REPORT OF THE
SPECIAL ADVISORY COMMISSION ON
MANDATED HEALTH INSURANCE BENEFITS

MANDATED COVERAGE FOR HOSPICE CARE

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 79

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COMMONWEALTH OF VIRGINIA

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SENATE

January 10, 2000

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 (Advisory Commission) to assess the social and financial impact and the medical efficacy of House Bill 699, regarding mandatory coverage for hospice care.

Respectfully submitted,

Stephen H. Martin
Chairman
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INTRODUCTION

The House Committee on Corporations, Insurance and Banking referred House Bill 699 to the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission) during the 1998 Session of the General Assembly. Delegate Vincent F. Callahan, Jr. was the patron of House Bill 699. The 1999 General Assembly passed a revised House Bill 699, and it was signed by the Governor. However, the Chairman of the Senate Committee on Commerce and Labor requested a review of the bill by the Advisory Commission.

The Advisory Commission held a public hearing to receive comments on House Bill 699 on September 21, 1999, in Richmond. The Virginia Association for Hospices (VAH) spoke in support of the bill. Written comments from the VAH were also received in support of the bill. No comments were received in opposition to the bill.

The Advisory Commission concluded its review of House Bill 699 on November 22, 1999.

SUMMARY OF LEGISLATION PROPOSED

As enacted, the bill requires individual or group accident and sickness policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis, individual or group accident and sickness subscription contracts, and health maintenance organization (HMO) plans to provide coverage for hospice services in policies, contracts, or plans delivered, issued for delivery, or renewed in Virginia on and after July 1, 1999.

The bill defines "hospice services" as "a coordinated program of home and inpatient care provided directly or under the direction of a hospice licensed under Article 7 (§ 32.1-162.1 et seq.) of Chapter 5 of Title 32.1, and shall include palliative and supportive physical, psychological, psychosocial and other health services to individuals with a terminal illness utilizing a medically directed interdisciplinary team."

The bill also defines "individuals with a terminal illness" as meaning "individuals whose condition has been diagnosed as terminal by a licensed physician whose medical prognosis is death within six months, and who elect to receive palliative rather than curative care." "Medicare" is defined as "Title XVIII of the Social Security Act." "Palliative care" means "treatment directed at controlling pain, relieving other symptoms, and focusing on the special needs of the patient as he experiences the stress of the dying process rather than treatment aimed at investigation and intervention for the purpose of cure or prolongation of life."

The documentation requirements for the section are to be no greater than the requirements for the same services under Medicare. The section does not prohibit an insurer, corporation, or HMO from offering or providing coverage for hospice services when it cannot be demonstrated that the illness is terminal or for individuals with life expectancies of longer than six months.

The bill does not apply to short-term travel, to accident only, to short-term nonrenewable policies of not more than six months duration, or to policies or contracts designed for issuance to persons eligible for Medicare, or similar coverage under state or federal government plans.

HOSPICE CARE

The modern system of hospice care began in 1967 when an English physician founded St. Christopher's Hospice in London. Section 32.1-162.1 of the Code of Virginia defines hospice as "a coordinated program of home and inpatient care provided directly or through an agreement under the direction of an identifiable hospice administration providing palliative and supportive medical and other health services to terminally ill patients and their families." Hospice care is a program of care delivered in the patient's home or in a facility that addresses the physical and emotional needs of a terminally ill individual. A hospice utilizes a medically directed interdisciplinary team. A hospice program provides care to meet the physical, psychological, social, spiritual, and other special needs that are likely to be experienced during the final stages of illness and during dying and bereavement. Section 32.1-162.1 requires that hospice care be available twenty-four hours per day, all seven days per week.

According to the Virginia Association for Hospices, Inc. (VAH), "hospice" refers to a supportive philosophy and concept of care available to those whose life expectancy is measured in weeks or months. The emphasis is on providing comfort and relief from pain for terminally ill patients with a life expectancy of six months or less. The VAH notes that hospice recognizes death as the final stage of life and serves to enable patients to live their final days to the fullest in the comfort of their own homes, surrounded by their loved ones.

The VAH notes that hospice services are available to persons who can no longer benefit from curative treatment. Most receive care at home. Services are provided by a team of trained professionals, including physicians, nurses, counselors, therapists, aides, and volunteers, who provide medical care and support services not only to the patient, but also to the entire family. The primary physician usually refers the patient to hospice. However, family members, friends, clergy, or other health professionals can also make referrals.

