These changes have the potential for a significant, unanticipated financial impact not only on the HMO industry, and ultimately their subscribers, but on the State as well. Care provided in an emergency room is the most expensive way to deliver health care. The bill removes any financial disincentive for subscribers to seek care in costly settings such as emergency rooms. For example, under the bill as finally passed, an HMO subscriber, including a State employee in a managed care plan, or a client of the State Medicaid program, could seek treatment at a hospital emergency room in contravention of the rules of the HMO, and perhaps the express direction of the primary care physician, and yet the HMO or the State would be liable for payment to the provider. The fiscal impact on the State Employee's and Retiree's Health and Welfare Benefits Program alone is estimated at $1.6 million for the remainder of FY 1996, and $3.4 million for FY 1997. Given that Maryland is currently shifting toward having a greater percentage of Medicaid patients in managed care plans, the ultimate fiscal impact on the State could be substantially more.

The specific language of the bills as introduced, and as they read during the public hearings in the House and Senate, never included the expanded language added by the Conference Committee. Fundamental fairness, as well as State budget considerations, require that the bill be vetoed.

Complaints by emergency health care providers gave rise to the bill's introduction. I am acutely aware of, and sympathetic to their concerns. These groups argue that HMOs often authorize nonemergent visits to the emergency room, only to disapprove the provider's request for reimbursement if the HMO determines, after the treatment, the patient in fact did not require emergency treatment. Thus, they argue, HMOs have little to lose by referring patients to the ER, knowing that the financial responsibility for collecting payment for any nonemergency service falls on the provider. This situation is exacerbated by provisions of federal law which require hospitals to provide an "appropriate medical screening examination" to any individual who seeks treatment, and to provide further care if the individual is determined to have an emergency medical condition.

It does appear inequitable if current law would allow an HMO to refer a patient to an emergency room, only to then deny coverage for the service provided by the hospital and other providers. Clearly the requirements of the federal law place an added burden on emergency room providers to treat any and all patients. It may also be true that HMOs require greater incentives to better manage the process of providing emergency services to their subscribers. However, just as the current law may in some cases unfairly place the burden of treatment and obtaining payment on the emergency health care providers, the language adopted on the last day of Session seems to swing the pendulum far in the opposite direction. While the General Assembly may ultimately adopt this approach, it should be done with a full and fair opportunity for all parties to participate in such a major policy change.

The bill contains an additional inequity identified by the Attorney General. As set forth in his bill review letter, it is possible that the bill could be inapplicable to HMOs operating in Maryland that are federally qualified. This is possible if a substantial number of enrollees of a federally qualified HMO sought care at out–of–network emergency rooms, which in turn could bring the HMO out of compliance with federal standards. Federal law provides that in such an eventuality, it is the State law, rather than the HMO, which suffers the consequences, and the law is rendered inapplicable to the federally