FINANCIAL ARRANGEMENTS BETWEEN PHYSICIANS AND HEALTH CARE BUSINESSES: PERSPECTIVES OF HEALTH CARE PROFESSIONALS

Management Advisory Report

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EXECUTIVE SUMMARY

OBJECTIVES

This inspection reports on results of interviews conducted with health care professionals and regulatory agencies concerning the practice of physician ownership and self-referral. The purpose of these interviews was to elicit information on the range of opinions that exist regarding the impact of financial arrangements between physicians and other health care entities to which they refer patients.

BACKGROUND

In the last 10 years, increasing attention has been focused on the financial arrangements that exist between physicians and the health care businesses to which they refer patients. In 1980, an influential article in *The New England Journal of Medicine* by the journal's editor, Dr. Arnold Relman, elicited strong debate in the medical community concerning the appropriateness of such arrangements and the impact that they might have on medical judgments made by physicians in determining what services their patients require. Since then, public scrutiny of those financial arrangements has increased.

Despite the intense debate over this issue, few studies have been conducted to determine the extent of such arrangements between physicians and the health care businesses to which they refer patients, or the impact of such arrangements on utilization of services, cost and pricing, competitiveness, and quality of care. This inspection is one in a series of reports issued by the Office of Inspector General (OIG) on this subject.

METHODOLOGY

The OIG conducted opinion interviews with 143 State officials, 17 health care experts and association representatives, 8 Medicare carriers and over 40 Medicare providers. These interviews were conducted face-to-face or by telephone.

FINDINGS

- Most respondents held strong opinions on the effect of physician ownership on the competitiveness of the market. The majority of State officials, nonphysician-owners and the associations we interviewed argued that physician ownership and self-referral has a negative impact on the competitiveness of the health care market, since physicians control both supply and demand in such circumstances. Physician-owners argue that competition is heightened, since physician investment creates more health care entities among which to choose.

- Certain respondents argue that the practice can increase health care costs and diminish quality since, without competition for referrals, providers can act freely in regard to price and service. Title XIX, States' attorneys, and the Medicaid Fraud Control Units (MFCU) representatives were especially concerned about costs, although representatives from medical boards generally thought the practice has a neutral effect on both cost and quality of care. Physician-owners suggest that their financial involvement will help to ensure good quality of care and have no detrimental affect on costs.

- Respondents were split on whether Congress should act to regulate such arrangements. The majority of physician-owners and State Board representatives argued against Congressional action; most MFCU officials, title XIX officials, nonphysician-owners and most of the associations we interviewed argued for various kinds of congressional intervention.

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INTRODUCTION

BACKGROUND

In the last 10 years, increasing attention has been focused on the financial arrangements that exist between physicians and the health care businesses to which they refer patients. In 1980, an influential article in *The New England Journal of Medicine* by the journal's editor, Dr. Arnold Relman, elicited strong debate in the medical community concerning the appropriateness of such arrangements and the impact that they might have on medical judgments made by physicians in determining what services their patients require. Since then, public scrutiny of those financial arrangements has increased.

In 1982, the Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, U.S. House of Representatives, expressed its concern regarding the emergence of such arrangements. In 1988, a bill was introduced in the U.S. House of Representatives that would generally prohibit physicians from referring their patients to health care businesses in which they hold financial interests. That bill, "The Ethics in Patient Referrals Act," was reintroduced in 1989 and is now pending. The Subcommittees on Health and Oversight, Committee on Ways and Means held a joint hearing on the bill in March 1989. Further hearings are anticipated.

Despite the intense debate over this issue, few studies have been conducted to determine the extent of such arrangements between physicians and the health care businesses to which they refer patients, or the impact of such arrangements on the use of services, cost and pricing, competitiveness, and quality of care. This inspection is one in a series of reports issued by the Office of Inspector General (OIG) on this subject.

OBJECTIVES

Section 203(c)(3) of the Medicare Catastrophic Coverage Act of 1988 mandated the Office of Inspector General to conduct a study and report to Congress concerning:

- physician ownership of, or compensation from, an entity providing items or services to which the physician makes referrals and for which payment may be made under the Medicare program;

- the range of such arrangements and the means by which they are marketed to physicians;

- the potential of such ownership or compensation to influence the decision of a physician regarding referrals and to lead to inappropriate utilization of such items and services; and

- the practical difficulties involved in enforcement actions against such ownership and compensation arrangements that violate current anti-kickback provisions.

As part of this study, the Office of Inspector General interviewed State officials, industry and association representatives, Medicare carriers, and Medicare providers regarding their perspectives of physician ownership and self-referral. This inspection reports on the results of those interviews. The purpose of the interviews was to elicit information regarding the range of opinions that exist on the impact of financial arrangements between physicians and other health care entities to which they refer patients.

