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Assessment of Levels of Hospice Care Coverage Offered to Commercial Managed Care Plan Members in California: Implications for the California Health Insurance Exchange

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Abstract

The implementation of the Affordable Care Act that provides for the expansion of affordable insurance to uninsured individuals and small businesses, coupled with the provision of mandated hospice coverage, is expected to increase the enrollment of the terminally ill younger population in hospice care. We surveyed health insurance companies that offer managed care plans in the 2014 California Health Insurance Exchange and large hospice agencies that provided hospice care to privately insured patients in 2011. Compared with Medicare and Medicaid Hospice Benefits, hospice benefits for privately insured patients, particularly those enrolled in managed care plans, varied widely. Mandating hospice care alone may not be sufficient to ensure that individuals enrolled in different managed care plans receive the same level of coverage.

Keywords

hospice; mandated hospice benefit; Affordable Care Act; contract with a managed care plan; Health Insurance Exchange

INTRODUCTION

Hospice care in the United States is typically provided to someone expected to live less than six months due to a terminal disease or condition. It is free if an individual is eligible for Medicare. It is largely true for Medicaid as well, since nearly all states provide Medicaid hospice benefits. In contrast, individuals who are not covered by Medicare or Medicaid need to acquire private insurance in order to receive hospice care. In addition to lack of insurance as a barrier to hospice care for younger individuals, information about hospice benefit levels

offered by private health plans is either limited or outdated.¹ By contrast, federal and state regulations on hospice benefits for Medicare and Medicaid beneficiaries clearly specify the services covered, the level of care provided and the length of time a patient is eligible to receive hospice care.^{2–3}

We expect more younger individuals to have private insurance as states begin enrolling uninsured individuals and small businesses in mandatory health plans as of October 2013.⁴ With the implementation of the Affordable Care Act of 2010, states have selected and certified health plans that low and moderate-income individuals can afford to purchase.⁴ Hospice care is one of the essential health services that many states including California have required the certified health plans to provide.⁵ California has contracts with 11 health insurance companies that offer affordable health insurance plans through the California Health Insurance Exchange, or Covered California. Each company offers five different types (minimum, bronze, silver, gold or platinum) associated with different premium rates and out-of-pocket costs.⁶ Regardless of which type a patient chooses, the plan must provide hospice care as a covered benefit. What is unknown, however, is the level of coverage, such as services covered by the plans, requirements for the covered services, and the dollar or day caps on the services. It is important to examine such details since they are directly related to measures of care quality, such as ‘getting needed care without problems.’

There are three different approaches to the design and administration of hospice benefits for the privately insured: Medicare-like model, comprehensive model and unbundled model.¹ The first two models are similar; while the Medicare-like model is markedly similar to Medicare Hospice Benefits in requiring a waiver of curative treatments, the Comprehensive Model continues to pay for curative treatments while the patient is under hospice care. By contrast, the Unbundled Model approach deviates widely from these two models; it is popular among managed care organizations (MCOs) that opt to carve out and/or unbundle their hospice benefits and link it to case management. For example, they prefer to contract with hospices for only nursing and home health aide services and to dictate subcontractors (e.g., pharmacy, laboratory, home medical equipment, etc.). The unbundled approach is not well accepted by the National Hospice and Palliative Care Organization, whose central guiding principle in managed care contracting is the philosophy that “unbundled care is not hospice care.”⁷

These three broad approaches still remain, but the details are elusive. For example, the 2013 policy booklets of two popular HMO plans—Kaiser Permanente⁸ and Blue Shield of California⁹ offered to California public employees—suggest that the two HMO hospice benefits seemingly follow a Medicare-like model, while the Anthem Blue Cross PPO plan¹⁰ appears to take the unbundled approach. However, such documents do not contain detailed information on level of coverage, such as the services covered, the extent to which the covered services are subject to pre-authorization, day or dollar caps on the covered services, the number of in-network hospices, or the availability of other non-home care settings including in-network nursing homes and other residential facilities.

