SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

BILL: CS/SB 2226

SPONSOR: Health, Aging and Long-Term Care Committee and Senator Peaden

SUBJECT: Medical Practice

DATE: March 6, 2002 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Harkey	Wilson	HC	Favorable/CS
2.			BI	
3.				
4.				
5.				
6.				

I. Summary:

The bill provides for the use of a "surgical first assistant" in surgical procedures in hospitals, ambulatory surgical centers, and mobile surgical facilities and requires that health insurance policies and health maintenance contracts pay for the required services of a surgical first assistant when medically necessary.

This bill amends ss. 395.002, 395.0197 and 641.31, F.S., and creates ss. 627.64165 and 627.6572, F.S.

II. Present Situation:

Internal Risk Management Program for Hospitals, Ambulatory Surgical Centers, and Mobile Surgical Facilities

Part I of ch. 395, F.S., provides for the regulation of hospitals, ambulatory surgical centers, and mobile surgical facilities. Section 395.0197, F.S., establishes requirements for risk management programs in these facilities. Each facility must hire a licensed risk manager. The Agency for Health Care Administration (AHCA) is given access to all licensed facility records to carry out its responsibilities for ensuring that risk management programs meet statutory requirements.

The internal risk management program is considered to be part of what is known as the quality assurance process that hospitals, ambulatory surgical centers, and mobile surgical facilities use in their daily operations to ensure that adverse incidents, service-related accidents, and patient dissatisfaction are conscientiously examined on a continuous basis. An internal risk management program must provide for: 1) the investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents causing injury to patients; 2) the development of appropriate measures to minimize the risk of injuries and adverse incidents to

patients; 3) the analysis of patient grievances that relate to patient care and the quality of medical services; and 4) the development and implementation of an incident reporting system based upon the affirmative duty of all health care providers and all agents and employees of the licensed facility to report adverse incidents.

The responsibility for the internal risk management program is with the governing board. The board is required to hire a licensed risk manager to implement and oversee the program. Risk managers are exempted from liability and legal action for activities they undertake in implementing an internal risk management program that is in conformity with law so long as they are not intentionally fraudulent in their conduct.

Each hospital, ambulatory surgical center, or mobile surgical facility must report within 15 working days certain specified adverse or untoward incidents that occur in the facility or that arise from health care prior to admission to the facility. These reports are not available to the public, except that a health care professional against whom probable cause of violation of the law has been established, upon written request, may obtain the records on which the determination of probable cause was made.

Under s. 395.0197(1)(b), F.S., facilities are required to develop measures to minimize the risk of adverse incidents to patients. The required measures include:

- Providing risk management and risk prevention education to all personnel who are not physicians;
- Prohibiting a staff member of the facility from attending a patient in the recovery room unless the staff member is authorized to attend the patient in the recovery room and is accompanied by at least one other person;
- Prohibiting an unlicensed person from assisting or participating in a surgical procedure unless the facility has authorized the person to do so following a competency assessment and the assistance is done under the direct and immediate supervision of a physician; and
- Development, implementation and ongoing evaluation of procedures, protocols, and systems to accurately identify patients, planned procedures, and the correct site of planned procedures so as to minimize the performance of a surgical procedure on the wrong patient, a wrong surgical procedure, a wrong-site surgical procedure, or a surgical procedure unrelated to the patient's diagnosis or medical condition.

Surgery Assistants

The American College of Surgeons and 15 surgical specialty organizations undertook a study on the need for a physician as an assistant at surgery for all procedures listed in the "Surgery" section of the American Medical Association's Current Procedural Terminology (CPT ™) 2000. Each organization was asked to review codes applicable to their specialty and determine whether the operation requires the use of a physician as an assistant at surgery: (1) almost always; (2) almost never; or (3) some of the time. The results are presented in a 158-page table in *Physicians as Assistants at Surgery: 1999 Study*. The report says, "The decision to request that a physician assist at surgery remains the responsibility of the primary surgeon and, when necessary, should be a payable service."

The title of surgical first assistant does not always apply to a physician. The different uses of the title are described in the Association of Surgical Technologists' "Surgical First Assistant Resource Guide".

> How employers determine titling or labeling the various OR roles may be a primary source of confusion not only for the insurance industry, hospital administrators, and the public, but for the practitioners themselves. Misnomers are known to occur in the use of the terms surgeon's assistant, surgical assistant, first assistant, or even second scrub.
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> Many believe the term surgeon's assistant should only be used in reference to a physician assistant (PA) either working in the employment of a surgeon or who works regularly in the operating room. Sometimes, this individual may be referred to as a surgical PA. Some in the PA profession might even argue that only those who have graduated from one of the PA programs providing more extensive surgical education should be titled as a surgeon's assistant.
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> Surgical assisting and first assisting deal specifically with the intraoperative assistant role and are terms more appropriately used interchangeably, although there are some important distinctions to be made. The broader of the two terms is surgical first assistant and generally encompasses tasks that are distinguished as (1) second assisting, such as holding retractors, suctioning and sponging the operative site, or applying dressings and (2) first assisting, such as providing aid in exposure, providing hemostasis (clamping or tying off bleeders), and suturing.

According to AHCA, most current reimbursement coverage pays only for the services of physicians in the surgical process. Accordingly, when procedures require additional assistance, the assignment of a second physician is required; otherwise payment for an assistant's services may be denied. Florida Medicaid currently recognizes and provides reimbursement for Registered Nurse First Assistants (RNFA) as a surgery assistant.

Under s. 395.002(20), F.S., the *medical staff* of a hospital is defined as physicians licensed under ch. 458 or ch. 459, F.S., with privileges in a licensed facility as well as other licensed health care practitioners with clinical privileges as approved by the licensed facility's governing board.