SOCIAL IMPACT

The VAH estimates that hospice programs service more than 200,000 terminally ill patients and their families each year in the United States. The VAH estimates that hospice admissions for all of Virginia's licensed hospices were approximately 6,800 in 1996, based on data compiled by the National Hospice Organization in 1995. It is estimated that Virginia's hospices provide care for approximately 14% of patients and families who could benefit from hospice care. A study, prepared by Lewin-VHI, Inc. for the National Hospice Organization in 1995, found that 95% of hospice users were enrolled in hospice for seven months or less.

COVERAGE UNDER MEDICARE

Under Medicare, hospice is primarily a program of care delivered in the patient's home by a Medicare participating hospice. There were 58 licensed hospices in Virginia as of September, 1999. Of those licensed, at least 50 are certified by Medicare to provide hospice care in accordance with federal standards.

The following hospice services are covered under Medicare Part A:

- physician services;
- nursing care;
- medical appliances;
- medical supplies;
- drugs, including outpatient drugs for symptom management and pain relief;
- short-term inpatient care, including respite care;
- home health aide and homemaker services;
- physical and occupational therapy;
- speech/language pathology services;
- medical social services; and
- counseling.

According to the Health Care Financing Administration (HCFA), there is no deductible for these hospice care benefits. However, co-payments are required for outpatient drugs and inpatient respite care. Patients can be charged five percent of the cost, but not more than five dollars for each prescription. Co-payments are also required for respite care, for which the patient can be charged five percent of the Medicare allowed rate (about five dollars per day in 1997), depending on the area of the country in which he or she lives.

When hospice care is chosen, Medicare does not pay for treatment for the terminal illness, but it does pay for symptom management and pain control. Medicare will continue to pay for treatment of a condition not related to the terminal illness.

Medicare will pay for hospice care only if all three of the following conditions are met:

- a patient's doctor certifies that the patient is terminally ill;
- the patient chooses to receive care from a hospice instead of standard Medicare benefits for the terminal illness; and
- care is provided by a Medicare participating hospice program.

FINANCIAL IMPACT

MEDICARE REIMBURSEMENT RATES

Most people needing hospice services are above the age of 65 and receive Medicare benefits. The VAH notes that Medicare reimburses hospices on a per diem basis for four types of hospice care: home care, respite care, inpatient care, and continuous care. "Home care" is the usual mode of hospice care and includes visits to the patient and caregiver in the home by the members of the hospice team as well as 24-hour telephone support. The base per diem rate is $99. "Respite care" is short-term, inpatient care, usually in a skilled nursing facility, to provide the caregiver(s) a chance to recover from intense periods of around-the-clock care. The base per diem rate is $102 for respite care. "Inpatient care" is short-term care in a skilled nursing facility or hospital to treat the symptoms of the terminal illness. The base per diem rate is $440 for inpatient care. "Continuous care" is short-term, around the clock care in the home to assist the caregiver in dealing with the symptoms of the terminal illness. The base per diem rate is $578 for continuous care. Geographic factors are applied to determine the actual per diem rate.

The Lewin-VHI 1995 study, done for VAH, found that Virginia's Medicare hospice savings were 16% higher than comparable Medicare fee-for-service care for patients with terminal illnesses not utilizing hospice care. The study determined that hospice care, as defined by Medicare, is a cost containment measure and for every dollar Medicare spent on hospice users in the State of Virginia, it saved $1.19 in Part A and Part B expenditures.

In addition, according to the Lewin-VHI study, the average Medicare expenditure for hospice users enrolled less than 12 months (including expenditures incurred prior to enrollment in hospice) was $21,231. The study also found that in the last year of life, the average Medicare expenditure for hospice users was $914 less than for non-users. Savings were found to be greatest in the last month of life, when the Medicare expenditure for hospice users averaged $2,544 less than the expenditure for non-users.

CURRENT INDUSTRY COVERAGE

Staff re-surveyed fifty of the top writers of accident and sickness insurance regarding the bills that were added to the Advisory Commission's agenda for 1999. Twenty companies responded to the re-survey by August 1, 1999. Fifteen of the respondents completed the survey. Eleven of the fifteen (73%) respondents indicated that they currently provide the hospice coverage required by House Bill 699 in their standard contract. The four remaining companies did not provide the coverage prior to the enactment of House Bill 699.

Eight companies provided estimates of the premium associated with the mandate for individual policies of $0.02 to $3.00 per month, with one estimate of .1% of premium. Ten companies provided estimates on the impact of the mandate on group premiums. The estimates ranged from $0.03 to $3.00 per month. One company estimated $0.48 per member per month.

COVERAGE IN OTHER STATES

According to information provided by the National Insurance Law Service, only three states (Massachusetts, Kentucky, and Nevada) mandate coverage for hospice care. Six states (Colorado, Maryland, Michigan, Minnesota, New York, and Washington) require insurers to provide optional coverage for hospice care (Appendix B).