The primary objective of this study was to design and implement a survey of the hospice benefit levels offered by MCOs participating in the California Health Insurance Exchange,

in which managed care has been stronger than in any other state. In addition to the survey of Covered California health insurance companies, we also surveyed hospice agencies to identify insurance-related issues that hospice agencies experience in their provision of hospice care to privately insured patients enrolled in managed care plans. The survey results will be used to develop a survey instrument for a future large-scale study that has two goals: 1) to determine the variation in levels of hospice benefits and 2) to help state policymakers standardize the level of hospice coverage.

METHOD

We conducted two surveys – one for health care insurance providers participating in Covered California, and the other for large hospice agencies operating in California. Since the goal of the surveys was to receive input for the design of a final questionnaire, they were exploratory in nature, relying on semi-structured interview protocol so that respondents could answer at will.

Survey of Covered California Individual Health Plans

Eleven health insurance companies offer affordable health insurance plans in Covered California (see Table 1 for the providers' profiles). Research assistants contacted the companies, five of which agreed to participate in the interview. The interview questions focused on three categories: 1) a list of hospice agencies that each Plan has contracts with, 2) whether prior authorization is required for each of the 18 services that are considered to be necessary to address needs of a hospice patient and family, and 3) the maximum length of stay allowed for hospice care (see Appendix I for the interview questions). At the time of survey, the companies had not finalized detailed levels of coverage for hospice care. Therefore, our survey was focused on the managed care plans that the companies were offering at the moment. As a result, the level of coverage that Covered California plan members will actually experience might be different from the level of coverage we identified in this survey. However, we believe that the level of coverage for each plan will be similar to what we identified due to operation within the same company policies.

Hospice Agency Survey

Using the 2011 California Annual Home Health and Hospice Utilization Database spreadsheet obtained from the Office of Statewide Health Planning and Development,¹² we selected 75 hospice agencies that served more than 500 patients in 2011. For each agency, we extracted the number of hospice patients with private insurance, the number of hospice patients with managed care plans, the number of hospice patients ages 64 or under, and the unique hospice provider ID assigned by the California state agency. The interview with the hospice agencies (see Appendix II for interview questions) focused on their perceived insurance-related issues for privately insured individuals, particularly those under managed care plans. The interviewees were encouraged to discuss any contract issues freely.

RESULTS

Covered California Individual Health Plans

Five companies participated in our survey: Chinese Community Health Plan (CCHP), Kaiser Permanente, Contra Costa Health Plan, Sharp Health Plan, and Western Health Advantage. CCHP was created in 1986 to serve Chinese Hospital Healthy System patients. Its Covered California plan serves Region 4 (San Francisco) and Region 8 (northern San Mateo) with the help of nine hospitals and 315 physicians. Nearly four decades ago, Contra Costa Health Plan began enrolling Medi-Cal patients and became the model for managed care health plans across the nation. For its Covered California plan, it works with 10 hospitals and approximately 5,000 physicians in the Contra Costa Area (Region 5). Kaiser Permanente is considered one of the nation's largest non-profit HMO companies and a pioneer for usage of online communication tools between providers and patients. With 35 hospitals and 14,219 physicians, Kaiser Permanente Covered California HMO plans are able to serve patients across all 19 regions (but not in all areas within those regions) with the exception of Region 9 (Santa Cruz, Monterey, and San Benito). Sharp Health Plan is a nonprofit local health insurance company serving the San Diego Communities (Region 19). It provides coverage across 10 hospitals and works with 2,600 physicians. Finally, Western Health Advantage is also a nonprofit health insurance company providing services in the northern California regions (Region 2 – Napa, Sonoma, Solano, Marin; Region 3 –Sacramento, Placer, El Dorado, Yolo). There are 3,000 physicians working with Western Health Advantage at 15 hospitals.

Because they did not want to reveal their names in relation to the survey responses in the publication, we refer to the companies as Plans A, B, C, D and E in the following sections. Since our survey respondents are all HMO plans, the findings from our study may not be generalizable to other types of plans such as preferred provider organizations (PPOs) or exclusive provider organizations (EPOs). Table 2 summarizes the responses by the interviewed plans.

Names of Hospice Agencies Having Formal Contracts with Each Plan—All of the five health insurance companies indicated that their managed care plans are formally in a contractual relationship with hospices. Plans D and E were the only health plans that could reveal *some* of the names of hospices that they have contracts with. Plans B and C indicated that they are not able to reveal the names of hospices they have contracts with. Plan A was not able to provide the names of its contracted hospices since every medical group in the network of the Plan has its own.

