

INITIATIVE FINANCIAL INFORMATION STATEMENT

Physician Shall Charge the Same Fee for the Same Health Care Service to Every Patient

SUMMARY OF INITIATIVE FINANCIAL INFORMATION STATEMENT

Like most health care providers, medical doctors licensed under Chapter 458, Florida Statutes, establish a set fee for each service they provide. This set fee is referred to as the “usual and customary charge” and is supposed to reflect all the costs associated with providing a particular service. In practice, the usual and customary charge is actually the ceiling under which purchasers of health care negotiate a fee schedule that the physician will accept as full payment for services provided. This proposed constitutional amendment would require medical doctors to charge to all purchasers the lowest fee the physician has agreed to accept from anyone as full payment for the same health care service, procedure or treatment.

Based on the information provided through public workshops, arguments before the Florida Supreme Court, and information collected through staff research, the Financial Impact Estimating Conference principals expect that the proposed amendment will have the following financial effects.

1. Physicians may be able to create new business arrangements for billing purposes that do not violate the language of the amendment and will allow them to continue cost shifting among their patients.
 - If these new business arrangements are allowed, current billing practices may continue and there may be no financial impact on state and local governments.
2. Physicians may change the schedule of fees they currently accept as full payment to a single rate for each particular service they provide. The health care market may set the fee for each service as some percentage of Medicare’s reimbursement rate. As a result,
 - Medicaid’s expenditures for physician services will increase significantly since its rates are currently the lowest fee accepted as full payment by most physicians. To keep physicians in the program, Medicaid rates will need to increase to at least the Medicare reimbursement rate, and possibly the reimbursement rates of commercial payors. Raising Medicaid’s reimbursement rates to the same level as Medicare or that of commercial payors would require an increase of between 40% and 115%. These increases would result in a financial impact of between \$157 million and \$471 million in state revenue for Medicaid expenditures for physician services.
 - Public health centers (e.g., county health departments, community-funded hospitals) may lose revenue from fees collected from self-pay patients; however, these losses may be offset by increases in revenues from higher Medicaid reimbursements. Because it is unclear how much these two effects will offset each other, the total financial impact cannot be determined at this time.
 - The amendment will affect the cost of providing health care coverage to state and local government employees. If the government’s health plan reimburses physicians at a rate higher than other plans, the cost to the plan will probably decrease. If the government’s health plan has a lower fee schedule, the cost of physician services will likely increase. However, the total financial impact on these health plans cannot be determined at this time.

FINANCIAL IMPACT STATEMENT

The overall financial impact of this amendment on state and local governments, while substantial, cannot be fully determined. If doctors change the fees they accept because of this amendment, annual state Medicaid cost increases well in excess of \$150 million are expected. Furthermore, the amendment could significantly increase the cost of other medical care delivered or paid for by state and local governments.

I. SUBSTANTIVE ANALYSIS

A. Proposed Amendment

Ballot Title:

Physician Shall Charge the Same Fee for the Same Health Care Services to Every Patient

Ballot Summary:

Current law allows a physician to charge different prices for the same health care provided to different patients. This amendment would require a physician to charge the same fee for the same health care service, procedure or treatment. Requires lowest fee which physician has agreed to accept. Doesn't limit physician's ability to provide free services. A patient may review the physician's fee and similar information before, during or after the health care is provided.

1) Statement and Purpose:

Many physicians in Florida agree to accept fees for health care covered by health insurance plans or other governmental or private third-party payor programs which limit payments for particular medical treatments, services or procedures. Yet many Floridians, including those in Health Maintenance Organizations or other "managed-care" programs and those without any coverage at all, pay substantially-higher fees for the same medical services. The purpose of this amendment is to insure that all Floridians are able to obtain the lowest prices for medical services which doctors will accept. Doctors will remain free to set their own fees, or to agree to any charges or fee schedules from third-party payors, subject to general law, but they can no longer charge some Floridians more for the same services just because the patients are not in the lowest-cost health insurance plan. In order to help consumers protect themselves against over-charges, patients and their representatives are to be given access, upon request, to the fee data necessary to determine whether they are receiving the lowest agreed-upon fee or whether this amendment is otherwise being violated.