METHODOLOGY

The OIG conducted opinion interviews with the following:

(1) one hundred and forty-three State officials in 50 States representing Medical Licensing Boards responsible for the licensing and disciplining of physicians, title XIX agencies responsible for administering State Medicaid programs, Medicaid Fraud Control Units (MFCUs) and State Attorney General's offices responsible for pursuing cases of Medicaid fraud and abuse;

(2) seventeen health care experts and representatives from numerous associations, including the American Medical Association, American Imaging Association, American Clinical Laboratory Association, American Society of Internal Medicine, American College of Radiologists, College of American Pathologists, and Consumer Federation of America;

(3) eight randomly-selected Medicare carriers responsible for review and processing of Part B claims submitted by providers, including Travelers of Connecticut, Empire of New York, Blue Shield of Florida, Blue Shield of Kansas City, Blue Shield of Michigan, Occidental of California, Blue Shield of Arkansas, and Nationwide of West Virginia;

(4) a subsample of over 40 Medicare providers selected in our national survey of providers, consisting of both physician-owners and nonphysician-owners.

FINDINGS

Most respondents held strong opinions on the effect of physician ownership on the competitiveness of the health care market. Some respondents strongly feel that the practice increases competition by expanding the number of health care providers, while others feel just as strongly that the practice creates a monopoly for physicians in the market.

Health care providers and experts are split on the competitive effects of physicians ownership and self-referral. Physicians who have become involved in such arrangements, and the associations that represent them, argue that their investments increase competition in the health care market by creating new entities providing services. Some observers, including health care providers who compete with physician-owners, see the practice as anti-competitive, with higher potential for overutilization of services and higher cost to consumers. Most State officials we interviewed agree with this view, although representatives from medical boards were less inclined to view the practice as anti-competitive than colleagues in the Medicaid Fraud Control Units (MFCUs) or title XIX offices.

Nineteen of the 24 physician-owners we interviewed (79 percent) believe their investments either contribute to increased competition or have a neutral effect on the market. Several physician-owners we interviewed argued that physicians see the need for service in a community before others, and consequently can contribute to improving access and the availability of services through prudent investment. They suggested that such investments also can enhance competition by creating more health care entities from which patients can choose and that independent, non-physician owned entities simply resent the introduction of new competitive forces in the marketplace. Proponents of this view cite the 1987 Federal Trade Commission position that physician ownership and referral has pro-competitive effects, including increased investment activity by physicians who identify a need in their community and physician oversight to ensure better quality care for their patients.

Fifteen of the 23 nonphysician-owners (65 percent), 27 of the 36 MFCU representatives (75 percent), and 25 of the 49 title XIX representatives (51 percent) we interviewed believe the practice is essentially anti-competitive. For example, one MFCU director stated that based on his experience, physicians would "invariably" refer their patients to the entity in which they had an interest. A director of a Medicaid agency in another State feels that "when a physician owns another health care entity he/she naturally refers each patient to his/her own facility, excluding other facilities which may be better or less expensive."

Eleven of the 17 associations consulted (65 percent) shared this view. One association representative argued that other entities competing with the captive entity can not fairly compete on the basis of price, quality or service--because no matter how competitive they are in these areas, the physician will always refer to the entity in which he or she has an economic interest. "The physicians-owners are not putting their referrals into the stream of commerce," one consumer advocate argued. "Eventually a deterioration in price and quality will result where competition does not exist."

Respondents generally felt that the practice has little effect--either positive or negative--on quality of care. However, different respondents again argued both sides.

Sixty-seven percent of the State officials interviewed felt that physician ownership has no effect on quality of care or had no opinion on the matter. Nonphysician-owners were the most likely group to see the practice as detrimental to quality of care; almost half of the nonphysician-owners we interviewed expressed this opinion. Physician-owners were the most likely group to believe the opposite; 16 of 24, or 67 percent, considered their investments to have a positive effect on the care patients receive.

The respondents who consider physician ownership and self-referral to have a positive impact on health care feel it is primarily due to the physician's knowledge and concern for the business. One respondent stated that physician ownership of health care entities to which they refer "provides continuity of care and could possibly assure better quality of care." Some respondents thought that quality assurance would be a higher priority with physician-owners or investors.

Other respondents thought that physicians might make good managers because they have a working knowledge of the product and services delivered. Some respondents, however, challenged this view. "In the limited partnership arrangements," argued one association representative, "physicians have absolutely no connection with the management or day to day operations. How can a limited partner ensure quality?"

Many physician-owners interviewed cited the ability of their investment dollars to meet a community need as one way to increase quality of care on a general scale. Accessibility of services in rural and remote regions was stated as a possible advantage of physician investment in health care enterprises by several respondents. One Medicaid official noted: "If the physician sets up in a rural area where no health care businesses exist, it is a definite benefit to the community."

Most of the concerns expressed regarding quality of care were related to unnecessary testing. For example, one State official maintained that "poor or inadequate care may result if the physician is solely motivated to provide additional services from his business arrangements in order to increase revenues." A nonphysician-owner argued that, in situations where a physician has a financial interest in another health care business, "[v]olume takes precedence over quality and medical necessity."

The individuals we interviewed disagreed on the impact of physician ownership and self-referral on the total cost of health care. Generally, those who believe competition will decrease as a result of these arrangements believe costs will eventually increase. Others believe that arrangements between physicians and health care entities will have no impact on cost; a small minority believe costs will decrease.

