HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/CS/HB 863 Physician Referrals
SPONSOR(S): Health & Human Services Committee, Health Quality Subcommittee, Brannan
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	12 Y, 0 N, As CS	McElroy	McElroy
2) Criminal Justice Subcommittee	11 Y, 0 N	Padgett	Hall
3) Health & Human Services Committee	14 Y, 0 N, As CS	McElroy	Calamas

SUMMARY ANALYSIS

Healthcare providers routinely refer patients to other healthcare providers if more specialized care is required. The Florida Patient Self-Referral Act of 1992 (Act) prohibits a Florida health care provider from referring a patient to an entity in which the health care provider holds an investment interest. There are limited exceptions to this prohibition, including an exception which allows health care providers to refer patients to hospitals in which the health care provider holds an investment interest.

Florida also prohibits a health care provider from offering, paying, soliciting or receiving a kickback, directly or indirectly, overtly or covertly, in cash or in kind for referring or soliciting a patient. Violations of the prohibition are considered patient brokering.

A Preferred Provider Organization (PPO) contracts with a network of health providers who participate for an alternative or reduced rate of payment. Generally, the member is responsible only for required cost-sharing if covered services are obtained from contracted (participating, preferred, or network) providers. A Health Maintenance Organization (HMO) provides health care services pursuant to contractual arrangements with preferred providers who have agreed to supply services to members at pre-negotiated rates. Traditionally, an HMO member must use the HMO's network of health care providers in order for the HMO to make payment of benefits. Currently, a health care provider is not required to notify a patient when the referred health care provider is an out-of-coverage provider.

CS/HB 863 prohibits a health care provider from referring patients to any hospital in which the health care provider holds an investment interest. This eliminates the special exception in the law for hospitals and an individual or entity that participates in any such referral may now also be subject to the anti-kickback and felony patient brokering statutes.

The bill also requires health care providers to give a written notice to a patient any time the health care provider refers a patient to a provider not covered by the patient's insurance.

The bill has no fiscal impact on state or local governments.

The bill provides an effective date of January 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Florida Patient Self-Referral Act of 1992

The Patient Self-Referral Act of 1992 (Act) prohibits the referral of patients by a health care provider to an entity that the referring health care provider holds a financial interest, if the financial interest is a type that is regulated by the Act and an exemption does not apply.[1] The prohibition against patient self-referral stems from a concern that a health care practitioner with a personal financial involvement may overutilize health care services, thus driving up the cost of health care and possibly adversely affecting quality.[2]

The Act does not apply to certain financial interests, including an investment interest in an entity which owns or leases and operates a hospital.[3] For those financial interests subject to the Act, a health care provider is prohibited from referring a patient to an entity that the health care provider has an investment interest, unless:[4]

- For entities whose shares are publicly traded:
  - The provider's investment interest is in registered securities purchased on a national exchange or over-the-counter market and issued by a publicly held corporation; and
  - The entities total assets at the end of the corporation's most recent fiscal quarter exceeded $50 million; or
- For entities other than publicly held corporations:
  - No more than 50 percent of the value of the investment interests are held by investors who are in a position to make referrals to the entity;
  - The terms under which an investment interest is offered to an investor who is in a position to make referrals to the entity are no different from the terms offered to investors who are not in a position to make such referrals;
  - The terms under which an investment interest is offered to an investor who is in a position to make referrals to the entity are not related to the previous or expected volume of referrals from that investor to the entity; and
  - There is no requirement that an investor make referrals or be in a position to make referrals to the entity as a condition for becoming or remaining an investor.

The entity in which the health care provider holds an interest must also meet the following conditions for a referral to be exempt for the Act:[5]

- The entity or corporation does not loan funds to or guarantee a loan for an investor who is in a position to make referrals to the entity or corporation if the investor uses any part of such loan to obtain the investment interest; and
- The amount distributed to an investor representing a return on the investment interest is directly proportional to the amount of the capital investment, including the fair-market value of any preoperational services rendered, and invested in the entity or corporation by that investor.