2) Amendment of Florida Constitution:

Art. X, Fla. Const., is amended by adding the following section at the end thereof, to read:
"Section 22. Physicians' Health Care Charges."

a) A physician shall charge all purchasers the lowest fee for health care which the physician has agreed to accept as full payment for the same health care when the same health care is being paid for in whole or in part through any agreement between the physician and any other purchaser. Nothing in this section shall be deemed to limit the physician's right to provide any health care for free.

b) To assist patients to determine a physician's fee and compliance with this Section, a patient shall have access to any fee schedules agreed to by the physician, and any other records of the physician related to the patient's health care which might contain information indicating whether the physician is in compliance with this Section. This right of access, whether or not exercised, may not be waived, and may be exercised prior to, during or after the health care is provided. This right of access is not intended to conflict with, supercede or alter any rights or obligations under general law related to the privacy of patient records.

- c) Definitions. As used in this section, the following terms shall have the following meanings:
- i) "Health Care" means services, procedures, treatment, accommodations or products provided by a physician described by this section.
 - ii) "Physician" means one licensed pursuant to Chapter 458, Florida Statutes, or any similar successor statute, and any corporation, professional association or similar organization established and operated for the purpose of providing health care by such licensees.
 - iii) "Purchaser" means patients, third-party payors or others paying for a patient's health care, and does not include a patient receiving care without charge.
 - iv) "Charge" means require, charge, bill, accept or be entitled to receive as payment for health care.
 - v) "Patient" means an individual who has sought, is seeking, is receiving, or has received health care from the physician.
 - vi) "Have access to" means, in addition to any other procedure for producing such records provided by general law, making the records available for review, inspection and copying upon formal or informal request by the patient or a representative of the patient, provided that current records which have been made publicly available by publication or on the Internet may be made available by reference to the location at which the records are publicly available."

3) Effective Date and Severability:

This amendment shall be effective on the date it is approved by the electorate, and shall apply to any health care payment agreement entered into or renewed after the effective date. If any portion of this measure is held invalid for any reason, the remaining portion of this measure, to the fullest extent possible, shall be severed from the void portion and given the fullest possible force and application.

B. Effect of Proposed Amendment

There are currently no laws prohibiting a physician from accepting different prices for the same health care provided to different patients, a practice often referred to as "cost shifting." This proposed constitutional amendment would require a medical doctor licensed under Chapter 458, Florida Statutes, to charge to all purchasers the lowest fee the physician has agreed to accept as full payment for the same health care service, procedure or treatment. A patient may review the physician's fee and similar information before, during or after the health care is provided to verify whether the purchaser is paying the same lowest fee charged to any other purchaser.

Background

Floridians for Patient Protection (FPP) is the sponsor of this proposed constitutional amendment. FPP is an organization of medical malpractice and negligence victims and their families with significant representation by the Academy of Florida Trial Lawyers. As of April 2004, FPP raised almost \$12 million in support of their amendment campaign which includes this and two other

proposed amendments. FPP argues that the proposed amendment is necessary to address the issue of cost shifting. In their brief filed before the Florida Supreme Court in support of this proposed amendment, FPP wrote that:

“The expressed purpose of this amendment is to protect the uninsured and the medically under-insured, as well as Floridians who do not wish to bear the burden of cost shifting. The purpose of this amendment is to insure that all Floridians are able to obtain the lowest prices for medical services which doctors will accept.”

Physician Fees and Cost Shifting

Like most health care providers, medical doctors establish a set fee for each service they provide. This set fee is referred to as the “usual and customary charge” and is supposed to reflect all the costs associated with providing a particular service. However, in practice, the usual and customary charge is actually the ceiling under which purchasers of health care negotiate a fee schedule that the physician will accept as full payment for services provided.

The difference between a physician’s usual and customary charges and the amount accepted as full payment can vary significantly from one health care purchaser to another because of a practice known as “cost shifting.” Cost shifting refers to the practice of charging private third-party payors more to make up for losses from patients who are either uninsured or covered by public-assistance programs (Medicare and Medicaid) that have non-negotiable fee schedules.

If a patient is uninsured, the physician may negotiate a fee on an individual basis that he or she will accept as full payment for services rendered, although there are no federal or state laws that govern these negotiations. Depending on the physician’s payor mix, some uninsured patients may be required to pay the full usual and customary charges while others may be given a significant discount. When physicians require uninsured patients to pay usual and customary charges, these patients are often charged the most of any purchaser of health care in the provider’s payor mix for the same services.

