REPORT OF THE
SPECIAL ADVISORY COMMISSION ON
MANDATED HEALTH INSURANCE BENEFITS

MANDATED COVERAGE FOR HOSPITAL STAY FOR HYSTERECTOMY

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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COMMONWEALTH OF VIRGINIA

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December 28, 1999

To: The Honorable James S. Gilmore, III
Governor of Virginia
and
The General Assembly of Virginia

The report contained herein has been prepared pursuant to §§ 9-298 and 9-299 of the Code of Virginia.

This report documents a study conducted by the Special Advisory Commission on Mandated Health Insurance Benefits to assess the social and financial impact and the medical efficacy of a provision incorporated in House Bill 871, regarding a proposed mandate of coverage of minimum stay for hysterectomy.

Respectfully submitted,

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INTRODUCTION

During the 1999 Session of the General Assembly, House Bill 871 was passed by the House and the Senate and was signed by the Governor. The Chairman of the Senate Committee on Commerce and Labor requested a review of the provision requiring a minimal hospital stay after a hysterectomy by the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission). House Bill 871 was patroned by Delegate H. Morgan Griffith. The provision on minimum stay was patroned by Senator Jane Woods.

The Advisory Commission held a hearing on August 24, 1999, in Richmond to receive public comments on Senate Bill 871. Kathy Wright, representing the American Cancer Society (ACS), addressed the proposal in the absence of the patron.

The Advisory Commission concluded its review of House Bill 871 on September 21, 1999.

SUMMARY OF THE PROPOSED LEGISLATION

The bill requires an accident and sickness insurance policy or subscription contract or health care plan to provide coverage for a minimum stay in the hospital of not less than twenty-three (23) hours for a laparoscopy-assisted vaginal hysterectomy and forty-eight (48) hours for a vaginal hysterectomy as outlined in Milliman and Robertson's guidelines. The bill includes language stating that nothing in this section shall be construed as requiring a 23 or 48 hour stay, if the attending physician and patient determine that a shorter stay is appropriate. The bill applies to individual or group policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, and subscription contracts and health care plans provided by health maintenance organizations. The bill does not apply to short-term travel, accident only, limited or specified disease policies, or to short-term nonrenewable policies of less than six months' duration.

MILLIMAN AND ROBERTSON'S GUIDELINES

The Milliman and Robertson's Length of Stay Efficiency Index (Index) defines a quantitative measure of best practice care for a substantial portion of hospital days. It bridges the gap between optimal practice, which is recognized as a goal that may not be achieved 100% of the time, and best practice, which is actually being achieved. The Index provides a statistical confidence range within which the level of efficiency can be expected to fall. The ability to define this range can assist providers and insurers in determining which specific diagnoses or procedures can be targeted to provide them with maximum savings.

HYSTERECTOMY

Hysterectomy is the surgical removal of the uterus or womb, where a fetus is nourished from conception to birth. It has become the second most common gynecological operation in the United States. It takes place while the patient is under general anesthesia. There are three basic types of hysterectomies. A total hysterectomy is the removal of the uterus and the cervix, which is the lower part of the uterus. The cervix is usually removed to prevent subsequent cervical cancer. A subtotal hysterectomy is the removal of the upper part of the uterus. The cervix is not removed. In most cases, the fallopian tubes and ovaries are preserved, but, depending on the medical condition, they may or may not be removed. A radical hysterectomy is a procedure that is performed when cancerous conditions prevail. It could involve removal of the uterus, ovaries, fallopian tubes, the upper portion of the vagina, and the pelvic lymph nodes, as cancer can be unpredictable.

The Journal of the American Medical Association (JAMA) printed the results of a 14-year surveillance focusing on hysterectomy, pregnancy, and abortion from 1980-1993. The sponsors of the report were the Centers for Disease Control and The American College of Obstetricians and Gynecologists. The original study appeared in the Centers for Disease Control and Prevention's magazine, Morbidity and Mortality Weekly Report, August 8, 1997, Vol.46, No. SS-4.

Estimated numbers and rates of hysterectomies by year in the United States, 1980-1993

Year	Number of hysterectomies	Rate	Standard Error
1980	647,004	7.1	0.50
1981	668,922	7.2	0.44
1982	644,850	6.9	0.49
1983	667,302	7.0	0.38
1984	657,144	6.9	0.39
1985	665,463	6.9	0.44
1986	638,556	6.5	0.41
1987	648,013	6.6	0.45
1988	571,204	5.7	0.36
1989	533,620	5.3	0.30
1990	585,605	5.8	0.26
1991	539,906	5.3	.022
1992	573,943	5.6	0.21
1993	546,683	5.3	0.26
TOTAL	8,588,215		

*Per 1000 female, civilian residents aged >15 years

†Break in lines (after 1987) reflects change in rates resulting from redesign of the National Hospital Discharge Survey; the changes in sampling design precluded comparison of the two time periods (1980-1987 and 1988-1993).

