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Research Brief

TO: Representative Harriet Drummond
FROM: Tim Spengler, Legislative Analyst
DATE: February 18, 2015
RE: Cost of End-of-Life Care in Alaska
LRS Report 15.200

You asked for information on costs related to end-of-life care in Alaska. Specifically, you asked for any cost estimates available for care given in the final three months of life to terminally ill individuals. Additionally, you wished to know if there is a cost discrepancy between the insured and uninsured.

The Department of Health and Social Services (DHSS) provided us with information regarding the cost of end-of-life care in the state, which we provide, verbatim, in the paragraph below.[1] The department's response pertains to the cost for hospice care, which centers on making a dying patient as comfortable as possible, as opposed to medical (curative) treatment. You will note that hospice care averages around $175 a day. Where care includes pharmacy, medical equipment, and physician services, average costs are around $293 a day.[2] Medicaid pays for hospice services in the state.

Following DHSS' response, we provide information on end-of-life hospitalization costs in the United States, and on the cost discrepancy between the insured and uninsured. Finally, we include fiscal notes and other legislative information for a few states that have codified death with dignity laws or considered related bills.

DHSS Response

A Medicaid recipient is eligible to receive hospice services if his or her medical prognosis is a life expectancy of six months or less. Hospice services include routine and continuous home care, inpatient respite care, and general inpatient care and are paid at the Medicare hospice payment rate established under 42 CFR 418.306. Medicaid will also pay for hospice-related physician services and for room and board provided in a nursing facility for an individual who qualifies for hospice and who has an intellectual disability or related condition.

Hospice services do not include curative treatment, but instead focus on palliation of pain and symptoms and quality of life.

During FY2013 and FY2014, the average total cost of care per Alaska Medicaid hospice patient, was $174.39 per day for hospice services only. The average total cost of care, including all services (hospice, pharmacy, waiver, durable medical equipment, physician services, etc.) was $293.15 per day. Note: These figures do not reflect the significantly higher costs of care for terminally ill individuals who decline hospice services and choose to continue curative treatment.

[1] Tony Newman is legislative liaison for the Department of Health and Social Services. Mr. Newman can be reached at (907) 465-1611.

[2] These figures do not include the much higher cost for patients who decline hospice services and continue curative treatment.

End-of-Life Hospitalization in the United States

A ten-page brief from the U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality (AHRQ) provides information about end-of-life hospitalizations in the United States for the year 2007.[3] Below we highlight some of the document's findings. The brief can be accessed at *http://www.hcup-us.ahrq.gov/reports/statbriefs/sb81.pdf*.

- Thirty-two percent of all deaths in the U.S. in 2007 were inpatient hospital deaths;
- The inpatient death rate in 2007 was 1.9 percent. However, these hospital stays ending in death were responsible for 5.1 percent ($17.6 billion) of all hospital inpatient costs;
- Average hospital costs for a stay ending in death were $23,000, about 2.7 times higher than for a patient discharged alive;
- Medicaid had the highest costs for a hospital stay ending in death at $35,000, which is nearly 5.5 times higher than for a Medicaid patient discharged alive. However, Medicaid had the lowest death rate among payers, 0.8 percent; and
- Medicare covered 67 percent of all inpatient deaths, with a total cost of over $10 billion, which accounted for 6.9 percent of all Medicare inpatient costs.

Another document, while somewhat dated, may also be of interest to you. The 2001 article from the journal *Health Affairs* entitled "Medicare Beneficiaries' Costs of Care in the Last Year of Life" can be accessed at *http://content.healthaffairs.org/content/20/4/188.full.* The document includes the following information.

- The typical Medicare decedent averaged roughly four significant diseases in the last year of life, while the average for survivors was slightly more than one in the typical calendar year. Decedents' high end-of-life costs are largely a consequence of this substantial disease burden.
- The share of Medicare spending for persons in the last year of life has been stable for two decades. For the mid-1990s decedents' per capita Medicare program outlays were about six times higher than that for survivors. This ratio is slightly lower than a similar estimate for 1979.
- Based on data for the calendar year of death, Medicare paid 61 percent of decedents' costs, Medicaid paid ten percent, and other payers 12 percent. Out-of-pocket costs accounted for 18 percent.