Payor Mix

A provider’s payor mix is the proportion of patients with private third-party payors (Blue Cross Blue Shield, Humana, etc.), patients covered by public-assistance programs (Medicare and Medicaid), and patients that are uninsured. For example, an internist or general practitioner may have a payor mix of 20% of patients with Blue Cross Blue Shield, 10% of patients with Humana, 10% of patients with Aetna, 20% of patients with Medicare, 15% of patients with Medicaid, 10% uninsured or self-pay, and 15% of patients with other private or public third-party payors. The difference between a physician’s usual and customary charges and the actual amount the physician agrees to accept as full payment from any of these purchasers can vary significantly due to this payor mix.

As a result of varied payor mixes and the need to cost shift the expenses of publicly-funded patients, research indicates that physician fees accepted as full payment average between 50% and 60% of usual and customary charges. This is based on an actuarial study of physician reimbursement rates conducted by an independent firm contracted by the Agency for Health Care Administration (AHCA) in 2003. The study found that Medicaid pays the least for physician services out of all payors in their payor mix. Medicaid fees for physician services in Florida average about 25.3% of usual and customary charges. Medicare’s fee schedule is the next highest at 35% of usual and customary charges, followed by private third-party payers whose average physician reimbursements are 54.3% of usual and customary charges.

AHCA's actuarial study's findings are supported by an earlier study conducted by the Lewin Group for California's Medicaid program research institute, Medi-Cal Policy Institute. In their 2001 study, the Lewin Group compared physician and dentist reimbursements schedules among all 51 state and territorial Medicaid programs with the reimbursement rates in Medicare. The Lewin Group's analysis found that Florida's Medicaid program only reimbursed at 53% of Medicare's reimbursement rate for the same services.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

Section 100.371, Florida Statutes, requires that the Financial Impact Estimating Conference "...complete an analysis and financial impact statement to be placed on the ballot of the estimated increase or decrease in any revenue or costs to state or local governments resulting from the proposed initiative."

As part of determining the fiscal impact of this proposed amendment, the Financial Impact Estimating Conference principals held a public workshop on June 4, 2004. The principals heard testimony on the fiscal effects of this amendment from representatives of Floridians for Patient Protection (FPP) and the Florida Medical Association (FMA). Additionally, a questionnaire was mailed on June 8, 2004, requesting input from various state agencies, local governmental entities, and other organizations regarding fiscal impacts and the development of cost estimates. Representatives of these entities were invited to the June 17, 2004 meeting of the Financial Impact Estimating Conference to answer questions or provide additional information on potential costs.

In her testimony before the Conference principals, the FPP representative stated that there were two fiscal effects associated with this amendment: 1) Medicaid; and 2) state employee health plans. FPP noted that while these programs may be affected, it would be "speculative" to put a dollar value to either effect. FPP acknowledged that there may be a cost to the Medicaid program by requiring higher physician reimbursements, but there may be cost savings to the state employee health plan by reducing physician reimbursement rates.

In speaking against the proposed amendment, the FMA representative stated that it would have a "devastating" financial effect on state and local governments. The FMA's position is that physicians will have to drop their lowest paying fee schedules in order to prevent having to accept the lowest reimbursement as the only price that can be charged. Based on data that finds Medicaid pays only 57% of Medicare rates, the FMA stated that physicians would likely cancel their contracts with Medicaid and Medicare unless these programs increased their physician reimbursement rates.

In oral arguments before the Florida Supreme Court on June 7, 2004, attorneys for FPP acknowledged the possible financial effects of the proposed amendment would be to increase the costs to the Medicaid and Medicare programs because physicians would have to make a choice of whether to continue participation in the programs if their participation would require them to accept lower rates from other purchasers. Under questioning, the attorneys for the FPP agreed that the most likely scenario is that physicians would require higher payments from the Medicare and Medicaid in order to continue their participation.

In a second public workshop conducted by the Estimating Conference, representatives from several state departments and agencies were present to discuss information they provided in response to a questionnaire distributed by the Estimating Conference's principals. AHCA provided the most information on this particular constitutional initiative with the Department of Health, the Department of Management Services, and the Department of Corrections also providing more limited information. These entities all believe that the most likely result of the amendment would be to increase the cost

of providing physician services through Medicaid. They assume that the Medicaid reimbursement rate would need to increase to at least the same level as Medicare, although AHCA stressed that there is no certainty that physicians would accept Medicare as their ceiling and the cost may actually be higher than Medicare.

