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SFA BILL ANALYSIS

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House Bill 4080 (Substitute H-3 as reported without amendment)
Sponsor: Representative Penny Crissman
House Committee: Insurance
Senate Committee: Health Policy and Senior Citizens

Date Completed: 10-6-97

RATIONALE

The Public Health Code requires a health maintenance organization (HMO) contract with a subscriber or group of subscribers to include several types of covered health services, including emergency health services; however, emergency health services are not defined. Reportedly, in Michigan and elsewhere in the country, disputes have developed among managed care plans, emergency room health care providers, hospitals, and patients over what constitutes emergency services. In particular, there have been instances in which an HMO has denied payments for emergency services because the condition that caused the patient to go to the emergency room, in the final diagnosis, was determined in fact not to be an emergency; or, a health plan has refused to pay for an emergency room visit because the patient did not get prior authorization for the visit.

It has been argued that the denial of payment in such instances is punitive, because often persons go to emergency rooms with severe symptoms of distress that suggest serious, perhaps even life-threatening conditions, that turn out to be relatively mild problems. In fact, the recent Federal Balanced Budget Act (effective August 1997) addresses this situation regarding Medicaid recipients served by managed care organizations. The Federal Act requires certain managed care organizations to include coverage for certain emergency services, including a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, could reasonably be expected to place the patient's health in serious jeopardy. It has been suggested that a similar definition of emergency health services be included in that portion of the Public Health Code that governs HMOs.

CONTENT

The bill would amend Part 210 of the Public Health Code, which governs HMOs, to define "emergency health services", and to forbid an HMO from denying payment for emergency health services due to a patient's final diagnosis, or because the HMO had not given prior authorization before emergency services were provided.

The bill provides that "emergency health services" would mean medically necessary services provided to an enrollee for the sudden onset of a medical condition that manifested itself by signs and symptoms of sufficient severity (including severe pain), such that in the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health (or to a pregnancy in the case of a pregnant women); serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

An HMO could not deny payment for emergency health services up to the point of "stabilization" provided to an enrollee because of the final diagnosis or because the HMO had not given prior authorization before emergency health services were provided. "Stabilization" would mean the point at which no material deterioration of a condition was likely, within reasonable medical probability, to result from or occur during transfer of the patient.

MCL 333.21004

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

The bill would allow persons with HMO coverage to seek emergency care without fear that their insurance will not pay for the care because of lack

of prior approval, or the final diagnosis. This addresses a health industry concern. There have been recent complaints across the country regarding the denial of coverage by some managed care plans for health services provided in emergency rooms.

To illustrate the kinds of complaints that have led to legislation, one may consider the case of a person who believes he or she is having a heart attack and so seeks out care at the nearest emergency room. Upon examination, the patient is diagnosed as merely suffering from gastritis or indigestion. As a result, because the final diagnosis suggests that this was not in fact an emergency, the health plan refuses to cover the cost of services provided. In another case, a health plan might refuse to pay because the patient did not obtain prior authorization for an emergency room visit. The issue often revolves around the differing perception of an "emergency" by the person in distress (or parents, neighbors, or co-workers when someone else is in distress) and the insurance entity, and the willingness of emergency providers to furnish care but the refusal of insurers either to pay the providers or reimburse the patient for the cost of the care. The emergency room should not be used as a doctor's office, and insurers' rules are meant to prevent that costly and wasteful practice; however, patients with the appearance of the symptoms of an emergency should have a reasonable opportunity to visit an emergency room without fear of one day being denied coverage for the visit.

Supporting Argument

The bill would place a clear, practical definition of "emergency health services" within the act governing HMOs. Health maintenance organizations are currently required as part of their basic contract to provide emergency health services to customers, but that term has remained undefined. The bill would help to resolve disputes over when services provided in an emergency setting would be covered. If the definition were met, an HMO could not deny coverage based on the final diagnosis (e.g., indigestion rather than a heart attack) or based on the fact that prior authorization for such treatment had not been provided. The definition would require the "sudden onset" of a medical condition that manifested itself by "signs and symptoms of sufficient severity, including severe pain". It also would require payment for services "up to the point of stabilization". This language is similar to that enacted at the Federal level, and it has widespread support among the interested parties that have been holding discussions on this issue.

Opposing Argument

Some people have argued that a bill addressing HMOs should not be dealt with alone, but that companion legislation covering Blue Cross and Blue Shield of Michigan and commercial health insurance companies should move at the same time.

Response: Legislation addressing coverage of emergency services by other kinds of insurance entities is anticipated in the near future. Health maintenance organizations are a special case in some ways because their governing act requires the provision of emergency medical services as a part of the basic contract.

Legislative Analyst: G. Towne

FISCAL IMPACT

This language appears to be substantively similar to that included in Section 4704 (Increased Beneficiary Protections) of the Federal Balanced Budget Act of 1997. Section 4704 is applicable to managed care organizations serving Medicaid recipients and is not expected to have any fiscal impact.

Likewise, House Bill 4080 (H-3) would apply to all other enrollees of health maintenance organizations, including Medicaid enrollees, and appears to be cost neutral.

Note: As used in the case, "cost neutral" refers to the total health care system's cost. To the extent that such payment practices exist, the impact of this bill would be to shift costs from the enrollee to the HMO.

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.