REVIEW CRITERIA

SOCIAL IMPACT

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

The VAH estimated that there were 6,800 hospice admissions in Virginia in 1995, based on data from the National Hospice Organization. The VAH also estimated approximately 50,000 disease-related deaths in Virginia in 1995. The 6,800 hospice admissions in 1995 were 14% of the 50,000 Virginia deaths.

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

Twenty of the top fifty writers of accident and sickness insurance in Virginia responded to the State Corporation Commission's Bureau of Insurance survey by August 1, 1999. Fifteen of the respondents completed the survey. Eleven of the fifteen (73%) indicated that they provide the hospice coverage required by House Bill 699 in their standard contract.

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.*

Proponents of the mandate believe that when there is no hospice coverage in an individual's contract, many terminally-ill patients may accept curative care when they no longer desire it and when it may no longer be beneficial. Other patients who are terminally ill may go without hospice services or curative care.

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.*

Hospice care is typically billed on a per diem basis. Per diem rates for Medicare are $99 for home care, which is the usual type of hospice care provided. For respite care, Medicare reimburses $102. Inpatient care reimbursement is $440, and continuous care reimbursement is $578.

e. *The level of public demand for the treatment or service.*

The VAH estimates that there were 6,800 admissions to Virginia hospices in 1995. There were approximately 50,000 deaths in Virginia in 1995 that were disease related.

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

Proponents argue that consumers are usually unaware of the need for hospice care or not motivated to pursue this type of care until they need it. When a consumer is diagnosed with a terminal illness, it is too late to request coverage.

The Virginia Association of Hospices believes that a hospice benefit improves access to better end-of-life care for Virginians. The Association includes 39 members in Virginia. This includes one organization with multiple licenses.

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

The level of interest of collective bargaining organizations in negotiating privately for the inclusion of this coverage in group contracts is not known.

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.*

No information or findings of the state health planning agency or the appropriate health system agency regarding the social impact of hospice care was presented during the review of House Bill 699.

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.*

Coverage for hospice care is not expected to increase or decrease the cost of the care over the next five years.

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

Coverage for hospice care is not expected to increase the inappropriate use of hospice care. The language in the legislation and the requirements of Virginia regulations require that an individual have a terminal illness. Physicians must make a recommendation for the care, and the patient must accept. The appropriate use of hospice care may increase, if those who currently do not have coverage decide to accept palliative care rather than curative care.

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

Proponents make the argument that hospice care is less expensive than the alternative curative care. They point to the results of the 1995 Lewin-VHI study that found for every Medicare dollar spent on Virginians for hospice care there was a net savings of $0.19. Proponents believe hospice care can allow patients to end aggressive and expensive 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 mandate of hospice care is not expected to significantly affect the number of hospice providers in the next five years. However, there could be some increase in the number of hospices in the state, if many more patients seek palliative care.

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.*

Eight companies provided estimates of the premium increases associated with the mandate for individual policies from $0.02 to $3.00 per month, with one estimate of .1% of premium. Ten companies provided estimates on the impact of the mandate on group premiums. The estimates ranged from $0.03 to $3.00 per month. One company estimated $0.48 per member per month.

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.

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

The mandate of coverage for hospice care is not expected to increase the total cost of health care. Hospice care, in many cases, would be provided instead of curative care. Proponents believe that, in those instances, there will be a net savings in the overall cost of healthcare.

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.

Proponents make the argument that hospice care improves the quality of life for those individuals with a terminal illness. The hospice approach is thought to ease the physical and psychological pain of the patient's illness. VAH believes that palliative care allows the patient and family to make the most of their remaining time together.

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.

Hospice care is not the traditional type of care reimbursed by health insurance. Health insurance covers "curative" care, the care that improves one's health. "Hospice" care is provided when the illness is terminal and the patient will not recover. The care is medical, however, and includes pain control.

The VHA believes that hospice care addresses the public's concerns about end-of-life care that includes fear of dying and of pain, fear of unwanted medical treatment, and concerns about the needs of the immediate family.

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

Proponents make the argument that the mandate will save money. The 1995 Lewin-VHI study found a net saving of $0.19 for every dollar Medicare spent on hospice care for Virginians.

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

The public is generally unaware of the benefits or need for hospice care until confronted with a terminal illness. It is unlikely that an offer of coverage would be an effective means of providing coverage.

RECOMMENDATION

The Advisory Commission voted on House Bill 699 on November 22, 1999. The Advisory Commission voted 8-0, with one abstention, to recommend that coverage for hospice care be mandated.

CONCLUSION

The Advisory Commission believes that coverage for hospice care is desirable. The coverage is not expected to significantly increase the overall cost of health care in Virginia.

