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SFA BILL ANALYSIS

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Senate Bill 664 (as introduced 9-20-01)
Sponsor: Senator Bev Hammerstrom
Committee: Health Policy

Date Completed: 10-23-01

CONTENT

The bill would amend the Public Health Code to add a provision to the patient bill of rights entitling patients or residents to adequate pain and symptom management, palliative care, and hospice care.

Currently, all health facilities are required to post, in a public place, a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. The rights include the right to appropriate care, regardless of race, religion, disability, etc.; the right to information about their medical condition and treatment; confidential treatment of personal and medical records; freedom from mental or physical abuse; and the right to refuse treatment, among others. In the case of a nursing home patient, these rights can be exercised by the patient's representative.

Further, the bill would specifically require the attending physician at a nursing home or home for the aged to document patient discharge and transfers. Currently, this documentation is required, but the personnel who must complete it is not specified.

MCL 333.20201 Legislative Analyst: C. Layman

FISCAL IMPACT

A plain reading of this bill appears to indicate that each health care facility would have to provide, in writing, a document describing the rights and responsibilities of patients, including the statement that patients would be entitled to adequate pain management and hospice care. Using a literal interpretation of the term "entitle", in conjunction with the changes proposed by Senate Bills 660 through 663, a facility (and therefore possibly first- and third-party payers, including the State) could end up with an unlimited liability.

Because of the quasi-subjective nature of pain, one could imagine a patient demanding a significant battery of technological devices, e.g., infusion pumps or transcutaneous electrical nerve simulators, to combat his or her uncomplicated postsurgical pain. For certain, a physician still would be the legitimate gatekeeper of treatment decisions, but that doctor could find himself or herself facing a persistent patient for treatments that could have previously been put aside by a reference to a pre-existing definition of "pain". More to the point, if this type of scenario were to unfold and the patient were covered by either Medicare or Medicaid, the situation could become complicated rapidly, in that Medicare (and therefore Medicaid) restricts reimbursement of certain pain-attenuating therapies based on a chronic intractable/acute pain dichotomy.

Fiscal Analyst: J. Walker

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