The 14-year surveillance revealed a slight downward trend in the rate of procedures performed during the first half of the fourteen-year surveillance period and a leveling off during the second half.

Factors affecting lower hysterectomy rates are practices related to health-care reform, such as quality assurance, peer review, and second opinion. Alternatives to hysterectomy have become increasingly available, and, more women in the U.S. have been opting to delay childbearing. Even though hysterectomy rates are declining, the estimated overall annual cost of this procedure in the United States is greater than $5 billion.

According to The Institute of Minimally Invasive Surgery, in a review of a brief entitled "Laparoscopically Assisted Vaginal Hysterectomy: Outcomes, Patient Satisfaction, Costs," compiled in 1995 and updated in January 1998, hysterectomies can be performed open, vaginally, or vaginally with laparoscopic assist. It is currently estimated that about 70% to 80% of the approximately 500,000 to 600,000 hysterectomies performed annually in the United States are done by the historic open approach. The open approach (which uses both a vaginal and abdominal incision) usually means a longer hospital stay, longer recuperation, higher level of post-operative pain, poorer cosmetic results, and higher cost. A four to six-inch abdominal incision allows surgeons to use larger instruments and his/her hands in the abdomen. This procedure typically results in a three to six-day hospital stay and a four to eight week recovery time. In the remaining cases, the uterus was removed vaginally.

In most cases (except with some types of cancer), hysterectomies can safely be performed vaginally (with or without assistance of laparoscopy). Vaginal hysterectomy results in a shorter hospital stay, faster recovery, and no or minimal abdominal scarring. It can be done as a same-day surgery and is less expensive. Vaginal hysterectomy may not be possible or maybe limited in some cases, such as for the removal of fibroid tumors, when the patient has had previous pelvic surgeries, or when the surgeon is treating related disorders near the uterus. Generally, the medical condition, patient preferences, and professional guidance by the physician will dictate the surgical approach to removing the uterus.

LAPAROSCOPICALLY ASSISTED VAGINAL HYSTERECTOMY (LAVH)

The 14-year surveillance reports that laparoscopically-assisted vaginal hysterectomy (LAVH) became a viable alternative to abdominal hysterectomy in the late 1980s and its use increased significantly in the early 1990s. Laparoscopy is a surgical technique involving small incisions (1/4 to 1/2 inch) in the abdomen through which major surgical procedures can be performed. Its potential to convert an abdominal hysterectomy into a vaginal hysterectomy is considered its greatest benefit.

LAVH takes place while the patient is under general anesthesia. A description of laparoscopy as detailed by the Women's Surgery Group's on-line web-site explains that

one incision is made in the umbilicus ("belly button"). A laparoscope (a tiny telescope) attached to a thin, fiber-optic camera is placed through this incision allowing the surgeon to continuously view a magnified (up to six times) image of the patient's internal organs on a video monitor in the operating room. An additional two or three incisions (1/4-1/2 inch) are made in the lower abdomen. The laparoscopy is performed when cutting the ligaments, which releases the uterus from the abdomen. Mini-surgical electrodes, lasers, instruments, and sutures are passed through these incisions to complete the operation through an incision made in the vagina (much like a traditional vaginal hysterectomy).

The combination of small instruments and magnification enable surgical precision and quicker recovery due to gentler handling of the tissue in the pelvis. The precision becomes extremely important in the treatment of the condition and allows for a more rapid, less painful recovery. Also, there are significant cost savings with this technique that include discharging the patient from the hospital within forty-eight (48) hours of their surgery and some as early as eighteen hours, instead of four days. Many women return to normal activities within two to three weeks, instead of six to eight weeks. LAVH has become increasingly popular around the country.

Increasingly, LAVH has become the adopted procedure as an alternative to abdominal hysterectomy in selected cases. The use of LAVH raises practical issues pertaining to hysterectomy surveillance. First, its use may increase, if this method of hysterectomy achieves wider acceptance and application. As surgeons become more skilled in LAVH and as demands to contain health costs grow, the procedure might be performed more frequently in the ambulatory surgical setting.

A study reported in the Medical Journal of Australia, 1997; 166:205, states that new gynecological laparoscopic surgical procedures have virtually exploded in recent years. It further states that there has also been a rapid change in attitude toward hospital budgets and the way funds are allocated. One of the statements in the conclusion reads, "...It is important that surgeons develop an interest in operative cost and cost analysis so that health care resources can be used optimally." The report concluded that audits like this study are important in patient management and in guiding hospitals in funding and bed allocation.

