PHYSICIANS' GUIDE TO STATE LEGISLATION

CASE STUDY

DEFINITION OF EMERGENCY SERVICES

Issue

Retrospective denial of payment by insurance companies, health maintenance organizations (HMOs), and managed care plans for emergency services rendered to patients, based on final diagnosis rather than the presenting complaint.

ACEP Position

"A patient has made an appropriate visit to an emergency department when: an unforeseen condition of a pathophysiological or psychological nature develops which a prudent layperson, possessing an average knowledge of health and medicine, would judge to require urgent and unscheduled medical attention most likely available, after consideration of possible alternatives, in a hospital emergency department." (adopted October 1982 by the ACEP Board of Directors)

ACEP also has endorsed the following policy/definition of a bona fide emergency, which was adopted by the Health Care Financing Administration:

"The College believes that reimbursement for a bona fide emergency should cover services provided in a hospital emergency department after the onset of a medical condition that is manifested by symptoms of sufficient severity (including severe pain) that, in the absence of immediate medical attention, could reasonably be expected to result in placing health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part." (August 1984).

Background Information

For several years prior to 1992, the Maryland Chapter of ACEP has been haphazard and generally unsuccessful in its lobbying efforts with the Maryland legislature. There was a strong dependence on the Maryland State Medical Society for help with Maryland ACEP's political agenda, but the chapter felt that the medical society only paid lip service to emergency medicine's legislative goals and did not fight strongly for them when it really counted. Maryland ACEP had experienced no satisfaction with their prior political efforts, had no legislation passed, and believed that insurers (particularly HMOs) were dominating emergency medicine in the political arena.

Legislative History in Maryland

In the summer of 1992, all members of Maryland ACEP who were interested in advance planning were invited to meet and discuss the chapter's political efforts. This group identified legislative ineffectiveness as the chapter's number one problem. They recommended that the Maryland ACEP Board of Directors hire a lobbyist, if financially feasible, to help with the chapter's legislative agenda.

After receiving advice from the state dental and podiatric medical associations, several lobbyists were solicited and evaluated. The Board chose an experienced lobbyist with a good reputation who was willing to work for a flat fee; the lobbyist submitted the lowest bid ($6,000 plus costs not to exceed 10%) for the services to be rendered.

The Board decided that the chapter's main activity for the year would be to reintroduce a bill defining a bona fide emergency visit as based on presenting symptoms rather than a final diagnosis. Similar bills had died at the committee stage in the three previous legislative sessions. The Maryland State Medical Society initially was asked to find a sponsor for the bill, but when this did not occur quickly, the chapter's newly hired lobbyist easily found sponsors for the bill in both chambers of the legislature. This action served notice to the Society that Maryland ACEP was now a serious player in state politics. The chapter also developed an "arms-length" relationship with the Society with regard to legislative activity, which proved extremely valuable later in the session.

Because similar bills had previously been killed in committee, the chapter's first efforts were at the committee level. Brochures from national ACEP, detailing the training and responsibilities of emergency physicians, were sent to all members of the appropriate committees. Contact was made and relationships were established with key committee members. The lobbyist's advice, activities, and expertise were crucial in this initial process.

In the Maryland House of Delegates, it soon became obvious that the bill would not get out of committee without some unusual strategy, so the chapter attempted a bold initiative. Chapter representatives went to the chairman of the key House committee and offered to have certain ED groups regulated by the state in a single-payor reimbursement plan, similar to the manner in which Maryland hospitals were paid. The offer immediately got the attention of this influential legislator, and he appointed several of his committee members to a "work group," with instructions to work with the Maryland Chapter on this issue.

On the Senate side, the chairman of the key committee was already strongly allied with the HMO insurance industries. The chapter agreed to help him with other aspects of health care reform (especially practice parameters) that were important to him in exchange for consideration of the bill. All other members of the committee also were contacted and lobbied.

By that time, the chapter's activities had definitely attracted the attention of the HMO and insurance associations. They spent more than $100,000 trying to defeat the bill in committee, arguing that this was not an issue worthy of legislative action and using financial scare tactics (for example, premiums would increase if the bill passed). The chapter countered with explanations of the federal mandate to see all patients and argued that the "prudent layperson" language, already written into other areas of Maryland law, was also a reasonable standard in matters of health care. Financial aspects were downplayed, and the cost-effective nature of early treatment was stressed. Testimony was presented, with graphic case examples. Using disgruntled HMO members to discuss their experiences and testify in favor of the bill proved to be especially effective.