Health Insurance

Part VI of chapter 627, F.S., governs rates and contracts for health insurers delivering or issuing individual health insurance policies. This part does not govern group or blanket policies, which are governed under part VII, except for exclusive provider organizations (EPOs) under s. 627.6472, F.S., which limit coverage to service from network providers, and preferred provider organizations (PPOs) under s. 627.6471, F.S., which provide greater benefits if an insured obtains services from a network provider, and lesser benefits (greater deductibles and coinsurance) if the insured obtains services from a non-network provider. Section 627.6699, F.S., is the "Employee Health Care Access Act." The section provides for the regulation by the Department of Insurance of group health insurance coverage provided to small employers (businesses with at least 1 but not more than 50 eligible employees).

Health Maintenance Organizations

Health maintenance organizations (HMOs) are governed under Parts I and III of chapter 641, F.S. HMOs manage the delivery of health care services as a way of controlling health care costs by modifying the behavior of physicians and other health care providers. Techniques that HMOs use to manage health care costs include reviewing the medical necessity or appropriateness or the site of services; contracting with selected health care providers; financial incentives or disincentives related to the use of specific providers, services, or service sites, and controlled access to services by a case manager.

Florida Insurance Mandate Requirements

State laws frequently require private health insurance policies and health maintenance organization contracts to include specific coverage for particular treatments, conditions, persons, or providers. These are referred to as "mandated (health) benefits."

Recognizing that "most mandated benefits contribute to the increasing cost of health insurance premiums," while acknowledging the social and health benefits of many of the mandates, the Legislature in 1987 called for a "systematic review of current and proposed" mandated benefits. At that point, the Legislature had approved 16 mandated benefits. In the 13 years since, the Legislature has approved an additional 35 mandated benefits. With 51 mandated health benefits, Florida now has one of the nation's most extensive sets of coverage requirements. A procedural requirement established for reviewing mandated benefits--that proponents submit an impact analysis for any proposed mandate benefit prior to consideration--is found in s. 624.215, F.S. (Source: House Committee on Insurance, Interim Project, "Managing Mandated Health Benefits: Policy Options for Consideration," January 28, 2000.)

Although there has never been a study on the cumulative cost of mandated benefits in Florida, a 1998 Blue Cross/Blue Shield report studied the cumulative cost of mandated benefits in various states including Maryland (only Maryland had more mandates than Florida--47 at the time of the study, according to the report). According to the report, Maryland mandates are estimated to add 15.4 percent to the average monthly premium for a group policy. In Maine, 19 of its 31 mandates were found to increase premium costs on groups of 21 or more by just over 7 percent.

III. Effect of Proposed Changes:

Section 1. Amends s. 395.002, F.S., to define *surgical first assistant* to mean the first assistant to the surgeon during a surgical operation.

Section 2. Amends s. 395.0197(1)(b), F.S., to authorize a primary operating surgeon to select a "surgical first assistant," from among available individuals who are approved or credentialed by the facility (hospital, ambulatory surgical center, or mobile surgical facility).

Section 3. Creates s. 627.64165, F.S., to require an individual health insurance policy to provide coverage for the services provided by a surgical first assistant selected by the primary surgeon to assist in a covered surgical procedure. The bill clarifies that a health insurer may not be required

to make additional, supplemental, or duplicate payments to the hospital or provider solely because of the use of a surgical first assistant.

Section 4. Creates s. 627.6572, F.S., to require a group, blanket, or franchise health insurance policy to provide coverage for the medically necessary services of a surgical first assistant selected by the primary surgeon to assist in a covered surgical procedure. The bill clarifies that a health insurer may not be required to make additional, supplemental, or duplicate payments to the hospital or provider solely because of the use of a surgical first assistant.

Section 5. Adds subsection (40) to s. 641.31, F.S, to require health maintenance organizations to provide coverage for the medically necessary services provided by a surgical first assistant selected by a primary surgeon contracted with the HMO to assist in a covered surgical procedure. If the HMO mandates the use of contracted surgeons for certain procedures, the HMO may also require that the surgical first assistant be under contract with the HMO. The bill clarifies that an HMO may not be required to make additional, supplemental, or duplicate payments to the hospital or provider solely because of the use of a surgical first assistant.

Section 6. The bill will take effect July 1, 2002, and will apply to policies or contracts issued or renewed after that date.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

Since the bill may require local governments to incur expenses to pay additional employee health insurance costs, the bill falls within the purview of Article VII, Section 18 of the Florida Constitution, which provides that cities and counties are not bound by general laws requiring them to spend funds or to take action which requires the expenditure of funds unless certain specified exemptions or exceptions are met. The law is binding on counties and municipalities if the Legislature determines that the law fulfills an important state interest. This bill requires that similarly situated persons (private and public employee health care coverage) must provide coverage of the services of a surgical first assistant, but does not state that the act fulfills an important state interest.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Art. I, s. 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Art. III, s. 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

There could be a potential increase in health maintenance organization costs and private insurance costs as this bill increases the coverage requirements of insurers. These costs could ultimately be passed to consumers in the form of higher premiums. For persons without health insurance coverage, the costs would be paid out of pocket, or be passed on to the hospital as uncompensated care.

C. Government Sector Impact:

The impact on the Department of Management Services, Division of State Group Insurance (DMS/DSGI) to include coverage of the services of the surgical first assistant required in this bill is unknown.

According to AHCA, the Medicaid program already pays for a second physician or a registered nurse first assistant (RNFA) based on Medicare guidelines and as determined by the primary surgeon.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Section 614.215, F.S., requires that any proposal for legislation which mandates a health benefit coverage must be submitted with a report to the Agency for Health Care Administration and the legislative committee having jurisdiction which assesses the social and financial impacts of the proposed coverage. Such a report has not been submitted.

VIII. Amendments:

None.