AVERAGE LENGTH OF STAY (ALOS) FOR HYSTERECTOMY

The Virginia Health Information (VHI) produces reports derived from the Patient Level Database including data from all hospitals in each health planning region, each county and city in Virginia. The pertinent data is based on hysterectomy as the primary or principal diagnosis. The available data, as reported, revealed a downward trend in length of hospital stay (LOS) for calendar years 1996 -1998. In 1996, the average length of stay (ALOS) for hysterectomy was 3.05 days (13,246 procedures performed); in 1997, the ALOS was 2.99 days (13,589 procedures performed); in 1998, the ALOS was 2.44 days (13,446 procedures performed). Primary or principal diagnosis is

defined as the medical condition that is ultimately determined to have caused a patient's admission to the hospital. The principal diagnosis is used to assign every patient a diagnosis-related group. This diagnosis may differ from the admitting diagnosis.

The second section of the report contains Virginia data when hysterectomy is diagnosed as secondary. Secondary diagnosis is defined as a medical condition derived from, or consequent to, a primary event or condition. Even when hysterectomy is the secondary diagnosis, the numbers are higher, but the downward trend remains.

In some instances, it is difficult to predetermine the length of hospital stay following any type of surgery. Several factors such as medical complications or patient's individual healing process could impact the length of hospital stay.

Obstet Gynecol 1997 Feb;89 (2): 304-11 reports the results of a complete systematic review of literature comparing complications, postoperative recovery time, and costs following laparoscopy-assisted vaginal hysterectomy (LAVH), total abdominal hysterectomy (TAH) and vaginal hysterectomy.

The review identified 3,112 LAVH cases, 1,618 TAH, and 690 vaginal hysterectomies. LAVH compared with TAH cases demonstrated significantly greater incidence of bladder injury, significantly longer operating room time, and significantly shorter hospitalization. Use of analgesia was less for LAVH, and return to full activity was sooner when compared to TAH. The cost for LAVH was higher in seven out of eleven studies, but when disposable instruments and hospital length of stay are considered, the remaining four studies reported a lower cost for LAVH.

The review concluded that although LAVH involves a shorter hospital stay, speedier postoperative recovery, and less analgesia use, there is also a high rate of bladder injury and lengthier surgery. These outcomes must be weighed when choosing intervention.

The Manitoba (Canada) Center for Health Policy and Evaluation studied patients discharged from all Winnipeg hospitals over a four-year period (1989/90 to 1992/93) and concluded that hospitals that had the longest patient stays for hysterectomy also had the highest re-admission rate (5%). The hospital where the stay for hysterectomy was the shortest had no hysterectomy re-admissions. While some hospitals kept their patients longer than other hospitals, at times twice as long, there is nothing to suggest that these patients received more effective care.

This particular study concluded that hospital stays are getting shorter in Manitoba, just as they are in other centers across North America. For the diagnostic categories of prostatectomy, hysterectomy, heart attack and bronchitis or asthma, the length of stay fell by 22% over the four-year period of study.

At the same time, there have been no indications that the quality of health has declined. Fears that re-admission rates, an established indicator of quality of care, would jump, as a result of earlier discharge, appear to have been unfounded.

MEDICAL EFFICACY

Neither insurers nor other opponents challenged the medical efficacy of requiring a minimum stay for hysterectomy. The practice of medicine, drugs, and surgical procedures are improving, such that most in-hospital treatments are shorter, safer, more economical, and more effective. However, there are other medical concerns. According to the 14-year surveillance, the marked increase in concurrent oophorectomy (surgical removal of one or both ovaries) with vaginal hysterectomy may be a consequence of the improved access to the ovaries afforded by the laparoscopy. During 1991-1993, 47% of vaginal hysterectomies associated with laparoscopy were accompanied by bilateral oophorectomy, whereas only 22% of vaginal hysterectomies performed without laparoscopy were accompanied by bilateral oophorectomy.

A statement prepared for the U.S. House of Representatives Committee on Commerce, Subcommittee on Health and Environment by Linda Peeno, M.D. on October 28, 1997, presents a case maintaining that, managed care, in order to work, must alter the decision-making of physicians by interjecting complex management methods into the doctor-patient protection. The physician has less ability to make independent decisions about treatment. This is particularly true when the data provide statistical quantification, such as length-of-stay, admissions-per-thousand, referral rates, etc. Such data is often used to change physician behavior toward a norm determined by the managed care plan or the industry as a whole. With report cards that quantify length of stay or admissions or referral rates, physicians may strive to meet goals established by the plan or a financial arrangement or, by the industry and not make the patient and patient care the ultimate priority.