The Senate committee initially rejected the bill by a vote of 4 to 7, but the chapter's lobbyist managed to get the vote reconsidered at a later date. Committee members were lobbied strongly by Maryland Chapter members who lived in their districts, and some political deals were made. The reconsidered vote was 9 to 2 in favor of the bill. On the House side, the HMOs also were unsuccessful in killing the bill, but did manage to have the "prudent layperson" language deleted from the House version.

In the full House and Senate, more obstacles arose. The speaker of the House was

inclined to let the bills die without calling for a vote, but a legislator who had been convinced to "champion" the bill kept pushing the speaker for a vote. Finally, after much interchamber dealing, and a result of strong efforts by the chapter's lobbyists and key legislators, a vote was taken and both versions of the bill (with and without the "prudent layperson" language) were passed, just 90 minutes before the end of the legislative year. It was left to the governor to decide which version would be signed into law.

The governor was lobbied hard by those on both sides of the issue. Letters from patients and physicians were solicited, and key legislators were asked to intervene. The governor's personal physician happened to be an emergency physician, and he was enlisted to lobby his patient for passage of the better bill. The governor finally signed the bill preferred by Maryland Chapter, which included the "prudent layperson" language. The "Maryland Definition" was now law.

Arguments in Favor of this Position

- An ED is not nearly as desirable a location to obtain care, as is a doctor's office or clinic; therefore, the "prudent layperson" is not likely to seek care in an ED unless he or she truly believes that the condition is urgent.
- This is not a money issue for emergency physicians and EDs, because the patient can in most cases be billed if payment for the visit is denied by the insurance carrier or HMO.
- Early treatment of most conditions is very cost-effective, saving money by avoiding later, more expensive treatment and decreasing the chance of subsequent hospitalization.
- Patients who were seen for legitimate emergency conditions and whose claims were later denied can be asked to testify. They tend to make strong arguments in favor of this position.
- This position can be presented as an example of blatant cost shifting by HMOs and other insurers, giving them an unfair advantage over consumers and providers.
- In discussion on this position, use examples of common, routine symptoms that can have catastrophic consequences, such as simple headache vs. intracranial bleed, "indigestion" or "heartburn" vs. acute myocardial infarction, and "stomach flu" requiring hours of observation and IV rehydration.
- Argue that the public should not be expected or required to make astute medical judgments concerning the seriousness of their symptoms; argue rather that the "prudent layperson" standard is not only reasonable but also necessary and appropriate for effective health care delivery.
- Emergency care makes up less than 1% of national health care costs.

Arguments Against this Position

- Too much routine and nonurgent care is already provided in the "expensive" ED setting.
- Emergency physicians tend to consider every presenting complaint, no matter how trivial, a bona fide emergency for reimbursement purposes.
- Patients admitted to the ED are a "captive audience" subject to any costly diagnostic test or treatment that the emergency physician chooses to order. The emergency physician has no incentive to control costs and will in fact make more money if excessive testing is done.
- Retrospective denial of payment for ED treatment is relatively rare and not worthy of legislative intervention.
- Managed care is the only hope for curbing runaway health care costs without sacrificing quality. The ability to deny payment for "unnecessary" treatment is essential to any managed care plan, or else costs can never be contained.
- Letting patients decide when to seek care in an ED will lead to more "convenience care" and ultimately result in higher insurance premiums; these would affect the affordability of

insurance and access to care for all citizens of the state.

- Insurers may show examples of high ED charges for what was eventually diagnosed as a "routine" or nonurgent medical condition. Alternately, they may ask legislators to recall the "ridiculously expensive" bill received after they or one of their family members last used an ED.

Potential Proponent Organizations

The state medical association; emergency medical services organizations; consumer advocacy groups; advocates for the poor, and organizations of older citizens, such as the American Association of Retired Persons are potential allies. However, be aware that any or all of these groups may not share the same feelings about this issue.

Potential Opponent Organizations

The insurance and HMO industries, managed care plans; and, in the state of Maryland, the state Chambers of Commerce organization and certain labor unions are potential opponents.

Keys to this Legislative Success

An efficient and knowledgeable lobbyist was essential and well worth the cost. The importance of one or more legislative "champions" cannot be overemphasized. The ability to compromise and a willingness to work with key legislators was necessary for success. A strong and timely lobbying effort by constituent Maryland Chapter members with their legislators also was important.

Editor's note: ***On January 19, 1994, the ACEP Board of Directors adopted the following "Definition of Emergency Services" which is recommended to be used in similar legislative initiatives: "Emergency services are those health care services provided to evaluate and treat medical conditions of recent onset and severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that urgent and/or unscheduled medical care is required."***

For more information on this issue,
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