Respondents further disagreed on the effect of such arrangements on the total cost of health care. The MFCU and title XIX officials were especially concerned that financial arrangements between doctors and other health care businesses will increase costs. Representatives of medical boards and physician-owners believe costs will neither increase nor decrease as a result of such arrangements. Few respondents in any of the groups we interviewed believe costs would actually decrease as a result of physician financial involvement in the market.

Of those expressing concern regarding higher costs, one State official remarked that "the financial incentives cause the costs to rise." Another stated: "If the physician is financially motivated, the obvious result will be an increase in prices." The director of a Medicaid agency feels that "physicians control the marketplace and drive up the costs. They have a captive audience for their products and the patients invariably go where their doctor has suggested." Some respondents argued that the issue of cost is directly related to the issue of competition; where competition is diminished, providers can raise prices with impunity. These respondents believe that physician ownership impede competition and creates the possibility for inefficient and costly health care.

Of the smaller group (4 percent of State officials, 25 percent of physician-owners) who feel costs would decrease as a result of physician ownership and self-referral, several believe that if doctors own a facility the proximity of the facility and the convenience to the doctor may decrease the cost to the patient. This group shared the view that the competitive impact of physician ownership and investment affects costs; but they argue that the *increased* competition created by new providers entering the market will cause prices and costs to *decrease*, not increase.

Respondents generally agreed that ethical questions come into consideration when a physician-owner refers a patient to an entity in which he or she has a financial interest.

Both those supporting and opposing physician ownership and referral believe that such arrangements can result in ethical dilemmas for physicians. Nineteen of the nonphysician-owners (83 percent), 13 of the associations (93 percent), and 13 of the physician-owners (53 percent) we interviewed believe that a conflict of interest may exist with respect to such arrangements. One-third of the representatives interviewed from State medical boards cited potential conflict of interest as a disadvantage of the practice.

"It's just one more factor other than medical necessity which can influence a physician's decision," one respondent said. An association representative noted that, when a doctor orders a service or item, he acts as the consumer for the patient and should not have a competing fiduciary interest. "Medical ethics aside, this practice violates tenets of basic business ethics," he argued. However, physician-owners and others that are supportive of the practice suggest that physicians can deal with ethical issues that arise and make the right decision. "It's in the eye of the beholder," one physician-owner said. "It depends on whether the physician allows it to cloud his decision-making."

Not surprisingly, respondents disagreed on the need for Congress to legislate in this area.

Thirteen of the physician-owners (54 percent) and 26 of the State board representatives (57 percent) we interviewed did not believe that congressional intervention in this area is warranted. These respondents believe that abusive arrangements, when they exist, should be addressed on a case-by-case basis. Nonphysician-owners (87 percent) and the association representatives (65 percent) we spoke to tend to argue that congressional intervention is needed. The MFCU representatives, States' attorneys, and title XIX representatives agreed.

Physician-owners argue that post-payment and utilization review by third party payors is sufficient to address over-utilizers and abusers of the system, and that legislation to prohibit ownership will simply "hurt the 99 percent of the physicians who are honest." Most of the State respondents opposing congressional action believe physician ownership to be a State issue. Others oppose congressional intervention because they feel physician ownership is not a problem. "This is small ticket stuff, insignificant in terms of the total dollars being spent on health care," one official argued. One respondent felt that "there are much more important health issues and national problems than physician ownership."

The majority of MFCU representatives, title XIX officials, States' attorneys, and nonphysician-owners support Federal legislation of some kind. Many support laws to generally prohibit physicians from referring patients to a health care entity in which they have a financial interest. Others advocate mandated disclosure of financial interest, or simply want Congress to draw the line between legitimate and illegitimate arrangements.

FURTHER REPORTS

On May 1, 1989, the OIG reported to Congress on the areas outlined in Section 203(c)(3) of the Medicare Catastrophic Coverage Act. This report, "Financial Arrangments Between Physicians and Health Care Businesses: Report to Congress," (OAI-12-88-01410), detailed information obtained from OIG surveys in regard to the nature, range and prevalence of ownership and compensation arrangements between physicians and health care businesses. Information from the Medicare Part B Annual Data (BMAD) files was used to assess the use of selected ancillary services of patients associated with physician-owners or investors, as compared to the use of ancillary services of Medicare beneficiaries in general. Finally, the report detailed the enforcement experiences of the OIG in connection with physician ownership or compensation arrangements which violate Federal anti-kickback laws.

The OIG also issued a Management Advisory Report in April 1989, "Financial Arrangements Between Physicians and Health Care Businesses: State Laws and Regulations," (OAI-12-01412). This report described certain State laws and regulations which affect physician ownership and self-referral.

The OIG will produce additional reports on the subject of financial arrangements between referring physicians and other health care businesses. Reports focusing on physician ownership and other market forces in the independent clinical laboratory, independent physiological laboratory and durable medical equipment industries will be issued in fall 1989.