The finding that a list of hospice agencies with a formal contract may not be readily available has important implications for the survey design. In particular, the question regarding a list of hospice agencies may be more appropriate to ask at the level of a medical group or clinic. This conclusion seems to be all the more valid because, according to the 2007 National Home and Hospice Care Survey (NHHCS) survey data,¹¹ the largest percentage of hospices (46%) reported physician offices as a major hospice referral source, followed by a hospital (36%). Table 2 summarizes the survey results by survey respondents.

Hospice Services Requiring Prior Approval—The survey questionnaire lists 18 hospice services, for which we asked whether prior approval was required. When it comes to receiving services from *nurse home visits*, Plans A and B indicated that they require prior approval. A representative of Plan C expressed that their plan requires prior approval for home health nurses in particular. By comparison, Plan D does not require their managed care patients to receive prior approval for nurse home visits only because they do not cover the service. For *chaplain visits*, Plans A and E do not need prior approval, but plan B does mandate prior approval. Plans C and D do not cover chaplain visits, and therefore do not require prior approval.

Plans B and E were the only ones mandating prior approval for *art therapy*. By contrast, Plan A does not require prior approval for art therapy. Plan C does not cover art therapy; therefore, if a patient obtains those services, he/she is not required to obtain prior approval and will be responsible for all expenses related to that service. For Plan D, art therapy falls under Mental Health Services, which is covered. However, prior approval depends on the line of business.

All five health plans require prior approval for *social worker visits*, *short-term general inpatient care* in a hospital, SNF or hospice inpatient facility and *chemotherapy*. For managed care patients receiving *respite care* to relieve their caregivers, all 4 health plans require prior approval except Plan D, which indicated that only some of their plans require prior approval for this service. Plan D mandates prior approval for *continuous home care* provided in the patient's home for short-term pain or symptom management only when the plan covers the service. Plan A requires prior approval only if the service is first authorized by the medical group. For a managed care patient to receive *intravenous therapy or transfusion*, all plans except Plan D, which contains limitations on transfusions, require prior approval.

Plan D is the only plan that does not require prior approval for *tube feeding* (including nasogastric and other enteral feedings), *hyperdermclysis*, *total parenteral nutrition (TPN)*, *respiratory therapy* (assuming that DME/respiratory system is not required), and *radiation therapy*. However, Plan D does require prior approval for *3D radiation therapy* and *respiratory therapy* that requires *DME or respiratory system*. All of the other plans require prior approval for the five services mentioned, but Plan A requires them to be authorized by the medical group. For *palliative sedation* Plan A is the only health plan that does not require prior authorization. Plans A and C are the only two plans that require prior approval for *hospitalization for conditions not related to the hospice diagnosis*, e.g., a broken leg from falling.

Reviewing these responses made it apparent that our initial assumption that the plans covered all of the listed services was incorrect. Furthermore, responses from Plan D indicated that there are different coverage levels depending on the types of policy plans, which most likely also have different premiums. These findings revealed that two more screening questions should have been included in the questionnaire before the question about prior approval, with the first question asking whether or not a service is covered and the second asking which policy addresses the covered service. Despite the mistake of having

omitted these two screening questions, the responses from the plans generally suggest that there may be substantial variation across HMO plans in service coverage and in the requirement for prior approval for those services. As such, this section of the questionnaire deserves intensive focus to ensure the collection of more detailed data.

Restrictions to the Length of Stay—Plans B and C are the only health plans that do not restrict the length of time for which a patient is eligible to receive hospice care. Plan D has 15 different policies, each of which includes different restrictions for the length of time a patient can receive hospice care. Plan E allows patients to receive care for 12 months or less, and Plan A limits care to only 100 days.