[1] S. 456.053, F.S.
[2] S. 456.053(2), F.S.
[3] S. 456.053(3)(k), F.S.
[4] S. 456.053(5)(b), F.S.
[5] *Id.*

A health care provider found to have violated the Act is subject to one or more disciplinary actions or penalties, including:

- A penalty of up to $100,000 for each arrangement if a health care provider or other entity enters into an arrangement that has the principal purpose of assuring referrals between the provider and the entity;[6]
- Discipline by his or her regulatory board (hospitals are subject to penalties imposed by the Agency for Health Care Administration (AHCA));[7] and
- Being charged with a first degree misdemeanor[8] and subject to additional penalties and disciplinary action by his or her respective board if a health care provider fails to comply with the notice provisions of the Act and s. 456.052, F.S., which requires a physician to disclose to a patient if he or she has a financial interest in an entity to which the patient is being referred.[9]

A health care provider may not submit a claim for payment for a services provided pursuant to a referral prohibited by the Act; and if the provider receives payment for such services, he or she must be refund the payment.[10] Additionally, any person who knows or should know that such a claim is prohibited and who presents or causes to be presented such a claim, is subject to a fine of up to $15,000 per service to be imposed and collected by that person's regulatory board.[11]

Anti-Kickback and Patient Brokering Prohibitions

Anti-Kickback Statutes

Individual health care practitioners are prohibited from providing or receiving kickbacks for referring patients. Section 395.0185, F.S., prohibits any person from paying a commission, bonus, kickback,[12] or rebate or engaging in any form of split-fee arrangement with a physician, surgeon, organization, or person for patients referred to a licensed facility.[13] A health care provider is also specifically prohibited from offering, paying, soliciting or receiving a kickback, directly or indirectly, overtly or covertly, in cash or in kind for referring or soliciting a patient.[14]

Patient Brokering

Patient brokering is paying to induce, or make a payment in return for, a referral of a patient to or from a health care provider or health care facility. Such payments include commissions, bonuses, rebates, kickbacks, bribes, split-fee arrangements, in cash or in kind, provided directly or indirectly.[15] A violation of the patient brokering statute is punishable as either a first[16], second[17], or third degree felony,[18] based on the number of patients involved, and may also be remedied by an injunction. Private entities bringing

[6] S. 456.053(5)(f), F.S.
[7] S. 456.053(5)(g), F.S.
[8] A first degree misdemeanor is punishable by up to one year in jail and a $1,000 fine. Ss. 775.082 and 775.083, F.S.
[9] S. 456.053(5)(j), F.S.
[10] S. 456.053(5)(c)–(d), F.S.
[11] S. 456.053(5)(e), F.S.
[12] A kickback is a remuneration or payment, by or behalf of a health care provider to any person as an incentive or inducement to refer patients for past or future services. S. 456.054(1), F.S.
[13] The Agency for Health Care Administration (AHCA) enforces this provision and if the violator is not licensed by AHCA, the law authorizes AHCA to impose a fine of up to $1,000 nonetheless, and to recommend disciplinary action to the appropriate licensing board.
[14] S. 456.054, F.S. Violations of this provision are considered patient brokering.
[15] S. 817.505(1), F.S.
[16] A violation involving 20 or more patients is a first degree felony and a mandatory $500,000 fine. S. 817.505(4)(c), F.S. A first degree felony is punishable by up to 30 years imprisonment. S. 775.082, F.S.
[17] A violation involving between 10-19 patients is a second degree felony and a mandatory $100,000 fine. S. 817.505(4)(b), F.S. A second degree felony is punishable by up to 15 years imprisonment. S. 775.082, F.S.
[18] A violation involving fewer than 10 patients is a third degree felony and a mandatory $50,000 fine. S. 817.505(4)(a), F.S. A third degree felony is punishable by up to five years imprisonment. S. 775.082, F.S.

an action under the patient brokering statute may recover reasonable expenses, including attorney fees.[19]

Vertical Hospital Integration

When large hospitals or other medical facilities merge with one another or systematically acquire other, non-hospital, health care provider businesses, such transactions can lead to less market diversity, less competition and, sometimes, coercive monopolies.

