SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based only on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/SB 866

SPONSOR: Banking and Insurance Committee and Senator King, and others

SUBJECT: Health Maintenance Organizations

DATE: March 6, 2000 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Emrich	Deffenbaugh	BI	Favorable/CS
2.			HC	
3.			FP	
4.				
5.				

I. Summary:

Committee Substitute for Senate Bill 866 provides for the following:

Prohibits a health maintenance organization (HMO) contract from prohibiting or restricting a subscriber from receiving in-patient services in a contracted hospital from a contracted primary care or admitting physician.

Prohibits a contract between an HMO and a contracted primary care or admitting physician from containing any provision prohibiting such physician from providing inpatient services in a contracted hospital to a subscriber.

Requires an HMO to pay a contracted primary care or admitting physician, pursuant to such physician's contract, for providing inpatient services in a contracted hospital to a subscriber.

In order for these provisions to apply, inpatient services must be determined by the HMO to be medically necessary and covered services under the organization's contract with the contract holder. Further, the committee substitute shall take effect on July 1, 2000, and shall apply to provider contracts entered into or renewed on or after that date.

This committee substitute substantially amends the following sections of the Florida Statutes: 641.31, 641.315, and 641.3155.

II. Present Situation:

Health Maintenance Organizations and Provider Contracts

Health maintenance organizations (HMOs) provide a comprehensive range of health care services for a prepaid premium. Such organizations stress preventive care and make efforts to avoid unnecessary hospitalization and expensive tertiary care. Subscribers must surrender certain

freedom-of-choice selections of health care providers and health-care-related services. Subscriber choice is typically restricted to a "gatekeeper" physician (primary care physician) or other health care professional who is either an employee of, or has contracted to provide professional services on behalf of, the subscriber's HMO. Furthermore, subscribers are restricted in their choice of hospitals and other health care delivery facilities that they may utilize.

The Department of Insurance regulates HMO finances, contracting, and marketing activities under part I of chapter 641, F.S. The Agency for Health Care Administration regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a Certificate of Authority from the Department of Insurance, a HMO must receive a Health Care Provider Certificate from the Agency for Health Care Administration. Any entity that is issued a Certificate under part III of chapter 641 and that is otherwise in compliance with the licensure provisions under part I may enter into contracts in Florida to provide an agreed-upon set of comprehensive health care services to subscribers in exchange for a prepaid per capita sum or prepaid aggregate fixed sum.

Section 641.31, F.S., sets forth certain requirements HMOs must meet when contracting with subscribers and provides for certain coverage that must be included in the contract. Among the provisions included are those relating to rates charged, contract amendments, services, subscriber grievances, dependent coverage, including adoption, emergency services and care, preexisting conditions, open enrollment, disease-specific conditions, and point-of-service provisions.

Requirements for contracts between a HMO and its providers are established in s. 641.315, F.S. Among the provisions included are those relating to obligations for fees, liability for covered services, collection of money for services, contract terms, notice of cancellation, provider-patient communication, exclusive provider contracting, and contract termination.

Section 641.3155, F.S., relates to HMO provider contracts and payment of claims. Specifically addressed are time frames for payment of uncontested claims, contesting of claims, prompt payment, and payment reconciliation.

In general, current Florida law does not address the authority of a HMO to include or prohibit any provider contract element relating to the provision of inpatient hospital services.

The “Hospitalist” Concept

The hospitalist “specialty” is simultaneously an old and a new health care delivery concept. The term “hospitalist,” according to the National Association of Inpatient Physicians (NAIP), is a physician dedicated to the care of hospitalized patients. They coordinate all aspects of an inpatient’s care, including regular visits to the bedside, ordering tests and medications, integrating recommendations from specialists, and updating the family until the patient is discharged, when care is transferred to the patient’s primary care physician. Generally, throughout the literature, others describe hospitalists as licensed physicians who devote a minimum of 25 percent of their practice to management or coordination of adult hospital inpatient care, nursing home care, or rehabilitative care. The concept is old in the sense that for more than 20 years pediatric practice in the United States has involved consultation with physicians specializing in hospital-based care of

children, referred to as "intensivists" rather than "hospitalists." It is a relatively new concept when applied to adult health care.

According to the NAIP, an organization that represents the interests of hospitalists, the term "hospitalist" is merely "a job description." Hospitalists may be allopathic or osteopathic physicians. Approximately 55 percent of hospitalists are trained in general internal medicine; 35 percent are trained in an internal medicine subspecialty, most commonly pulmonary or critical care medicine; about 6 percent are trained in family practice; and the remainder are mostly pediatric hospitalists trained as pediatricians. There is no separate specialty board certification currently available for hospitalists.

The National Association of Inpatient Physicians estimates that there are, nationally, 5,000 physicians currently practicing as hospitalists, an increase from an estimated 300 in 1995. The estimated number of hospitalists practicing in Florida is 300, and they are located in all regions of the state.