There was greater uncertainty, however, related to the effect the amendment would have on state and local governments' employee health plans' costs. Some local governments responding to the Estimating Conference's survey stated that they believe there would be increased costs to their health plans because of the amendment (one stated that it would probably be between 3% and 4%), while others said there would be no effect. The Department of Management Services' Division of State Group Insurance was also uncertain about the effect. They argue that increases in fees and the elimination of discounts negotiated by the state's third party administrator (TPA) will result in greater costs per member for claims payments, especially under the state's Preferred Provider Organization (PPO) plan. They argue that these increases would also be necessary in the state's Health Maintenance Organization (HMO) contracts. However, these effects were not quantified, and when further questioned by the Estimating Conference principals, the State Group Insurance representative stated that an independent actuarial study would be necessary to determine the impact.

A. FISCAL ANALYSIS

The fiscal impact summary for this proposed amendment is based on independent research; oral and written statements from the proponents, opponents, and state departments and agencies; and discussions among the Estimating Conference principals and their professional staff. Based on this information, the Financial Impact Estimating Conference principals expect that the proposed amendment will have the following financial effects on state and local government:

- **Medicaid payments to physicians licensed under Chapter 458, Florida Statutes, would need to increase in order to maintain a sufficient number of physicians for the state to remain in compliance with federal Medicaid requirements.** Since Medicaid is usually the lowest fee accepted by physicians for their services, doctors would have to reduce all fees to all purchasers in their payor mix to the Medicaid reimbursement level. The resulting decrease in revenue would force most physicians to stop serving Medicaid patients so that their private third-party payors would not decrease their fee schedules to the Medicaid level.

However, federal regulations [42 U.S.C. 1396a(a)(30)(A)] require that states must assure that Medicaid payments are consistent with efficiency, economy, and quality of care, which requires the states to consider the costs of providing quality care when setting rates. Furthermore, Section 30 (A) requires that *payments be sufficient to enlist a sufficient number of providers so that services are available to Medicaid beneficiaries at least to the extent that such medical services are available to the general public, i.e., to assure sufficient access to services for Medicaid beneficiaries.*

If the constitutional amendment is ratified, these federal regulations may require the state of Florida to increase its Medicaid physician reimbursement rates to at least those of the next highest payor, Medicare. Since Medicaid reimburses at approximately 25% of usual and customary charges, this would require a 40% increase in Medicaid expenditures for physician services in the next fiscal year.

If the proposed amendment had been in effect in the last state fiscal year for which complete data is available (FY 2002-03), Medicaid physician services would have cost an additional \$125 million in state revenue (\$306 million total) in the fee-for service program and an additional \$32 million in state revenue (\$110 million total) in increased capitation payments for Medicaid HMOs. Since there has been growth in Medicaid expenditures every year, it is assumed that the program will spend the same amount or greater in the next fiscal year resulting in a combined increase in expenditures of \$157 million in state revenue (\$416 million total).

The total financial impact to the state would be an additional cost of \$157 in state revenue (\$416 million total) due to increased Medicaid expenditures for physician services.

Or, the market may require that Medicaid reimbursement rates increase to the equivalent of the current commercial payor mix (54.3% of usual and customary charges). Based on current data, this would require a 115% increase in Medicaid expenditures for physician services in the next fiscal year.

Under this scenario, if the proposed amendment had been in effect in the last state fiscal year for which complete data is available (FY 2002-03), Medicaid physician services would have cost an additional \$376 million in state revenue (\$915 million total) in the fee-for service program and at least an additional \$95 million in state revenue (\$231 million total) in increased capitation payments for Medicaid HMOs. Since there has been growth in Medicaid expenditures every year, it is assumed that the program will spend the same amount or greater in the next fiscal year resulting in a combined increase in expenditures of \$471 million in state revenue (\$1.146 billion total).

The total financial impact to the state would be an additional cost of \$471 in state revenue (\$1.146 billion total) due to increased Medicaid expenditures for physician services.

- **Medicaid physicians' fees may not be affected because of new forms of business arrangements for billing purposes.** Facing the threat of having to reduce all their fees to the lowest they have accepted as full payment, physicians may incorporate their practices into several separate corporations, each of which would only accept payments from a single purchaser of health care, or some other business arrangement that allows them to continue cost shifting among patients. In this scenario, it may be the corporation, not the physician, which will bill the purchaser of the health services. Thus, the physician will no longer have a "payor mix." Outside of the additional costs associated with the initial incorporation and the separate billing services that would be needed, it is unlikely that the amendment would have any effect on state and local government.

