HEALTH CARE REFORM

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

VOLUME II

Issues Relating to Private Health Insurance Reform

MARCH 15, 1993

Physician Ownership and Referral Arrangements and H.R. 345, "The Comprehensive Physician Ownership and Referral Act of 1993"

APRIL 20, 1993

Serial 103–13

Printed for the use of the Committee on Ways and Means

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SUBMISSIONS FOR THE RECORD

ISSUES RELATING TO PRIVATE HEALTH INSURANCE REFORM

MONDAY, MARCH 15, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to call, at 2 p.m., in room B–318, Rayburn House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
TUESDAY, MARCH 9, 1993

PRESS RELEASE #5
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

**THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING
ON
HEALTH CARE REFORM:
ISSUES RELATING TO PRIVATE HEALTH INSURANCE REFORM**

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on issues relating to private health insurance reform. This hearing will be held on Monday, March 15, 1993, beginning at 1:00 p.m., in B-318 Rayburn House Office Building.

In announcing this hearing, Chairman Stark said, "The lack of standards for private health insurance is a travesty. The widespread use of medical underwriting, experience rating and restrictions on enrollment have deprived too many businesses and individuals of affordable health insurance coverage."

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND:

Health insurance reform has been put forward as a critical component of many health care plans. Various practices of the insurance industry appear to increase the problems faced by employers and individuals who seek to purchase health insurance.

The wide use of experience rating to set premiums, rather than the use of community rating, has increased premiums for small and medium-sized firms. Other common practices make it virtually impossible for certain groups or individuals to purchase affordable health insurance, including but not limited to: medical underwriting, the segregation of workers with high risks from group rates, coverage denials, exclusions for pre-existing conditions, exclusions based upon the industry classification of the group, and refusals to renew insurance.

Testimony will focus on the variety of problems in the current health insurance market, and the impact of such practices on employers, families and individuals seeking to obtain or renew health insurance.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Monday, March 29, 1993, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

(MORE)

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

* * * * *

Chairman STARK. Good afternoon.

Today the Subcommittee on Health will hold its fifth in a series of hearings on health care reform. We are attempting to lay the foundation needed to work with our new administration to enact a comprehensive health care reform plan.

The health insurance system in this country is probably the greatest example of a failed marketplace. Health insurers and their actuaries have become increasingly sophisticated at predicting and excluding high-risk cases, leaving too many Americans unable to buy the health insurance they need.

We have all heard stories about insurance companies raising premiums for businesses because a worker or dependent had the misfortune to contract a serious illness. Something is wrong with the system when insurance becomes unaffordable simply because some people need it.

Regrettably, this "dare to use it and you certainly lose it" approach has become far too pervasive and the consequences are evident to the American people.

Problems concerning health insurance coverage are also evident in self-insured plans. For example, a recent court decision involving the H&H Music Co., upheld the right of a self-insured firm to reduce benefits for an individual who contracted AIDS. This decision suggests that consumers have almost no protection under the law and are increasingly vulnerable when a high-cost illness strikes.

The lack of standards for private health insurance has created a national problem. The widespread use of medical underwriting, experience rating, and restrictions on enrollment have deprived too many businesses and individuals of affordable health insurance coverage.

It is virtually impossible to have a discussion about health care with any citizen in this country without hearing a heartbreaking

story of a family denied health insurance because they have a history of cancer, high blood pressure—even chronic ear infections.

Other health insurance problems have become household concerns, including "job lock," the real fear of losing health insurance because of a change in jobs, and the large annual increases in health insurance premiums.

As we proceed down the road toward health care reform, we should keep in mind the problems that will be described during the hearing this afternoon. These are the problems that must be addressed in any reform in order to provide peace of mind to the American people.

I want to emphasize that this hearing on private health insurance, like other hearings held by the subcommittee this year, is focused on problems rather than on solutions. We will, of course, direct our attention to the solutions once the White House submits its health care reform plan to the Congress.

I look forward to the testimony we will hear today. But before we begin, I want to suggest to the witnesses that there are sophisticated techniques in marketing that lead to risk selection which we really do not intend to cover today. It would be helpful to this subcommittee if the witnesses can address this in their discussion.

We begin our testimony with two expert witnesses, both of whom have testified before the committee previously.

We have Gordon Trapnell, who is president of Actuarial Research Corp., and Harry Sutton, senior vice president and chief actuary of the R.W. Morey Co. of Minneapolis. He is here representing the American Academy of Actuaries.

As for all our witnesses today, their written statements will appear in the record in their entirety and we would be happy to have you summarize your testimony or expand upon it, if you choose.

Gordon, why don't you lead off.

STATEMENT OF GORDON R. TRAPNELL, PRESIDENT, ACTUARIAL RESEARCH CORP., ANNANDALE, VA.

Mr. TRAPNELL. Thank you, Mr. Chairman.

I was afraid that after my last appearance before you in which I explained the antiselection death spiral for multiple-employer trusts, that you would never want to see me again or any other actuary.

Chairman STARK. Excuse me, Gordon, but could you move the microphone closer to you? The acoustics in this room are terrible. Thanks.

Mr. TRAPNELL. I will try again.

I was a afraid that after my last testimony before you in which I explained the antiselection death spiral for multiple-employer trusts, that you wouldn't want to see me or any other actuary again. But I am happy that as controversial as those remarks were regarded at the time, that the National Association of Insurance Commissioners has now developed a model law to fix most of the problems I presented, and that over 20 States have now adopted it.

My colleague, Harry Sutton, will discuss their achievements and impact; perhaps pointing out that there are still some loopholes in these laws that need to be fixed. Most of the same problems that

were present in the small group market are also present in the market for individual insurance and similarly needed to be addressed.

I have submitted the usual turgid treatise on actuarial principles for your staff to wade through. I will try to highlight a few points.

Chairman STARK. Single-spaced.

Mr. TRAPNELL. The most important aspects to understand about setting premium rates of health insurance policies are the different segments of the market, which are primarily by the size of the insured unit and the types of medical services insured, which form the risk that insurers face in insuring each segment. The type of insurance organization may also be a factor, although it is my belief that rating practices are an evolution as a more competitive form of insurer appears with a competitive advantage that allows them to adopt rating practices that are less restrictive and competition gradually forces them to adopt characteristics similar to those that you find in the insurance field.

The services that I want to address are what I will refer to as "comprehensive major medical services," by which I mean hospital care, physician services, and other services that are provided in conjunction with them, such as practitioners, such as physical therapists, drugs, medical supplies, and other services, when there are substitutes, such as nursing homes and home health services.

I will not discuss services that have much less risk to insurers and tend to be treated in different manners, such as first dollar prescription, dental, vision, long-term care.

I will also address the primary risks that are insured against, which are primarily of four types: Estimated distribution of probabilities of unrealized claims, and how this applies to any particular policy; determining what the impact of large numbers will be on these distributions; forecasting inflation and change in the utilization over time; and detecting changes in the group insured which is affected by the natural tendency of people to select against an insurance company.

The basic nature of insurance premiums is really quite simple. It is just a ratio. The numerated ratio is the sum of all the claims that insurance expects to pay and the related administrative costs and whatever loading they include for risk, which, if they get to keep, becomes their profit.

The denominator of the ratio is the sum total of the premium payments that they will receive, which may or may not be different from the total number of people covered. But this ratio will be higher if the people who are going to be included in a group are more expensive to care for and it will be lower if they are less expensive. And determining who will be covered is really the tricky part, especially if participation is voluntary.

Each individual buying for themselves, or if a firm decides which insurer to use, will seek the best rate they can get. Since the rate depends on how expensive the people included in whatever pool the insurer uses to determine the premium rate for these risks, the lowest rate for any purchase will be that which doesn't allow any other unit that is more expensive to join.

This forces insurers to subdivide their markets by how expensive each applicant is expected to be. Because if they do not, another

insurer will offer a lower premium to just those people who have a lower anticipated cost.

This basic principle forces all insurers to segment their markets into any group, which in advance you can't determine how relatively expensive they will be.

Chairman STARK. Nothing happens if it turns red. You don't have an electronic gadget.

Mr. TRAPNELL. This is actually going much more slowly than I expected.

How many minutes should I take?

Chairman STARK. Go ahead.

Mr. TRAPNELL. Anyway, to run quickly through the segmentation by size, perhaps the most important single attribute of most health insurance to understand is that there are no premium rates. For a majority of persons covered by health insurance that is covered, the basic nature of the coverage is self-insurance, and for a large employer with a self-insured plan, there is only expenses to pay, and sometimes they even know how many people may be covered by them.

Chairman STARK. No premium tax.

Mr. TRAPNELL. And no premium tax and no regulation. They are forced to determine what their premium rate is for anyone who is allowed to enroll in an HMO; because those premium rates, they are paid out to the HMO in return for the services provided to their employees and there is no refund if it is more or less expensive than anticipated.

The reason why nearly all large employers are self-insured, at least for their indemnity coverage, is that the risk of pooling, the pooling risk, which you might say the fluctuation in utilization may occur in a group of individuals from year to year, is minimal. And in the evolution of insurance, as this became clear, the other advantages of self-insurance are avoiding regulation, avoiding mandated benefits, keeping the cash flow—which is, why should you send all 3 months of extra premiums to an insurance company if you can keep the cash itself—plus creating a much more competitive market for the administrative services by isolating just what they are, and putting the insurance companies in competition with third-party administrators and other companies that target these services providing more administrative costs for them.

This characterizes most firms with a thousand or more employees. An insurer, if they have an insurer, it is really a version of self-insurance, because the insurer will determine what the premium rate is based upon a projection of their experience, and give them a dividend or rate—other rate consideration, if there is any money left over at the end of the year.

The other extreme is the small group market where the premium rates are real and where insurers have largely segmented their rate structure by actuarial characteristics, such as age, sex, particularly the area of residence and family composition; and indirectly by characteristics such as occupation, mostly by excluding those that they think will be very expensive. We have been rather exhaustive in the problem and how it affects rates throughout the last few years.

Let me make a few comments with respect to parallels with how rates are set by some insurers for individual policies that has parallels to how they are set for small groups. Some insurers start a new policy form every year or two, which differs in some minor way from the ones that they have already offered.

They will then put all of their new applicants into this new form. To the insurance regulators, they will then stop selling it for the old form. What happens is the people insured under the old form, which has no new applicants, will have an increased cost as the effects of having screened them through the underwriting process wears off.

The preexisting exclusion clause expires, and this compounded with inflation, will yield sharp rate increases under the old closed policy. That will discourage all those who have that policy from keeping it, and any who are still healthy enough to apply and get a new policy will switch to a new form, and their agents will be happy to accommodate them.

This results in a rate spiral for the closed policies that is very similar to what happened with the small group market. It is not quite as bad as the tier rating was, which allowed in a—in small group markets allowed an insurer to raise the rate at any level that they thought appropriate.

Chairman STARK. Sort of after-the-fact underwriting.

Mr. TRAPNELL. Yes. You can't do that in the individual market. You have to raise the rate for everybody in a particular State, under a particular form, but you can only start a new form—and this is another example of what I think should be called a principle identified by the great Barnum, when he noted that, yes, you can display a lamb with a lion in a cage together, provided you keep a large reserve supply of lambs.

To view lambs in this analogy are the new insurance forms that they keep bringing out when the old ones have deteriorated, and you have—it is funny that all of these problems were identified and addressed in the context of the small group market, but have been largely ignored when the same general principles applied in the individual market.

Again, I want to make it clear I am describing the practices of some companies, not all companies that are out there. But the fact that some companies can do this puts pressure on the other companies to do the same. Because if you have a policy whose rate is not going to increase rapidly in the future, it looks—it means you have to charge a higher rate to begin with, and it looks like a poor buy. And all the instincts of individuals shopping for insurance is to buy the one with the cheapest price, but that may not reflect the best long-term arrangement for the purchaser.

Thank you, Mr. Chairman.

I am sorry for having exceeded my time. I am much too long winded.

[The prepared statement follows:]

Testimony by Gordon R. Trapnell, F.S.A.
President
Actuarial Research Corporation

Health Insurance Premium Rates

1. History

The health insurance business evolved from two separate sources: the Blue Cross and Blue Shield plans and the prepaid group practice plans. Each of these originally prefunded the cost of major health services for members of employment groups for a capitation payment or community rated premium (usually different for single employees and families). By providing access to all providers and benefiting employees in all areas of the U.S., the Blue model proved to be extremely popular and rapidly obtained a dominant market share.

Life insurance and casualty insurance companies also entered the field to compete with the Blues by exploiting market niches left by the persistence of the Blues to their original, simple product lines: full payment for inpatient and emergency hospital care by Blue Cross and payment of a schedule of fees for surgery and inpatient physician visits and related items. Initially, most of the opportunities were provided by offering lower premiums to individuals or groups that have lower than average health care costs. The insurance industry also developed different products that appealed more to some consumers, through widening the scope of benefits (e.g. drugs, nursing homes, home health services, dental and vision benefits), offering different approaches to cost sharing (e.g. applying deductibles and coinsurance to certain hospital expenses), and more comprehensive approaches to the design of insurance packages (especially major medical coverages) and financial devices that permitted employers to retain more of the cash flow through partial or full self insurance ("minimum-premium" plans, administrative services only, stop loss coverages, etc.). Over time, the Blues also developed comparable products.

The primary inroads of the insurance companies were obtained by offering a lower rate to employers whose costs were below the community rate. This was accomplished primarily by offering "experience rates", i.e. setting the premium for each employment group on the basis of the actual claims incurred by that group in some previous year adjusted for inflation, and by paying dividends (or "rate credits") at the end of each year that reduced the cost to the employer to the actual claims plus a predesignated administrative and profit allowance (or "retention"). Insurers also varied their rates for individuals and small groups by actuarial categories, that reflected the increase in cost by age (as much as five times for adults over age 60 to those under age 25) and the variation by geographical area (there are areas where the average cost is nearly ten times that in other areas). The cumulative impact of these practices over many years undermined community rating by the Blues, who were forced to adopt similar practices to be competitive (much as many HMOs have been forced by competition to go first to "community rates by class" and then to experience rates).

The insurance companies also made major inroads by developing partially or fully self insured arrangements, using stop loss insurance to limit employer risk. These have the effect of allowing an employer to retain the cash float between the time that services are performed and when payment for them is made. The Blues have followed with similar products.

The last entrant into the market were HMO's that paid physicians for services performed from their own offices (usually using an "independent practice association" or "IPA" as an intermediary). Many multiple specialty physician groups and clinics also formed HMOs. Under the influence of the federal qualification laws, HMOs tended to offer a relatively standardized benefit package and only a few copayment options at community rates. In recent years, there has been a movement toward offering more options with different levels of copayments and even deductibles, varying rates by actuarial factors, and even by experience.

2. Market Segmentation and Risk

Health insurance is sold in several distinct markets with different insurers or divisions of insurers typically involved in each segment. The segmentation is primarily by <u>type of medical care insured</u>, <u>size of group electing coverage</u> and <u>organizational form</u> of the insurer.

The insured services may be divided into (i) the traditional scope of major medical contracts (i.e. hospital, physicians and other acute care services), (ii) first dollar (or "plastic card") prescription coverage, (iii) dental services, (iv) vision services and (v) long term care. The traditional coverage, which we will refer to as "comprehensive hospital and medical", includes hospital, physician, physician supervised services (including clinics and laboratories), allied practitioners (independent labs, physical therapists, visiting nurses, etc.), prescriptions, medical supplies and other acute care providers that either supplement or are substitutes for hospital or physician care (e.g. short recuperative stays in nursing homes, podiatrists, dental surgery, etc.) Most states have mandated additional benefits by defining the services to be physician services for the purposes of insurance contracts. Typical mandated services are chiropractors, clinical psychologists, and optometrists.

The segmentation by size of the employment groups insured has fallen roughly into the following categories: individual and very small groups (less than four employees), baby groups (4-9 employees), small groups (10-24), medium sized groups (25 to around 100 or so), intermediate sized groups (100 to about 1000) and large groups. In each case, the relevant size is that of the group that elects coverage from a particular insurer as a group. The primary reasons for this segmentation are the degree of risk in setting an aggregate premium for the group, the opportunities for purchasers to select against the insurer and the related opportunity for the insurer to screen out persons with existing health conditions.

A number of small groups that purchase insurance through an association are regarded by insurers as part of the small group market for administration and rating. This is because each employer makes their own decision as to whether to obtain coverage through the association, based on the perceived costs and benefits to them employer rather than the collective advantage of the association.

Some "groups" are really collections of individuals, and rated and underwritten accordingly. The main types are "affinity groups" or associations and "franchise" agreements under which there is a group contract with an employer but so few employees enroll that the relationship is really that of individual insurance policies, and each "certificate" has the same legal standing as an individual insurance policy.

In serving these market segments, there are a variety of types of insurance organizations, including:

- Life insurance and casualty insurance companies (including some with Blue Cross and Blue Shield franchises)
- Blue Cross and Blue Shield "service" plans
- Service plans insuring or administering a single medical service (such as prescriptions, dental care, vision care)
- HMOs, including prepaid group practice plans, HMOs based on multiple specialty clinics and HMOs that insurer through independent practice associations (IPAs)
- Multiple employer trusts (METs) and welfare plans (MEWAs)
- Reinsurance companies selling stop loss coverages
- Self insured plans administered by insurers or "third party administrators" (TPAs).

As was the case with the Blues, the HMOs began insuring only large employers, but most have now expanded into the small employer market and some into the individual market as well.

3. Basic Elements of Premium Setting

a. The Nature of Premiums

A premium rate for any type of health insurance policy is a simple ratio of the anticipated claims that will be paid and cost of administration and "risk charges" (the net of which over all insurance lines will become profit) divided by (ii) the number of units insured, i.e. the number of separate premiums to be collected. The numerator of this ratio depends on who is to be covered. If persons with health conditions that are expensive to treat are included, then the ratio will be high. If there are no unhealthy persons, it will be relatively low. If the premium for any particular employment group is extended to cover another group with higher or lower average health care costs, the premium for the combined group will go up or down correspondingly. These obvious facts appear to be overlooked often by commentators who refer to premium rates as if they were prices set by supply and demand in competitive markets. There are competitive markets that affect premium rates for some types of policies, but insurers will not offer them if they anticipate that the payments under the policy will be higher than the total premiums collected. Since the profit margins of most insurers are very low, this leaves a very narrow range for premium rates for most products.

The most important principles of setting premium rates for any insurance risk is to determine a set of risks that have in common that each purchaser is subject to an identified risk but cannot determine which in any year will be affected. Competition among insurers tends to subdivide the risks that can be included in the same insurance "pool". This is because if an insurer identifies a subset within any class of insured risks that will have a lower average cost, a lower premium can be charged to the members of that subset. As members of that subset take advantage of the lower rate, the average cost to other insurers of the class will rise. This will force premium rates for such remaining members to rise as well, and as most members of the subclass find an insurer willing to offer a rate that reflects their lower cost, the market becomes segmented in a way that identifies the subgroup as a separate class. Other insurers are forced to follow the practice of the one that identified the subclass, or be left with only the more expensive risks in the class.

For groups or individuals that purchase insurance (i.e. are not fully or partially self insured), premium rates are set in advance based on the anticipated payments of the insurer. If a group of individuals includes some who are in poor health, the insurer will project the cost of the group to be higher than if they are all healthy. The most important information available on which to base a projection of what any group of individuals will cost is the health conditions that have been diagnosed and treated among the members. Since health conditions tend to persist when they appear, i.e. are highly correlated serially, the most effective summary measure of such health conditions available is usually the claims submitted by members of the group in the recent past. This "experience" is thus a very potent measure of the claims an insurer can expect in the future, and a far more accurate index of the future cost than the actuarial characteristics of the group, such as the composition by age and sex.

b. Selection

The basic fact of life that underlies much of the behavior of the insurance companies in individual and small group markets is that the reward for selecting a healthy group of insureds are an order of magnitude higher than the rewards to efficient administration or claim management. This fact combined with the willingness of individuals and small business owners to change insurers for a lower rate next year leads to the dominance of the strategy of select and ultimate rating, which leaves those with an expensive health condition in their group subject to very large rate increases (which reflect the expected cost in the next years of the condition being insured against). The high and rapidly rising costs of health care are increasing the financial incentives to change insurers for lower rates.