Other issues associated with hysterectomy length-of-stay mandates relate to quality of care. In "Committee Opinion Number 191," October 1997, the American College of Obstetricians and Gynecologists, states that the organization is concerned with the compromise in quality of care that can occur as a result of the "cost-saving" measure of reducing length of hospital stay. The opinion acknowledges that standard data that is recorded for given gynecologic procedures has radically changed in the past several years and is continuing to change. However, length-of-stay determinants are based on a range of individual factors, such as concurrent disease process, severity of illness, intensity of care required, and therapeutic approach. Although standard protocols for predetermined number of days can offer general guidance, individual patient characteristics, physician judgment, and physician-patient consultation always should determine length of stay in individual cases.

After gynecologic surgery, a patient's readiness for release from the hospital should be based on positive discharge criteria that include stable vital signs, no

evidence of untreated infections, adequate oral intake, and satisfactory bowel and urinary tract function. Before discharge, instructions regarding diet, medications, wound and drainage device care, activity, and follow-up should be communicated to the patient or her caregivers. The patient or her caregivers should understand the instructions, be able to provide ongoing care, and monitor recovery as needed.

The National Center for Policy Analysis in "Brief Analysis No.224," dated February 21, 1997 cites critics as saying that length-of-stay laws take away the opportunity for future cost reductions as technology advances. As medicine improves, patients recover in shorter times than they did in the past. Mandating how long patients can remain in the hospital will discourage efforts to find quicker cures and procedures.

SOCIAL IMPACT

According to Virginia Health Information (VHI), from calendar year 1996 through 1998, 40,281 Virginia women were treated as inpatients for hysterectomy. Hysterectomy was the primary diagnosis. From calendar year 1996 through 1998, more than 41,600 women were inpatient hysterectomy patients when hysterectomy was diagnosed as secondary. According to the Virginia Hospital and Healthcare Association (VHHA), the age group with the highest number of cases was age 18 to 44.

The Reproductive Science Center of the San Francisco Bay Area reports on its Web-site that complications of hysterectomy (by any route) include risk of bleeding, infection, anesthetic problems, or injury to bowel or bladder. Generally, the laparoscopic approach results in less blood loss, less bowel irritation and, thus, less post-operative gas pain. The potential for subsequent post-operative adhesions is also lessened. Since patients can move around sooner, complications such as thromboembolism (blood clots) and pulmonary problems are reduced. Finally, hospital costs are significantly reduced for either the patient and/or any insurers.

The National Center for Health Statistics, state that 25% to 50% of patients may experience one or more complications from surgery, including fever and infection, urinary tract infections or discomfort, and sudden hormonal decreases that may cause menopausal symptoms, constipation and depression.

The language in § 38.2-3418.9 does address the provision of being hospitalized less than 48 hours for hysterectomy when deemed appropriate by the attending physician and patient. Subsection 38.2-3418.9 is silent regarding the need to be hospitalized longer than 48 hours if necessary. This could affect an insurer's interpretation of "minimum hospital stay," therefore allowing for misunderstanding by the general public.

FINANCIAL IMPACT

Respondents to the 1999 Bureau of Insurance's survey provided cost figures between $.06 and $2.00 per month per standard individual policy and between $.02 and $2.00 per month per standard group policy to provide the coverage specified in HB 871. Insurers providing coverage on an optional basis provided cost figures ranging from $.32 to $4.00 per month per optional individual policy and between $.02 and $4.63 per month per optional group policy. One indemnity company estimates a monthly premium of $74.11 per policyholder to provide for coverage in the bill. A company offering HMO products estimates a monthly premium of $92.52 per policyholder to provide for coverage in the bill.

Some of the local hospitals and medical laboratories in the Richmond area report that an abdominal hysterectomy could range in cost from $12,000 to $13,500; a vaginal hysterectomy could range from $11,157 to $12,500; and a LAVH could range from $15,000 to $16,526. According to VHI, the average total charge for a hysterectomy in Virginia is $8,396.40. However, the data does not distinguish the type of hysterectomy performed.

The review of a brief entitled "Laparoscopically Assisted Vaginal Hysterectomy: Outcomes, Patient Satisfaction, Costs," compiled in 1995 and updated in January 1998, states that medical outcomes are exceptional and patient satisfaction has been reported at 98% when LAVH is utilized. Direct cost savings are estimated at $1,300 per procedure for LAVH versus the open approach and indirect savings can be estimated, with a three-week differential in return to work (120 hours), a 79% labor force participation and a $25 per hour output, at $1,260 per case.

CURRENT INDUSTRY PRACTICES

The Bureau of Insurance (Bureau), in its capacity as staff to the Advisory Commission, resurveyed fifty of the top writers of accident and sickness insurance in Virginia regarding hospital stay for hysterectomy (HB 871). Twenty (20) companies responded. Five companies indicated that they write no applicable health insurance policies in Virginia, or provide no coverage in this area and could not provide the information requested. One company was unable to provide the estimated premium costs, specific information relating to the number of hysterectomies covered per year, and the length of hospital stay for hysterectomy. Of the fourteen respondents that completed the survey, all cover hysterectomy. The average claim(s) per year for LAVH ranged from 1 to 567. On average, the claim(s) for vaginal hysterectomy per year ranged from less than one to 1,522.