However, to the extent that the physician's license number is necessary to bill, it is possible that the separate corporate accounting structure system may not be permissible and would not allow the physician to continue cost shifting. In this case, the first assumption would come into play and there would be a significant effect on the state's Medicaid program.

- **Revenues from physician services in public health care centers may decrease, resulting in increased expenditures for state and local governments.** Persons receiving care from public health care centers (i.e., county health departments, local government owned hospitals, etc.) sometimes pay for physician services on a sliding

scale based on their income. Sliding scales may not be allowable under this proposed amendment since the lowest fee on the scale would have to be charged to all patients. To the extent that physician fees are used by these public health facilities to continue operations and they would decline with the adoption of this amendment, state and local governments would have to increase expenditures from other revenue sources or cut services.

However, these facilities are sometimes both the provider of physician services and at other times the purchaser. It is possible that these two roles may cancel out each other, resulting in no fiscal effect. For example, county health departments provide physician services which are billed to Medicaid. If Medicaid reimbursements increase, the county health departments will receive additional revenue. If, at the same time, the county health department contracts with area physicians in certain specialties, these rates may need to increase after the amendment passes as physicians respond to the changes in the market. So, in the first case the county health departments earn additional revenue when billing Medicaid directly, but their costs increase when contracting for other physician services. It is possible that the increased revenue would completely offset the increased costs for contracting with specialty physicians, resulting in no fiscal effect on state and local government.

- **State and local governments' employee health plans may either be positively or negatively affected depending on whether their current physician fee schedule is higher or lower than the next highest or lowest fee schedule of other purchasers using the same physician networks.** If a government employee health plan's fee schedule is currently the lowest fee accepted by a physician, the physician will likely require higher fees to remain in the health plan's network, eventually resulting in higher costs for the health plan. If the government employee health plan's fee schedule is currently the highest accepted by a physician, the health plan should be able to reduce its reimbursement to the next lowest fee schedule accepted by the physician, thus saving the health plan money.

Actuarial information was not provided by the Department of Management Services' Division of State Group Insurance on the effects of the proposed amendment on the state employee health plan. The Division did submit a written response that indicated that they believe there would be an increase in costs that would negatively affect the health plan's trust fund, but these costs were not quantified in the response. A few local communities responded with the information as well, but with mixed fiscal assessments. Some communities indicated an increase in costs while others indicated no effect.

B. FISCAL IMPACT ON STATE AND LOCAL GOVERNMENTS:

1. Revenues:

Based on the information provided through the public workshops, arguments before the Florida Supreme Court, and staff research, state and local governments' revenue would decrease as a result of no longer being able to charge a sliding fee for physician services. The decrease in revenue would be approximately \$12 million for the county health departments based on collections in FY 2002-03; however, these losses may be offset by higher Medicaid reimbursements. Because it is unclear how much these two effects will offset each other, the total revenue impact cannot be determined at this time.

2. Expenditures:

Based on the information provided through the public workshops, arguments before the Florida Supreme Court, and staff research, there are two possible fiscal effects on state and local government expenditures.

1. Physicians may be able to create new business arrangements for billing purposes that do not violate the language of the amendment and will allow them to continue cost shifting among their patients.
 - If these new business arrangements are allowed, current billing practices will continue and there will be no financial impact on state and local governments.
2. Physicians may change the schedule of fees they currently accept as full payment to a single rate for each particular service they provide. The health care market may set the fee for each service as some percentage of Medicare's reimbursement rate. As a result,
 - Medicaid's expenditures for physician services will increase significantly since its rates are currently the lowest fee accepted as full payment by most physicians. To keep physicians in the program, Medicaid rates will need to increase to at least the Medicare reimbursement rate, and possibly the reimbursement rates of commercial payors. Raising Medicaid's reimbursement rates to the same level as Medicare or that of commercial payors would require an increase of between 40% and 115%. These increases would result in a financial impact of between \$157 million and \$471 million in state revenue for Medicaid expenditures for physician services.
 - The amendment will affect the cost of providing health care coverage to state and local governmental employees. If the government's health plan reimburses physicians at a rate higher than other plans, the cost to the plan will probably decrease. If the government's health plan has a lower fee schedule, the cost of physician services will likely increase. However, the total financial impact on these health plans cannot be determined at this time.