During the final few days of the 1999 Legislative Session, language intended to prohibit HMOs from mandating the use of hospitalists was amended by the Senate onto Committee Substitute for Senate Bill 2554, relating to insurance contracts. The adopted language stated *"[n]o health maintenance organization's contract shall prevent a subscriber from continuing to receive services from the subscriber's contracted primary care physician or contracted admitting physician during an inpatient stay*." Another related provision stated: "*a health maintenance organization shall not deny payment to a contract primary care physician or contract admitting physician for inpatient hospital services provided by the contracted physician to the subscriber."* The language was amended out of the bill by the House of Representatives and did not become law.

The 1999 proposed legislative language was in reaction to an effort to require use of hospitalists for the delivery of adult inpatient hospital care, except obstetrics and gynecology, as announced in a letter dated February 12, 1999, from Prudential HealthCare-South Florida (PHC) to its physician providers.[1] In a letter addressed to "Dear Colleague," the company's medical director for South Florida notified the plan's network of physicians " . . . that beginning March 15, 1999, IntensiCare Corporation, a hospital management company, will begin a transition towards principal responsibility for all PHC members during the time of confinement in an acute or sub-acute setting." The transition was to proceed in two phases. Phase One starting on March 15th at nine named facilities and "all sub-acute facilities," and Phase Two starting on June 15th "at all other PHC contracted hospitals and will continue at all sub-acute facilities." Plan providers were instructed that "[a]ccording to the above-noted schedule, when a PHC member needs inpatient or sub-acute care, the medically necessary admissions will be approved to the appropriate facility by one of our participating 'Hospitalists.'" The letter goes on to state three anticipated benefits to result from this change and then: "We will be communicating this information of enhanced acute care to our members, through our customary publications, as well as our Member Services. Please

[1] Aetna U.S. Healthcare bought Prudential last year and has decided to end the mandatory utilization of hospitalists effective March 27, 2000. Representatives with Aetna stated that it was "a business decision" to terminate the program.

join us in optimizing the benefits of this program by sharing this information with your Prudential patients."

As a result of the concept of "hospitalist" being raised during the latter part of the 1999 Session and because little was known about the extent of the use of hospitalists in the state, the Senate President assigned as an interim project of the Senate Health, Aging and Long-Term Care Committee a study of the emerging physician specialty "hospitalists." The report from that interim project, Interim Project Report 2000-56, September 1999, served as the source of most of the information presented in this portion of this analysis.

Senate staff research identified seven major findings, as presented in their project report:

Mandating that a hospitalist deliver all adult inpatient hospital care is universally opposed by representatives of all physician organizations, including the representatives of hospitalists, as well as other participants in the health care system such as patients and hospitals.

Use of hospitalists in the delivery of adult inpatient hospital, nursing home, and subacute care services is anticipated to result in significant efficiencies and cost savings, and early results when examined by interested parties, seem to indicate that such anticipation may be correct; however, while use of hospitalists is growing rapidly, the experience is so limited and the time frame so short that no meaningful determination about cost trends can be made at this time.

Hospitalist proponents insist that hospitalists improve the quality of care of hospital, nursing home, and subacute care services because of their focused expertise; more immediate availability to the patient and staff; higher volume of setting-specific experience; and greater familiarity with the institutional personnel and settings in which they practice, relative to physicians caring for few patients on an infrequent basis in, generally speaking, unfamiliar settings.

Use of hospitalists may exacerbate the communication problems that already exist between primary care physicians (PCPs) and the specialists who provide most adult inpatient hospital treatment.

Use of hospitalists may force patients to take on a more formal responsibility in coordinating their health care between hospital services received and physician office services received to ensure continuity of care. This may be necessary because, if the patient's PCP is not the admitting physician, such physician may not have the ability to access the patient's hospital record, which is the hospital's property, leaving PCPs to rely on the patient care summaries provided by the hospitalists attending to the patient.

To the extent that PCPs limit, or are limited in, hospital, nursing home, or subacute care experience, they may find it increasingly difficult to resume such practices and may be limiting their future ability to be credentialed to work in such settings due to the loss of skills necessary for working in such environments.

The catalysts for launching hospitalist programs are prompted by a variety of motivations and business arrangements.

Among the extensive supporting information contained in its report, Senate staff included the following:

The National Association of Inpatient Physicians, founded in 1997, has published a position statement strongly opposing mandatory implementation of hospitalist programs. In addition to its position statement, NAIP's co-presidents John Nelson, M.D. and Winthrop Whitcomb, M.D., on behalf of the board of directors, on May 3, 1999, sent a letter to the American Association of Health Plans and the Health Insurance Association of America to oppose, "in the strongest terms possible, the imposition of mandatory hospitalist programs by [managed care] organizations on patients and primary care physicians." They sent the same letter, on June 9, 1999, to the Blue Cross and Blue Shield Association and, on July 21, 1999, to Prudential HealthCare-South Florida and Cigna Healthcare of Texas. The stated basis of their opposition was, " . . . we believe that the success of the hospitalist model fundamentally depends on the ability of the primary physician, with whom the patient has a long-standing and trusting relationship, to endorse both the individual hospitalist and the hospitalist model of care to a patient."