The average length of stay for LAVH ranged from one day (24 hours) to three days. The average length of stay for vaginal hysterectomy ranged from one day to slightly less than two and one-half (2.4) days.

SIMILAR LEGISLATION IN OTHER STATES

Currently, the National Insurance Law Service and other states indicate that no legislation is in effect regarding hospital length of stay for hysterectomy. However, other length-of-stay mandates are common:

- Forty-three states have laws stipulating how long a woman may remain hospitalized after the normal delivery of a child;
- Fifteen states have laws governing length of stay after breast cancer surgery; and
- Congress mandated the 48-hour maternity stay in 1996.

The National Association of Insurance Commissioners (NAIC) also indicates that no states have legislation mandating length of stay for hysterectomy.

REVIEW CRITERIA:

SOCIAL IMPACT

a. The extent to which the treatment or service is generally utilized by a significant portion of the population.

According to Virginia Health Information (VHI), from calendar year 1996 through 1998, 40,281 Virginia women were treated as inpatients for hysterectomy. In these cases, hysterectomy was the primary diagnosis. From calendar year 1996 through 1998, more than 41,600 women were inpatient hysterectomy patients when hysterectomy was diagnosed as secondary. According to the Virginia Hospital and Healthcare Association (VHHA), the age group with the highest number of cases was women aged 18 to 44.

The Virginia Health Information (VHI) report is derived from the Patient Level Database that includes data from all hospitals in each health planning region, each county, and city in Virginia. The pertinent data is based on hysterectomy as the primary or principal diagnosis. The available data, as reported, revealed a downward trend in length of hospital stay for calendar years 1996 -1998. In 1996, the average length of stay for hysterectomy was 3.05 days (13,246 procedures performed); in 1997, the average length of stay was 2.99 days (13,589 procedures performed); in 1998, the average length of stay was 2.44 days (13,446 procedures performed). Primary or principal diagnosis is defined as the medical condition that is ultimately determined to have caused a patient's admission to the hospital. The principal diagnosis is used to assign every patient a diagnosis-related group. This diagnosis may differ from the admitting diagnosis.

b. The extent to which insurance coverage for the treatment or service is already available.

The Bureau of Insurance (Bureau), in its capacity as staff to the Advisory Commission, resurveyed fifty of the top writers of accident and sickness insurance in Virginia regarding hospital stay for hysterectomy (HB 871). Twenty (20) companies responded. Five companies indicated that they write no applicable health insurance policies in Virginia, or provide no coverage in this area and could not provide the information requested. One company was unable to provide the estimated premium costs, specific information relating to the number of hysterectomies covered per year, and the length of hospital stay for hysterectomy. Of the fourteen respondents that completed the survey, all cover hysterectomy. The average claim(s) per year for LAVH ranged from one to five hundred sixty-seven. On average, the claim(s) for vaginal hysterectomy per year ranged from less than one to 1,522.

The average length of stay for LAVH ranged from one day (24 hours) to three days. The average length of stay for vaginal hysterectomy ranged from one day to a little less than two and one-half (2.4) days.

c. If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatments.

The Manitoba (Canada) Center for Health Policy and Evaluation studied patients discharged from all Winnipeg hospitals over a four-year period (1989/90 to 1992/93) and concluded that hospitals that had the longest patient stays for hysterectomy also had the highest re-admission rate (5%). The hospital where the stay for hysterectomy was the shortest had no hysterectomy re-admissions. While some hospitals kept their patients longer than other hospitals, at times twice as long, there is nothing to suggest that these patients received more effective care.

This particular study concluded that hospital stays are getting shorter in Manitoba, just as they are in other centers across North America. For the diagnostic categories of prostatectomy, hysterectomy, heart attack and bronchitis or asthma, the length of stay fell by 22% over the four-year period of study.

At the same time, there have been no indications that the quality of health has declined. Fears that re-admission rates, an established indicator of quality of care, would jump, as a result of earlier discharge, appear to have been unfounded.

Other issues associated with hysterectomy length-of-stay mandates relate to quality of care. In "Committee Opinion Number 191," October 1997, the American College of Obstetricians and Gynecologists, states that the organization is concerned with the compromise in quality of care that can occur as a result of the "cost-saving" measure of reducing length of hospital stay. The opinion acknowledges that standard data that is recorded for given gynecologic procedures has radically changed in the past several years and is continuing to change. However, length-of-stay determinants are based on a range of individual factors, such as concurrent disease process, severity of illness, intensity of care required, and therapeutic approach.

d. If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment.