APPENDIX A

CHAPTER 858

An Act to amend and reenact § 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3418.8, relating to accident and sickness insurance; coverage for hospice care.

[H 699]

Approved March 29, 1999

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-4319 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-3418.8 as follows:

§ 38.2-3418.8. Coverage for hospice care.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for hospice services under such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1999.

B. As used in this section:

"Hospice services" shall mean a coordinated program of home and inpatient care provided directly or under the direction of a hospice licensed under Article 7 (§ 32.1-162.1 et seq.) of Chapter 5 of Title 32.1, and shall include palliative and supportive physical, psychological, psychosocial and other health services to individuals with a terminal illness utilizing a medically directed interdisciplinary team.

"Individuals with a terminal illness" shall mean individuals whose condition has been diagnosed as terminal by a licensed physician, whose medical prognosis is death within six months, and who elect to receive palliative rather than curative care.

"Medicare" shall mean Title XVIII of the Social Security Act.

"Palliative care" shall mean treatment directed at controlling pain, relieving other symptoms, and focusing on the special needs of the patient as he experiences the stress of the dying process, rather than treatment aimed at investigation and intervention for the purpose of cure or prolongation of life.

C. For the purposes of this section, documentation requirements shall be no greater than those required for the same services under Medicare.

D. Nothing in this section shall prohibit an insurer, corporation, or health maintenance organization from offering or providing coverage for hospice services when it cannot be demonstrated that the illness is terminal or for individuals with life expectancies of longer than six months.

E. The provisions of this section shall not apply to short-term travel, accident only, short-term nonrenewable policies of not more than six months' duration, or to policies 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 federal governmental plans.

§ 38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-200, 38.2-203, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 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, Chapter 9 (§ 38.2-900 et seq.) of this title, 38.2-1057, 38.2-1306.2 through 38.2-1309, Articles 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6, 38.2-3407.9, 38.2-3407.10, 38.2-3407.11, 38.2-3407.12, 38.2-3411.2, 38.2-3414.1, 38.2-3418.1 through ~~38.2-3418.7~~ *38.2-3418.8*, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3542, 38.2-3543.2, Chapter 53 (§ 38.2-5300 et seq.) and Chapter 58 (§ 38.2-5800 et seq.) of this title shall be applicable to any health maintenance

organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance organization.

B. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

C. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

D. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

2. That the provisions of this act shall become effective notwithstanding the provisions of § 9-299.

COVERAGE FOR HOS CE CARE IN OTHER STATES

STATE	CITATION AND EFFECTIVE DATE	SUMMARY
Colorado	10-16-104 (individual and group) (1997)	Optional coverage for benefits for home health services and hospice care which has been recommended by a physician as medically necessary.
Maryland	§ 15-809 (all plans) (1997)	Optional coverage for hospice care services.
Massachusetts	175:47S (individual) 176A:8R (hospital service) 176B:4Q (medical service) 176G:4H (HMOs) (1996)	Coverage for licensed hospice services to terminally ill patients with a life expectancy of six months or less.
Michigan	500.3406c (individual) 500.3615 (group) 333.21053a (HMOs) 1984	Optional coverage for hospice care.
Minnesota	62A.616 (all plans) (1995)	Optional coverage for nursing home care for the terminally ill, personal care attendants, and hospice care.
New York	32 § 3221 (group) (1984)	If a policy provides coverage for inpatient hospital care, it must provide optional coverage for hospice care. Coverage shall be at least equal to(i) a total of 210 days of coverage beginning with the first day on which care is provided, for inpatient hospice care in a hospice or in a hospital, and home care and outpatient services provided by the hospice, including drugs and medical supplies and (ii) 5 visits for bereavement counseling services, either before or after the insured's death, provided to the family of the terminally ill insured.
Nevada	689A.030 (individual) 689B.030 (group) 695B.180 (nonprofits) 695C.176 (HMOs) (1983)	Coverage for expenses arising from hospice care.
Washington	48.21A.090 (individual) 48.21.220 (group) 48.44.320 (nonprofits) (1983)	Optional coverage for home health care and hospice care for persons who are homebound and would otherwise require hospitalization. Coverage need only to be offered in conjunction with a policy that provides payment for hospitalization as part of health care coverage. Coverage for hospice shall include benefits for terminally ill patients for a period of not less than six months. In cases where the patient is facing imminent death, benefits may be provided for an additional six months of care if certified in writing by the attending physician. Coverage is to include home health care services, and respite care of not less than five days for each three-month period of hospice care, for necessary medical or palliative care.
Kentucky	KRS304.17A-250a	All health benefit plans must cover hospice care at least equal to Medicare benefits.