The responses to the question regarding length of stay under hospice care were surprisingly diverse compared to what Medicare Hospice Benefits specify. Medicare hospice benefits beneficiaries receive hospice care with no restrictions on the days of stay until death. The same is true for Medicaid patients, compared to which the 100-day limitation for members of Plan A appears to be surprisingly short. However, Medicare and Medicaid hospice patients must be re-certified 90 days after enrollment, then after another 90 days, and every 60 days after that. Furthermore, Medicare and Medicaid patients can revoke the election of hospice care at any time and later re-select it, but only if they get certified by a physician for a life expectancy of less than 6 months. Therefore, it may be necessary to add a few more questions to the final questionnaire, such as: 1) whether each plan requires its members to be re-certified before continuing hospice care, and 2) whether there is a lifetime limitation to the length of stay or selection of hospice care.

Hospice Agency Survey

Twenty-four hospice agencies participated in our survey. Their responses are organized under each interview question.

Percentage of Hospice Patients with Managed Care—Among our survey respondents, the percentage of hospice patients under age 65 ranged from 6% to 25%. The percentage of patients with private insurance, including managed care plans, ranged from 3% to 15%, except one hospice that enrolls its parent HMO members. Some hospice agencies included Medicare managed care plan members in their counts of patients with private insurance, while other agencies did not. Consequently, if we exclude Medicare managed care plans, the percentage of patients with managed care plans represents only a small fraction of a hospice's patient census.

Whether Having a Formal Contract with Managed Care—Since the interview criteria for the selection of hospice agencies included having more than 500 patients in 2011, all of the hospices had a formal contract with MCOs. Nevertheless, it should be noted that they were seeking contracts with more managed care and private insurance providers, and many hospices mentioned the enormous time and effort required to establish such contracts because negotiation is required for detailed coverage.

Negotiator Rate—We asked if a hospice receives less than the Medicare per diem rate for managed care patients. None of the agencies answered this question directly. However, a

couple of the agencies did mention the lower rate for managed care patients as an issue in their answers to other interview questions.

Issues with Managed Care and Private Insurance—Nearly all of the agencies mentioned problems with respect to the requirement of prior approval for hospice services. They raised concerns about delayed or refused services that the hospice specified in the plan of care for a patient. Other concerns were about settings of care. At least three agencies reported that placing managed care patients in a skilled nursing facility (SNF) was particularly difficult because the SNF did not have a formal contract with the MCO. A similar issue that some agencies observed was that MCOs increasingly limit the number of subcontractors (pharmacy, laboratory, a nursing home, etc.) that the agencies are allowed to work with. Some agencies also pointed out that particular MCOs limited nurse visits to a certain number of visits, beyond which nurse visits were not approved. At least three agencies described co-payments and annual deductibles as significant problems, as well as out-of-pocket costs for patients requiring higher levels of care than routine care, such as general inpatient or continuous home levels care. Four agencies cited the length of the patient's stay as the main problem with both managed care and private insurance.

One agency observed that younger individuals with private insurance providers tend to lack hospice benefits, emphasizing that, while hospice care is, by law, mandatory for HMOs, other type of private insurance plans are not required to offer hospice benefits. The agency continued to point out that individuals in its community did not realize that their private insurance covered home health benefits, but not hospice benefits. Since the agency provides both home health and hospice care, it tried to negotiate the tap into home service to cover hospice care.

One particular concern was noted: a majority of the interviewed agencies worried that the requirement of pre-authorization for enrollment even after the patient's primary care physician made the hospice referral would delay the enrollment of MCO patients. One agency responded as follows:

“Initial authorization is a problem. There can be delays in providing services. Our goal is to be in their homes within 24 hours within referral. However, companies that give authorizations are only open Monday through Friday. Another big problem is gatekeeper control. They require primary care physician authorization, and they require large volumes of documentation to prove that the patient is in need of the service. That is why it delayed services. When someone is at the end of their life I don't think it is appropriate for them to gate keep.”

Finally, the agencies that did not report a problem with managed care raised the issue of delayed payment. One agency's response was as follows:

“The only difficulties we have with private insurance and managed care is to get them to pay the claims. They routinely deny claims for questionable reasons or make mistakes scanning claims into their systems.”

DISCUSSION

Privately insured patients accounted for nearly 10% of patients in a large hospice agency in California in 2011 and the percentage of patients with commercial managed care plans was even lower. However, we expect this share to increase as uninsured individuals begin to enroll in federal mandated health plans and states begin to include hospice care as one of the essential benefits that participating health plans must provide.