Vertical integration broadly refers to transactions whereby a large medical entity, such as a hospital, acquires a smaller medical entity, such as a physician practice group, thereby expanding the hospital's market power. Vertical integration methods vary, including the following:

- **Complete buyout.** A hospital buys out a physician practice, including its physicians, staff, equipment, and patients. The physicians become hospital employees.
- **Asset purchase agreement.** A hospital acquires from a physician practice its channels of distribution, laboratories, equipment, or other assets.
- **Physician enterprise model.** A hospital and a physician practice enter into nonequity joint ventures together. The physicians preserve their autonomy and private practice model.[20]
- **Group practice subsidiary model.** A hospital purchases a physician practice group, but the physicians, who are not employed directly by the hospital, maintain control of the day-to-day operations of the practice group.[21]
- **Professional service agreement.** A hospital purchases a physician practice's technical component services and compensates the practice's physicians for professional services at the practice. The practice remains intact, while the hospital bills and collects professional fee-for-service revenue. The hospital compensates the practice for the services.[22]

Vertical integration has been on the rise in the last twenty years. Between 2002 and 2008 in the U.S., the share of physician practices owned by hospitals doubled,[23] and trends towards increased vertical integration continued from 2007 to 2013.[24]

Whether the trend towards vertical integration benefits consumers is heavily debated.[25] Proponents of vertical integration argue that it can improve the quality and efficiency of care by strengthening ties between physicians and hospitals and improving communication.[26]

[19] Ss. 817.505(4), (6), F.S.
[20] John W. McDaniel, The Physician Enterprise Model: A Nonemployment Alternative, ACMPE Executive View, Vol. 8, No. 1 (Spring 2012).
[21] Physicians Practice, Maintaining Independence as a Group Practice Subsidiary, https://www.physicianspractice.com/maintaining-independence-group-practice-subsidiary (last visited Mar. 19, 2019).
[22] MGMA, Physician-Hospital Alignment Models: An Evolving Lexicon, https://www.mgma.com/resources/resources/business-strategy/physician-hospital-alignment-models-an-evolving-l (last visited Mar. 14, 2019); CBIZ, Professional Services Agreement: An Alternative Strategy to Hospital Employment, https://www.cbiz.com/insights-resources/details/articleid/3197/ispreview/true/professional-services-agreement-an-alternative-strategy-to-hospital-employment-article (last visited Mar. 19, 2019).
[23] Laurence C. Baker, M. Kate Bundorf, and Daniel P. Kessler, *Vertical Integration: Hospital Ownership of Physician Practices is Associated with Higher Prices and Spending*, Health Affairs (May 2014), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2013.1279 (last visited Mar. 19, 2019).
[24] Cory Capps, David Dranove, and Christopher Ody, *The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending*, Journal of Health Economics (Apr. 22, 2018), https://www.sciencedirect.com/science/article/abs/pii/S016762961730485X (last visited March 19, 2019).
[25] Laurence C. Baker, M. Kate Bundorf, and Daniel P. Kessler, *Vertical Integration: Hospital Ownership of Physician Practices is Associated with Higher Prices and Spending*, Health Affairs (May 2014), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2013.1279 (last visited Mar. 19, 2019).
[26] *Id.*

Critics of vertical integration argue that it increases a hospital's market share, potentially reducing or eliminating competition. Removing competition in the medical marketplace, in turn, may allow hospitals to raise prices to a level that harms consumers. Vertical integration may lead to:

- Hospitals increasing their market power by amassing control over a larger bundle of services;
- Hospitals depriving their rivals of a source of destination for referrals; and
- Heightened incentives for physicians to supply unnecessary treatments to pay for kickbacks for inappropriate referrals.[27]

One study of the trends and effects of vertical integration in the U.S. found that some loose forms of vertical integration might be socially beneficial. However, the study concluded that vertical integration causes increased healthcare costs:

> Taken together, our results provide a mixed, although somewhat negative, picture of vertical integration from the perspective of the privately insured. Our most definitive finding is that hospital ownership of physician practices leads to higher prices and higher levels of hospital spending.[28]

Similarly, another recent study found that hospital acquisitions of physician practices were responsible for an average price increase of 14.1% in fees for physician services, with larger increases where the acquiring hospital was more dominant within its market. The study estimated nearly half of the price increases were due to the exploitation of "facility fees," which hospitals are allowed to charge for procedures performed by hospital-owned physician groups.[29] The study concluded:

> Overall, we believe these results paint a relatively negative picture of hospital-physician VI [vertical integration]. However, given the evolving nature of healthcare reimbursement systems, future analyses will be important.[30]