Insurers that do not follow select and ultimate rating find that they lose the lower cost groups and retain the more expensive ones. If they raise rates to reflect the average cost of those remaining, any that can pass an underwriting screen will then leave. Only ruthless rate action can avoid losses in this situation. Most of the Blues find their book of small group and individual business to be in this position, in some cases requiring a large subsidy from large groups to cover the losses.

c. Anti-selection Spiral

If the set of contracts held by an insurer includes a disproportionate number of poor risks (i.e. persons with a much higher than average expected cost for health care), there may be no rate action that will prevent a loss. For any increase that would cover the losses for the present set of groups insured, enough of those whose expected cost is below the new premium rates may leave that the average cost for those remaining is above the new premium rate. This phenomenon can easily happen if (i) the rate increase needed to fund the claims and expenses for all insured is very high, (ii) the new rate is substantially above the cost of alternative coverage and (iii) there are a number of employers in the set that can pass through the underwriting screens to secure such other coverage. The latter will by definition have lower than the average expected claims for the set and if enough of them leave, the rate needed to cover the cost of the rest will be higher as a result. But if the rate is increased to the level required when the first set leaves, more will leave, and so on. In advanced anti-selection spirals, some leave despite not being able to purchase other insurance or accept exempted persons or waivers.

To avoid anti-selection spirals, insurers are driven to rate groups in tiers, i.e. classes with different levels of rates. They will then reclassify groups according to the tier that best matches the expected cost for the group. The more responsible insurers limit the number of tiers to reflect the ongoing (rather than temporary) characteristics of groups and limit the percentage rate increase on any anniversary. Less conscientious insurers will have unlimited tiers so that differentials are great enough to reflect the expected cost in the next year. For a small group with members suffering from very expensive conditions, the expected cost can be very high.

Another approach to avoiding anti-selection spirals is to cut benefits rather than to increase premiums by more than the competition. Those currently using benefits are hurt most and leave if they can. This tactic works especially well in open enrollment systems such as the FEHBP. If followed successfully, enrollment tends to drop quickly so that financial losses are avoided at the expense of market share.

The point is that selection by the insured forces insurers to screen new applicants and charge the expected cost for each group insured. And such screening and rating limits the effective coverage of insured groups. Most small employers have no protection against finding that their rates will be doubled or tripled because their groups now included members with very expensive conditions.

4. The Employer Sponsored Plan Market

a. Large Employment Groups

The most important aspect of health insurance for large employers to understand their insurance practices is that there is almost none of the type of the primary type of risk that insurance addresses. This is the spreading of risks that are unpredictable for a particular purchaser over enough others facing similar risks that each can pay the average cost. With as many as 1,000 employees, however, fluctuations in utilization become a relatively minor factor. The degree of risk to an insurer or self insured employer depends on the probability that the total claims in a year will vary by more than a reasonable margin (e.g. 5%) from the projected level of claims for the group based on all the information that an insurer is in a position to maintain and analyze on a routine basis. The variance of the distribution of aggregate health insurance claims diminishes rapidly as the size of the group rises. A risk margin of 5% to 10% will cover around 95% of the potential fluctuations in claim levels produced by random factors for groups of 1,000 and 1%-2% is enough with 5,000. It follows that the most basic function of insurance, to spread the risk of unexpected fluctuations over those equally subject to the risk, is not needed for large groups.

There are still substantial risks associated with predicting the cost of health insurance for such groups. But the risk is primarily in the potential error in forecasting changes the basic trends utilization and inflation of health care costs. Further, although premiums for insured employer sponsored plans are normally set for one year at a time, the projection period is usually eighteen months to two years or more as a result of the lags in paying claims, obtaining and analyzing tabulations of data and providing premium information in advance.

Insurers, however, do not have a comparative advantage over employers in absorbing the risk of higher than expected inflation, which if higher than projected is usually higher throughout an insurer's service area. The risk of high inflation is systematic rather than random. Thus there are no winners with whom the losses can be spread. In response an insurer will add enough margin to be sure that premiums will be adequate to cover not only the fluctuations that may be expected from a group of any size but also the highest level of inflation that they believe to be probable. The margins added by insurers raise the cost of insurance (although they are usually returned through dividends or lower future premium rates).

Thus with as many as 1,000 employees, fluctuations in utilization become a relatively minor factor, so that the primary function of insurance, the spreading of risks that are unpredictable for a particular purchaser over enough others facing similar risks that each can pay the average cost, is removed. The risk in large groups relates almost entirely to the capacity to forecast inflation and broad utilization trends and detect any factor that will lead to significant changes in the group of insured persons (e.g. closing a plant, permitting some employees to enroll in an HMO). Further, rating factors such as age, sex, geographic area, etc. - need not be taken into consideration (unless there are major changes in the composition of the group). The impact of these factors will be the same from year to year for most large employment groups.

As the minimal nature of the utilization pooling risk was recognized, competition gradually led to financial arrangements that were in effect self insurance. First, insurers were forced to offer experienced based rates, to be competitive with insurers that offered lower rates to groups with lower costs. (Blue Cross plans were able to resist this trend somewhat in states in which they enjoyed the competitive advantage of substantial hospital discounts, but competitive pressures have now forced nearly all of these plans to adopt experience based rates as well.)

Similarly, the pressure to offer the lowest possible cost to the lowest cost groups led to payment of dividends at the end of each year, based on the excess of premiums collected over actual claims incurred and formula determined "retention" charges, which was in effect self insurance with an aggregate stop loss at the level of the premium rates. (Since deficits were usually carried forward, even this remnant of insurance was usually not really present.)

As health insurance premiums rose and became an increasingly important consideration for employers, insurers found other ways to offer reduced costs. One cost addressed was state insurance taxes, which vary from 2% to 3% of premiums. It was observed that most of the premium taxes could be avoided by recharacterizing the standard experience rated participating arrangement as a combination of self insurance, aggregate stop loss and a charge for administrative services. Employers would pay on a "minimum premium" based on the last two of these to the insurer and deposit the rest of projected experience rate into a special bank account of the employer, from which the insurer would draft checks to pay claims. No premium tax was payable on these funds since they were never in the possession of the insurer. If the cost exceeded the deposits to the special account in any policy year, the insurer would pay the excess. These minimum premium arrangements also gave the employers the advantage of keeping the funds in the possession of the employer until actually needed to pay claims, reducing borrowing costs. (Since there was a one time reduction in cash

outlays during the first year of self insurance, many employers changed to self insurance to cover a poor year, and sometimes under the impression that the delay in payment was a "saving".)

Again as costs rose, other savings available from self insurance became more important, especially with the passage of ERISA, which allowed self insured plans to avoid state mandated benefits. In recent years, avoiding state anti-managed care laws has also become desirable, as more of the large employers have adopted managed care plans, especially for mental health benefits. Self insurance has also created a more competitive market for administrative services. In most cases employers have hired with an insurer or third party administrator (TPA) to pay the claims from a special bank account established for the purpose. TPAs captured a major share of this market through lower prices feasible from reduced overhead and sales loadings, forcing insurers to set up separate operations with similar functional forms to be competitive.

These considerable advantages of self insurance - capturing for the employer's use the cash from the lag in paying claims, avoiding margins added by insurers (even if returned at the end of any year), and avoiding premium taxes, state mandated benefits and anti-managed care laws - coupled with the minimal utilization pooling risk, has led nearly all large employers to self insure. The result has been that health insurance has become largely a service business for groups of 1,000 or more, i.e. determining eligibility, paying claims, advising employers as to funding meals and government regulations affecting their coverages and providing stop loss insurance if a large employer has reason to be particularly risk averse.

Another important consequence of the ubiquitousness of self insurance for public policy is that in a self insured plan, there are no premium rates. There are only aggregate claims and expenses. Frequently, large employers are unsure even of the average number of employees actually covered during any period, and have almost no information on the number of dependents. Thus if asked for premium rates, they can only provide estimates of the average claims per employee or family, which may not be accurate. An exception is those that enroll in an HMO during an open enrollment period, since the employer must pay an explicit premium rate for each employee enrolled, which varies by the composition of the employee's family.

Since the health care needed by any particular individual will be a small portion of the total claims paid by a large employer, the cost of covering existing illnesses in the families of new employees does not present a significant threat to the experience of a large employer. Further the average added cost to cover preexisting conditions is predictable, reflecting the hiring practices of the employer and the industry. Consequently, there are usually no restraints on covering preexisting conditions in large employment groups, even though through self insurance most large employers are exempt from any regulation as a result of ERISA.

The business of providing administrative services to large employers is dominated by insurance companies (including the Blues) providing only administrative services and stop loss insurance, "third party administrators" (TPAs) and HMOs, the latter usually through members electing coverage from the HMO's network either on an enrollment or point of service choice basis. The traditional Blue Cross and Blue Shield plans have maintained a strong position in this market in many states, through their competitive advantages (chiefly the hospital discount but also networks of participating physicians in some states), the loyalty of the unions, and by adopting the tactics of the commercial insurers and TPAs.

b. Intermediate Employment Groups (100 to 1000 Employees)

For intermediate sized employment groups, the risk of claim fluctuations becomes a significant factor, and employers find some level of insurance protection desirable to smooth out their health insurance expenditures from year to year. This fact has led to modifications to the insurance practices for both insured and self insured approaches to fit these circumstances.

Historically, most intermediate sized employment groups were fully insured, since the risk of fluctuations that the employer would find difficult to finance was large enough that few firms could afford self insurance. Competitive pressures on insurers, however, led to a modified form of experience rating and participating policies. Insurers developed a "credibility" approach that mixes the concepts of full insurance and participating insurance. Under this approach, an experience rate is determined using a weighted average of the group's experience and the average of the experience of all of the firms with similar characteristics (i.e. taking into consideration the composition of each group according to the composition by age, sex, area of residence, wage levels, occupation, etc.). In most situations, additional credibility can be obtained by considering several years of experience. A risk charge of around 10% will then give the insurer reasonable protection against fluctuations. The weight is referred to as the "credibility factor". With a high credibility factor the rate will be based primarily on the firm's own experience and a low credibility factor will give a correspondingly lower weight to the firm's actual experience. The credibility factor is usually 1.00 for groups of 1,000 or more (where the

utilization fluctuation risk is negligible) and drops to around 25% for a firm with 100 employees. A dividend or rate credit can also be calculated by subtracting the actual claims and formula based "retention" charges from the premiums collected for a year. In this way many of the advantages of experience rates and participation can be extended to intermediate sized groups, and competition forced virtually all insurers to offer them.

The advantages of self insurance can be obtained for intermediate sized groups, through aggregate stop loss insurance, which sets a maximum on the claims for which the employer is responsible. An aggregate stop loss policy will for a relatively modest premium pay the excess over some level such as 115% or 125% of the expected claim volume. A variation on the same basic approach is for an insurer to charge a "minimum premium", which covers the cost of an aggregate stop loss policy and administrative services. The insurer pays claims out of the employer's funds unless the stop loss threshold is exceeded. Only the stop loss policy is subject to premium taxes and the plan is not affected by state mandated benefit laws. Stop loss insurance can also take the form of an insurance policy with a very large deductible per person, e.g. $50,000. This type of policy protects a self insured employer from the expense of a rare but extraordinarily expensive health condition.

The other advantages of self insurance for an employer - cash flow, lower administrative charges, avoiding state mandated benefits and avoiding nearly all premium taxes - has led to a continued trend toward self insurance with aggregate stop loss becoming the dominant form of insurance arrangement for intermediate sized groups.

As in the case of large employers, the hiring of any particular new employee with an expensive health condition in the family can only add a relatively small increase in claims. Most of the employers in this size group are willing to pay the additional cost of preexisting conditions in order to smooth the process of hiring.

This segment of the business was traditionally dominated by the large life insurance companies and the Blues. In recent years, however, TPAs have made major inroads through self insurance with stop loss coverages provided by an insurer. HMOs have also bid aggressively for members and have become a significant factor in many areas of the country.

c. *Moderate Sized Employment Groups (25 to 100 Employees)*

For moderate sized groups, the risk of claim fluctuations becomes the dominant factor, with very large fluctuations in claims volume from year to year. Most employers find pure self insurance impractical, especially as modern technology has produced the distinct possibility of extraordinarily high claims. For this reason, nearly all employers of this size have some insurance protection, either through an insured policy or aggregate stop loss insurance. (A well capitalized employer might find self insurance desirable, if reserves could be accumulated to prefund years of high claims. The federal tax laws virtually preclude such prefunding, however, disallowing any deductions for reserve accumulation or interest earnings on the reserves.)

Historically, nearly all medium sized employment groups were fully insured. Initially, factors such as the composition by age, sex, family status, area, occupation, annual wages, etc. were used to determine premium rates. Since the credibility factor for any year's claims is relatively small for firms with 100 employees, and so small as to regarded as insubstantial at 25 employees, most insurance was not experience rated. Nevertheless, competitive pressures to offer groups with lower projected costs lower rates led to taking experience into account in offering rates, and to extend participating policies using credibility approaches down to firms of 50 employees.

Stop loss insurance can also be used to provide many of the same advantages to groups with 25 to 100 employees. Since the chances of claim costs in excess of say 125% of the expected cost based on projections of past experience are substantial for groups of this size, however, the premiums for the stop loss are a major part of the cost. Nevertheless, the employer enjoys most of the same advantages as self insured employers, i.e. capturing cash flow and avoiding mandated benefits and premium taxes. Consequently, a large proportion of moderate sized employers have done so, in many cases motivated by the reduced outlay for insurance by around a third in the year of change, i.e. the value of the lag in claim payments. (Based on the sales pitches of some insurers, it would appear that a large proportion of the employers do not understand that claims are just postponed by self insuring rather than being reduced.)

The facts enumerated above have also led to moderate sized groups constituting a market in which insurers can offer full coverage regardless of the health conditions in the group if they have enough information about the group to set an expected rate. In most cases insurers are willing to cover preexisting conditions for an increase in premiums and most moderate sized employers do so.

This segment of the business is dominated by the large life insurance companies and the Blues primarily through administrative services only contracts and stop loss insurance and TPAs. HMOs have also entered this market segment, especially as they have developed "point of service" contracts.

d. Small Group Market (5 to 25 Employees)

Until recently, most small groups have been insured almost exclusively by insurance companies and the Blues, using premiums that vary be age, sex, family composition, area and size. Rates may also be varied by occupation, although occupation has been used primarily indirectly to exclude certain occupations believed to attract a disproportionate number of persons who have health conditions that are expensive to treat, will overuse health services or appear as employees only when there is a reason (i.e. it is difficult to determine who is employed and an owner may "employ" sick friends or relatives, or fail to report employees in good health). Nineteen states have now adopted laws guaranteeing issue to any group with 25 or fewer employees. Nearly all insurers paid claims on a fee for service basis only, although HMOs are now aggressively entering this market.

Rates for small groups are set for only six months or a year in advance, and until the small group reform laws began being adopted in the last couple of years were subject to unlimited rate increases at any renewal date. If the only reasons for varying rates among small groups insured are actuarial characteristics, the approach to rating may be described as "community rating by actuarial class".

The natural competitive pressures on insurers led a number to adjust rates based on the average health of the group as assessed by level of claims, following "tier rating" systems. Alternatively, insurers could form multiple employer trusts that appeared to offer competitive rates at least initially, but actually by sacrificing access to insurance at reasonable rates if anyone in the insured group developed a health condition that is expensive to treat.

The entrepreneur owners of many small firms behave in purchasing health insurance like individuals insuring their own families. Many are extremely price sensitive and thus ready to switch insurers to obtain a lower rate. Most do not understand enough about insurance to value a longer term relationship with an insurer or to investigate how rates are likely to be handled for renewal years. A normal reaction to the kind of premium increases frequently found among small groups is to seek an alternative supplier. These characteristics make them vulnerable to aggressive rating practices that may be described as "select and ultimate" or durational rating, since the rates depend on whether rates will be raised if according to the insurer's data the cost to pay claims for the group will be well above average.

One approach developed by insurers to exploit these characteristics (and protect the insurer from risk) is the artificial multiple employer trust (MET). An insurer may start a new MET each year or, offering a favorable rate that reflects the impact of screening risks and the preexisting exclusion clause. By the third or forth year, however, the rates for an MET must be increased sharply to cover the combination of inflation, the expiration of the preexisting condition clause, and a wearing off of the effects of the original underwriting. When rates are increased sharply, those of the member firms that can pass through the underwriting screen will look for a new carrier, or a new MET, perhaps offered by the same insurer. The loss of these employers with an expected average cost of 35% to 40% of the average raises the average cost of those that remain. Thus for the employers that do not leave there will be sharp rate increases, driving out all except those with an existing expensive condition that the owner is willing to pay for (e.g. a member of the owner's or a key employee's family). Eventually the rates may reach a level that makes it impractical to continue the trust, and any firms still relying on it are left without insurance.

A similar rating approach is to establish rate "tiers". These are multiple classes with progressively higher rates. Firms can be moved from tier to tier depending on the health conditions in the group. The effect is similar to what occurs with the periodic introduction of new METs, but can produce more abrupt rate changes since the insurer can use the claims experience of each group to determine the appropriate tier for the next year.

These practices are being restricted in many states through small group reform laws, which in most cases in addition to restricting the rate changes that insurers may charge to groups with ill members require offering insurance to any small employment group seeking insurance. A bill introduced by Senator Bentsen that was attached to the 1992 tax bill would have imposed similar restrictions nationwide.

The most important point to observe is that the methods of the insurance industry are what should be expected when the financial incentives and behavior of small entrepreneurs is taken into consideration. The real underlying problems stem from (i) inflation (that make guaranteed premiums impossible), (ii) effectiveness of underwriting (and necessity to underwrite if coverage is voluntary or not heavily subsidized) and (iii) the option of the insured to take

advantage of continued good health to obtain lower rates. This readiness to change for a minor cost advantage leads directly to durational rating. The effectiveness of underwriting and preexisting exclusion clauses in the context of short term coverage leads naturally to select and ultimate pricing.

One common marketing device used to sell to small groups has been the artificial multiple employer trust (MET), artificial in the sense that it is formed by an insurer solely as a device for selling small group health insurance. The life and rating cycle of these trusts have reinforced the tendancy of small groups to change insurers frequently to obtain lower rates if they remain insurable (and to exempt persons with existing health conditions and waivers).

The artificial MET, tier rating, and durational rating approachee of some insurers made it very difficult for more traditional insurers to maintain stable rates regardless of the health condition of groups. As a result, some of the insurers not following such practices have had to subsidize their small group line, drawing on profits earned elsewhere in their business.

Insurers encounter a number of problems with anti-selection in the small group market. In some types of business, it is difficult to determine who is really employed. The danger to the insurer is that nearly all of those who could claim to be covered who are in poor health will be enrolled, but not all of those in good health. These problems may be especially acute in a family business, seasonal employment or where turnover is high. Friends or family members of the owner who are sick may appear as new employees. These problems are especially acute when there is a precipitous decline in enrollment. The insurer may find that only persons in very poor health are still claimed as eligible employees or dependents. Since these problems are more frequently found in some types of businesses, in the absence of state prohibitions insurers would avoid insuring certain occupations. (Some occupations are also avoided under the expectation that they attract a disproportionate number of persons with health conditions that will be very expensive to treat. The real problem for insurers, however, is the potential for antiselection. A high average cost is not a problem for the insurance business in itself, since as long as the increased cost can be predicted, a higher premium can be charged. The problem is that when the level of premium rates is higher, the incentive to applicants to enroll only when they know more about their health than the insurer can determine through underwriting is correspondingly greater.)

In response to these problems, insurers usually insist on screening each new applicant and in the absence of legal restraints (including small group reform laws), insurers usually impose waiting periods for coverage of preexisting conditions. Some insurers are willing to cover preexisting conditions in the larger of these groups (over 15 or over 20 employees) for a moderately higher premium, provided that underwriting does not disclose any conditions that will be very expensive to treat. Few employers with 15 to 25 employees are willing to see employees exempted or their existing conditions excluded. Most will pay more instead.

e. Very Small Groups (Fewer than 5 Employees)

From the perspective of insurers, very small employment groups have many characteristics similar to individual families. For a large number of small employers there is an owner that acts for the group strictly according to their personal needs.

The pressures on insurers, and hence their rating practices, from very small groups fall between those for individual policies and those described above for small groups. For the smallest groups (one or two employees) they are almost indistinguisable from those for individual insurance, since such groups are often dominated by an entrepreneur that acts like an individual in seeking insurance, and will usually switch when offered a lower premium. Many of these entrepreneurs have also proved to be willing to exempt individuals from coverage (at least those not in their families).

