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Senate Bill 781 (Substitute S-1 as passed by the Senate)
Senate Bill 782 (as passed by the Senate)
Sponsor: Senator Valde Garcia
Committee: Health Policy

Date Completed: 12-6-01

RATIONALE

In August 2001, the Michigan Commission on End of Life Care published its final report on the State's policies on pain management and care of the dying. Governor Engler had formed the Commission under two executive orders and charged its 12 members with recommending methods to remove barriers to pain management, increasing citizen access to end-of-life care, and evaluating and improving end-of-life curricula for health care professionals, among other directives.

The report concluded that there exist many barriers to providing adequate end-of-life care. One such barrier, the report stated, is the current statutory definition of "terminal illness" as a disease that limits life expectancy to less than six months. This definition evidently is problematic because the causes of death are shifting from contagious diseases to chronic conditions such as heart disease, cancer, stroke, and diabetes. It can be difficult to determine when patients with most of these diagnoses are terminally ill. This shift is combined with a trend toward more deaths occurring at home; according to the report, 26% of Michigan residents died at home in 1998. As a result, limiting end-of-life care and attention to the last six months of life apparently prevents many chronically ill patients from receiving hospice care.

To target this, the Commission recommended that, "The Legislature should amend the Michigan Dignified Death Act (MDDA) to eliminate the terminology 'life expectancy of less than six months' and replace it with language to require physicians who identify a patient with limited life expectancy due to advanced illness to provide the patient with information about options for management of pain and symptoms."

CONTENT

The bills would amend the Michigan Dignified Death Act to delete references to "terminally ill patient" and replace them with "patient with reduced life expectancy due to advanced illness".

Senate Bill 781 (S-1) also would require the Department of Community Health, by July 1, 2002, to update its written summary of information for terminally ill patients. The update would include the new language proposed in these bills, including a clause referring to "adequate and appropriate pain and symptom management as a basic and essential element of medical treatment". Further, the bill states that these proposed changes could not be construed as creating a new mandated benefit for any coverage issued under the Insurance Code, the Nonprofit Health Care Corporation Reform Act, or any other health care payment or benefits plan.

Senate Bill 782 would strike the definition of "terminal illness" from the Act's definition section. (Currently, "terminal illness" is defined as a disease or condition due to which a patient's death is anticipated in six months). In addition, the bill would include, in the Act's legislative findings, language encouraging health care providers to initiate discussions with their patients regarding advance medical directives during initial consultations, annual examinations, and hospitalizations, at diagnosis of a chronic illness, and when a patient transferred from one health care setting to another.

(The Act requires physicians to inform terminally ill patients about recommended medical treatment for the terminal illness; about alternatives to the recommended medical treatment; about the advantages,

disadvantages, and risks of the recommended treatment and of each alternative treatment; and about the procedures involved in each treatment. A physician who is recommending medical treatment for terminal illness also must inform the patient that he or she may designate a patient advocate to make medical treatment decisions; that the patient has the right to make an informed decision regarding receiving, continuing, discontinuing, and refusing medical treatment for the terminal illness; and that the patient may choose palliative care treatment, including hospice care and pain management.

The Act also provides that a life insurer, health insurer, or health care payment or benefits plan may not, because a terminally patient has decided to refuse or discontinue a medical treatment as a result of information received under the Act, refuse to provide or continue benefits or coverage within the scope of an existing policy or contract, limit the amount of coverage or benefits available to the patient within the scope of an existing policy or contract, or charge the patient a different rate for coverage or benefits under an existing policy or contract.)

MCL 333.5656-333.5660 (S.B. 781)
333.5652-333.5655 (S.B. 782)

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

Terminal illness bound by a six-month-or-less prognosis is an American invention based on a financial rationale. The definition exists to limit the Medicare or Medicaid hospice benefit to those very close to death, as opposed to those who are chronically ill. It has no basis in clinically validated, scientific studies. There are several reasons to eliminate this definition of terminal illness in Michigan statutes.

First, physicians resist the six-month prognosis determination. Because prognostication is not an exact science and cannot be precisely determined for an individual patient, physicians are reluctant to “guesstimate” about such a significant matter. Doctors report that they are uncomfortable communicating an indeterminate, unscientific

prognosis with patients and families who turn to them for treatment. In addition, many physicians are well aware that a patient’s condition can dramatically decline following a declaration that he or she has less than six months to live, perhaps because the physician’s judgment is heard as a truth not to be disputed.

Next, the six-month prognosis impedes legitimate access to the Medicare/Medicaid hospice benefit. Reportedly, hospice providers fear that they will be scrutinized or sanctioned if they have a Medicare or Medicaid patient who lives longer than six months. In response, many patients may be discouraged from signing onto hospice until late in their illness, or they may be discharged from hospice if they live longer than six months. These realities are reflected in the decrease in average lengths-of-stay in hospice. While the number of hospice patients has increased, the number of days the average patient is under hospice care has decreased on the State and national levels.

Last, the six-month prognosis excludes terminally ill patients who are best cared for under a hospice approach, but are deemed ineligible. According to Hospice of Michigan, the State’s experience with Dr. Jack Kevorkian and the ensuing physician-assisted suicide ballot proposal demonstrated that approximately 75% of patients seeking such assistance were not terminally ill by current definition. Chronically ill people and their families are in serious need of comfort and support, but most are ineligible for the Medicare/Medicaid hospice benefit because of this definition. Services provided by hospice and paid for under this benefit include home visits by a spiritual advisor, a social worker, and a doctor and nurse trained in palliative care; yet these valuable resources must go unused by people suffering from Lou Gehrig’s Disease, Multiple Sclerosis, Alzheimer’s Disease, and many other painful diseases because of an arbitrary definition.

Opposing Argument

Removing the definition of “terminal illness” from State statute would not change Americans’ cultural attitudes about death and dying. Many people are reluctant to sign up for hospice care because they fear giving up curative treatments. This reluctance is reflected in the increasingly shorter lengths-

of-stay in hospice. It seems illogical and counterproductive to extend a benefit that is not used to its fullest extent. Furthermore, changing State statute would not alter Federal statute and the Medicare/Medicaid benefit limit of six months. While deleting the terminal illness definition could result in patients staying in hospice longer, they could do so without insurance or Medicaid coverage.

Response: This current definition of terminal illness does not meet the needs of patients, their families, or their physicians. Referring instead to "patient with reduced life expectancy due to advanced terminal illness" would more adequately describe chronically ill patients. Amending State statute could encourage Federal agencies to do the same, thus allowing more eligible patients to receive the end-of-life care they deserve, as well as the insurance or Medicare/Medicaid benefit to cover it.

Legislative Analyst: C. Layman

FISCAL IMPACT

Senate Bill 781 (S-1)

Other than printing and distribution costs of an updated summary as required in the Act, this bill should result in no additional costs to State or local government.

Senate Bill 782

As this bill primarily is focused on the provision of various information by physicians to patients with reduced life expectancy due to advanced illness (or their surrogates), there should be no fiscal impact on State or local government. However, it might be noted that if an affected person chooses to accept hospice services as a result of this information, the patient, if he or she is a Medicaid or Medicare recipient, may have to pay for these services out-of-pocket if the person's existing status does not meet the classical definition of "terminally ill", which is still the hospice trigger for Medicare and Medicaid.

Fiscal Analyst: J. Walker

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This analysis was prepared by nonpartisan Senate staff for use by the Senate in its deliberations and does not constitute an official statement of legislative intent.