Insured and Uninsured Costs

While perhaps counterintuitive, it is a truth universally acknowledged that uninsured individuals nationwide are often required to pay a higher rate for health services than those with insurance; this is especially true of hospital charges.[4] This occurs for two main reasons:

1. Health insurers typically negotiate discounted provider rates, based on their large volume of enrolled members, often 30 to 50 percent less than "charged" rates. Similarly public programs–Medicaid, Medicare, and state employee health–also negotiate significant discounts. These "provider rates" do not apply to those with no insurance coverage.

[3] The Agency for Healthcare Research and Quality's (AHRQ) stated mission is to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work within the U.S. Department of Health and Human Services and with other partners to make sure that the evidence is understood and used (*http://www.ahrq.gov/*).

[4] For information on this section of the report, we contacted policy specialists at the National Conference of State Legislatures, as well as reviewing other sources.

2. Those with insurance also have a wide range of consumer protection laws including provisions of the Patient Protection and Affordable Care Act (ACA), which allow (or require) a review of charges.

Of course, a number of individuals without insurance ultimately do not pay their medical provider or hospital bills. There are myriad reasons why this occurs, not the least of which is the high cost of medical care. The below paragraph from an NCSL program specialist outlines this phenomena, called uncompensated care.[5] [Emphasis added.]

> Uncompensated care is an umbrella term used to refer [to] all health services rendered for which there is no usual source of payment, such as insurance, Medicaid/Medicare and the patient does not have the financial means to pay out of pocket. However, there are streams of funding available to hospitals and providers to pay for a portion of this care, such a Disproportional Hospital Share (DSH) payments and, in some cases, state/municipality–specific funding. **On average, a person who is uninsured has considerably lower annual health care expenses than a person who is insured.** This difference reflects the uninsured population's lower health services utilization rate and lower intensity of service use compared to the insured population. Compared to nonelderly people who had insurance for a full year, for whom average per capita medical expenditures were $4,876, nonelderly people who were without insurance for a full year used health care services valued at about half that amount, or just $2,443 per capita per year in 2013. Nonelderly people who were uninsured for part of the year had annual medical expenditures about 30% lower than people who were insured for the full year, spending an average of $3,439 annually per capita. Part-year uninsured individuals spent more per capita than full-year uninsured individuals largely due to higher spending in the months that they had coverage.

A 2013 report from the Kaiser Family Foundation "Uncompensated Care for the Uninsured in 2013: A Detailed Examination" provides further information on the topic (*http://kff.org/uninsured/report/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination/*).

Death with Dignity Fiscal Notes and other Information

Below you will find links to fiscal notes and measures in four states with Death with Dignity laws or bills.[6]

- **Colorado House Bill 15-1135:**
  http://www.leg.state.co.us/clics/clics2015a/csl.nsf/fsbillcont3/7D2B561E0A83252487257D9000776DB8?open&file=1135_01.pdf
  Fiscal Note:
  http://www.leg.state.co.us/clics/clics2015a/csl.nsf/fsbillcont3/7D2B561E0A83252487257D9000776DB8?Open&file=HB1135_00.pdf
  Note: Bill introduced this year; pending.

- **Kansas House Bill 2108 (2013):** *http://www.kslegislature.org/li_2014/b2013_14/measures/hb2108/*
  Fiscal Note: *http://www.kslegislature.org/li_2014/b2013_14/measures/documents/fisc_note_hb2108_00_0000.pdf*
  Note: Bill died in committee.

- **Vermont Senate Bill 77:** *http://www.leg.state.vt.us/docs/2014/Bills/Intro/S-077.pdf*
  Fiscal note: *http://www.leg.state.vt.us/jfo/fiscal_notes/2013_S_77_as_amended_by_HHS.pdf*
  Note: Enacted in 2013.

[5] Provided by Melissa Hansen, program principal, NCSL. Ms. Hansen can be reached at (303) 364-7700.

[6] Please note that we did not conduct a comprehensive search for such measures. Three states have enacted Death with Dignity laws: Oregon, Vermont, and Washington.

- **Washington Ballot Initiative (2008):** *www.wsha.org/files/i1000 text.pdf*
  Fiscal Impact:
  http://ballotpedia.org/Washington_%22Death_with_Dignity_Act%22,_Initiative_1000_(2008)#Fiscal_note
  Note: Law went into effect in 2009.
  More information on death with in Washington is available at
  http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct.

We hope this is helpful. If you have questions or need additional information, please let us know.