The problem of anti-selection becomes the dominant factor in screening and rating the very small group market. Not only are the problems noted above more likely to occur, but the impact on the cost to insure the groups is much higher. In addition, the cost to an insurer to verify the facts on which the coverage is based become relatively high, undermining the economies of group insurance. In response to these problems, insurers invariably screen each new applicant and seldom cover preexisting conditions (unless they are very sure that any applicants with such conditions were excluded by their underwriting).

f. Specialized Service Plans

The observations about comprehensive hospital and medical insurance are even more true for the other types of health benefits, such as plastic card prescription, dental and vision care plans. (An except is long term care, which is not supported by employer contributions.) The level of risk to the insurers is generally much lower. In addition, the benefits have been designed in a way that tends to reduce fluctuations, in particular by avoiding customary and prevailing charges. As a result, most of this insurance is purely a service business with very little risk absorption involved even for small employers.

5. Individual Insurance

a. Individual Insurance Rating Practices

The other extreme in the market segmentation is individual insurance. Providing individual coverage has become an increasingly specialized business. This is partly the result of the conditions under which insurance must be offered and partly the result of regulation.

The dominant forces shaping individual comprehensive health insurance policies have been (i) the explosive pace of inflation in medical costs which makes prefunding future benefits impractical, (ii) the effectiveness of relatively simple techniques used to screen applicants for existing health conditions, (iii) the option of insured persons to switch insurers at any time to obtain a rate that reflects their good health and (iv) rate regulation by the states, which has led to unpredictable and lengthy delays in obtaining rate increases in some states.

The first factor, high and unpredictable inflation, discourages selling policies that accumulate substantial reserves that would discourage switching insurers. The next two drive insurers to offer individual coverage with select and ultimate rates (also known as "durational rating"), which offer a much lower renewal premium to those who can submit continuing evidence that they are insurable (reflecting their option to purchase a competitor's product at a similar rate). The delays in considering rate increases have made the availability and timing of rate increases to keep up with inflation in medical costs unpredictable to the point that many insurers have stopped offering individual policies or offered then only an a "conditionally renewable" basis (i.e. all policies can be canceled together but not individually). The impact of all of these tendencies have been heightened by the growth in the cost of health care.

Nearly all individual insurance policies vary premium rates by age, sex, family composition and area. Except where prevented by regulation, there is some degree of underwriting to eliminate those seeking insurance to take care of an existing health condition. Insurers do not differentiate, however, between those who are only interested in insurance when they discover they will have high medical care costs and those who find themselves without coverage involuntarily (through loss of employment after the COBRA extension expires, divorce, etc.). But relatively few of the insured had no opportunity to utilize a COBRA extension or convert to an individual policy.

Some of the insurers that offer individual insurance policies follow a pattern of rating that is similar to the small group cycle described above. A new policy form is introduced every few years (sometimes each year), that differs in relatively unimportant ways from existing policies. All new applicants that can pass through an underwriting screen are signed up on the new form. Without an influx of healthy new subscribers, the average cost to pay claims for those insured under the closed forms increases, as the effects of underwriting wears off and the preexisting exclusion clause expires. Under state regulation of individual health insurance, which looks only to the loss ratio to determine what rate increase is appropriate, the insurer is entitled to an increase that covers both inflation and the deteriorating average health of the insured groups. This produces rate increases in excess of inflation, which in turn leads to those still in good health seeking another policy with a lower premium rate. The agents of the issuing company are happy to accommodate them, offering the newly opened policy form. As the healthy leave, the average cost of those remaining rises rapidly, leading to requests for still higher rate increases. Under these conditions, it is not unusual to see rates doubling within a few years. The rates for those in poor health who can not obtain a new policy may well become unaffordable, despite the obvious increased need to continue protection.

Not all insurers follow these rating practices, but the fact that some do makes it very difficult for the others. The premium rates to new applicants of those not constantly introducing new policy forms are higher, and appear to be poor buys. Purchasers may also underestimate the chances that they will in time become unhealthy and be stuck with rapidly increasing premium rates. Consumer information is poor, and it is prohibitively expensive for private citizens or consumers groups to obtain comprehensive information on which to base an evaluation of rating practices by insurers.

Some insurers have proved to be more adept (and willing) to engage in the screening and rating practices necessary to survive in the individual market than others. The business has become increasing specialized as most of the large life and casualty insurance companies have dropped out, leaving the market to the Blues and a set of relatively new companies that underwrite aggressively and follow cyclic rating practices. The markets for individual insurance in most states are strongly influenced by the practices of the local Blue Cross and Blue Shield plans, which are very different from one state to another.

In recent years insurers have offered policies with "waivers" (i.e. that exempt claims arising from a specified existing condition or organ), substandard premiums (i.e. much higher for a person likely to have more than average claims)

or excluding an individual in the household from a family policy. These policies have made coverage available to persons who would otherwise be uninsurable. Most insurers, however, either accept or completely reject an applicant, rather than offer more expensive policies.

b. Associations

There are three primary types of associations that offer health insurance to individuals. These are associations that are formed for reasons other than offering insurance (e.g. professional associations with restricted membership, alumni associations, etc.), independent associations with a relatively weak affinity among members and for whom the availability of insurance is a strong motivation for joining and associations formed by insurers as a marketing vehicle for insurance. All types have in common, however, that the relationship between the association and the insured members is essentially that of individual insurance. The underwriting and rating practices of the insurer with the contract depend on how strong the membership restrictions are and if very strong, the proportion of members who are insured. Independent associations with a strong affinity basis who enroll most of their memberships may exert considerable pressure on the insurer to offer competitive rates and avoid cyclic rating practices. Otherwise associations are little more than brokers for the insurers.

6. Role of the Blues

Each of these markets described above is affected strongly by the nature of the local Blue Cross and Blue Shield plan. This in turn depends on the competitive advantages of the plans given by law and regulation, the aggressiveness of management, the degree of support from local institutions (especially labor unions) and the degree of historical market dominance of the plan, which reflects the nature of the local economy and political factors as well as the regulatory advantages. The primary competitive advantages of the Blues have been:

- Discounts from hospitals that range from a few percent to over 25% in some states.
- Exemption from premium taxes in most states.
- Lower federal income tax rate (20%) and exemption until surplus exceeds three months of premiums.
- Participating physicians that accept reduced fees as full payment in some states.
- Market power in obtaining acceptance of maximum fee schedules for HMO, PPO and triple option products.
- In some states Blue Shield plans do not have to pay some of the practitioners that are mandated to other insurers (e.g. chiropractors).
- In most states, very low sales costs resulting from avoiding the hugely expensive marketing forces typical of commercial insurers.

Before the advent of "preferred provider plans" (PPOs), there were states in which these competitive advantages were so large that even the large group market was dominated by Blue Cross, since other insurers were not able to compete with the hospital discount. The market power of a dominant market share has also affected the capacity to obtain discounts from physicians for PPO products. In a few states the dominance of the Blues is reinforced by the support of unions and public agencies in recognition of the public service role.

In return for the legal advantages the Blues are typically required to subsidize individual and small group coverages. Some states require open enrollment for all individuals for basic hospital and surgical and Medicare supplemental coverages. Some of the plans have continued to subsidize those coverages without any legal requirement. The subsidies may also occur indirectly by charging average administrative costs rather than varying administrative charges to reflect actual costs and directly by lower premium rates than the expected cost. Increasingly in recent years, the Blues have been forced to subsidize individual hospital-medical and Medicare supplemental coverages through rate regulation that prevents adequate rate increases. Some have adopted rating and screening practices that are indistinguishable from those of other insurance companies. At the extreme, some of the plans have become mutual insurance companies.

The Blues also typically subsidize small group plans. These are largely community rated by actuarial class. The Blues have traditionally accepted nearly all groups that applied, and screening of new groups continues to be liberal compared to the practices of commercial insurers. Since the advent of insurers and agents that aggressively underwrite new groups, they have increasingly become in affect a residual pool for small groups in those states that require them to take all applicants. The relatively lax screening of small groups and community

rating by class has led to a relatively expensive mix of plans insured with the Blues.

The result of the subsidies to individual hospital-medical, Medicare supplemental and small group coverages is that the Blues in many states serve an important quasi public utility role. The availability of the Blues to provide residual coverages to persons and groups that would otherwise not have access to insurance (perhaps without waivers, exempted individuals, etc.) has provided an important safety valve on public discontent with private insurance in the states where the plans serve this role, typically the Northeast, Midwest and a few southern states. Other plans range from the quasi-public utility model to commercial look a likes, including some mutual companies.

Chairman STARK. Mr. Sutton.

STATEMENT OF HARRY L. SUTTON, JR., SENIOR VICE PRESIDENT AND CHIEF ACTUARY, R.W. MOREY CO., MINNEAPOLIS, MINN., ON BEHALF OF THE COMMITTEE ON HEALTH, AMERICAN ACADEMY OF ACTUARIES

Mr. SUTTON. Thank you, Mr. Chairman, and Members.

I represent the Academy of Actuaries, and I am going to follow up on what Gordon said. He described very briefly the small group markets and the statistics are much more detailed, and I am going to summarize mine. I am going to indicate where we are in small group reform at the State level, and what I think are some of the problems with it. I might edge in a solution or two, but I will try to avoid that since you really don't want them.

Chairman STARK. We need all the help we can get.

Mr. SUTTON. The Academy of Actuaries has three or four study groups looking at the effect of the rating systems, the effect of a standardized benefit plan, and various other aspects which we are doing research on, and as soon as we have information available, we will make it available to your committee.

I am not going to repeat what Gordon said about small group. We have testified before. Approximately 34 States have now passed some version of small group health insurance reform. Twenty of those, as Gordon said, do or will ultimately have guaranteed access through guaranteed issue.

Today, however, only the State of Connecticut seems to be actually operating that well, as well as the State of Hawaii, which is an unusual situation, which started in 1974, and Hawaii has about 98 percent of their people through Federal and local insurance programs; 98 percent of their population is covered, which is kind of an objective for the rest of them. Most of the States that have guaranteed issue have proposed some form of reinsurance pooling or assignment of risk, such that no carrier will be loaded down with a lot of disproportionate number of risks. However, there have been problems with that mechanism that it actually operates and probably Connecticut is the only State in which it is operating so far today.

But here are some of the problems we see. While the State laws have changed the structural aspects of small group insurance, none of them have addressed with that the basic idea of cost. Health care cost probably exceeds the ability of the average person to purchase it on his own today.

Various surveys show that the cost per family is $3,000 or $4,000, and in small group markets, it would be $5,000 or $6,000 a year for a family, and you can see that a family earning $20,000 cannot afford to spend $6,000. States are limiting retentions and limiting commissions, but these are relatively small savings, although they may be as much as 5 or 10 percent of the administrative—or the total premium costs.

In addition, the States impose other costs. Underwriting is more complicated, in spite of the fact that a lot of people thought that if you had guaranteed issue, you wouldn't need to underwrite, but the complexity of the reinsurance pools requires more underwriting than they used to do before, in our opinion.

One carrier has a whole separate department doing nothing but underwriting insurance pools, where they had no underwriting department at all before. Also, as Gordon pointed out, most States permit removing mandated benefits, in some cases, even remove premium taxes to try to lower the cost, but bare-bones insurance doesn't decrease costs, it just shifts the costs to the individual, or if he doesn't have coverage and he hasn't got much money, it winds up being unpaid as if he weren't insured at all for those particular services, or a high deductible.

There is no evidence to date, and mostly because the small group reform has not progressed very far. Only two of the States have any kind of experience, only eight more were supposed to start guaranteed issue in 1992, but most of them haven't started yet or they have no data. And the large bulk of the ones that have this will not be starting until 1993 or 1994, so it is going to be several more years before we see exactly how these small State reforms work out.

The effects in Connecticut are very difficult to measure because the State is in a horrible recession, so probably the total number of people has dropped, even though we think maybe 7,500 people were picked up in small group, most of them with a member of a whole group in the reinsurance pool, so we know it has been creating access to uninsurable people. The total effects of it are unknown at this time.

I might say that looking at States in modeling the effects of the rating systems proposed by the various States, and every State is different, which is a complexity for the carriers to deal with, nobody thinks that small group reform will essentially reduce the number of uninsured people. It will create legal access; it will increase the cost because of covering uninsured people and, therefore, to the extent that small group reform is assumed to eliminate a lot of uninsured people, it is not likely to do that.

Another thing is that small group reform will at least concentrate the market in the small group area. In Vermont, 40 carriers dropped out of the market because of their community rating mandate.

A large number of carriers are dropping out of New York, and probably even more will drop out of New Jersey when they figure out what the law means.

Chairman STARK. How many were left in Vermont?

Mr. SUTTON. Vermont is a small State, just—there are probably still at least 100 carriers in there, but I don't—consensus is——

Mr. TRAPNELL. They found some good loopholes.

Mr. SUTTON. The consensus is that Vermont will be controlled by two carriers, Blue Cross-Blue Shield and Community Health Plan, a large HMO with community rates, and they are the most likely to survive. But there are a number of smaller insurance companies that will have a piece of the market, or at least try in Vermont. We can say that the number of group insurers getting out of business in a State is correlated with the degree to which rate differentials are restricted.

In other words, flat community rating, with the same rate for all groups, as in New York and Vermont, has resulted in many carriers withdrawing from the State, likely to be the same in New Jer-

sey. There are many forms of community rating, such as age, sex rates where you have no variation by claim experience, and called "community rating by class" in the HMO vernacular, and that is a possibility of solving a problem, but it is not straight community rating in the New York sense.

I would like to paint a very brief picture of what is going to happen in States that move to community ratings. The number of carriers will shrink dramatically and maybe—or only three or four carriers will dominate those States.

We think, because of the complexity of dealing with the change, a lot of the smaller insurance carriers will just go out of the business. The Blues will stay in because they are a dominant carrier in each State, and if they drop out of that business, they are going to lose too much of their business.

Ultimately, the dominance by a few carriers and HMOs in a State will create severe pressure on the providers. Now, that may be an objective reform to put the pressure on providers, but undoubtedly some hospitals will have to close if reimbursement drops, physicians will be upset and may leave the State, but where can they go if all States have this, other than Canada, and go back there.

So concentration, put more pressure on Medicare and Medicaid since they have reduced rates, there will be pressure between all payers to kind of equalize cost because there won't be the ability to cost shift that we have had before. It may be a good outcome or bad outcome, and there may be such a reduction in competition that there is a serious lack of alternatives in a given State.

The worse problems are likely to be in inner cities, where a lot of hospitals may go under, and in rural areas, because reimbursement for Medicaid and Medicare may be inadequate to keep them in business when the limited number of carriers negotiate pretty good deals.

To the extent that you have a voluntary system and the best risk groups have the option of self-insuring, or not even buying coverage at all because of premium rates are too high, may create the cycle that Gordon talked about, that the rates will continue going up. Now the only solution to that is to mandate coverage and require every employer to get coverage or have a State plan that will provide coverage to people that are not insured, to eliminate the fact that so many people can't pay for their health care in the rising cost of the private market.

To quote my term, the current State small group health insurance reform initiatives are in large part sound in fury, signifying nothing, because our modeling shows there will be very little increase in the number of small groups covered. Even forgetting the economy, and under some circumstances with severe rating like community rating, the number in the short term, at least, could drop sharply. Because if there is nobody to subsidize community-rated premiums for low-cost groups, they are going to drop out.

The rates for those that are insured will rise, and while there is disagreement as to how much, there is still carriers looking for loopholes that Gordon mentioned. Self-insurance is a loophole, MEWAs are a loopholes for the self-insured, multiemployer trust.

If you are going to force everybody into an insured system, you have to eliminate the loopholes and force everybody into the same system to increase the aggregate pool. As long as they can get out, including buying individual insurance for their employees, they are going to pick the lowest cost one and stay out of the pool where the risks are being averaged out.

We do not see that the small group reform—and I will be interested in the last two speakers today, because they may not agree with me, and all actuaries don't agree. But a large number of us feel that essentially the small group reform is spending millions of dollars and we have not accomplished much as far as eliminating the uninsured population.

Thank you.

[The prepared statement follows:]

SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
HEARINGS ON
HEALTH CARE REFORM:
ISSUE RELATING TO PRIVATE HEALTH INSURANCE REFORM

TESTIMONY
BY THE
COMMITTEE ON HEALTH
AMERICAN ACADEMY OF ACTUARIES

March 15, 1993

The American Academy of Actuaries is a national organization formed in 1965 to bring together into a single entity actuaries of all specialties within the United States. In addition to setting qualification standards and standards for actuarial practice, a major purpose of the Academy is to act as a public information organization for the profession. Academy committees regularly prepare testimony for Congress, provide information to congressional staff and senior federal policy makers, comment on proposed federal regulations, and work closely with state officials on issues related to insurance.

This testimony was prepared for the Academy's 20-member Committee on Health. The committee is made up of representatives from the entire range of health actuarial practice. The committee includes actuaries who work as consultants, are employed by insurance companies, are actuaries for government health programs and the National Association of Insurance Commissioners, and are employed by nonprofit health organizations. The knowledge of other senior health actuaries knowledgeable of state reform efforts was also drawn upon to prepare this testimony.

INTRODUCTION

In previous testimony before this subcommittee, the Academy's Committee on Health outlined the current problems with private health insurance coverage and the problems with employer-provided small group health insurance in particular (March 12, 1992). Very briefly, the current high cost of medical claims and high rate of increases in these costs are of grave concern to all employers. However, the impact of high medical costs has posed the most serious problems for small employers and has had the greatest impact on marketing practices for the small group health insurance.

Although employer-sponsored health insurance coverage among small employers has always been much less universal than among larger employers, there are indications that with rising health care costs, fewer small employers are providing health insurance now than in the past. Moreover, rising claim costs and the demand by small employers for more affordable health insurance has led to almost fundamental changes in insuring practices in the small group market.

These new practices, which include durational rating and premiums based on heath status, have made health insurance more affordable for the healthier small employer groups. However, lower premium rates for medically underwritten small groups denote higher rates. These rates are sometimes substantially higher, especially for groups dominated by older workers, groups with less healthy individuals, and groups in industries with higher health and occupational risks. The results have been widespread differentials in premium rates among small employer groups. In addition, medical underwriting, which permits insurers to offer healthy groups premiums that reflect their excellent health status, can lead to substantial rates increases in future years if one or more members of the group begin to experience health problems.

Widening premium differentials and the year-to-year unpredictability of premium increases have become foremost concerns of both state and federal policy makers who view these developments as a major obstacle to the access of health care for an increasing number of working Americans and their dependents. In response to these problems, the National Association of Insurance Commissioners (NAIC) drafted a model bill for small group health insurance reform in 1990. This bill, which states could consider for adoption, was designed to limit rate differentials among small groups and the restrict amount that a group's premium could be raised at the time of its annual renewal.

Even prior to the NAIC's small group reform, a few states had already begun to consider reform initiatives. Subsequent to promulgation of the NAIC model bill, there has been an major increase in state activity.

This testimony summarizes the small group health insurance reform initiatives of the various states, comments on some of their major weaknesses, and gives a preliminary assessment of the initial results of the states' efforts and what may be expected over the next two or three years as a result of these initiatives.

OVERVIEW

STATE SMALL GROUP HEALTH INSURANCE REFORM INITIATIVES

As of March 1993, approximately 70% of the states had enacted some measure to reform small group health insurance markets. The scope of these thirty-four states' reforms varies widely. Approximately twenty states have mandated guaranteed issue for small groups (i.e., any small employer that wishes to purchase coverage within the framework of the state law must be offered coverage by any carrier the employer approaches). Generally there are continuous coverage provisions which involves limited pre-existing conditions the first time an individual is insured. If an employee changes jobs, or the small employer changes insurance carriers, coverage is generally guaranteed as long as it is continuous.

Almost all thirty-four states have modified how insurers can establish both initial and renewal premium rates. Though the new rating provisions vary, they are all designed to restrict the differences in premium rates among small employer groups and to limit the rate of increase over time. The intent is that by minimizing rate variations between different small employers, health insurance will be more affordable to a larger segment of small employers and, in turn, more employers will choose to cover their workers.

Of the nearly twenty states mandating guaranteed issue, most have a pooling arrangement for catastrophic risks. This is to protect individual insurance carriers against the possibility of being selected by a disproportionate number high-cost groups.

A majority of the states will not begin requiring guaranteed issue until 1993 or later. There are provisions permitting carriers to withdraw from the small group market. In most cases they would have to terminate their existing small group business and drop out of the market. Some states have made provision to freeze existing enrollment under certain circumstances. Carriers withdrawing from the market are generally not allowed to re-enter the market for five years after withdrawal.

Approximately twenty-five of the states have also addressed costs by permitting removal of mandated benefits from specialized or "bare bones" insurance packages for small employer groups. A few states have also waived premium taxes for specialized programs or insurance packages, in order to make small group products more affordable.

