House
Legislative
Analysis
Section

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CONTINUATION OF HEALTH CARE

House Bill 4485 as passed by the House
Sponsor: Rep. Sandra Caul

House Bill 4486 as passed by the House
Sponsor: Rep. Randy Richardville

House Bill 4487 as passed by the House
Sponsor: Rep. Gerald Law

Committee: Health Policy

Second Analysis (7-29-99)

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 doctor 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, those with a terminal illness, 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 physician'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 primary care physician were terminated. "Termination" or "terminated" would include the expiration, nonrenewal, or ending for any reason of a contract or participation between a physician 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 physician, or who were undergoing a covered course of treatment from any other physician within the plan at the time of the termination.

If the participation or affiliation between the health plan and an insured's current physician were terminated, the bills would require the health plan to permit the insured to continue an ongoing course of treatment for a period of 90 days from the date of a 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. A terminally ill person could remain with his or her physician for the remainder of the person's life for care directly related to the treatment of the terminal illness. "Terminal illness" is currently defined in the Public Health Code as "a disease or condition due to which, in the opinion of a physician, a patient's death is anticipated within 6 months after the date of the physician's opinion."

The bills would allow, but not require, a primary care physician 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 physician in the health plan, and that physician's participation with the plan also ended, the physician could also provide written notice of the termination to the insured within the same time period as above. The written notices could include a description of the procedure for receiving continuing care for an ongoing course of treatment.

The above provisions would apply only if the physician 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 utilization review, referrals, preauthorization 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). The bills would take effect July 1, 2000.

FISCAL IMPLICATIONS:

According to the House Fiscal Agency, the bills will result in no significant fiscal impact to state or local government. (7-23-99)

ARGUMENTS:

For:

Changing physicians can be very stressful for patients, especially considering that doctors and their patients enjoy a relationship that is built on trust and that takes time to develop. It is reported, however, that between 20 and 30 percent of health care providers leave a health plan during each three-year period. Whether a doctor leaves a health plan by choice or is terminated by the plan, the result is that a patient must find another doctor within the health plan that is accepting new patients or that can provide the medical expertise that a particular medical condition necessitates. In such circumstances, a patient may experience a lapse in medical care due to the length of time it may take to find another participating provider or to get a new patient appointment. This is particularly problematic for those patients with chronic medical conditions that need continual supervision, pregnant women, and patients with terminal illnesses. 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 doctor'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 or pregnancy, 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 wishes, and the wishes of the patient, and provides a transition period while a new physician is being sought.

Against:

The bills would permit, but would not require, the physician to notify patients that he or she was no longer on a particular health plan panel. The committee-passed version would have required physicians to notify their patients. However, it was argued that it was unfair to require physicians to bear the entire expense, both in cost and time, of the patient notifications, especially in those cases in which a physician was terminated against his or her wishes. The health insurers, on the other hand, maintain that it is the physician who has the most accurate, up-to-date patient records; therefore, the physicians should do the notifying because their patient addresses would more likely be correct.

Some people believe that the benefit of the legislation is being eroded by the disagreement over who should tell a patient that he or she must begin the search for a new doctor. Without timely notification, how is a patient to know that upcoming visits to his or her doctor may not be covered? Also, since many doctors have a several-months-long waiting list for new patient visits, a lapse in care may be experienced if patients are not notified in a timely manner. This would be

particularly troublesome for those patients receiving care for cancer, diabetes, severe asthma, or other conditions that need close medical supervision.

Perhaps a compromise could be reached, in which the doctors and health plans share the burden of patient notifications. For instance, perhaps the health plan could do the patient notifications, but only after the physician supplied the names and addresses of his or her patients covered by that particular plan. Since the legislation would be of tremendous benefit to patients, an equitable method of timely patient notification should be developed and specified in the bills.

Against:

The bills are flawed in several respects. First, no one is required to notify patients when a physician leaves the panel of a health plan, as previously discussed. Secondly, a patient could only continue to see his or her physician for the three-month transition period if the physician was so inclined. Managed care plans typically pay a physician a flat fee per month or year for each patient in the plan, regardless of the number of office visits, as opposed to fee-for-service plans that pay a set rate depending on the procedure or service provided. The bills, though, would require a physician providing the transitional care to continue to accept the lower payment schedule of the managed care plan rather than charging patients the full fee for each service offered. Further, the physician would bear the expense of the patient notification, which would include staff time as well as postage. And, some offices may not have the resources to complete the notification process within the specified 15-day time period. Though certainly physicians value the relationship developed between themselves and their patients, and most are committed to delivering a high quality of care, the fact remains that physicians would be put at a financial disadvantage when choosing to provide the transitional care allowed for under the bills. However, as health plans also are struggling to deliver a quality product while containing costs, shifting the financial burden to the insurance companies could result in further cuts in covered services. A concern has been raised, therefore, that since there is little incentive for a physician to either notify his or her patients under such circumstances or to continue to provide medical care for the specified transition period, the bills may do little to provide the level of protection for patients that they are purported to do.

POSITIONS:

The Michigan State Medical Society (MSMS) supports the bills. (7-27-99)

The Michigan Osteopathic Society supports the concept of continuity of care. (7-26-99)

The Michigan Association of Health Plans supports the concept of continuity of care, but has concerns regarding the merit of the legislation and whether the bills will address the issue. (7-29-99)

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.