Vertical integration also increases the likelihood that a health care provider will refer a patient to a hospital for services even though less expensive and higher quality alternatives are available. For example, one study found that orthopedic surgeons working in a hospital-owned practice were 27% more likely to refer patients to hospital-based MRI scans which were $277.19 more expensive.[31] Another study found that patients were more likely to choose a high-cost, low-quality hospital when the admitting physician's practice is owned by that hospital.[32]

Health Insurance Networks

Preferred Provider Organization[33]

A Preferred Provider Organization (PPO) is a health plan that contracts with providers, such as hospitals and doctors, to create a network of providers who participate for an alternative or reduced rate of payment. Generally, the member is only responsible for the policy co-payment, deductible, or co-insurance amounts if covered services are obtained from network providers. However, if a member

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[27] *Id.*
[28] *Id.*
[29] Cory Capps, David Dranove, and Christopher Ody, *The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending*, JOURNAL OF HEALTH ECONOMICS (Apr. 22, 2018), https://www.sciencedirect.com/science/article/abs/pii/S016762961730485X (last visited Mar. 19, 2019).
[30] *Id.*
[31] Michael Chernew, Zack Cooper, Eugene Larsen-Hallock and Fiona Scott Morton, *"Are Health Care Services Shoppable? Evidence from the Consumption of Lower-Limb MRI Scans"* Yale Institution for Social and Policy Studies (July 30, 2018), https://pdfs.semanticscholar.org/4d16/0450b82516df29fa3dded778919b77b49a88.pdf (last visited Mar. 19, 2019).
[32] Baker, Laurence C. & Bundorf, M. Kate & Kessler, Daniel P., 2016. *"The effect of hospital/physician integration on hospital choice,"* Journal of Health Economics, Elsevier, vol. 50(C), https://www.sciencedirect.com/journal/journal-of-health-economics/vol/50/suppl/C (last visited Mar. 19, 2019).
[33] *See generally* s. 627.6471, F.S.

chooses to obtain services from an out-of-network provider, those out-of-pocket costs likely will be higher. Currently, a health care provider is not required to notify a patient that the referred health care provider is an out-of-coverage provider.

Health Maintenance Organization[34]

A Health Maintenance Origination (HMO) is an organization that provides a wide range of health care services, including emergency care, inpatient hospital care, physician care, ambulatory diagnostic treatment and preventive health care pursuant to contractual arrangements with preferred providers in a designated service area. The network is made up of providers who have agreed to supply services to members at pre-negotiated rates. Traditionally, an HMO member must use the HMO's network of health care providers in order for the HMO to make payment of benefits. The use of a health care provider outside the HMO's network generally results in the HMO limiting or denying the payment of benefits for out-of-network services rendered to the member.[35] Currently, a health care provider is not required to notify a patient that the referred health care provider is an out-of-coverage provider.

Effect of Proposed Changes

CS/HB 863 prohibits a health care provider from referring patients to any hospital in which the health care provider holds an investment interest. This eliminates the special exception in the law for hospitals. An individual or entity that refers patients in violation of the limitations in the bill is subject to penalties under the anti-kickback and felony patient brokering statutes, punishable as a first, second, or third degree felony and a mandatory fine.

The bill also requires health care providers to give a written notice to a patient any time the health care provider refers a patient to a provider not covered by the patient's insurance.

The bill is effective upon becoming a law.

B. SECTION DIRECTORY:

Section 1: Amends s. 456.053, F.S., relating to financial arrangements between referring health care providers and providers of health care services.
Section 2: Amends s. 456.0575, F.S., relating to duty to notify patients.
Section 3: Provides an effective date of January 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

[34] *See generally* part I of ch. 641, F.S.
[35] Section 641.31(38), F.S., creates an exception to this general rule. It authorizes an HMO to offer a point-of-service benefit. The benefit, offered pursuant to a rider, enables a subscriber to select, at the time of service and without referral, a nonparticipating provider for a covered service. The HMO may require the subscriber to pay a reasonable co-payment for each visit for services provided by a nonparticipating provider.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 5, 2019, the Health Quality Subcommittee adopted an amendment that changed the effective date to upon becoming a law. The bill was reported favorably as a committee substitute.

On April 4, 2019, the Health and Human Services Committee adopted an amendment that changed the effective date to January 1, 2020. The bill was reported favorably as a committee substitute. The analysis is drafted to the committee substitute as passed by the Health and Human Services Committee.