Comments regarding unreasonable financial hardship on those persons recommended for hysterectomy were not presented during this review.

Local hospitals and medical laboratories in the Richmond area report that an abdominal hysterectomy could range from $12,000 to $13,500; a vaginal hysterectomy could range from $11,157 to $12,500; and a LAVH could range from $15,000 to $16,526. According to VHI, the average total charge of a hysterectomy in Virginia is $8,396.40. However, this data does not distinguish the type of hysterectomy performed.

e. The level of pubic demand for the treatment or service.

According to Virginia Health Information (VHI), from calendar year 1996 through 1998, when the primary diagnosis was hysterectomy, 40,281 Virginia women were treated as inpatients. From calendar year 1996 through 1998, more than 41,600 women were inpatient hysterectomy patients when hysterectomy was diagnosed as secondary. According to the Virginia Hospital and Healthcare Association (VHHA), the age group with the highest number of cases was aged 18 to 44.

The available data, as reported, revealed a downward trend in length of hospital stay (LOS) for calendar years 1996 -1998. In 1996, the average length of stay (ALOS) for hysterectomy was 3.05 days; in 1997, the ALOS was 2.99 days; in 1998, the ALOS was 2.44 days.

f. The level of public demand and the level of demand from providers for individual and group insurance coverage of the treatment or service.

Issues associated with hysterectomy length-of-stay mandates relate to quality of care. In "Committee Opinion Number 191," October 1997, the American College of Obstetricians and Gynecologists, states that the organization is concerned with the compromise in quality of care that can occur as a result of the "cost-saving" measure of reducing length of hospital stay. The opinion acknowledges that standard data that is recorded for given gynecologic procedures has radically changed in the past several years and is continuing to change. However, length-of-stay determinants are based on a range of individual factors, such as concurrent disease process, severity of illness, intensity of care required, and therapeutic approach.

Although standard protocols for predetermined number of days can offer general guidance, individual patient characteristics, physician judgment, and physician-patient consultation always should determine length of stay in individual cases.

After gynecologic surgery, a patient's readiness for release from the hospital should be based on positive discharge criteria that include stable vital signs, no evidence of untreated infections, adequate oral intake, and satisfactory bowel and urinary tract function. Before discharge, instructions regarding diet, medications, wound and drainage device care, activity, and follow-up should be communicated to the patient or her caregivers. The patient or her caregivers should understand the instructions, be able to provide ongoing care, and monitor recovery as needed.

g. The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts.

No information was received from collective bargaining organizations addressing potential interests in negotiating privately for inclusion of this coverage in group contracts.

h. Any relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit.

The Advisory Commission is not aware of any information or relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of this mandated benefit during this review.

FINANCIAL IMPACT

a. The extent to which the proposed insurance coverage would increase or decrease the cost of treatment or service over the next five years.

The National Center for Policy Analysis in "Brief Analysis No. 224," dated February 21, 1997 cites critics as saying that length-of-stay laws take away the opportunity for future cost reductions as technology advances. As medicine improves, patients recover in shorter times than they did in the past. Mandating how long patients can remain in the hospital will discourage efforts to find quicker cures and procedures.

b. The extent to which the proposed insurance coverage might increase the appropriate or inappropriate use of the treatment or service.

Opponents may point to a statistic in the 14-year surveillance that cites a marked increase in concurrent oophorectomy (surgical removal of one or both ovaries) with vaginal hysterectomy may be a consequence of the improved access to the ovaries afforded by the laparoscopy. During 1991-1993, 47% of vaginal hysterectomies associated with laparoscopy were accompanied by bilateral oophorectomy, whereas only 22% of vaginal hysterectomies performed without laparoscopy were accompanied by bilateral oophorectomy.

c. The extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service.

The practice of medicine, including drugs, and surgical procedures is improving, such that most in-hospital treatments are shorter, safer, more economical, and more effective. However, other medical concerns relate to quality of care issues. This mandate seeks to protect women in Virginia so that each hysterectomy inpatient would receive consistent care.

d. The extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next five years.

The number and type of providers of the mandated service are not expected to increase over the next five years as a result of this bill.

e. The extent to which insurance coverage might be expected to increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders.

An increase in the administrative expenses of insurance companies and the premiums and administrative expenses for policyholders is anticipated because of the expenses associated with such things as policy redesign, form filing, claims processing systems and marketing, and other administrative requirements.

Respondents to the Bureau of Insurance's survey provided cost figures between $.06 and $2.00 per month per standard individual policy and between $.02 and $2.00 per month per standard group policy to provide the coverage specified in HB 871. Insurers providing coverage on an optional basis provided cost figures ranging from $.32 to $4.00 per month per optional individual policy and between $.02 and $4.63 per month per optional group policy. One indemnity company estimates a monthly premium of $74.11 per policyholder to provide for coverage in the bill. A company offering HMO products estimates a monthly premium of $92.52 per policyholder to provide for coverage in the bill.

f. The impact of coverage on the total cost of health care.