Timely access to hospice care is an ongoing issue: more than 35% of Medicare decedents died within just one week after enrollment.¹³ This issue is more acute for younger patients. Short-term hospice use does not greatly benefit hospice patients and their families or generate more savings in overall health care costs.¹⁴ One of the barriers to timely access to hospice care is the requirement by MCOs of large amounts of documentation from primary care physicians who refer patients to hospice care, as well as the requirement of pre-authorization for these referrals. Although there is no study specifically examining the burden for hospice referral, physicians reportedly spend one hour per week and staff spend 20 hours per week just dealing with prior authorization for procedures and services.¹⁶ Our interview participants were concerned that such burdensome practices may postpone enrollment in hospice care or even discourage otherwise hospice-eligible patients from enrolling at all.

Some plans do not even cover services determined by Medicare as core services (e.g., nurse visits, social worker visits). If plans cover them, they are likely to place a limit on the number of visits and/or require prior approval. Indeed, prior approval is required for many of the hospice services as a condition for payment by the MCO. Our study health plan participants responded that their plans mandate prior approval for nearly all the hospice services listed in the interview—even for some services considered to be core services by Medicare. Two plans required prior approval for inpatient care for a broken leg resulting from a fall. Indeed, our hospice agency respondents expressed complaints about delayed or refused hospice services such as IV therapy to a cancer patient when prior approval for such care is required. Although we did not collect information on the prior authorization forms in our interview, the current plethora of prior authorization forms is a major concern among physicians.¹⁶

As a condition for coverage, Covered California HMO plans require that plan members choose only the contracted hospice. Although our health plan survey participants did not specify why they were unable to reveal the list of hospices that hold formal contracts with the health plans, we speculate that for at least some of the plans it may be related to having a very limited number of contracted hospice agencies—those that agree to a low ‘negotiator rate’ of hospice care for plan members.¹⁷ According to the 2007 NHHCS,¹¹ one in two hospice agencies did not have a formal contract with any managed care or private insurance provider. This implies that if a managed care patient were to choose a hospice that does not have a contract with the HMO plan, giving up hospice care or turning to a contract hospice may be the only options.

CONCLUSION

Anticipating the increase in hospice use among the newly insured younger individuals resulting from the Affordable Care Act, our study examined the variation in the level of coverage in the managed care plans offered by companies participating in the 2014 California Health Insurance Exchange. We also surveyed large hospice agencies that deal with MCOs for the younger patients not covered by Medicare or Medicaid. As expected, we found that there is wide variation in the level of coverage offered by plans. For this reason, standardizing the level of coverage across plans is important. The first step would be to make the covered services transparent and standardized. Then, the prior authorization process should be standardized, including standardizing the forms used for this process. It is particularly important to streamline and standardize the process of prior authorization for initial enrollment in hospice care, a major concern raised by our surveyed hospice agencies. In conclusion, mandating hospice care alone may not be sufficient to ensure that individuals enrolled in different managed care plans receive a comparable level of coverage. Using the survey results, we are developing a survey instrument for a large-scale study which has the aim to help state agencies in charge of health insurance exchanges standardize the level of hospice coverage.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1