VARIATIONS IN STATE LEGISLATION

Guaranteed Issue

As indicated above, approximately twenty states have included some form of guaranteed issue in their small group reform legislation. The comprehensive legislation in these states includes limitations on pre-existing conditions, waiting periods to become eligible for coverage, and portability of eligibility (if an employee changes jobs). All of these states require restrictions on rate variations and guarantee renewability of coverage. No employee can be rejected for coverage.

Most states allow carriers to require that 75% of a group participate in order for the group to qualify for coverage. Participation-requirement provisions have been included in most state laws for nearly fifty years. These requirements protect insurance carriers against severe anti-selection through the enrollment of only one or two employees in the group who are high medical risks. Without the protection of participation requirements for small groups, carriers experience serious deterioration in the health status of their insured pools and a concomitant increase in average cost.

Most states do not have laws regarding employer contribution requirements but states generally permit carriers to use their existing rules in establishing a minimum employer contribution. The purpose of carriers requiring employer contributions is to assure high level of participation within the group and, hence, avoid having only the poorer health risks in the group elect the coverage.

Some states require that insurers offer to all small employers any benefit package that is offered to any small employer. Other states only require guaranteed issue for a prototype benefit plan or in some cases multiple prototype plans. (Depending upon the state, prototype plans are variously referred to as the minimum benefits package, the uniform package or the standard package).

Definition of a Small Group

There is wide variation in state legislation concerning the definition of the small group market by employer size. This market is generally considered to range from groups of three employees to twenty-five employees. A number of important states go as low as one employee to include sole proprietors and self-employed individuals, thus creating conflict with regulation of the individual insurance market. Although twenty-five is the dominant assumption for an upper limit, a number of key states such as New York and Ohio use fifty employees. Some other states use a number such as thirty.

Carriers must generally enroll all employees who apply and their eligible dependents. Provisions are usually available to exclude individuals covered under a spouse's program but provide that they can enroll later if the alternative coverage is terminated.

The problem of changes in the size of the group over time has not been addressed. The issue of whether a twenty-life group that grows to a forty-life group remains in the small group market or exits to the typical experience rated market is not addressed. Likewise, if a larger group shrinks to meet the small group size definition, the changes required are not addressed.

Rating Mechanisms

The most common approach under state laws is that proposed through the NAIC model bill. The NAIC model permits unlimited variation in premium rates based on differences in claims cost by age, sex, and industry. Within this framework, variations caused by duration, claim

experience, or other factors related to costs, are limited. The purpose of this is to permit substantial variation in rates based on average expected cost, but not to permit huge rate increases to a small number of these groups that have catastrophic claims. In some states, there is a gradual shifting toward tighter and tighter rate limits, which means that the highest rates will gradually decrease relative to the average cost for all small groups, and the lower rates will increase to a level closer to the average cost. A phase-in period may be from three to five years.

Two states, Vermont and New York, have mandated community rating. Connecticut, the first state to enact reform, is now seriously considering implementing community rating. Community rating essentially means identical rates for all small groups with the same benefits plans, although the rates could vary between single individuals and families. Other approaches could involve "community rating by class" which means that there could be a separate rate for each employee based on age or sex, but no specific rating relative to actual experience of the individual or small group.

Most actuaries agree that sudden adoption of community rating is likely to cause an overall increase in the cost of insured health care. Also, it may cause an increase in the uninsured population by mandating the largest premium increases on those least likely to be able to afford it -- young adults.

Most states do permit variations in classes which states define either by delivery system or by marketing arrangement. For example, rates may differ for an HMO program or PPO program offered by the carrier, or they may differ for distinctive marketing arrangements (eg., a Chamber of Commerce plan) that can be expected to develop a population with different experience. Under these programs there is usually a restriction on the difference between average class rates. Generally all classes can have differences in rates for different benefit designs.

If a particular state's law permits wide variation of rates within the rating band provisions, the rates charged most groups will change very little. In this case, only the very high cost groups that have rates based on experience will have rates reduced substantially, and some of the low cost groups will have their rates raised. However, if the state law also requires guaranteed issue, then the average rate for insured groups can be expected to rise because of the entranced into the insured groups of individuals and small groups that were previously uninsurable risks.

Reinsurance or Other Pooling Arrangements

Pooling systems are being developed to protect any one carrier from a disproportionately high enrollment of high-risk individuals. These are established in states where there are guaranteed issue requirements or where very high risk people are assumed to be enrolling since underwriting is not permitted to result in rejection. At one time, there were approximately nine different arrangements proposed by the NAIC. However, as states have begun to enact reform legislation, the approaches to reinsurance seem to be emerging into two or three models.

The most frequently used model is a reinsurance pool with all carriers required to participate to the extent of their small employer business. In some of these states, HMOs may be exempt if they are financially sound since they involve a different health delivery system. Also, a number of states have made participation in the pool voluntary for insurers of all types.

Typically, each insurer chooses the individuals or groups they wish to reinsure, and the insurer pays a premium to do so. The reinsurance programs generally insure only those claims in excess of $5,000 per life during a calendar year. The reinsurance premiums are usually set at 150% of the standard premium when an entire group is reinsured, and at 500% when individuals (but not the entire group) are reinsured.

Based on the experience in Connecticut, reinsurance premiums range from $1,000 per year for each individual in a group that is entirely reinsured to $10,000 per year for an individual in a higher age category where only that one person is being reinsured. In other states, the range of premiums would differ depending upon how the pool is structured and how the reinsurance is priced. The cost of reinsuring is ultimately born by all of a carrier's small groups. The cost of the reinsurance for high risk lives that would have formerly been rejected from coverage must be added across the board to the general premium rates for the carrier and not affect the small employer.

If the reinsurance premiums are inadequate, the laws usually require that all carriers be assessed a percentage of their small group premium to cover the deficit in the pool. Any deficit that insurers have to pay through assessments will, again, add to the general premium level being paid by their small groups. In almost all cases, the laws do not state what would happen if this assessment, which is usually limited to 4-5% of premium, is inadequate to cover the losses in the pool.

There are other variations found in the pooling arrangements. In a number of states, participation in the reinsurance pool is voluntary, although an assessment by the pool may be required of non-participating carriers under certain circumstances. Another model would allocate a percentage of the uninsurable groups or individuals to each carrier, regardless of which carrier the employer applied to for coverage. To date, this model has not been implemented.

Underwriting Complexity

Many analyses of small group reform have indicated that there should be savings because of the guaranteed issue, which may eliminate the need for underwriting. However, because of the reinsurance pooling arrangements, this has been a mistaken assumption. The fact is that underwriting is much more complicated for reinsurance pools than for determining if a group or individual is to be accepted or rejected for insurance coverage.

In the absence of reform and a reinsurance pool, if the carrier rejected the individual then underwriting was limited. However, under the reforms, if a reinsurance premium would be $10,000 to cover claims in excess of $5,000, then careful underwriting is required to determine if the reinsurance is really needed or whether the carrier would be likely to save money by not placing the individual in the reinsurance pool. At least one carrier has set up an entire underwriting department to manage the reinsurance pool business where they previously did not have such a department.

Group underwriting involves other facets than medical underwriting of individuals. The employer must be a legitimate group, and the employees must be full-time workers or meet the state's requirements, which is 20 hours of work in at least one state. Historically, there has been a tendency for small employers to try to enroll persons other than true employees, especially relatives. With medical underwriting, the inclusion of non-legitimate employees is not necessarily a serious problem. However, with guaranteed issue an extra effort is needed to verify eligibility to avoid the addition of high risk non-group members.

Guaranteeing continuous coverage requires considerable investigation into prior coverage and verification as to the length of prior coverage with a different carrier. Continuous coverage requirements vary in definition from a lapse of one month to four months. For a larger group, there may be a conflict with COBRA eligibility with a prior employer where employment is terminated. An inadequately addressed facet of group underwriting is the fact that experience of the group can be normal only if almost all employees enroll.

Some states have mandated continuous coverage with governmental forms of insurance such as Medicaid and Medicare Disability, again adding a complexity with high-risk people coming into the small group pool.

Closing Loopholes or Escape Mechanisms

Most state legislation makes some attempt to block loopholes. Small groups in one insurance class (for example, all with the same benefit package) can not be permitted to voluntarily switch to another class (which might have lower rates) unless all members of the class are given the option to switch to the other class. In addition, carriers can not re-underwrite after several years to put the small employer into a lower cost class. The carrier can not switch or offer coverage for a richer benefit plan with similar premiums for small groups that are still in excellent health, or alternatively offer the lower risk group a richer benefit package at a higher premium that is not commensurate with the full cost of the increase in benefits had they been offered to all insured small groups. Any differences in class, such as HMOs or PPOs, must develop a significant difference in average cost for the same benefit plan design.

There are still other loopholes which are often not addressed, partly because of federal laws, such as the ERISA pre-emption provision. These loopholes include MEWAs or self-insured multiple-employer trusts, association group coverage, and individual health insurance policies issued to small employers.

One final escape route is for a group to drop coverage totally, since none of the state reform efforts to date include mandated coverage. The more low risk groups that drop coverage the greater the increase will be in average cost of coverage for those groups that remain insured.

Other Issues to Consider

There are a number of other complexities in small group reform which can cause problems in some states and will require considerable change for carriers. It has been very common in recent years to put loss ratio limits on both Medigap individual policies and individual health insurance sold by carriers. In general, the legislation increases the loss ratios required, and indirectly limits the marketing and administrative expenses of the carrier. A number of states are now dramatically tightening loss ratio requirements on small group coverage.

Average marketing and administrative costs, including profit margins, have ranged from 25-35% on very small groups. This cost is related to high underwriting expense, commissions to agents or brokers, and the effect of very high turnover in small employers (up to 35% per year). The turnover can be because the employer goes out of business, an event that happens frequently with small businesses or because employers look for a carrier that will offer a lower premium rate for a newly underwritten groups.

Several states have raised loss ratio requirements for small group health insurance to 80% and individual coverage to 75%. Often these reductions are phased in over a period of time which seems particularly difficult to comply with considering the rapid inflation trends in insurance markets and the unknown results of small group reform. The only sure way to comply with loss ratio requirements may be to lose money.

Some of the states have specifically permitted commissions, but have limited them to a level of 4-5%. The objective is to lower marketing expenses and to discourage agents increasing their commissions by urging employers to switch carriers. Restrictions on commissions should improve the longevity of group insurance contracts. However, with lower commissions, agents may be unwilling to expend the effort to market small group coverage, particularly for the smallest sized groups. On the other hand, reduced commissions and the availability of guaranteed issue with very dampened rate fluctuations may make it attractive for agents to solicit the business of high-cost, previously rejected groups.

Not the least of the problems for actuaries in the small group reform environment is the requirement for actuarial certification that a given carrier, Blue Cross plan or HMO is actually conforming with the state regulations. In an environment where rating systems have dramatically changed and guaranteed issue is involved, it will be extremely difficult to project claim costs or health care expenditures. A shift of small groups from one carrier to another or termination of coverage due to rate increases will compound the problems.

Impact of Small Group Reform To Date

Since small group reform has been in effect for more than one year in only two states, Hawaii and Connecticut, early experience is limited. In Hawaii, almost 98% of the population is covered by health insurance. Connecticut enrollment in the small group prototypes for uninsurable risks is relatively small (an estimated 7,500 members) and the change in enrollment in the small group market has been difficult to measure.

Most of the states whose plans started operations in 1992 have not yet published any results. Moreover, many states with statutes on the books have not met their deadlines for installing small group reform. In spite of enabling legislation, departments of insurance and other state agencies have had great difficulty dealing with the complexity of setting up the reinsurance pools, the trade-offs and cost issues in establishing low-option prototype plans, and obtaining requisite market summaries from small group carriers.

Although much of the insight that could be garnered from state experimentation in the long-term is still missing, difficulties in implementing programs and very early reactions by insurance carriers do offer some insight into the impact of state reform efforts. Moreover, based on some of the early impacts, one can at least speculate about some of the likely longer-term effects.

From the state initiatives currently enacted into law, one outcome is certain. When fully implemented, none of the state laws will have effectively addressed controlling cost, which is the primary problem for employer-provided small group health insurance. Some states have limited insurance agents' commissions and other marketing expenses, but these small savings will soon be overwhelmed by increases in medical care costs, which continue to inflate at a higher rate than other goods and services. In addition, the reforms impose other costs on insurers that they did not previously have. For example, underwriting is much more complicated for reinsurance pools than for determining if a group or individual is to be accepted or rejected for insurance coverage. In fact, the Academy's Committee on Health is aware of one insurer that has set up an entire underwriting department to manage its reinsurance pool business. Previously this insurer had no underwriting department.

Members of the Subcommittee should also note that a state's permitting or encouraging "bare bones" insurance coverage does not decrease cost either. This just shifts the cost to the individual or to the state and other payers when the individual can't pay his or her share of the expense of a serious illness. If not all benefits can be afforded, careful choices of benefits that are not to be covered or are to be covered less generously are necessary to establish incentives for more careful utilization. Bare bones benefit packages per se do not necessarily reduce health care costs in either the short- or the longer-term.

A second finding from state reform efforts to date is that there is no evidence to suggest that moving closer to community rating, as states are doing, has had any substantial impact on insurance coverage. Connecticut is the only state with a law in effect long enough to make an even preliminary judgement. Unfortunately, coverage is poorly measured in the state, and the coverage trend has been confounded by a serious recession in the state's defense-related industries.

In addition, most actuarial modeling continues to suggest that there will be at least modest declines in coverage initially and some predict greater substantial declines. To the Academy Committee's knowledge, no actuarial model predicts increases in coverage of any more than about 3%. Of course, over time any modest increases in coverage would likely to be more than offset by the decreases in coverage likely to result from the continued escalating upward trend in health care costs. At best, state reform efforts of the type recently enacted will temporary slow declines in small group coverage. At worst, these state reform efforts will cause coverage to decline more rapidly in the small group market.

A third outcome from current state reform initiatives is almost certain to be that fewer insurance carriers will be operating in most, if not all, states. To date, no two states have the

same small group reform statute, although many states have enacted laws similar to the NAIC model. The complexity of living with different rate banding restrictions, rate class descriptions, and different degrees of community-type rating will make it both difficult and expensive for a national carrier to stay in business in all fifty states. As a result major carriers, such as Prudential, Guardian, and New York Life, have already withdrawn from the small group market in a number of states. (Many large carriers withdrew from the small group market even prior to the small group reform movement.)

There also seems to be a strong correlation between the level of rating restrictions and the number of carriers leaving the market. Vermont and New York saw major exodus from the market when community rating was adopted, even with New York's risk-adjustment mechanism. The Connecticut legislature is now considering pure community rating, and a number of other states are considering moving in this direction.

The trend and ultimate result seems clear. Even though state reforms that greatly restrict current rating practices will bring greater stability and orderliness to local and regional small group health insurance markets, it is questionable whether many insurers will be willing to reenter the small group market given the multiplicity of laws. In addition, many insurers now in the small group market are likely to exit at least in some states.

Thus, the confusion caused by state reform has shifted the advantage to single state carriers. These are the Blue Cross/Blue Shield plans who tend to operate in only one state or part of a state. Also, because of the move to community rating, there may be a tremendous advantage for HMOs; who often do not underwrite and generally do not use pre-existing limitations at all and compete with community rates in an individual state. On the other hand, in states where Blue Cross plans have used community rating and are the insurer of last resort, their small group business may be very expensive for older age and high risk groups since the carriers that underwrite may have enrolled a big part of the low cost market. Unless the reinsuring and pooling arrangements permit Blue Cross to bring its existing business into the pool, their rating could still be non-competitive with the carriers who have a large in-force business which has been underwritten in the past two or three years.

When viewed as a whole, the currently enacted state reforms of employer-provided small group health insurance are likely to have little impact on the major problems in this market -- cost and coverage. Some good will come from these efforts through stabilization of premium rates, creation of legal access to health insurance for all small groups, and reduced churning in the small group market. At the same time, there will be negative impacts in the form of higher average rates and possibly reduced coverage. Although actuaries disagree about how much rates are likely to rise and to what extent coverage will fall, over time the average rate for insured groups could increase substantially as more and more healthiest small groups either decide to drop coverage or find ways to evade state reforms through individual insurance, self-insured arrangements or other loopholes. Under ERISA pre-emption, there is little states can do to prevent employers of any size from self-insuring, and, in the absence of mandating that all employees be covered, lower-risk groups will always be able to drop coverage or insure individually.

Chairman STARK. Thank you.

You raised a few questions. One of the things I would like you both to comment on is that in many plans, and there has been a great deal of discussion and I have never heard it discussed in much detail, but every time we talk about a variety of plans to get insurance companies together, or to share, or to bid, or to form into cooperative pools, or any of those sorts of things, there is always at the end of this statement a suggestion, the idea that we will then, of course, get together and adjust the risk. And there has been precious little, very few Ph.D. dissertations, or even suggested legislation on how one goes about adjusting that risk. And now that I have you folks here that know how to adjust numbers with the precision of a Cray computer, could you give me just a short outline and the state of the art of risk adjusting, and give us some indication of its accuracy and efficacy?

Mr. TRAPNELL. It just so happens that I was deeply involved in a study of the potential for health risk adjustment to make whole insurers for having lost in the selection game, you might say, and finding themselves with a disproportionate share of persons with higher health care costs. Which we refer to as "health risk adjustment," which is an attempt to find a set of transfer payments that will compensate for differences in how expensive it is to treat individuals according to their health status or their health condition.

The study that I was involved in wanted to focus itself narrowly on differences in the health condition of a person. They did not want to adjust, for example, for a tendency of individuals—some individuals to use services more than others.

They thought that was an inappropriate reason for a premium differential, but as far as just the deterioration of health and its implications for how expensive the person is, they wanted us to find a set of payments that, on the whole, transferred between one insurer and another, would create a level playing field as far as adverse selection is concerned, so that an insurer that had better cardiac care, for example, would not be penalized by all the heart patients electing to enroll with that carrier.

There are, basically, at the present time—there are two main systems that have been developed and several others——

Chairman STARK. I beg your pardon; you said there are how many?

Mr. TRAPNELL. Systems of health risk adjustment.

Chairman STARK. How many?

Mr. TRAPNELL. There are probably five or six of them.

Chairman STARK. Two main you said, not 2 million?

Mr. TRAPNELL. The two most frequently discussed ones are called diagnostic cost groups, which is, basically, a system of adjusting payments to Medicare risk carriers that depend on the hospital discharges that occurred in a prior period.

Since it is a prospective system, they don't compensate for the HMO or the risk plan that had the hospitalization, but they are just future payments for how much more expensive a person will be, given that he was hospitalized with a certain condition in a prior period.

They actually pay about, well, something in the order of about 20 percent of the total cost that occurs because the person was hos-

pitalized, because most of the cost is in the year of hospitalization and for that matter, recall the huge proportion of Medicare payments that go to people in the last year of their live. This system doesn't help the carrier for whom somebody died because the person is not there in the next year for them to get a higher payment.

The two things I want to point out about this system are: It was developed and estimated for the Medicare population, for these narrow contracts, for the risk contracts, Medicare, not for anybody under 65 or general circumstances, the competition of the type we are talking about here.

Another system that has gotten a lot of attention is called ambulatory care groups, or ACGs, developed by a Dr. Weiner of Hopkins; and this one goes the other extreme. It ignores hospitalization. It ignores all treatment. And it looks only at the diagnoses that have appeared in the medical records of individuals and uses this—hundreds of different situations are boiled down to 51 different categories, and Dr. Weiner was primarily interested in helping managed care plans analyze their treatment patterns. He wasn't really looking for a system of adjustments.

Consequently, no one has—this has not been tested widely in the context of payment. And, in fact, I don't think they have a systematic study of the relative cost of people that are in each of these ambulatory care groups.

Another system that is worth mentioning is that the Kaiser Permanante health plan, lately supplemented by a grant from Blue Cross, have developed a system of health risk adjustments which is—doesn't go as thoroughly into the health conditions as either of the other two groups I mentioned but has the advantage—it was developed by insurers for their own use. And many practical—and then for people under age 65.

So it has many—it is very promising from a practical point of view of something that might be available in the near future and something that you may want to ask the Blue Cross Association to comment on further when they appear.

Other systems have been developed but largely for the narrow purpose of adjusting the risk that any prepaid plan gets under Medicare risk contracts. For example, the payment will vary by such things as whether you satisfied the deductible or not. And, obviously, that is not practical for people under age 65.