The total cost of health care is not expected to be significantly affected.

MEDICAL EFFICACY

a. The contribution of the benefit to the quality of patient care and the health status of the population, including the results of any research demonstrating the medical efficacy of the treatment or service compared to alternatives or not providing the treatment or service.

The medical efficacy of a minimum length of stay for hysterectomy is not questioned. Opponents may argue that legislating the length of stay might be inappropriate because improvements in medical procedures, technology or drugs may further reduce the advisability of lengthy hospitalization. Medical advances continue to alter treatment protocols.

b. If the legislation seeks to mandate coverage of an additional class of practitioners:

1) The results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered?

Not applicable.

2) The methods of the appropriate professional organization that assure clinical proficiency?

Not applicable.

EFFECTS OF BALANCING THE SOCIAL, FINANCIAL AND MEDICAL EFFICACY CONSIDERATIONS

a. The extent to which the benefit addresses a medical or a broader social need and whether it is consistent with the role of health insurance.

One argument for this mandate is that it is consistent with the role of health insurance and addresses a medical and social need. Legislation mandating minimum hospital stays for childbirth preceded this legislation, and both pieces of legislation could be perceived as proactive support that would protect women from premature discharge following in-patient care.

Opposition to this mandate could state that the requirement overlooks the advancements in medical technology. Technology has vastly improved all providers' ability to treat patients more efficiently while simultaneously assuring quality, appropriateness, and effectiveness of care. Mandates such as this only serve to interfere with the physician/patient relationship by arbitrarily preempting physicians' clinical decision-making ability.

b. The extent to which the need for coverage outweighs the costs of mandating the benefit for all policyholders.

Opponents may question the need for this type of mandate as proposed in the bill because the ALOS for women in Virginia closely resembled the LOS provided by insurers according to responses to the Bureau survey: VHI indicates that in 1996, the average length of stay (ALOS) for hysterectomy was 3.05 days; in 1997, the ALOS was 2.99 days; in 1998, the ALOS was 2.44 days. Respondents to the Bureau survey report that the LOS for LAVH ranged from 1 to 3 days. The LOS for vaginal hysterectomy ranged from 1 day to 2.27 days.

Proponents believe that House Bill 871 is a necessary step to preventing insurers from dictating how physicians manage the treatment of in-house hysterectomy patients.

Respondents to the Bureau of Insurance's survey provided cost figures between $.06 and $2.00 per month per standard individual policy and between $.02 and $2.00 per month per standard group policy to provide the coverage specified in HB 871.

c. The extent to which the need for coverage may be solved by mandating the availability of the coverage as an option for policyholders.

In the case of group coverage, the decision whether to select the optional coverage or not would lie with the master contract holder and not the individual insureds.

RECOMMENDATION

The Advisory Commission voted unanimously (9 – Yes, 0 – No) on September 21, 1999 to recommend that the provision on minimum length of stay for hysterectomy incorporated in House Bill 871 be enacted.

CONCLUSION

Information provided to the Advisory Commission during its review indicated that treatment for hysterectomy was generally available. Technology, medical advancement, along with physician skill and patient involvement create an overall climate for shorter hospital stays. Simultaneously, there have been no indications that the quality of care has declined. A mandate is necessary to guarantee that the women of Virginia continue to be consistently hospitalized for at least twenty-three hours for a laparoscopy-assisted vaginal hysterectomy and forty-eight hours for a vaginal hysterectomy.

any such policy, contract or plan delivered, issued for delivery, or renewed in this Commonwealth on and after July 1, 1999.

B. The reimbursement for patient costs incurred during participation in clinical trials for treatment studies on cancer shall be determined in the same manner as reimbursement is determined for other medical and surgical procedures. Such coverage shall have durational limits, dollar limits, deductibles, copayments and coinsurance factors that are no less favorable than for physical illness generally.

C. For purposes of this section:

"Cooperative group" means a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group. "Cooperative group" includes (i) the National Cancer Institute Clinical Cooperative Group and (ii) the National Cancer Institute Community Clinical Oncology Program.

"FDA" means the Federal Food and Drug Administration.

"Member" means a policyholder, subscriber, insured, or certificate holder or a covered dependent of a policyholder, subscriber, insured or certificate holder.

"Multiple project assurance contract" means a contract between an institution and the Federal Department of Health and Human Services that defines the relationship of the institution to the Federal Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

"NCI" means the National Cancer Institute.

"NIH" means the National Institutes of Health.