Profile of Covered California Health Plans

COVERED CALIFORNIA HEALTH PLANS	ABOUT THE INSURER	PLAN TYPE	NETWORK	PRICING REGIONS SERVED
Anthem Blue Cross of California	A major U.S. health insurance company with more policy holders in CA than any other insurer. An independent licensee of Blue Cross Blue Shield of CA.	PPO HMO EPO	Hospitals: ~ 300 Physicians: ~ 30,000	All 19 pricing regions
Chinese Community Health Plan (CCHP)	Formed in 1986 to serve Chinese Hospital Health System patients.	HMO	Hospitals: 9 Physicians: 315	San Francisco, northern San Mateo only
Kaiser Permanente	One of the nation's largest nonprofit health insurance companies.	HMO	Hospitals: 35 Physicians: 14, 219	All 19 regions but not in all areas within those regions
Contra Costa Health Plan	The first county-sponsored health insurance company in the nation to receive federal qualification and to offer Medicare.	HMO	Hospitals: 10 Physicians: ~ 5,000	Contra Costa
Health Net Inc.	A publicly traded MCO that delivers services through health plans and government-sponsored managed care plans.	PPO HMO	Hospitals: 204 Physicians: ~ 44,000	13 regions
Sharp Health Plan	San Diego's only locally based commercial health insurance company.	HMO	Hospitals: 10 Physicians: 2, 600	San Diego
Western Health Advantage	A nonprofit health insurance company.	HMO	Hospitals: 15 Physicians: 3,000	Two regions
Molina Healthcare	A national MCO and a physician-led company.	HMO	Hospitals: 29 Physicians: 4,568	Four regions
Valley Health Plan	Licensed in 1985.	HMO	Hospitals: 4 Physicians: 993	Santa Clarita
L.A. Care Health Plan	Nation's largest publicly operated health insurance company. An independent local public agency created by the state of CA and LA County to serve especially vulnerable and low-income populations.	HMO	Hospitals: 35 Physicians: 1,005	Two regions of Los Angeles
Blue Shield of California	CA based non-profit health insurance company	PPO EPO	Hospitals: 223 Physicians: 22,048 (does not include hospital-based physicians)	All regions

Table 2

Summary of Survey Results by Five Health Plans

HEALTH PLANS	A	B	C	D	E
Managed care plan formal contract with hospices	Yes (unable to reveal hospice names)	Yes, provided the names of eight hospices	Yes (unable to reveal hospice names)	Yes, provided the names of six hospices	Yes (unable to provide the hospice names since every medical group has its own contracted hospice.)
Hospice services requiring a prior approval:					
☐ Services from nurses	1 Yes (but home health services only)	1 No	1 Yes	1 Yes	1 Yes
☐ Chaplains' visits	2 Do not cover	2 Do not cover	2 Yes	2 No	2 No
☐ Nurses' visits	3 Yes	3 do not cover	3 Yes	3 Yes	3 Yes
☐ Art therapy	4 Do not cover	4 Depends on line of business (falls under Mental Health Services)	4 Yes	4 Yes	4 No
☐ Social work visits	5 Yes	5 Yes (Referral is requested from physician)	5 Yes	5 Yes	5 Yes
☐ Short-term inpatient care in a hospital, SNF or hospice inpatient facility	6 Yes	6 Yes (length of stay depends on the plan)	6 Yes	6 Yes	6 Yes
☐ Respite inpatient care to relieve caregivers	7 Yes	7 Yes (only some plans; other plans do not cover)	7 Yes	7 Yes	7 Yes
☐ Continuous home care provided in the patient's home for short-term pain or symptom management	8 Yes	8 Yes (only when the plan covers the service)	8 Yes	8 Yes	8 Yes
☐ Intravenous therapy	9 Yes	9 No	9 Yes	9 Yes	9 Yes
☐ Transfusions	10 Yes	10 No (limitations exist)	10 Yes	10 Yes	10 Yes
☐ Tube feeding (including nasogastric and other enteral feedings)	11 Yes	11 No	11 Yes	11 Yes	11 Yes
☐ Hyperdermclysis	12 Yes	12 No	12 Yes	12 Yes	12 Yes
☐ Total parenteral nutrition or TPN	13 Yes	13 No	13 Yes	13 Yes	13 Yes
☐ Respiratory therapy	14 Yes	14 Yes (only when DME/respiratory system is required)	14 Yes	14 Yes	14 Yes
☐ Radiation therapy	15 Yes	15 No (but, prior approval required for 3D radiation therapy)	15 Yes	15 Yes	15 Yes
☐ Chemotherapy	16 Yes	16 Yes	16 Yes	16 Yes	16 Yes
☐ Palliative sedation	17 Yes	17 Yes	17 Yes	17 Yes	17 No
	18 Yes	18 No	18 No	18 No	18 Yes

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HEALTH PLANS	A	B	C	D	E
☐ Hospitalization for conditions not related to the hospice diagnosis, (e.g., leg broken from falling)					
Restrictions to length of stay to receive hospice care	No limit	15 different plans with different requirements	No limit	12 months or less	100 days or less