I would only note, as far as using this system for—in the near future for transfers among insurance plans, it will take some time to find a system that incorporates all of the desirable elements, for example, hospital discharges, and ambulatory care, diagnosis, and, perhaps, some of the treatments that people will avoid if they have any sense, to estimate the coefficient of ways, that is the transfer amounts, to test the system to find out what is wrong with it, what the opportunity for beating and gaming the system are and to implement it.

And I remember telling Karen Davis when she was in the Carter administration, that I thought it would be 5 to 10 years before you could develop a system like this in Medicare. And we still don't have one.

Chairman STARK. So you are still in the 5- to 10-year estimate? Is that what you are suggesting?

Mr. TRAPNELL. Perhaps we could do it faster than 5 years if it was a real crash effort.

Chairman STARK. Let's just assume that they were going to take the District of Columbia and divide up all the residents into five insurance company plans. Is there any system that exists that would warm the hearts of all five of those insurance companies if we say this is the risk adjusting, we are going to plug in at the end of the year to make sure you all don't have any bad selection or any extreme, untoward cost relative to the other?

Is there a system you would pick now that you could do anything with?

Mr. TRAPNELL. I would say if those—two of those insurers were Blue Cross and Kaiser, perhaps it would warm the hearts of two of them.

Mr. SUTTON. Mr. Chairman, maybe I could give you at least one other practical approach that is being tried. Whether it will work or not, is a different question.

The State of New York, which has mandated community rights, has a health status adjustor which is essentially a demographic age and sex, health status adjustor.

Now, Mr. Enthoven, in his managed competition fame, says, if there is no real health status adjuster available, until we work on one, we could use age, sex as a proxy. This would assume you want to leave Medicaid and Medicare out of the health sets adjuster, just use it for people under 65 because they have decidedly different problems, like totally disabled people and so on.

But in New York, essentially, there is a formula for each carrier to determine whether it is better or worse on the average age, sex mix of its total market, the small group market for New York.

And, by and large, the two carriers that I have talked to, they each add a tax of between 6 and 7 percent which they have to add to their regular community rates however they figure them out. This one was an HMO, and one was an insurance carrier.

So, essentially, this money goes into the pool and then the carriers with use age, sex mix, which tends to be Empire Blue Cross, will get the money from all the other carriers.

So, essentially, it was partially designed—it was Blue Cross in New York, as an insurer of last resort, has high average age people because the insurance carriers offered low rates to younger people. And so this is a method——

Chairman STARK. So this scientific model came up and said, the way we adjust this actuarially, scientifically, and fairly, is to add a premium tax of 6 or 7 percent on, and donate that to the——

Mr. SUTTON. Yes. But it is based on the age, sex. If you happened to have an old population, you wouldn't have a tax. But, by and large, HMO, as commercials, have the younger population as opposed to Blue Cross of New York. What it does is equalize between the two of them.

They have one other aspect, and that is that there is a small pooling arrangement with organ transplants and some very expensive cases like AIDS. It does not cover the full costs, but it creates incentives to manage those cases by paying, say, half the costs.

And so what it means is a constant percentage of the premium of each carrier will be paid into a pool; and if you have a liver transplant, they will pay the plan or the carrier $100,000.

Chairman STARK. Sign everybody up with the American Family Life and if they get cancer, you collect the indemnity.

Mr. SUTTON. $100,000 from the state, right. So it is just certain types of—mostly organ transplants or catastrophic cases which are not pooled, does not cover the majority of catastrophic cases, which are intensive care, newborn, and other types of accidents.

Chairman STARK. Thank you.

Mrs. Johnson.

Mrs. JOHNSON. Thank you and welcome. It was very helpful to hear your review of the State efforts. Coming from Connecticut, I have watched those closely.

I would remind you that in Connecticut's first effort, they didn't do anything about mandated benefits. And since we are a very high mandate State, that made that small plan really unaffordable to most people.

But there are two issues that I want to pursue with you. The first, in my estimation, insurance reform is not a solution to cost control. It is a solution to insurance security because you can't be dropped and you can't be denied access.

Mr. SUTTON. Right.

Mrs. JOHNSON. It should expand the pool if we do it right and connect it with cost reforms. But most importantly, it should refocus the industry on prevention and wellness as opposed to risk selection.

In other words, it should force the competitive game into, how early can you identify illness, and how good are you at implementing guidelines and new information about what works and what doesn't work?

And I think if all the resources of the insurance industry were moved in that way, then we will get a dedication of resources, do outcomes research, and we will get systems that will be capable of implementing and using the outcomes research; and that will have an extraordinary impact on usage and particularly duplication and those kinds of things.

Would you agree with that generally?

And I guess part of that is, my conception of insurance reform is not small group reform. I think what other reforms are adopted we have to apply to everybody.

Mr. SUTTON. I would agree with you in theory, with one exception. First of all, a lot of small carriers are not going to be able to live with the data requirements in managing care. Therefore, they will, I think, drop by the wayside. The bigger carriers are going to have to learn to manage care.

Preventive care is a different question. You can't argue in terms of one individual getting its inoculations when he is a child and all these things. By and large, any savings from that is moved so far out into the future, in my opinion, it is not going to affect current rates very much.

But I agree with you in the sense that it is a change in style of how you are going to manage health care in the longer term, which will create an effect. The small group reforms are going to jumble

the market considerably, make it very confusing, get a lot of carriers to drop out, and expensive to administer in some cases. So, unfortunately, the effects of that might hide the other.

But I agree with you; the object is to manage health care and learn to deliver the kind of care that is efficient and productive. Wellness programs and so on are important, but it is more likely that any savings there will be deferred way down the line and will not affect current costs much, in my opinion.

Mrs. JOHNSON. Yes.

Mr. TRAPNELL. I was just going to add that, unfortunately, in Connecticut there is still a strong reward to those insurers who are good at underwriting as opposed to good managing, which scored some of the incentives that you described. And as long as an insurer can benefit from being smarter by who to put in the reinsurance pool, for example—and that gives them enough of a competitive advantage to overcome the differences in their outlays—if they manage care well, the system will not have the—will not conform to the incentives that you described.

Mrs. JOHNSON. Well, how much difference would it make if there were a mandate that everyone carry insurance, the mandate being on the individual that you had to prove proof of insurance?

The reason I am interested in having it on the individual is I want the individual to have a choice. I would ask—this is an assumption I am asking you to make and then to comment on—how that would affect insurance reform, if everyone has to have insurance and if there are income-related subsidies so that everyone can afford the premiums. Then you have all the well people in as well as all the sick people. And I think then that this changes the circumstances for small companies that have, in the past, relied on risk selection because it gives them an opportunity, then, to manage a pool that is both healthy and ill.

But how important is universal participation to the success of insurance reform?

Mr. SUTTON. In my answer, first, I would say it is absolutely critical. I happened to be on vacation in Hawaii, and I visited some of their HMO clients there and discussed—they run 200 days per thousand, which is a third of Connecticut's normal, the employers pay almost the full premium for the employee. By law it is 80 percent. But rather than try to collect it from the employees, everybody has to be covered.

Mrs. JOHNSON. This is in Hawaii?

Mr. SUTTON. Hawaii, right. So their experience in small group is not bad in a way.

Now, they don't have very many carriers. HMS and Kaiser control 80 percent of the total market. So you have two carriers dominating the market who also know how to control health care costs. There is one other HMO there.

So I think, in order to keep average premium rates at least lower than they would otherwise be, if you don't keep the low-cost people in the pool by subsidizing them in or whatever, your average premium rates are going to be quite high, which is probably part of the problem in Connecticut.

Mr. TRAPNELL. I would only add to that that there is the—one of the major difficulties with the small group reform, especially in-

cluding the guaranteed issue in it, is it is taking this relatively small base of employers that have been willing to pay for health insurance and giving them the extra cost of allowing any selection into the group by people who wait until they really need the care and many other games that small employers play.

Mrs. JOHNSON. So you really have to have mandatory participation. You have to have all the large and the small employers effectively, and any risk pool has to be participated in by anybody. That is the way——

Mr. TRAPNELL. It is one more extension of what I call the free rider problem that we already have, that many employers, by not offering health insurance, are taking—you know, the cost of their employees is being shifted through charity care and Medicaid back to employers that do offer the care so that in that situation, if an employer is in an industry that does not generally provide health insurance, they are at a tremendous competitive disadvantage if they offer health care.

Mrs. JOHNSON. That is one of the reasons I think we have to have mandatory coverage. Thank you.

Thank you, Mr. Chairman.

Chairman STARK. Mr. McDermott.

Mr. MCDERMOTT. Just as an aside—you may not know the answer to this—how has mandatory auto insurance worked? Is everybody covered by insurance in those States where they have mandatory auto insurance?

Mr. SUTTON. The answer is no. Some States that have mandatory auto insurance have as many as 25 percent of the younger people buying a clunker—even though there are laws to do it, they buy a car from somebody else and they have it without insurance.

Mr. MCDERMOTT. So the merits of that kind of a law——

Mr. SUTTON. Is still difficult.

Mr. MCDERMOTT. You might expect the same to be true in health care, mandating that on the individual basis.

Mr. SUTTON. You will never get 100 percent coverage. If Hawaii is an example of mandated coverage for everybody, including the low option for dependents, there is still several percent that fall between the cracks because you can't drive them into a premium or they aren't employed or they are self-employed or something.

Mr. TRAPNELL. There are many other regulatory ways to get over small employers. Small employers still have to pay withholding taxes, unemployment insurance, get licenses, personal property taxes. There are many ways in which you can fine most of the employers with at least two or three employees. The place where you will find the large evasion is the same place that has become infamous lately, you might say the nanny care. If there is nanny care, there is no particular reason to think that all the immigrant workers, domestic workers for whom Social Security taxes aren't paid are going to get health insurance. There is every reason to expect the opposite.

Mr. MCDERMOTT. Let me move to another——

Mr. SUTTON. Excuse me. One short point. In Minnesota there was certainly consideration to removing employer coverage and having individual coverage, say, get rid of a small group and for

lower income people and small employers, have individual coverage, get rid of the employer as a mechanism.

Then they figured out they had to have the money that was coming in from the employers. But they were planning to enroll people in Minnesota when they get their fishing license, when they get their hunting license, when they get their driver's license, and catch them any way you can; and they had to furnish their numbers.

So when they showed up in the hospital without coverage, and then some even suggesting garnishing their wages to be sure they pay the health insurance premium in order to get them in when—particularly when there was no employer involved.

Mr. MCDERMOTT. I simply was raising the issue in response to Mrs. Johnson's suggestion.

Let me move to another issue, that is the self-insured. Currently, self-insureds are exempt from most of this insurance reform. And my understanding is that more than 60 percent of employees today are presently covered under self-insurance programs and that even small and relatively small companies are now moving to self-insurance.

I would like to hear you talk a little bit about the incentives for self-insurance and whether you can allow self-insurance to continue if you are serious about getting at the health reform that is in this country.

Mr. SUTTON. You are correct. The percentage that are self-insured, which is all the big companies over 1,000 and the majority of companies over 500 employees, are self-insured, maybe variously estimated at 50 to 65 percent. So, essentially, you are correct.

What has happened is that for MEWAs and multiple employer trust interests——

Mr. MCDERMOTT. The MEWA is——

Mr. SUTTON. Multiple employer welfare arrangement, which is included in ERISA, which exempts groups with 25 or less employees. They don't take all the risk.

The typical coverage is self-insured, but they purchase from an insurance company, say a catastrophic coverage that covers claims in excess of 40,000. Plus they calculate—they purchase what we call aggregate stop-loss and that, for a couple thousand dollars, an insurer will cover their claims in excess of a 25 percent of a pro forma premium so that while they might lose 25 percent more than they think, the 25—if they are a very low-risk group and their risk of having a bad claim is not very high, they might be more willing to take that risk than pay 50 percent higher health insurance premiums. It is all cash flow. Sometimes it is not a good deal, but most of them don't understand, if they don't even have a personnel director and they just do what somebody tells them when they have 25 employees, they have an owner and 24 people working and that is it.

Mr. TRAPNELL. I was going to add, the so-called self-insurance for firms, particularly under 100, and egregiously for the really smaller ones, 25 to 30 employees, are only nominally self-insured. They are really insured, but the insurance carrier, in order to avoid premium taxes and other regulation, has recharacterized the arrangement of self-insurance; and observing that the fluctuation from—if you

have enough—if you have even as many as 25 people, you are going to pay a certain number of claims each year. And what the—the protection that the employer needs is that doubling or tripling in a particular year. The aggregate stop-loss can protect them against that risk and let them pay——

Mr. SUTTON. For 1 year.

Mr. TRAPNELL. For 1 year at a time, right. But the real nature of the arrangement is really not different than when the employer—I mean when the insurer took the entire risk. It is typically the insurance company, and a lot of these arrangements will actually pay the claims themselves out of a bank account that happens to be the employers' money.

Mr. MCDERMOTT. In managed competition, some people are talking about HIPCs providing the insurance options for people to buy into. Will that system work if you allow 60 percent of the people to be out under self-insurance?

Mr. SUTTON. OK, the managed competition proposal is not very well defined as to what size employers it applies to. Typically, up to 100. So it is relatively smaller employers and does not affect the large employer market unless you expand it to 1,000 or 10,000, although there have been discussions of that. So that, essentially, they are dealing with individual, small employers and unemployed people who, essentially, have to buy a risk premium, for the most part. It would not contemplate self-insurance. But if self-insurance were legal, it would be a loophole and probably worsen the risk pool of the HIPCs that it is dividing between multiple HMOs or carriers.

Mr. TRAPNELL. What is crucial is that for any particular employer that there be no choice as to whether to be in the HIPC or out of the HIPC. Because, otherwise, employers will be in or out depending on what is to their advantage. And what will happen is the cost of the people in the HIPC will go way up, if they have a selection. You have to have firewalls to keep this action a voluntary decision.

Mr. SUTTON. The HIPC has a monopoly for the groups that are eligible to use it. Therefore, there is no escape valve by self-insurance.

Mr. MCDERMOTT. There is none.

Mr. SUTTON. There is none. As I read it, it is a geographic monopoly and you act like a very large employer contracting with a bunch of HMOs or whatever. But if you are going to have insurance at all, you have to join that, and it is mandatory in their basic—they want mandatory coverage.

Mr. MCDERMOTT. Have you read that in a written proposal someplace?

Mr. SUTTON. I have the statements from the Jackson Hole group, and it is in there.

Mr. MCDERMOTT. It seems to me as if it is an enormous loophole, as you suggest.

Mr. SUTTON. They don't specifically discuss self-insurance, they just state a HIPC is a geographic monopoly for small groups and individuals who are eligible for coverage.

Mr. MCDERMOTT. So they leave open the door that could possibly allow self-insurers out?

Mr. SUTTON. Out. Their assumption is that everybody has to be in the HIPC and, therefore, you don't have an escape valve for groups subject to the HIPC.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Chairman STARK. Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman, I have no questions.

Chairman STARK. Mr. Sutton, you mentioned New York, and I believe it is true that a number of large commercial insurers have stopped writing smaller group and individual policies, the stated reason being the reforms enacted recently by the State of New York.

Does this create a problem for the consumer in New York? Is there any indication that these large, socially conscious, commercial insurers leaving New York will impact adversely on people wishing to purchase health insurance in New York?

Mr. SUTTON. I think, ultimately, there could be problems with a limit on the number of carriers in the market. I think—but I can't speak for those carriers since I don't work for any of them—that one of their problems is they have a volume of business in force and they think it will be disrupted and they cannot make money or they will lose money by continuing it and they are dropping out.

Now, when the thing settles down and you know how the thing is working, assuming the laws will permit it and the playing field were level, I think some of those big carriers would come back in. But if every State law is different, I think the carriers will have a hard time negotiating a different working arrangement in every single State.

Chairman STARK. Would you think we would be better off having a single Federal standard?

Mr. SUTTON. I have said in my statement that because of the proliferation of very different statutes, as you read in my written testimony, that if the Federal Government would lay out the rules to which each State must apply, it would be a lot simpler for the carriers to conform, and they wouldn't have to go out of business in that State unless they wanted to go out of business everywhere. However, they greatly fear Federal regulation, as a few of us know.

Chairman STARK. Ah, it is not so bad.

Redlining is an obvious way that an insurer could get around open enrollment: Just ignore going into a particular part of a community or an entire community for some reason, if it had people who are, from an underwriting standpoint, undesirable.

Are there any other major ingenious ways for insurers to get around open enrollment and guaranteed issue requirements that may not be so commonly known?

Mr. SUTTON. There was one in Connecticut which has been plugged.

Chairman STARK. What was it? We might as well plug it elsewhere.

Mr. SUTTON. In Connecticut, there is a prototype small employer health plan which most carriers put their uninsurable people in. Some of the carriers, even though they were participating in the small group market in general, happened to pay zero commissions for that particular plan, whereas they paid 10 percent commissions for the other ones, and, therefore, their agents, if somehow they

thought someone was uninsurable going to the reinsurance pool, they wouldn't bother to submit that case. Now they have to pay equal commissions for all their submissions, I believe, in Connecticut.

Chairman STARK. You get a prize for a good one. Do you have one more for us, Mr. Trapnell?

Mr. SUTTON. They are ingenious at coming up with ways in finding loopholes.

Mr. TRAPNELL. I was struck by—I appeared before a task force in Vermont where they were redesigning their health care system and one of the subjects that came up was from the insurance commissioner. He says they are having a big problem with so many of the small groups dropping out of the community pool and becoming self-insured. And one of the consumer representatives said, you assured us that when we were discussing these arrangements, that self-insurance had gone as far as it could and it could not really apply to these groups with less than 25.

But, of course, it turned out that they are not really self-insured at all; that they have an aggregate stop-loss that, in effect, gives them the same arrangement. They just call it something different. And if you don't include every other loophole that people can find, there are lots of very smart people out there figuring out how to beat the system.

Chairman STARK. OK, thank you both very much.

Mrs. Johnson.

Mrs. JOHNSON. What is your objection to an aggregate stop-loss?

Mr. TRAPNELL. I don't have any objection to aggregate stop-loss itself. I was only pointing out that when an insurance company that used to provide a small—a policy to a small group in which they fully insured and said, well, gee, that requires us to pay this 5 percent load for the cost of the community pool, and we have to community rate you and you are a very low age group so we will have to increase your premiums by 100 percent, but we have a real deal for you, you are going to self-insure.

Mrs. JOHNSON. In other words, so what pushes the amount is the risk-sharing costs?

Mr. TRAPNELL. Well, the community rate in Vermont was pushing them to find any other way to avoid having to subsidize older age groups.

Mrs. JOHNSON. Is there a way to tie the constraints on rate variation and rate increase, that are usually a part of these insurance reform proposals, to cost controls? So that as rates of inflation declined in health care, then a rating constraint would clamp down in the insurance market?

Because you really have to deal with cost control before we can expect to deal with rating constraints, although pressure on rates will help with cost control.

But the problem that you describe, and both of you have emphasized this is a real weakness in insurance reform, is the risk pooling and the costs. And that is because in a sense if you put new insurance reform before cost control you have sort of put the cart before the horse.

If you tied those two things, which I think you could probably do in law, do you think that would be possible?

Mr. TRAPNELL. I think that they are really separate issues. I think the high level of cost has driven people to take advantage of arrangements for advantage that they would not have considered when health care costs were at a much lower level because it wasn't worth the time and effort.

But as the costs keep rising, you get more and more pressure to find every advantage you can because a lot of thinking and a lot of administrative costs are worth it for a small advantage in health care costs as they get to be very expensive.

I think most of the loopholes that both Harry and I have mentioned could have been dealt with in these small group reforms if they had been anticipated and either prohibited or enough flexibility put in the laws that they could address them as they arose, and there are probably many, many more out there that we have not thought of that will appear.

One old example is of pushing in the balloon and it pops out someplace else, unless you have a really comprehensive set of rules to prohibit it.

Mrs. JOHNSON. Thank you.

Mr. TRAPNELL. When it comes to the cost control, if you really want to control cost, or to put the onus on the plans, they have to feel that they are going to get the same revenue for any group of people regardless of how they are selected, and that therefore they have to compete on price and quality.

One way to do that is to provide, if you want to have a single-payer system and make the payments vary, for age, sex, area, family composition and health status, that is what the plans will have to provide, full health services without any balance billing and with designated cost sharing, then you have a system that puts all of the pressure on the providers and insurers that organize them to control their costs.

Mr. SUTTON. Just a couple of minor points. A number of States don't mandate that HMOs be in the reinsurance pools. They are somewhat reluctant to go in because they have better deals with hospitals or they manage care better and may have fewer catastrophic claims, even given the same population.