"Patient cost" means the cost of a medically necessary health care service that is incurred as a result of the treatment being provided to the member for purposes of a clinical trial. "Patient cost" does not include (i) the cost of nonhealth care services that a patient may be required to receive as a result of the treatment being provided for purposes of a clinical trial, (ii) costs associated with managing the research associated with the clinical trial, or (iii) the cost of the investigational drug or device.

D. Coverage for patient costs incurred during clinical trials for treatment studies on cancer shall be provided if the treatment is being conducted in a Phase II, Phase III, or Phase IV clinical trial. Such treatment may, however, be provided on a case-by-case basis if the treatment is being provided in a Phase I clinical trial.

E. The treatment described in subsection D shall be provided by a clinical trial approved by:

1. The National Cancer Institute;

2. An NCI cooperative group or an NCI center;

3. The FDA in the form of an investigational new drug application;

4. The Federal Department of Veterans Affairs; or

5. An institutional review board of an institution in the Commonwealth that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI.

F. The facility and personnel providing the treatment shall be capable of doing so by virtue of their experience, training, and expertise.

G. Coverage under this section shall apply only if:

1. There is no clearly superior, noninvestigational treatment alternative;

2. The available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the noninvestigatonal alternative; and

3. The member and the physician or health care provider who provides services to the member under the insurance policy, subscription contract or health care plan conclude that the member's participation in the clinical trial would be appropriate, pursuant to procedures established by the insurer, corporation or health maintenance organization and as disclosed in the policy and evidence of coverage.

H. The provisions of this section shall not apply to short-term travel, accident-only or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or governmental plans or to short-term nonrenewable policies of not more than six months' duration.

§ 38.2-3418.9. Minimum hospital stay for hysterectomy.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue an individual or group hospital policy or major medical policy in this Commonwealth; each corporation proposing to issue an individual or group hospital, medical or major medical subscription contract; and each health maintenance organization providing a health care plan for health care shall provide coverage for laparoscopy-assisted vaginal hysterectomy and vaginal hysterectomy as provided in this section.

B. Such coverage shall include benefits for a minimum stay in the hospital of not less than twenty-three hours for a laparoscopy-assisted vaginal hysterectomy and forty-eight hours for a vaginal hysterectomy as outlined in Milliman & Robertson's nationally recognized guidelines. Nothing in this section shall be construed as requiring the provision of the total hours referenced when the attending physician, in consultation with the patient, determines that a shorter period of hospital stay is appropriate.

C. The requirements of this section shall apply to all insurance policies, contracts and plans delivered, issued for delivery, reissued or extended on and after July 1, 1999, or at any time thereafter when any term of the policy, contract or plan is changed or any premium adjustment is made.

D. This section shall not apply to short-term travel, accident-only or to contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

§ 38.2-4209. Preferred provider subscription contracts.

A. As used in this section, a "preferred provider subscription contract" is a contract that specifies how services are to be covered when rendered by providers participating in a plan, by nonparticipating providers, and by preferred providers.

B. Notwithstanding the provisions of §§ 38.2-4218 and 38.2-4221, any nonstock corporation may, as a feature of its plan, offer preferred provider subscription contracts pursuant to the requirements of this section that limit the numbers and types of providers of health care services eligible for payment as preferred providers.

C. Any such nonstock corporation shall establish terms and conditions that shall be met by a hospital, physician or other type of provider listed in § 38.2-4221 in order to qualify for payment as a preferred provider under the subscription contracts. These terms and conditions shall not discriminate unreasonably against or among health care providers. No hospital, physician or type of provider listed in § 38.2-4221 willing to meet the terms and conditions offered to it or him shall be excluded. Differences in prices among hospitals or other institutional providers produced by a process of individual negotiations with the providers or based on market conditions, or price differences among providers in different geographical areas shall not be deemed unreasonable discrimination. The Commission shall have no jurisdiction to adjudicate controversies growing out of this subsection.

D. Mandated types of providers listed in § 38.2-4221 and types of providers whose services are required to be made available and which have been specifically contracted for by the holder of any subscription contract shall, to the extent required by § 38.2-4221, have the same opportunity as do doctors of medicine to qualify for payment as preferred providers.

E. Preferred provider subscription contracts shall provide for payment for services rendered by nonpreferred providers, but the payments need not be the same as for preferred providers.

F. No contract between a nonstock corporation and a provider shall include provisions which require a health care provider or health care provider group to deny covered services that such provider or group knows to be medically necessary and appropriate that are provided with respect to a specific enrollee or group of enrollees with similar medical conditions.

§ 38.2-4214. Application of certain provisions of law.

No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, §§ 38.2-1312, 38.2-1314, 38.2-1317 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3405.1, 38.2-3407.1 through 38.2-3407.6, 38.2-3407.9,