John R. Nelson, M.D., Co-president of the National Association of Inpatient Physicians advocates voluntary use of hospitalists by the primary care physician. He believes that "hospitalists need to earn referrals, not be assured of them through managed care mandates." [Senate staff telephone interview, August 12, 1999]

Summary information from the Senate report indicated that:

(a)t this time, the only public policy issue that has crystallized relating to hospitalists is how managed care organizations are implementing hospitalist requirements. The issue is whether or not a hospitalist program is being implemented on a mandatory basis or a voluntary basis.

Hospitalists are not a creation of managed care. Hospitalists are creatures of modern medical economics. Since 1997, growth in the number of hospitalists and the use of hospitalists has escalated rapidly.

The Senate report contained the following recommendation:

It may be premature for government to become involved in "resolving" how the use of hospitalists should proceed. Given the visible nature of such services to consumers, practitioners, and payers, there is a better chance, than in many other situations, that the marketplace will settle the issue of under what circumstances such a service may be acceptable. Therefore, at this time, staff recommends no legislation.

III. Effect of Proposed Changes:

Section 1. Amends s. 641.31, F.S., relating to HMO contracts, to add a new subsection (39) to prohibit a HMO contract from prohibiting or restricting a subscriber from receiving in-patient

services in a contracted hospital from a contracted primary care or admitting physician, if such services are determined by the organization to be medically necessary and covered services under the organization's contract with the contract holder.

Section 2. Amends s. 641.315, F.S., relating to HMO provider contracts, to add a new subsection (11) to prohibit a contract between an HMO and a contracted primary care or admitting physician from containing any provision prohibiting such physician from providing inpatient services in a contracted hospital to a subscriber, if such services are determined by the organization to be medically necessary and covered services under the organization's contract with the contract holder.

Section 3. Amends s. 641.3155, F.S., relating to HMO provider contracts and payment of claims, to add a new subsection (5) to require an HMO to pay a contracted primary care or admitting physician, pursuant to such physician's contract, for providing inpatient services in a contracted hospital to a subscriber, if such services are determined by the organization to be medically necessary and covered services under the organization's contract with the contract holder.

Section 4. Provides for the Committee substitute to take effect July 1, 2000, and shall apply to provider contracts entered into or renewed on or after that date.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Health maintenance organizations would be required to pay primary care physicians for their hospital-based services. These organizations may experience greater costs by not having the

ability to utilize hospitalists to provide inpatient care, unless the primary care physician voluntarily agrees to such an arrangement.

Primary care physicians would be legally entitled to be remunerated by HMOs for providing hospital inpatient services.

C. Government Sector Impact:

The Agency for Health Care Administration indicates that this Committee substitute will have no fiscal impact on the agency.

The Division of State Group Insurance of the Department of Management Services indicates that this Committee substitute will require the division to revise and renegotiate its current contracts with HMOs to explicitly prohibit any provision that restricts or prohibits a treating physician's ability to provide inpatient services to the provider's patients. (Currently, the division's HMO contracts are silent on this issue, making it clear that the relationship between the HMO and its providers are private, contractual matters to which the division is not a party.) The division also indicates that since there is no evidence of unmet needs in inpatient services under the State Group Insurance Program, the direct fiscal impact of this Committee substitute is not expected to be significant.

The Division of State Group Insurance also indicates that it will incur costs totaling $28,200 associated with a mail-out of additional member notification to all state group health insurance enrollees of benefit changes as a result of this Committee substitute.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Proponents of this Committee substitute who represent physicians assert that its effect is to prohibit HMOs from imposing *mandatory* hospitalist programs on primary care physicians and their patients. However, it may be possible for a HMO to circumvent the Committee substitute's intent. For example, a HMO might offer a physician a contract which would list services that the physician would agree to provide that do not include any mention of the provision of *inpatient* services. Thus, the contract may not violate the committee substitute's provisions since it would not explicitly prohibit inpatient services.

Representatives with HMOs argue that they too want hospitalist programs to be voluntary, but assert that no legislation is needed because it would limit their ability to offer quality hospital care by limiting their selection of providers. Additionally, as noted in the Senate Interim Report, hospitalists are utilized because many primary care physicians currently do not provide hospital inpatient services. According to a recent article in the *Wall Street Journal,* only 25 of the 1,000 Florida AvMed primary care physicians and group practices admit and treat more than 50 percent of their patients that require hospitalization. The other 975 already hand over their hospital duties to someone else, albeit at their discretion.

VIII. Amendments:

None.

This Senate staff analysis does not reflect the intent or official position of the bill's sponsor or the Florida Senate.