Part of the problem is some of the reinsurance pools don't, although I know you have rates in Connecticut that have managed care rates that are slightly lower than indemnity rates, but I think that by and large the HMOs don't feel they get a good break. So the other solution is the health status adjustors, which we don't have the state-of-the-art to use well yet.

So it is a very difficult balance. A lot—most of the HMOs, and currently an HMO is the only one to drop out of the pool in Minnesota; at least one small carrier is thinking of dropping out, because they feel if they can control cost better they would be better off eating it internally than going in through the State pool and being pooled with a bunch of people that cannot control cost. So they would rather stay out.

Mrs. JOHNSON. Thank you.

Thank you, Mr. Chairman.

Chairman STARK. Thank you. And I want to thank both of you, Mr. Sutton and Mr. Trapnell, for your help.

Mr. TRAPNELL. Thank you, Mr. Chairman.

Chairman STARK. We appreciate your testimony.

We will continue with testimony from a panel consisting of Judy Waxman, who is the director of government affairs for Families USA; Jeff Smedsrud, who is executive vice president for Communicating for Agriculture; and the typo in my prepared remarks say that Gary Kushner was sentenced to be here this afternoon, but because of the weather he was reprieved. John Galles, the executive vice president of National Small Business United will present Mr. Kushner's testimony on behalf of National Small Business United.

Ladies and gentlemen, first of all, your entire statements will be included in the record, and we will lead off with Ms. Waxman and you can all follow along.

STATEMENT OF JUDITH G. WAXMAN, DIRECTOR, GOVERNMENT AFFAIRS, FAMILIES USA

Ms. WAXMAN. Thank you very much, and as you know, Congressman, Families USA is a national organization which advocates on behalf of consumers for health and long-term care reform.

Consumers in the past could feel with some confidence that insurance companies would help them pay for the care they needed, but times have changed. More recently, consumers have learned that having insurance no longer guarantees that we are covered for the care we may need.

Why has this changed? In the face of soaring health care costs, and employers' desires to cut their premium costs, insurance companies have instituted aggressive strategies in order to slow down the rapid rise in premiums and maximize their own profits. So more and more people, upon getting sick, learn they cannot get insurance or that the insurance they paid for does not cover their illness.

In fact, one recent study we found in the Midwest showed that almost half of all the unpaid hospitals bills came from patients that actually had insurance.

My written testimony explains many of the ways that insurance companies operate these days to deny people coverage, and thereby endanger the care that families can get. What I thought I would do in my oral testimony this morning is to use Families USA as an example of what happens to a small business when it tries to get coverage.

Families USA is a nonprofit small business with less than 25 employees. We have more women than men employees. We have a number of women at childbearing ages, and a number of our employees are getting up in years, into their 40s, if you will. We have a couple of people——

Chairman STARK. Hang on for 25 years, and you got it made.

Ms. WAXMAN. We have a couple of people who have had serious illnesses in the past but are "cured" and, actually, one or two with ongoing serious conditions.

Well, what happened is as follows. About 1988, we started to see dramatic increases in our premiums. In 3 years we saw a 27-percent increase, a 52-percent increase, and a 39-percent increase. Then, in 1991, we faced another 51-percent increase. We were getting priced out of the market.

We were living proof that over time people who need it the most cannot get coverage. We assume that those huge prices were due, of course, to increases in costs in general but also to the fact that we had a lot of women, older people, and a couple of sick people.

So what did we do? Well, we decided that it was time to see what other companies would cover us for insurance and we got introduced, then, to medical underwriting.

We contacted a number of insurance companies. Each employee was required to fill out numerous forms that detailed all of their past use of medical coverage. We found that just about every company we spoke to wanted to exclude certain of our employees from coverage, and/or institute long waiting periods for certain conditions.

Well, luckily, our board of directors is very concerned about health insurance for employees and said that exclusions would not do. Every employee had to be covered by the plan. We found that there was only one company that would cover us. We think we are probably lucky because, as we know, there are many other companies that cannot get coverage at any price. At this point we basically are at the mercy of this company and we will have to pay whatever it is they want.

Luckily, our rates were stabilized for the last 2 years. We have seen increases but not as dramatic as the increases in the past. But, we have had our benefit package changed and our cost sharing has increased because this company has said this is what we will sell you. And as to new employees, they are all screened and, again, excluded for certain conditions or given waiting periods.

One employee, in fact, was told a child with a slight case of asthma could not be covered for a period of time. We have also had to face what I will call techniques that companies use to avoid paying claims. Luckily, we have not had to deal with suddenly finding out that we have limited number of hospital days or number of visits because our administrators are wise to that problem and have helped us avoid that.

Yet, we have had to deal with what I will call claims harassment. Some groups have to deal with extreme harassment in that there are companies that confuse the consumer, delay payment, and deny valid claims for a variety of reasons. One story from Families USA is worth sharing. One woman who joined our staff was told that during her first year of employment she would not be covered for preexisting conditions and she was told that she had no conditions that would be excluded. What happened during that year was this: her adolescent son developed a problem for which he was given some tests to determine the severity of the problem. It turned out that the tests were negative. He had no problem. Yet the insurance company told us that she would not have those claims paid because he had a preexisting condition. We found that rather curious because apparently the provider told her there was no condition at all. She is still struggling to get those claims paid.

We are very typical, I am sad to say. We are a classic example of what is happening in the small group market. What we want to tell you today is that discrimination will continue until there is comprehensive reform. Everyone must be guaranteed coverage for a comprehensive package. The rules that govern insurance must be

changed so that all groups and individuals can get reasonably priced coverage. Consumers must be assured that they will actually be getting the protection they are paying for.

Thank you.

Chairman STARK. Thank you. Mr. Smedsrud.

[The prepared statement follows:]

TESTIMONY BY JUDITH G. WAXMAN
Director of Government Affairs
Families USA

Mr. Chairman and members of the Committee:

Thank you for inviting me to testify today. Families USA is a national organization which advocates on behalf of consumers for health and long term care reform.

Under our current health care system, insurance companies obviously play a very significant role. Most Americans who have insurance coverage through their employers have contact with the insurer who covers the business or who administers their self-insured plan. Consumers, in the past, could feel some confidence that insurance companies would help them pay for the health care they needed. But, times have changed. Insurance companies have changed the way they do business and consumers have learned that having insurance no longer guarantees that we are covered for the care we may need. Insurance companies are now driven by sky-rocketing health costs to practice outrageous acts that endanger the quality of care families can count on.

Why have insurance companies changed? Insurance companies have reacted to soaring health care costs and employers' desire to cut their premium costs by instituting aggressive strategies that slow down the rapid rise in premiums while maximizing the insurance company's profits. These practices, which have evolved dramatically over the past few years, have had a detrimental effect on health care coverage. More and more people, upon getting sick, learn that they cannot get insurance, or that the insurance they have paid for does not cover their illness. More and more frequently, even the insured consumer is left with enormous bills after an illness. One recent study in the midwest, showed that almost half of all unpaid hospital bills came from patients with insurance. [1]

WHY THE CHANGE?: THE ENVIRONMENT

Health care costs are soaring, and are far outfacing general inflation, growth in the economy and families' incomes.

In 1980, American families, who pay two thirds of the entire health care bill, on average paid a total of $1,742 for health care. This amount includes out-of-pocket expenses, health insurance, state and federal taxes that are spent on health care. In 1990, that figure rose to $4,296, a two and one-half-fold increase. By the year 2000, the average health payment by families is expected to rise to $9,397, an increase of 439% over two decades.

American businesses have also been hit hard by rapidly rising health costs. Businesses saw their payments for health insurance triple from 1980 to 1991 -- and by the year 2000 payments are expected to have risen *seven-fold* from 1980.

As costs have risen so dramatically, health care has become less affordable for Americans. Millions have been priced out of coverage or are employed by companies that have been priced out of coverage.

Businesses are looking to the insurance companies to lower their premiums so that they do not have to drop coverage for families or for the employees themselves. Insurance companies have responded with aggressive tactics to slow down the rapid rise in premiums and to maximize their own profits--often by reducing the quality of protection, or by denying and discouraging coverage for people who may need it the most.

INSURANCE COMPANY PRACTICES[2]

Insurance companies' efforts to contain their costs under the current system are adversely affecting the health of Americans. Tactics to deny or delay care--sometimes with tragic consequences--are becoming commonplace. Among the other tactics which are widespread are denying coverage to any group that the insurer thinks may have high claims for care, excluding individuals who the insurer targets as possible high users of care, shifting more of the cost of care on to the individual, reducing the services covered and denying coverage for services that have been received.

The consequence of these tactics is that individuals and families do not have the coverage they need. Lack of insurance coverage means a denial of health care services or financial devastation for the family or both. But, even if you have insurance, you can't assume you will be covered for the services you may need. Few people feel safe under our current system.

Exclusion from coverage based on certain conditions

The original Blue Cross and Blue Shield plans offered all consumers a comprehensive health insurance policy at a fixed rate regardless of the consumer's health status. As proprietary insurers began entering the market, and costs began to rise dramatically, insurers began to compete for customers by a variety of techniques. Insurers started to segregate healthy and sick people. Premiums could be lower if the plan only covered healthy people. Since sick people cost money in paid claims, insurers began to look for ways to exclude them from coverage. In effect, since premiums can be lower and more profitable for insurance companies which include only the healthiest people under their policies, a complex web of exclusions and limitations began to restrict the availability of health insurance for anyone who might need health care.

A technique called "medical underwriting" was born. Medical underwriting is the process by which an insurer evaluates the health history and the potential of poor health status of an individual or group and determines whether coverage will be offered. As a result of underwriting, insurers may exclude some individuals from coverage, or exclude coverage of pre-existing health conditions for a set period of time or totally. This practice severely curtails the availability of health insurance for many individuals and groups. For instance, redlining-the process by which insurers exclude entire industries-is applied to many different types of businesses. Businesses can be excluded from coverage for a variety of reasons. Construction firms are excluded because the insurer may believe it is a high risk industry; restaurants and florists, because some of their employees are believed to be at high risk of contracting AIDS; or doctors, lawyers and non-profit organizations, because insurers expect them to have higher than average claims rates.

Individuals can be excluded totally or for a waiting period for any condition designated by the insurer. Insurers reject or limit coverage for conditions such as chronic health problems, pregnancies, or even such common afflictions as allergies, back strain and obesity.

Some insurers are beginning to investigate the use of genetic testing in order to determine who they should exclude from coverage because of a genetic predilection toward possibly becoming ill in the distant future.

Discouraging coverage

Another widely used technique that can discourage people who need care from getting insurance or make insurance unaffordable, is called "experience rating". This technique, used by almost all insurers, is a process of setting premiums based on the actual or anticipated health care needs of each member of the group. No longer are risks spread evenly throughout the insured population. Instead, premiums are relatively lower for groups that appear healthy, but premiums rise rapidly if any member of the group has or develops a medical problem. Premiums also rise for individuals the insurer suspects may develop a health problem in the future.

Premiums are higher for women, older people and the sick. Although we as a nation have taken real strides in eliminating discrimination based on gender, age and health status, insurance companies have moved in the opposite direction. The health insurance industry is one of the last bastions whose policy and practice is to discriminate against women, older people, and the infirm.

Questions are now being raised about the accuracy and manipulative uses of risk rating. There is mounting evidence that the rates are not actuarially sound. Generally there is no review of the process used by insurers to determine the so-called risk of the people who seek coverage. The premium rates can be arbitrarily set, and may simply be a reflection of the insurer's view of who they want to cover.

The result of experience rating is that insurance is no longer affordable to many who want to protect themselves against the high cost of health care. People who are in greatest need of coverage are the most likely candidates to experience rapidly escalating premiums, thus making coverage less attainable over time.

Techniques to avoid paying claims

Limiting coverage

A technique used to limit claims paid is to limit what the policy covers. More and more policies shift costs on to the individual. Deductibles, coinsurance and copayments, all of which require the individual to pay more out-of-pocket, are increasing. Many people may be unaware that their policy only covers a finite number of hospital days or doctor visits, which means that they have to pay for care beyond those limits. Policies are now accompanied by growing lists of medical procedures that will not be reimbursed. These often include some preventive medicine that holds promise of holding society's costs down while improving the quality of our health.

Lastly, some states are allowing insurance companies to sell so-called "bare-bones" health plans. These plans eliminate many benefits that were previously required to be included in all policies, such as mental health or substance abuse coverage. Elimination of these benefits leaves the individual totally at financial risk for these services. They often include extremely low caps on benefits or such high deductibles that the so-called "insured" are discouraged from seeking timely primary care.

Claims harassment

More and more companies are engaging in practices that confuse the consumer, delay payment or otherwise discourage claims. Among the techniques that have been reported are: delayed responses to telephone or written inquiries or appeals; denials of valid claims; complex procedures requiring the policy-holder to coordinate claims, forms and signatures; unwritten internal rules for determining claims reimbursement; obtusely coded printout forms; elaborate rules for coordinating benefits should the consumer be covered by two plans; and slowing down the operations that lead to the outflow of funds.

Utilization review

Another widely employed technique to avoid paying claims is "utilization review." Utilization review is used to determine whether services are necessary--in the view of the insurer--and should be reimbursed.

The review can be done in a variety of ways. Sometimes it is in the form of a pre-certification process that must be completed in order for payment to be made. If not completed, reimbursement is denied, regardless of the need for care. The review could be a periodic review of services during the course of treatment. For example, a physician may be required to get certification for extra hospital days for an individual whose care requires a longer than usual hospital stay. Also, some utilization review is conducted after all treatment is completed by reviewing the medical records to determine if reimbursement should be made for all the services rendered.

The theory behind these review is a good one. Unnecessary care is not only wasteful, but it can be harmful. Insofar as utilization review helps to eliminate unnecessary care it can protect patients and save money. The problem is the utilization review can be used to deny people the care they need; especially when it is controlled by insurance companies committed to maximizing profits, not health care quality.

Physicians and patients are complaining that arbitrary barriers are being erected between the patient and the doctor to deny care. What services are approved can differ according the utilization review company that is used to review the care requested. There are probably two to three hundred companies that perform this function. Some are nationwide companies and some are small Mom and Pop operations that consist of an 800 number and an unskilled person who is assigned to make decisions about reimbursement. The large utilization review companies base their decisions on protocols developed on a large data base of medical outcomes. But, very few states regulate the guidelines that determine health care for most Americans.

A growing number of complaints have been heard on the stalling techniques used by these companies. Sometimes more than one reviewer is used to parcel out approval. Approvals may be delayed. Or the other approval is accompanied by disclaimers which make the provider and the patient hesitate to go ahead with the treatment. Appeals, too, can be cumbersome and time consuming which further discourages the provider from giving the care.

CONCLUSION

The only viable solution to insurance company abuses is comprehensive reform of the health care system. As long as costs continue to soar out of control, insurers will seek out ways to insure only business that will be profitable to cover, those businesses that employ young healthy workers. Discrimination will continue unless everyone is guaranteed coverage for a comprehensive set of benefits. Out-of-pocket expenses must be limited, especially for low-income people and the elderly trying to get by on fixed incomes. Insurance companies that continue to offer coverage in a reformed system, must be made to offer reasonably priced coverage to everyone who seeks it, and consumers must be assured that they will actually get the protection they are paying for.

1. Saywell RM Jr, Zollinger TW, Chu OK, MacBeth CA, Sechrist ME. Hospital and patient characteristics of uncompensated hospital care: policy implications. Journal of Health Politics, Policy and Law. 1989;14(2):287-307.

2. For elaboration on many of these points See: Light DW. The practice and ethics of risk-rated health insurance, JAMA. 1992;267(18):2503-2508.

STATEMENT OF JEFFREY SMEDSRUD, EXECUTIVE VICE PRESIDENT, COMMUNICATING FOR AGRICULTURE

Mr. SMEDSRUD. Thank you, Mr. Chairman, and members of the committee. My name is Jeff Smedsrud; I am executive vice president of Communicating for Agriculture. We are a national rural association that represents farmers, ranchers, and self-employed people. We have a long history in health reform issues.

Beginning in 1975, my father helped Minnesota lawmakers develop their State program for the medically uninsurable. Since that time we have helped 27 States adopt and implement risks pools. Last year, we sponsored a national conference that had 31 States represented and 93 participants coming that operate these programs.

Because of our work on this issue, we have become a resource for hundreds and hundreds of people who have called our office asking questions about what they can and cannot do when they have lost their insurance or when they are about to lose their insurance.

With that introduction, let us discuss problems with health insurance, but let me also state categorically much of what we hear about problems in health insurance are not, strictly speaking, problems in health insurance, there are 37 million Americans without insurance. Of that, about 9 out of 10 could get insurance but they cannot afford it.

True, insurance practices have led to part of that problem but also true some individuals have chosen not to buy coverage, and let us acknowledge that they, too, are part of the problem.

What are the things that happen to people that make them uninsured? Let us look at the 90,000 people in State risk pools for the medically uninsurable and look at how they got there. About a third arrived there because they had been canceled, although most were not canceled by insurance companies per se. Most were canceled by self-insured ERISA trusts. ERISA trusts are not governed by State laws.

About 25 percent of the people were in death spirals. So, technically, the cost of getting into a risk pool for the medically uninsurable was cheaper than the cost of keeping the plan that they had.

About 20 percent work for companies that just went broke, went bankrupt, their continuation of benefits ended. About 15 percent have exhausted their benefits with the company they worked for.

In recent years, a growing number of these people have been employees of very large companies that have put limitations such as a $50,000 lifetime cap on AIDS into their plans and then they in the process dump their old employees into risk pools. It is interesting to note these large companies, again, covered under ERISA laws, don't contribute to the cost of operating these pools.

Why are not more uninsured people in risk pools? They simply cannot afford the price of the premiums. Which brings us to problem number one: health care cost. Unless we stop the escalation of health care costs, no amount of reform of health insurance will solve the base problem.

But there are things that can be done and problems that can be recognized. A second problem is that there is no uniform easy-to-understand guideline of what insurance is and what it is not. In-

surance companies play by one set of rules, HMOs by a second set of rules, ERISA by a third set of rules, and in this confusion it is very, very difficult for us consumers to make wise choices.

In this confusion, you can sometimes get hurt. As I mentioned, many of the people that are canceled are canceled by ERISA-exempt trusts marketed to small businesses.

HMOs have also dumped people, and, in creative ways, so have large companies who have stripped benefits from their retirees, who have put limitations on the amount of benefits they pay, who have put waiting periods for preexisting conditions, actions that, by and large, are no longer allowed for small businesses which operate under State laws.

Problem number three: If you buy insurance you may be subject to a death spiral. That was talked about in great detail by the actuaries. Suffice it to say death spirals take place. Are they illegal? Heavens no. State insurance regulators approve the rates, the forms, and the filing practices for these types of practices every year.

Problem number four: Tax policy. Self-employed individuals used to be able to deduct 25 percent of their premiums from their taxes. Employees who pay for their own insurance, and these are almost always employees of very small companies, can deduct zero. And by and large, employees of large companies receive their insurance as an after-tax benefit. In America today, as your income goes up, your health care costs go down. The less you make, the more you pay for health insurance. And that is wrong.

A single mom waitress, for example, may pay 20 percent of her take-home pay for health insurance. True, she is eligible for a supplemental income credit, but very few people who are eligible actually apply for it and fully understand how it works.

A young farmer will pay $4,000 or $5,000 a year for health insurance. That is likely to be more than his monthly mortgage payment, likely to be more than his families' grocery bill. How many of us in this room will pay even 2 percent of our monthly take-home pay for health insurance? How many of us will incur even $1,000 for medical bills out of our pockets? It is unfair.

When Government policy changes tax laws so it helps the people who make the least and not the people that make the most, you will see a whole lot more people start to buy insurance.

Problem number five: Insurance has not been portable. Americans have expressed concern that if they went from one job to another their insurance wouldn't go with them. By and large, this problem should be diminishing. About 31—someone earlier said 34—States have passed laws that have improved portability of coverage. Many States are also looking at rating reforms.

In the process of looking at rating reforms, one thing needs to be made clear. Rating reforms that increase the cost to the consumers is not really a reform at all.

Finally, let us not forget cost shifting, which is driving up costs, particularly in rural America. We did a study of 617 hospitals in rural America. The hospital administrators flat out told us their average cost shift is 19 percent.

In conclusion, part of our goal has been to help people make the right choices when buying health insurance. There are paths to

take. You can find good insurance. Sometimes it is difficult. There are too many roadblocks. Group plans such as what our group has sponsored for our members is one example of a program that has worked very, very well.

