indicated levels of treatment may include indications respecting, among other items—

`(i) the intensity of medical intervention if the patient is pulse less, apneic, or has serious cardiac or pulmonary problems;

`(ii) the individual's desire regarding transfer to a hospital or remaining at the current care setting;

`(iii) the use of antibiotics; and

`(iv) the use of artificially administered nutrition and hydration.'

(2) PAYMENT- Section 1848(j)(3) of such Act (42 U.S.C. 1395w-4(j)(3)) is amended by inserting `(2)(FF),' after `(2)(EE),'

(3) FREQUENCY LIMITATION- Section 1862(a) of such Act (42 U.S.C. 1395y(a)) is amended—(A) in paragraph (1)—

(i) in subparagraph (N), by striking `and' at the end;

(ii) in subparagraph (O) by striking the semicolon at the end and inserting `, and'; and (iii) by adding at the end the following new subparagraph:

`(P) in the case of advance care planning consultations (as defined in section 1861(hhh)(1)), which are performed more frequently than is covered under such section;'; and (B) in paragraph (7), by striking `or (K)' and inserting `(K), or (P)'.

(4) EFFECTIVE DATE- The amendments made by this subsection shall apply to consultations furnished on or after January 1, 2011.

**(b) Expansion of Physician Quality Reporting Initiative for End of Life Care-**

(1) Physician's QUALITY REPORTING INITIATIVE- Section 1848(k)(2) of the Social Security Act (42 U.S.C. 1395w-4(k)(2)) is amended by adding at the end the following new paragraphs:

`(3) Physician's QUALITY REPORTING INITIATIVE-

`(A) IN GENERAL- For purposes of reporting data on quality measures for covered professional services furnished during 2011 and any subsequent year, to the extent that measures are available, the Secretary shall include quality measures on end of life care and advanced care planning that have been adopted or endorsed by a consensus-based organization, if appropriate. Such measures shall measure both the creation of and adherence to orders for life-sustaining treatment.

`(B) PROPOSED SET OF MEASURES- **The Secretary shall publish in the Federal Register proposed quality measures on end of life care and advanced care planning that the Secretary determines are described in subparagraph (A) and would be appropriate for eligible professionals to use to submit data to the Secretary.** The Secretary shall provide for a period of public comment on such set of measures before finalizing such proposed measures.'

(c) Inclusion of Information in Medicare & You Handbook-

(1) MEDICARE & YOU HANDBOOK-

(A) IN GENERAL- Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall update the online version of the Medicare & You Handbook to include the following:

(i) An explanation of advance care planning and advance directives, including—

(I) living wills;

(II) durable power of attorney;

(III) orders of life-sustaining treatment; and

(IV) health care proxies.

(ii) A description of Federal and State resources available to assist individuals and their families with advance care planning and advance directives, including—

(I) available State legal service organizations to assist individuals with advance care planning, including those organizations that receive funding pursuant to the Older Americans Act of 1965 (42 U.S.C. 93001 et seq.);

(II) website links or addresses for State-specific advance directive forms; and

(III) any additional information, as determined by the Secretary.

(B) UPDATE OF PAPER AND SUBSEQUENT VERSIONS- The Secretary shall include the information described in subparagraph (A) in all paper and electronic versions of the Medicare & You Handbook that are published on or after the date that is 1 year after the date of the enactment of this Act.