House
Legislative
Analysis
Section

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CONTINUATION OF HEALTH CARE

House Bill 4485 (Substitute H-1)
Sponsor: Rep. Sandra Caul

House Bill 4486 (Substitute H-1)
Sponsor: Rep. Randy Richardville

House Bill 4487 (Substitute H-2)
Sponsor: Rep. Gerald Law

Committee: Health Policy

First Analysis (4-27-99)

THE APPARENT PROBLEM:

Reportedly, between 20 and 30 percent of health care providers leave the panel of a health plan during any three-year period. For a patient who has designated a provider as his or her primary care physician, the disruption in receiving health care that can happen when a provider is terminated can be disastrous, especially for those patients receiving on-going treatment for a medical condition and those women who are in their second or third trimester of pregnancy. It can take time to locate another physician in the health plan that has new patient openings, and even longer to wait for a new patient appointment. In an attempt to address this and other health-related concerns, federal legislation in the form of S. 374, known as the Promoting Responsible Managed Care Act of 1999, has been introduced in the U.S. Senate. Among other things, the bill would provide for continuity of care when a provider's contract with a health plan is terminated. Some people feel that the state should not wait for the federal legislation to become law, but should provide similar protection for Michigan residents with health coverage. Therefore, legislation has been introduced that would add similar provisions to the state's health insurance laws to provide for a transitional period of care for those patients whose primary care physician was terminated from the health plan.

THE CONTENT OF THE BILLS:

The bills would, in general, provide for continuation of health care services under certain circumstances for a member, enrollee, or insured if the participation in the health plan by the treating health care provider or health professional were terminated. "Termination" or "terminated" would include the expiration, nonrenewal, or ending for any reason of a contract or participation between a health care provider or health professional and the health plan, but would not include a termination for failure to meet applicable quality standards or for fraud. The bill's provisions would apply to members, enrollees, and insureds of health plans who had designated a particular physician as a primary care provider or physician, or who were undergoing a covered course of treatment from any other provider or physician within the plan at the time of the termination.

Under the bills, a primary care health care provider or physician would have to notify the insured person in writing of the termination within 15 days after becoming aware of the termination. If an insured was receiving an ongoing course of treatment with any other provider or physician in the health plan, and that provider's participation with the plan also ended, the provider or physician would also have to provide written notice of the termination to the insured within the same time period as above. The written notices would have to include a description of the procedure for receiving continuing care for an ongoing course of treatment. If the participation or affiliation between the health plan and an insured's treating physician or provider were terminated, the health plan would have to permit the insured to continue the course of treatment for a period of 90 days from the date of the notice to the insured of the termination. In the case of a pregnancy, coverage would extend through postpartum care related to the pregnancy for those

insureds who were in the second or third trimester of pregnancy at the time of the termination.

The above provisions would apply only if the health care provider or health professional agreed to all of the following:

-- To continue to accept as payment in full reimbursement from the health plan at the rates applicable prior to the termination.

-- To adhere to the health plan's standards for quality of care and to provide the plan with necessary medical information related to the care.

-- To adhere to the health plan's policies and procedures; for example, policies concerning referrals, preauthorizations actions, and treatment plans.

House Bill 4485 would amend the Nonprofit Health Care Corporation Reform Act (MCL 550.1101 et al.) to apply to group and nongroup certificates of Blue Cross and Blue Shield of Michigan. House Bill 4487 would amend the Insurance Code (MCL 500.100 et al.) to apply to expense-incurred hospital, medical, or surgical policies and certificates of commercial health insurance companies. House Bill 4486 would amend the Public Health Code (MCL 333.1101 et al.) to apply to group and individual contracts of health maintenance organizations (HMOs).

FISCAL IMPLICATIONS:

According to the House Fiscal Agency, the bills will result in no significant fiscal impact to state or local government. (4-21-99)

ARGUMENTS:

For:

With somewhere between 20 and 30 percent of health care providers leaving a health plan in a three-year period, and considering the length of time it may take to find another participating provider or to get a new patient appointment, patients may have a lapse in medical care. This is particularly problematic for those with chronic medical conditions that need continual supervision. The bills would add a level of protection by requiring health plans to continue to cover services provided by a former panel member for up to three months (with the provider's consent). This would mean that an insured person could still be treated by his or her physician for up to 90 days while she or he is looking for a new doctor and waiting for an appointment. This continuity of care is extremely important for those undergoing continuing treatment for a medical condition, as an interruption in medical care could result in adverse effects on the person's health. This provision is also important for those providers terminated against their's and their patients' wishes and provides a transition period while a new physician is being sought.

Against:

The responsibility for notifying patients of a provider's termination with a health plan should not rest on the physician, especially when the termination is against the wishes of the provider. Under the bills, a physician would have only about two weeks to identify and notify all of his or her patients covered by the particular plan, and would have to bear the entire cost of the notifications. For small practices that do not have the benefit of a comprehensive billing system, this could result in a hardship, as much of the work might have to be done manually. Also, since many practices are very busy, additional personnel would have to be added, which, besides being costly, could compromise confidentiality. Further, it is not clear what sanctions or legal liabilities a physician may bear if he or she could not notify all patients within the set time period. Since by law a patient's contract is with the health plan, and not with the doctor, it should be the health plan that bears the responsibility of notifying patients. At the very least, if the physician is required to send out the notifications, the health plan should bear all or part of the expenses associated with the notifications.

POSITIONS:

Blue Cross/Blue Shield of Michigan supports the bills. (4-26-99)

The Michigan Association of Health Plans supports the committee version of the bills. (4-27-99)

The Health Insurance Association of America supports the committee version of the bills. (4-27-99)

The Michigan Osteopathic Society opposes the bills. (4-26-99)

The Michigan State Medical Society opposes the bills in their current form. (4-27-99)

Analyst: S. Stutzky

■This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.