We need reforms that work for consumers and make it easier for the consumer to understand the rules and most of all we need to do it right now.

Thank you very much.

Chairman STARK. Thank you.

[The prepared statement and attachment follow:]

STATEMENT OF JEFFREY SMEDSRUD, COMMUNICATING FOR AGRICULTURE, MARCH 15, 1993, BEFORE WAYS & MEANS, SUB-COMMITTEE ON HEALTH

Mr. Chairman and members of the Committee. .. . My name is Jeffrey Smedsrud, executive vice president of Communicating for Agriculture. We are a national rural association that represents 80,000 farmers, ranchers and small-town, self-employed Americans.

Along with our work in rural development, education and international exchange, we have a long history in health insurance reform issues. Beginning in 1975, my father helped Minnesota lawmakers develop their state program for the medically uninsurable.

Since then, we have helped 27 states adopt and implement risk pools for the medically uninsurable. We publish the annual "bible" of these programs -- how they work and who they help. Last year, we hosted the first national conference for state officials that have programs to help the uninsured. We had 97 attendees from 31 states. These pools continue today to be an important safety net for many Americans who cannot access private insurance.

Because of our work on risk pools and because I have spoken at hearings and conferences in many states regarding access to insurance, we have become a resource for many people who call wanting to know what programs are available . . . asking about their rights . . . groping to understand the kind of insurance they have, and whether it is -- strictly speaking -- insurance at all.

Several years ago we initiated legal action against an HMO that sought to cancel some 15,000 seniors without providing a continuation of benefits.

We have developed a data base of nearly one million rural Americans who have insurance -- and can tell you what kind of coverage they have, and why they choose the type of plans they do.

And we have developed for our own members a group insurance benefit that pools farmers together. This could serve as an interesting model as Congress and the President look at various pooling arrangements. Our negotiations with the insurance company has resulted in a high percentage of every dollar collected in premiums being returned back to the consumer, as well as other innovations to involve consumers in controlling their own health costs.

With that introduction . . .let us discuss the problems in health insurance. But let me state categorically: much of what we read and much of what we hear is often -- strictly speaking -- not problems of health insurance. For example . . .

There are approximately 35-37 million Americans without insurance. Of those without insurance, nearly 9 out of 10 are insurable -- but they can't afford it. For many, it is just barely out of reach. True, some are priced out by insurance riders and rate-ups. But also true, some Americans **choose** not to buy coverage. Let us begin to acknowledge that there are people who game the system. They are part of the problem, too.

Of the 90,000 people currently in state risk pools our best estimate suggests the following: about 33 percent arrived there because they have been cancelled, although most were not cancelled by a true "insurance company"; about 25 percent were in a death spiral, so the cost of the high risk pool was less expensive than

keeping the plan they were in; about 20 percent worked for companies that went broke and either there was no continuation of benefits, or they were used up; and about 15 percent have used up

the benefits of the plan they previously had and will be in a risk pool until he or she uses up the $500,000 or $1,000,000 in lifetime benefits; about 5 percent never had insurance.

Do these disclaimers absolve the insurance industry from blame for part of this situation? Absolutely not. Does the health insurance industry bear a certain responsibility? YES.

Mr. Chairman, you have asked us to discuss problems -- not solutions. We'd rather talk about steps to change health care for the better. Because steps can and should be taken immediately. But as more of us better understand what the problem is, we are collectively better able to respond with effective solutions.

Problem One -- health care costs too much. I state the obvious for a reason: Unless medical costs stop rising many times faster than the wages paid to workers, or the self-employed, no amount of re-structuring of health insurance will solve the basic problem -- too many people don't have insurance because medical care is too expensive.

Problem Two -- there is no clear, uniform, easy-to-understand guideline of what insurance is and what it is not. Insurance companies play by one set of rules . . . Health Maintenance Organizations, a second set . . . and ERISA-exempt, self-insurers, by a third. Consumers are confused. In this confusion it is difficult to make wise choices.

In our experience, most Americans who are cancelled, last had insurance offered through an ERISA-exempt trust -- sometimes known as a MEWA. These self-insured trusts, marketed to small businesses, are not required to meet the same reserve and financial requirements as do indemnity companies. They do not have to comply with many state laws.

HMOs have also dumped people. To those who say that the managed care movement is the White Knight for all health care reform -- come to rural America. There have been successes -- but also failures.

Self-insured plans administered by large companies also contribute to a problem. It is no longer an axiom that if you work for a large company your insurance needs will be met. Large companies are instituting waiting periods for pre-existing conditions and some are reducing benefits, and a few are excluding coverage for serious conditions such as HIV positive -- actions that are disallowed by state laws that govern health insurance of small businesses. A handful are even taking legal action against their retired employees to strip them of their negotiated, bargained for medicare supplement plans.

Problem Three -- if you buy insurance you may be subject to a "death spiral." Certain companies find ways to push those who had claims into special pools so that they can offer lower rates to new enrollees -- people who often must be in the plan for up to 12 months before they can collect many of the benefits. Death spirals are real. And they cause pain. Are they illegal? No. Each year state insurance regulators approve rates filed by companies that use this practice. Tier-rating can be eliminate, and should be.

Risk pools have been the life saver for many people caught in such spirals. One farmer member of ours paid $200 a month the year he bought a plan. Six months later he had a mild heart attack. The plan increased to $800 the next year. And this year it went up to $1,200. The state he lives in has a risk pool to help people like him -- but it isn't funded.

Problem Four -- tax policy. Self-employed individuals use to be able to deduct 25 percent of their insurance premiums; employees who pay for their own insurance -- these are nearly always workers at very small companies -- can deduct ZERO -- and those who work for large companies continue to receive insurance on a tax-free basis. In America today, as your income goes down, your health care costs go up. The less you make; the more you pay.

A single-mom waitress may pay 20 percent of her take home wages for insurance -- and it will likely have a high deductible. Is she eligible for the supplemental health credit -- yes; does she know about it -- probably not.

Many retirees will pay more out-of-pocket to be on Medicare than they ever did while working. The medicare supplement is not deductible from taxes.

A self-employed farmer, married, 2 kids, will pay $4,000 a year for health insurance for his family. He used to be able to deduct 25 % -- but not anymore. The plan will have a $1,000 deductible. It will pay 80 percent of the first $5,000 in expenses. Or maybe only 50 percent. His **after-tax** health care costs will likely be more than the family's house payment. And larger than the monthly grocery bill.

How many of us in this room will even incur $1000 in out-of-pocket medical costs this year? How many of us in this room will pay even 2 percent of our take home pay for health insurance?

Those in government must change tax policy so that those who make the least get the most in tax breaks, and not the other way around. And when you do, millions will no longer be uninsured.

Problem Five -- insurance has not been portable. Americans have expressed concern that if they changed jobs their insurance wouldn't go with them. This problem should be diminishing. 31 states have passed laws that improve portability of coverage. More are implementing these reforms.

Problem Six -- regulations. As Pogo said, "We have seen the enemy and he is us." State laws discourage large pooling arrangements. Mandated benefits drive up costs. It is becoming very difficult to manage multi-state pools, such as that provided by associations or HMOs or large businesses. On the Federal level, ERISA has not been amended.

It is interesting to note that while Congress will soon begin to debate ways to encourage large pooling methods, states are rushing to enact laws that protect their own jurisdiction. 23 states have or are about to enact significant reform. Nine states have versions of managed competition under serious discussion. How will all of these diverse requirements be melded into a new set of federal rules?

Problem seven -- cost-shifting. Particularly in rural America where we have many medicare dependent facilities, cost-shifting is raising the cost of insurance for those who buy fee-for-service plans. Cost-shifting occurs because medicare reimbursement rates are, according to those in medicine, too low.

A survey CA did of 617 rural hospital administrators revealed that the average cost-shift was 19 percent. Freezing medicare payments to hospitals as proposed in the President's economic plan will only add to the cost-shift.

There are those who say any future health reform should not inlcude taxation of health benefits. I would submit that we already have a sales tax paid by those who have private insurance -- its called cost-shifting. While the government and medical profession debate who's at fault, we as consumers -- particularly rural and small business -- are paying.

Problem eight -- it is difficult for consumers to make wise choices. And we aren't rewarded for doing so. Many states are looking at community rating methods, whereby insurance premiums would not be based on age, occupation, geography, health status. A little rating reform is needed. And it is already taking place. But what incentive will there be for the person who exercises regularly, lives a healthy lifestyle and refrains from choices that injure his or her health if we tell that person that your insurance costs will be the same as someone who seeks -- consciously or not -- to injure themself? What messages do we send insurance companies when their premium taxes are the same -- regardless of whether they return 50 cents on the dollar in benefits, or 80 cents on the dollar? A problem with insurance is that we don't reward efficiency and innovation.

In summation. . .Part of CA's goal has been to help people understand that there are many types of insurance, and that not every entity that calls its self "an insurer", is governed by an equal set of rules and standards.

Risk pools have helped people who have had problems. Our group will continue to develop these safety nets, and ask that Congress take a renewed look at risk pools -- funded on a broader basis -- as part of national reform effort.

I close by recalling a story my father tells of a meeting he had in 1975 with the late Sen. Hubert Humphrey -- a very great man in the mind of most of us Minnesotans. He asked the Senator for his help in persuading Minnesota state legislators to pass a risk pool. Sen. Humphrey told him it wasn't necessary -- because they'd be solving the health care problem in Washington, D.C. . . . real soon.

Thank you.

Chairman STARK. Mr. Galles.

STATEMENT OF GARY KUSHNER, CHAIR, HEALTH CARE POLICY SUBCOMMITTEE, NATIONAL SMALL BUSINESS UNITED, AS PRESENTED BY JOHN PAUL GALLES, EXECUTIVE VICE PRESIDENT

Mr. GALLES. Thank you very much, Mr. Chairman.

On behalf of Gary Kushner, who is chair of our health care subcommittee for National Small Business United, I am pleased to participate in this hearing today. Thank you for taking the time.

Let me, first, tell you that National Small Business United is the oldest trade association exclusively representing small businesses in this country. We have been in place for over 50 years now. It is hard to believe at this stage in the health care discussion that I can add any new light on the issue that has not been shed by previous speakers or speakers yet to come today, but let me try to focus your attention more on the customer of health care, the small business customer.

The health care problem will not be solved until we begin to understand the nature of that customer. In this country, there are over 20 million small business entities, excuse me, there are 20 million business entities. Of those 20 million entities, about 15½ million are sole proprietorships or independent contractors. Of the remaining 5 million, 96 percent of those businesses have fewer than 100 employees, and 84 percent of those businesses have fewer than 20 employees.

It is important to understand that those businesses largely are privately insured, not self-insured, not subsidized by the Federal Government, but fighting to pay their own way for health care, fighting to compete for employees in the labor force, and they are struggling with an overwhelming increase in cost increases.

Why, just since 1980, the average employee premium has grown from $840 a year to nearly $4,500 a year in 1992. We think primarily the problem for this problem is the result of government intervention, insurance companies taking advantage of government exceptions that serve their profit interests, but we also think that there are lots of individuals who simply choose not to participate in this system, hoping and praying that the government will pick up their fair share of the cost.

There is too much focus on institutions and on groups and too little focus on small businesses and individuals. It is high time we pay attention to individuals who are going without health care. We have segmented the market too drastically. Our Federal Government provides its support through Medicare and Medicaid. Our large businesses have been allowed to opt out and self-insure. Small businesses are trapped by being divided between small groups and individual groups.

We have heard a little bit about bare-bones plans where benefits have been cut back. I would rather turn your attention to the lower costs which are being paid. In a recent experiment in Florida, Governor Chiles has put together a number of insureds—a number of hospitals, doctors, and individuals who have gone without health care for a number of months and have provided them with health care that is about 40 percent less than conventional premiums.

We made the health care transaction overly complex. How many other individuals do you see when you go into a doctors' office besides the doctor? I would bet they number at least five individuals to every doctor. There are too many entities between the doctor and the consumer, and it is high time we think about making that relationship simpler, not tougher, not more complex.

One other factor contributing to the problems facing small business is fee-for-service medicine. Small businesses are uncomfortable living in a health care arena which encourages doctors to perform more services for more income rather than thinking about how to care for the individual in a way which serves their health in the long term.

Certainly individual underwriting, certainly individual rating, certainly the churning that goes on in the marketplace where insurance industries have gone in and attempted to steal customers or small businesses away from other insurance companies is a problem, but we think that it is high time that we address this problem in a major way.

We need to reduce the complexity in the system but find a way to maintain choice for small businesses and give small businesses some clout in the marketplace. It is high time that small businesses were allowed to combine themselves to transact business through insurance companies with health care providers in a way which allows them to negotiate fees for service or comprehensive coverage in the same way that larger businesses do or the Federal Government does.

We are seeking a level playing field, one which allows individuals and sole proprietorships to deduct premiums just like large businesses can. Small businesses will be fair contributors to the process if given a chance and a level playing field.

Thank you very much.

Chairman STARK. Thank you.

[The prepared statement of Mr. Kushner follows:]

Statement of Gary Kushner on behalf of National Small Business United

Mr. Chairman and Members of the Subcommittee:

Good morning. My name is Gary Kushner. I run an employee benefit consulting firm (Kushner & Company) in Kalamazoo, Michigan, and I am here today representing National Small Business United (NSBU), where I chair the Health Care Policy Subcommittee. I am also a former chair of the Small Business Association of Michigan.

National Small Business United is the oldest trade association exclusively representing small businesses in this country--for over 50 years now. NSBU is a volunteer-driven association of small businesses from across the country, founded from a 1986 merger of the National Small Business Association and Small Business United. NSBU serves over 65,000 individual companies with members in each of the 50 states, as well as local, state, and regional associations. The top priority for NSBU during the last several years has been fundamental health care reform.

We appreciate your holding this hearing today to explore the health insurance problems faced by millions of small employers. The current insurance-based financing system for health care poses large problems and concerns for small businesses. To be sure, employers of all kinds and sizes, as well as the public sector, are finding it increasingly difficult to finance the cost of health care for their employees and for the nation's citizens. The U.S. spends more per capita on health care than any other country in the world--more than double what Japan spends and 40 percent more than Canada, which is the second most expensive country. Twenty five years ago, health care consumed 5.9 percent of the GNP; in 1992, that number topped 14 percent, for a total of $840 billion. At this rate, we will see annual health care spending easily top $1 trillion by 1994.

But there are additional reasons for cost increases on the private sector, other than the aggregate cost of health care. There are three major groups who finance the costs of health care in this country: 1) the government, 2) self-insured companies--generally big corporations, and 3) businesses which insure through traditional insurance companies--generally small businesses. Together with individuals, these groups finance virtually all of the nation's health care spending. It is important to realize that, to the extent that one of these groups pays less, the others pay more. But the small businesses that are in the third, insurance-based, group pay the most.

The federal government has a system which has had good success in reducing the government's expenses for Medicare; it is a system which sets the amounts Medicare is willing to pay for particular services. However, it has done nothing to lower the overall costs of health care and has actually driven up costs for the privately insured. When providers cannot get adequate compensation from the government, they simply raise the prices charged to everyone else. Large, self-insured plans frequently have a great deal of clout in a given area and can negotiate with providers in order to reduce the impact of this "cost-shift" on themselves. However, small employers have no ability to reduce this cost-shift and must bear its full brunt. This same cost-shifting scenario also holds true for providers' expenses in delivering uncompensated care, primarily to the uninsured. For these reasons, no part of the business community is hit harder by the high costs of the uninsured than small business.

However, the health care cost problems of small employers cannot simply be dealt with at the macro level. There are unique equity problems faced by small businesses in financing the care of their employees, which go to the heart of how health care should be paid for--whatever its cost happens to be. These issues revolve around how small employers find and maintain adequate insurance coverage for their employees.

To illustrate the personal problems that have been created by the current system, following are two all-too-typical stories that have received media attention regarding the inequities of the small group insurance market:

- Health insurance was the last thing Ron Collins, an agricultural consultant from Hillsboro, Oregon, needed to worry about. Collins' wife was battling lymphatic cancer when his insurer of 16 years chose not to renew his company's health policy. The insurer stated that its decision was based on a decline in the volume of business in Oregon. After scrambling to find affordable coverage for his business that would also cover his wife, Collins

was told by insurers that they would not cover his business unless he placed his wife in Oregon's high-risk health insurance pool -- even though the program could take no more new policyholders. He finally ended up buying a conversion policy that cost $17,000 a year, $8,000 of which had to be paid up front.

- When Charles Gilbert's son Matthew was born in July of 1987 with severe birth defects, he was confident that his employer's insurer would cover the hundreds of thousands of dollars in medical costs he would incur. On July 1, 1989, Blue Cross canceled the entire policy of Gilbert's employer, stating only that the small company did not meet underwriting guidelines. This is, in essence, an industry euphemism for "claims deemed to expensive." Only through the intervention of Indiana state officials and former Vice President Dan Quayle did the Gilberts obtain a waiver to have the state's Medicaid program finance their son's medical care.

These two examples illustrate the tough choices that our current insurance system poses every day to our nation's small businesses and their employees. Certainly, these situations are not the result of overt acts of greed and malice on the part of insurers. Rather, it is the result of a system gone mad, a system in which insurers that do not engage in underwriting and other such practices will be driven from business. Even the insurers recognize the failings of the current system and are calling for fundamental change.

The insurance market for small employers is based upon individual underwriting. All employees--and their dependents--of a small firm are screened for past and present health conditions, which is used to determine whether a company will receive insurance and whether the conditions of some individuals will be excluded from that coverage. If individuals in these groups have conditions, those conditions are routinely excluded from coverage. Moreover, small employers with sick employees are frequently turned down for coverage altogether. When an employee gets sick while a given policy is already in effect, renewal time often finds the employer faced with premium increases which make the plan unsustainable. When this employer shops for a new plan, other insurance companies either will not provide coverage, or they will exclude from coverage the condition of the sick employee. These employers are often faced with the "Hobson's choice" of discontinuing coverage for a given individual in order to find coverage for everyone else. For the self-

employed, the matter is made worse: even if they bite the bullet and purchase expensive coverage, they currently get no deduction for that expense, while large corporations can fully deduct the most lavish benefit plans.

To illustrate the gravity of the problem in the small group insurance market, a survey from the late 1980s by the Health Insurance Association of America estimated that employers with fewer than 25 employees pay about 30 percent higher premiums than large employers. Further, a survey by the National Association of Manufacturers reports that the premiums for those small employers have continued to rise at a rate 50 percent greater than the rate of increase for all other employers. Therefore, the problem is not simply that all insurance--even that of large corporations--is too expensive (though it is); the problem is that small, marginal companies actually get a substantial and discriminatory price hike, which stem from the inequities of the current financing system.

The insurance industry argues that the major reasons for this disparity are the high acquisition and administrative costs for small firms, combined with their relatively low renewal rates. Insurers' marketing costs are higher and must be continuous because their book of small firm business is constantly revolving. One of the major reasons for higher-than-average premiums for small businesses is that they are always switching insurance companies (called "churning"). Why is this churning so prevalent?

A major reason that small businesses switch insurance companies so frequently is that their premiums are frequently increased substantially after the first year of coverage. One of the major reasons these hikes occur is because pre-existing condition exclusions often expire after the first 12-18 months of coverage. The resulting premium increases often push small companies into switching plans, which serves to both further escalate administrative costs and to perpetuate the under-insurance of their employees--because they suffer a new round of pre-existing condition exclusions. Also, the competitive pressures on insurance companies may encourage them to price a product at levels that are not sustainable past the first year. Premiums may also increase if new employee conditions have become present.

We must move back toward an insurance system that groups individuals in order to spread the risk of an individually large loss across a larger group. As it stands now for many small employers, insurance is merely financing their real costs and billing them back to the business, rather than spreading risk across larger populations.

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Naturally, this examination finally leads to discussion of how (or whether) the system can be changed to eliminate the described problems. Though we have been informed that this hearing is intended to primarily address the problems within the current system, we feel that we would be remiss if we did not address the solutions to the current problems. Therefore, we have attached an outline of our proposed solution at the end of this testimony. Wholesale reform which includes universal coverage is clearly necessary to resolve the complex and inter-related problems in the modern health care system. But we believe that retention of a mostly private sector system will ultimately best serve the interests of all interested parties.

Thank you for inviting us to testify today, to present some of the major problems encountered by small business. These problems must be solved quickly, and we hope to work with you in any way we can to assure passage of an equitable and sensible health care reform package.

