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HOUSE OF REPRESENTATIVES
AS REVISED BY THE COMMITTEE ON
GOVERNMENTAL OPERATIONS
ANALYSIS

BILL #: CS/HB 149

RELATING TO: Health Maintenance Organization Prohibited Contract Provisions (Hospitalists)

SPONSOR(S): Committee on Health Care Services, Representative Villalobos and others

TIED BILL(S):

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:

(1) HEALTH CARE SERVICES YEAS 14 NAYS 0
(2) GOVERNMENTAL OPERATIONS
(3) HEALTH CARE LICENSING & REGULATION
(4) HEALTH & HUMAN SERVICES APPROPRIATIONS
(5)

I. SUMMARY:

CS/HB 149:

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

- 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 organization to be medically necessary and covered services under the organization's contract with the contract holder.

The bill also stipulates that this act shall not require a hospital to accept an admission from a physician to whom the hospital has not extended admitting privileges.

The bill's effective date is July 1, 2000.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes []	No []	N/A [x]
2.	Lower Taxes	Yes []	No []	N/A [x]
3.	Individual Freedom	Yes []	No []	N/A [x]
4.	Personal Responsibility	Yes []	No []	N/A [x]
5.	Family Empowerment	Yes []	No []	N/A [x]

B. PRESENT SITUATION:

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 six 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 that purported to prohibit health maintenance organizations (HMOs) from mandating the use of hospitalists was amended 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 legislation by the House of Representatives and, therefore, 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. 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 join us in optimizing the benefits of this program by sharing this information with your Prudential patients."

The apparently unilateral and mandatory approach employed by the company catapulted a legislatively "invisible" issue, up to that point, into the legislative deliberations during the final days of the 1999 Legislative Session that ended April 30. The company's actions seem to have solidified opposition to the mandatory use of hospitalists. To date, while other HMOs in Florida have announced plans to implement a hospitalist program, no others are known to be pursuing a mandatory policy.

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. For this project, Senate staff indicated that they relied primarily on discussions with and interviews of representatives of family practice physicians, the managed care industry, the hospital industry, and representatives of hospitalists. Additionally, Senate staff requested representatives of managed care organizations to inquire of their membership about their intent to implement hospitalist services as a feature of their health care service delivery. Hospitalists publish information about issues of professional interest on the Internet. Senate staff used some of these Internet sites in developing an understanding of hospitalists within the context of their interim project.

Senate staff research identified 7 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 sub-acute 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 sub-acute 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 sub-acute 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.

Health Maintenance Organizations and Provider Contracts

Chapter 641, F.S., relates to health care services programs. Part I of this chapter, consisting of ss. 641.17-641.3923, F.S., is the “Health Maintenance Organization Act,” under which the Department of Insurance regulates HMOs. Part III of this chapter, consisting of ss. 641.47-641.75, F.S., authorizes the Agency for Health Care Administration to regulate HMO quality of care. Before receiving a license from the Department of Insurance, an HMO must receive a Certificate of Authority from the Agency for Health Care Administration. Any entity that is issued a Certificate of Authority 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 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 an 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 an HMO to include or prohibit any provider contract element relating to the provision of inpatient hospital services.

C. EFFECT OF PROPOSED CHANGES:

The bill requires that HMOs not prohibit, nor refuse to provide reimbursement for, inpatient services provided by a contracted primary care or admitting physician at 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, thus eliminating any mandatory use of hospitalists by HMOs.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 641.31, F.S., relating to HMO contracts, to add a new subsection (39) to prohibit an HMO contract from prohibiting or restricting a contracted primary care or admitting physician from providing inpatient services in a contracted hospital to the 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 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. Stipulates that this act shall not require a hospital to accept an admission from a physician to whom the hospital has not extended admitting privileges.

Section 5. Provides for the bill to take effect July 1, 2000.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

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

The Division of State Group Insurance of the Department of Management Services indicates that this bill 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 bill 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 bill.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

N/A

2. Expenditures:

N/A

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Unknown.

D. FISCAL COMMENTS:

None.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

The bill does not reduce the authority that counties or municipalities have to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

N/A

B. RULE-MAKING AUTHORITY:

N/A

C. OTHER COMMENTS:

For additional information on the concept of "hospitalists," readers should see **Study of the Emerging Physician Specialty "Hospitalists,"** Interim Project Report 2000-56, September 1999, from the Senate Health, Aging and Long-Term Care Committee.

The strike-everything amendment deleted the provision from the bill which specified that the bill is applicable to contracts entered into on or after the effective date of the bill. The material effect of this change requires the provisions of this bill to apply to all HMO contracts in existence on July 1, 2000. Consideration may need to be given to the original language which made the bill's provisions applicable to all HMO contracts renewed or entered into on or after the effective date.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

When the Committee on Health Care Services heard this bill on February 8, 2000, the committee adopted a strike-everything amendment, and one technical amendment to the strike-everything amendment. The strike-everything amendment modified the language that is added to HMO contract law, HMO provider contract law, and HMO claims payment law to more clearly focus on: contracted primary care or admitting physicians, contracted hospitals, medical necessity of services, and covered services.

The substantive amendment (1B) to the strike-everything amendment specified that this act shall not require a hospital to accept admissions from a physician to whom the hospital has not extended admitting privileges, this amendment was withdrawn and erroneously included in the committee substitute.

The strike-everything amendment deleted the provision from the bill which specified that the bill is applicable to contracts renewed or entered into on or after the effective date of the bill.

The Committee on Health Care Services reported the amended bill favorably as a committee substitute.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by:	Staff Director:
Phil E. Williams	Phil E. Williams

AS REVISED BY THE COMMITTEE ON GOVERNMENTAL OPERATIONS:

Prepared by:	Staff Director:
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