APPENDIX

National Small Business United
Recommendations for Reform of the U.S. Health Care System
Approved by the Board of Trustees, January 29, 1993

Introduction

On December 4, 1992 the NSBU Health Care Policy Subcommittee met in Chicago, Illinois to discuss potential changes and additions to NSBU's stance on federal health care reform. At this meeting, the Subcommittee concluded to recommend to the NSBU Leadership the endorsement of a "managed competition" framework for health care reform. Versions of managed competition have been proposed by many, including a group of health care reformers calling themselves the "Jackson Hole" group, moderate Democrats in the House of Representatives, and many key advisers to Bill Clinton.

On January 29, the NSBU Board of Trustees approved the following outline of how the NSBU would structure a managed competition model and how it should fit with the other necessary reforms, already proposed by NSBU.

Health Care Delivery Systems

National Small Business United supports the concept of Health Insurance Purchasing Cooperatives (HIPCs). HIPCs could be formed by groups or associations of businesses or individuals under guidelines established by the federal government and approved by state health boards. Small businesses and individuals would be able to join competing HIPCs and be enrolled in health care coverage packages of their choice from among those available through their HIPC. The non-profit HIPCs would not be able to reject members based upon health conditions.

Multiple competing HIPCs would be allowed for given geographic areas, and they would be given latitude to determine which sorts of insurance or HMO-like options (which some plans call Accountable Health Plans) they offer to their members. The HIPCs would provide information (on price, quality, etc.) on each of these Accountable Health Plans (AHPs) to their members, and

each individual would be able to choose the plan which best meets his or her needs. All plans would carry a minimum level of federally defined benefits, which would have tax-preferred status. All state mandates would be preempted by this federal package. The AHPs would be licensed and regulated at the state level, according to federal guidelines. All health care will be delivered by these AHPs, perhaps through a HIPC, though not necessarily.

Universal Coverage

Individuals would be required to choose whether to directly enroll in a HIPC, purchase coverage directly from an insurer/provider (AHP), or participate in an employer-provided option. All individuals would be allowed to deduct, for federal tax purposes, the full cost of the federally defined package, which would also be the required package. Additional tax-based subsidies should be made available to assist lower-income individuals (those below 200% of the poverty level) in purchasing coverage.

The Medicaid and Medicare programs should be restructured to distribute recipients of public support among the active HIPCs within each state. HIPCs would be required to participate in management of these cases. Competitive bidding for these government caseloads would be managed at a state level. The federal government should commit to paying the fair market price for these services.

A Federal Basic Package

States' mandates should be preempted and replaced with a federal basic package. Such a package should be designed by an independent board or commission, removed--to the maximum extent possible--from the political process. Such a package should only include necessary benefits, and it should be expanded only if clearly and irrefutably necessary and with great difficulty. A federal basic package should contain the following elements:

1. Hospitalization
2. Necessary physician visits
3. Surgery (including some outpatient)
4. Preventive care determined to be cost effective
5. Deductibles and Co-Pays tied to income level.

The basic package should identify increasing deductibles for individuals, as income rises. For individuals purchasing personal coverage directly, only their basic package (considering their income-based deductible) would be deductible for federal tax purposes. For individuals receiving employment-based coverage, the additional value of any package beyond their basic one would be counted as taxable income to the individual but would remain deductible to the business.

Insurance Reform

The insurance industry's pricing and underwriting practices should be reformed federally to promote uniformity and encourage access for all individuals and groups. Such reform should end practices such as durational underwriting, industry redlining, and denial of coverage for medical reasons and guarantee the portability and renewability of existing insurance contracts for individuals and groups. Insurers and other providers (AHPs) should be able to renew rates within reasonable parameters to reflect groups' demographic characteristics (e.g., age, sex, geography, and industry) and the health conditions and behaviors of individuals within groups.

HIPCs should have the flexibility to render care to higher-risk individuals in a strict managed care environment with an emphasis on appropriate case management as a means of guaranteeing the most disciplined and efficient delivery of care. While such an approach may impose limits on individual choice, it may be necessary to assure access to quality care at reasonable cost to the total HIPC group.

Cost Containment

The overriding force for cost containment will be that brought on by competitive pressures. These pressures will come from HIPCs competing for members by tough negotiating with AHPs, while the AHPs will be competing for HIPC business. This competitive system is likely to create organized health care delivery systems which will have incentives to cut costs and control expenditures. In addition, the end of tax subsidies for over-insurance will mean a decline in the importance of third-party payers. Since patients and consumers will therefore be likely to have higher deductibles and co-payments, they will shop more efficiently for care and demand lower rates from providers.

In addition, NSBU believes that most savings within the health care system can be determined most appropriately on the local level. In order to eliminate the duplication of services and the overspecialization of facilities as well as new construction and excessive technological purchases, Certificates of Cooperation would be available from the State Health Boards to local HIPCS and AHPs to confront these costs and more appropriately plan their costs and savings. These certificates would replace the Certificates of Need and place strict rules for engagement to reduce health care expenses and require payors, providers and consumers to confront costs and expenses.

NSBU also supports reforming the tax code to allow individuals to participate in a "medical IRA" program. Such a system would allow individuals to accumulate money, tax free, in an account to be used for medical costs. The unused portion of the money could be kept by the individual. Such a system would allow higher deductibles and thus more consumer behavior for a larger section of the population.

In addition to this competitive structure, NSBU is recommending several other key steps which are critical to dramatically containing health care costs:

- Reform the of the medical liability system.
- Development of practice protocols for medical procedures
- Development of a uniform administration and payment system
- Implementation of an Electronic Data Interchange (EDI) system, to allow providers and payers to immediately interact.
- Preemption of states' anti-managed care laws.
- Education of consumers and patients with wide collection and distribution of quality and cost data on providers.
- Development incentives for more cost effective primary care and primary care (family) physicians, rather than expensive treatments and specialists.

Financing

Federal financing of this new health care system will be expensive, since it calls for new and substantial subsidies for lower income individuals. While some revenues would come from our proposed limit on the ability of individuals to exclude all insurance benefits from income, they would be clearly insufficient to raise the necessary revenues.

However these revenues are raised, NSBU believes that the already excessive payroll tax burden must not be increased. If sufficient revenues cannot be derived through improved enforcement of existing laws and reduction of government waste, then Congress should look to the general income tax or some other broad-based source.

Chairman STARK. We appreciate your testimony, Mr. Galles, are you familiar with this testimony that Mr. Kushner prepared.

Mr. GALLES. Yes, I am.

Chairman STARK. A couple of questions arise and I think it is your competitor because probably you would say they are not a very good group but they sent me some information.

Mr. GALLES. Who would you be talking about, pray tell?

Chairman STARK. This postcard purveyor would purport to represent all the small businesses that you do and then some. And they did a survey, as they do periodically, and they were kind enough to send me the results, not only of small business people in my district but across the country.

And the question that they ask, and I believe I have phrased it fairly, would you, the businessperson, favor being required to provide health insurance to all of your employees even if it cost you nothing? To say it differently, 62 percent of their members said no.

Now, we can talk a lot about how we are going to hold down the cost and make insurance available, but do you think that would represent the feelings of your members? Do you think even if all they had to do was hand out the initial form to their employees and literally at no cost I suppose means not having to hire a payroll clerk to administer it, do you think your members are indifferent to whether or not their employees have health insurance?

Mr. GALLES. No, I don't think they are indifferent to whether their employees have health insurance. I think they have an inherent skepticism that you don't get something for nothing, and——

Chairman STARK. I would presume they figure either the Government or the employees would pay if they said the employees didn't.

Mr. GALLES. I expect they would think, too, that they would be contributing in some other way towards that.

Chairman STARK. You mean they are really skeptical.

Mr. GALLES. You bet.

Chairman STARK. Well, they endorsed a plan here that says individuals would be required to choose one of three choices. They would have to directly enroll in a health insurance purchasing cooperative, or they could purchase coverage directly from an insurer provider, that is an approved health plan, or they could participate in an employer-provided option. I presume this would include not just working people.

Now, one would presume, in your statement, that those folks who are unemployed would be required to purchase coverage directly from an insurer or a provider, seeing as arguably they would not be involved in these employer-related functions.

Let's assume for a minute that these people were relatively poor or, indeed, they were children, how would your members suggest that we require those people to get the money to buy the health insurance plan if we made it available?

Mr. GALLES. Well, my association would probably recommend that governments supply the kind of support that they pretend to supply through Medicare and Medicaid; that there is a need for the public partnership in this relationship to be fulfilled so that burdens are not shifted to the private sector when the public sector fails to pay its fair share.

Chairman STARK. So, if I understand your comment, obviously Medicare beneficiaries have insurance, so they are taken care of, but what you are suggesting is that Medicaid or a Government plan would pay the premium for people who didn't have sufficient income to do it, and we would bill the taxpayers for that money; right?

Mr. GALLES. I would think that would be subsidized in some way which would be according to their ability to pay.

Chairman STARK. And you have said you do not think—obviously, it shouldn't be on the payroll, and you say on your concluding page, it should look to the general income tax or other broad based source, which could be, say, a consumption tax to raise that money?

Mr. GALLES. Sure.

Chairman STARK. So if I can get through this, you really do mean we should require every person to purchase a health plan; and if we could both agree that certain people could not be expected to have the resources to do that, they should go ahead and do it?

Mr. GALLES. That is right on the mark. We believe it is time for people to take their own responsibility for health care in this country instead of looking for someone else to pay for it for them.

Chairman STARK. Do you have any idea what you think that would cost; in today's market, taking the lowest possible cost, minimal program that is available in the country?

Mr. GALLES. I think I have heard numbers of $30 to $40 billion to cover those individuals who are now uninsured.

Chairman STARK. I would tell you $50 to $100 billion, depending on how quickly we got it installed.

Mr. GALLES. We certainly found the money to cover our savings and loans when they needed money. It would be nice to find some money for our uninsureds.

Chairman STARK. And if your members would support an additional point on the tax rate, income tax rate, we could probably do it. It would take about two points. Wouldn't be bad, would it?

Mr. GALLES. How did we happen to pay for the savings and loans to do that?

Chairman STARK. We borrowed. Under the Democrats, we have stopped the borrowing and spending. It is pay-as-you-go from now on.

Mr. GALLES. OK. We will look forward to that.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. I wanted to return to Mr. Smedsrud, to your experience with helping States with risk pools. Because I think one of the things we are going to have to contend with almost no matter how we reform the health insurance market is the issue of spreading risk.

Could you give us a little greater insight into how you helped the 27 States that you worked with and what the outcome was in terms of insuring the medically uninsured, and have you seen any greater access amongst your members to insurance in States where you have worked with the risk pooling mechanism?

Mr. SMEDSRUD. It has varying degrees of success. And it is funded in many different ways. Minnesota has one of the largest pro-

grams, I believe about 30,000 people in the State program in Minnesota. Connecticut's, which was formed about the same time, 1975 or 1976, has varied between a high of about 4,000 people and a low of about 1,500 people in it.

It depends to a large extent to how affordable insurance premiums are made for the people who enroll in the pools. Minnesota has kept the insurance premiums relatively affordable, generally about 25 percent higher than those who would be a quote unquote standard risk. That has led to more people in the pools.

Some States have not put those sort of caps and provisions and have basically kept assessments very low, so that they have worked to the extent that they have provided a bridge or a stopgap measure for people who were previously totally unable to get insurance and their only option would have been to spend down their assets to Medicaid. It has succeed to that extent. Different funding mechanisms, including ERISA, all of those types of things would make them work a whole lot better.

Mrs. JOHNSON. That has been my impression.

Mr. Galles, in terms of the small business sector, what kind of mandate do you think is sustainable by small business? It certainly strikes me that they should have no objection to at least educating new employees about the insurance options and where they go to get it and what their choices are.

Mr. GALLES. Our association is supportive of a mandate on individuals. We understand that it is the workers themselves who determine what benefits they choose to seek from employers; that employers could offer them, but individuals might not appreciate them.

Certain contractors go out and hire young workers to work in their firms to build homes or buildings and a lot of those individuals would much rather have new cars than insurance.

Mrs. JOHNSON. Of course, the only way you could enforce an individual mandate, one of the key enforcement mechanisms would be to require employers, as a condition of employment, for employees to prove that they are a participating member in a health care plan. And you would have to have the employers liable for the health care if they didn't require that their employees—sort of like hiring illegal aliens. You have to ultimately have the employer take responsibility, if he does in fact go ahead and hire someone who does not show proof of paid-up insurance.

Actually, it is an easier enforcement challenge than the challenge in auto insurance, because you cannot do it through the insurance system. You can do it through the unemployment compensation system and then you can do it through the Medicaid system. For your stipend, you must show proof of membership.

So then you are really left only with the subsidy, the premium issue, and depending on what kind of organization you require them to participate in, your costs do vary considerably.

In your experience, or the experience of your members, one of the complicated things—and you may all want to contribute to this—is whether or not people should be required to have a basic benefit plan or whether they should have a choice between a variety of basic benefit plans.

Because there is a fundamental difference in plan design between those plans that will cover everything over $3,000 and those that are sort of copaid structured for basic benefit. And there is a real advantage both for the individual and for the Nation to have people live under whichever regime they choose.

You do, of course, select out someone when you have the catastrophic option for healthier people, but how important do you think it is that people have choice? In your experience, which direction do you think we ought to go; providing choice in plan option or a standard national benefit?

Mr. GALLES. Well, we would argue that under the diverse culture we live in, it is much wiser to provide people with choice. There are people that would rather pay a lower premium and have a higher deductible or a higher copay and absorb those costs themselves on an as-needed basis, and there are others who would have the protection of a lower deductible and a smaller copay.

We think those kinds of options are inherent in the system as we have it today, and to try to adjust that problem on top of the other problems we have is just substantially more than we could tend to with any overhaul of the system.

Ms. SMEDSRUD. I would add to that that one of the things we would suggest is standards on rules so that we have a common set of rules that govern whatever insurance is, various insurance mechanisms, and then a choice of benefits. So that farmers could choose higher deductibles if that is their nature or, plans that pay immediate costs. But lets try to move everybody toward the idea of what insurance was to be in the first place, which is something that covers unanticipated catastrophic events. To get there you have to have a standard level playing field so that all the rules are the same.

Mrs. JOHNSON. Thank you.

Chairman STARK. Mr. Galles, I would like to ask another question. I think I just heard you say you favor giving individuals choice; is that correct?

Mr. GALLES. Yes, sir.

Chairman STARK. On the other hand, in the HIPC you talk about, you say that they should have the flexibility to render care to high risk individuals in a strict managed care environment with an emphasis on appropriate case management, and while such an approach may impose limits on individual choice, it may be necessary to assure access to quality care.

Which are you for? Or who is going to make the choice as to who this high risk individual is? You give them choice when they sign up, but once they are in the plan you cut them off. How do you work that one out?

Mr. GALLES. I think there is a choice at a point in time where the individual can choose to participate in the HIPC or choose to participate in another accredited health care plan.

Chairman STARK. But then if they get sick, you cut off the choice?

Mr. GALLES. No, sir, there would be a certain amount of time for them to be treated through the provided system that they have chosen, and that care would be managed through that system, whether it would be the HIPC or through conventional insurance.

Chairman STARK. Let's suppose they didn't like it. Somebody is in the plan, and I will pick a Kaiser plan, which is a really good HMO, and they figure they are not getting the care they want and they want to go to Mayo. That is the choice you had. How do you accommodate that, or do you just say no, I am sorry?

Mr. GALLES. Well, I expect there is an ability to pay that fits in there somewhere along the way.

Chairman STARK. So you give people the ability to choose if they can afford it?

Mr. GALLES. That is correct.

Mrs. JOHNSON. Would the Chairman yield?

Chairman STARK. Certainly.

Mrs. JOHNSON. I think at least one of the things that interests me is not only choice of design of plan, that is the kind of design differences we have just discussed, but also choice on care structure, so that the premiums would be higher or lower depending on the degree to which you are willing to accept the constraints of a managed system.

Chairman STARK. I am talking about once you are in the HIPC. If you are a higher risk individual, they can manage you and impose limits on individual choice. Now, that may be good, but they are going to have trouble selling that to my mother.

Mrs. JOHNSON. Well, we have discussed your mother before. My opinion is if your mother had to pay to be outside the managed system, if her costs were such that she ought to be in it, then she would have to make that decision whether she could pay or whether she could not.

Mr. GALLES. I think we would have a hard time providing Mayo Clinics to the entire U.S. population as well.

Chairman STARK. We don't have any trouble under Medicare. If you are in Medicare, you can go to Mayo.

Mr. GALLES. I understand that.

Chairman STARK. Works just fine.

Mr. GALLES. Hence Mayo Clinics for the rest of the population?

Chairman STARK. Mayo or Johns Hopkins or anyplace you choose to go.

Mr. GALLES. It would be interesting to see where the rest of the revenues come from.

Chairman STARK. Whose?

Mr. GALLES. Mayo's.

Chairman STARK. I am just telling you we manage to allow choice under Medicare without much problem.

Mr. Lewis.

Mr. LEWIS. Thank you, very much, Mr. Chairman. Mr. Chairman, I would like to ask unanimous consent to submit a statement for the record.

Chairman STARK. Without objection, the gentleman's statement will appear in the record.

Mr. LEWIS. Thank you, Mr. Chairman.

[The statement follows:]

OPENING STATEMENT OF HON. JOHN LEWIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. Chairman, thank you for convening this hearing today. I look forward to hearing the testimony of our witnesses. As we consider health care reform, I believe we must carefully consider what reforms are critical to any plan. Currently, too many people cannot afford health insurance, and others cannot change jobs because they fear losing their coverage. We cannot allow people to be held hostage to health insurance. We all know there is no one reason for all these problems, but now we must give serious thought to possible solutions to make quality, comprehensive health care affordable and accessible to all.

Thank you, Mr. Chairman.

Mr. LEWIS. Mr. Galles, under the plan or system you support, if the plan is going to be truly universal, how do you make it possible for the working poor to be included? People that cannot afford to pay for any medical insurance?

Mr. GALLES. I believe I mentioned earlier there is a need for a public and private partnership for working poor individuals where those individuals are supported in the system through subsidies that go directly to individuals, not to the businesses involved.

Mr. LEWIS. Who should provide the assistance, the subsidy?

Mr. GALLES. The same way we provide subsidies today, through the taxes that support Medicare or Medicaid.

Mr. LEWIS. If you live in a community, say, a small town or a rural place in the Midwest or in the deep South, where there is only one medical facility, one doctor, one hospital, who would you compete with?

Mr. GALLES. I am not sure what you are getting at. You, obviously, don't have competition under those circumstances.

Mr. LEWIS. But I thought I heard you, in response to the Chairman's question, that you were leaning toward managed competition.

Mr. GALLES. Certainly where managed competition is possible, that should be an option available and pursued.

Mr. LEWIS. What is the position of your membership, that particular system or plan that your membership is supporting?

Mr. GALLES. We are not supporting any one system. We support a multidimensional system that provides people with numerous choices.

Mr. LEWIS. Thank you. Thank you, Mr. Chairman.

Chairman STARK. Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman.

Mr. Galles, I feel a little bit like I do about the President right now, I like the rhetoric but I am a little fuzzy on his details.

You said in response to the chairman's question a few minutes ago that you thought it was time that individuals were responsible for their own problems, responsible for getting their own health care, which sounds good to me, but then it seems to me that you are suggesting that anybody who does not have health insurance or cannot provide the financial wherewithal to get health care be provided that by some broad-based tax; is this what you are saying?

Mr. GALLES. That is correct.

Mr. MCCRERY. So your first statement doesn't really jibe with the second one; does it?

Mr. GALLES. There are an awful lot of people in this country who work to make a living and supply themselves with health care and pay taxes and there are other individuals who cannot find jobs and who cannot afford health care, and in a compassionate society we look for ways to help those individuals who cannot find that coverage.

Mr. MCCRERY. But we know that a large sector of the universe of uninsured folks in this country are employed.

Mr. GALLES. They are.

Mr. MCCRERY. So how would they get coverage.

Mr. GALLES. I would hope we would find a way to streamline the system that we have in place and reduce costs as much as we can so that those who can afford coverage will.

I did call to your attention the experiment in Florida which has a reduction in conventional premiums of about 40 percent. That is a solution. We were not supposed to focus on solutions today, more on problems, but there are ways of getting at reducing costs so that those who can afford some premiums will do that.

I would hope, at the same time, there are systems of support for those individuals who find themselves not capable of purchasing health care, and I would think we should at least level our tax system so individuals purchasing their own health care find the same tax advantages that corporations and individuals working for large corporations find themselves.

Mr. MCCRERY. I don't think you have stated yet if you would favor mandating small business folks to provide health insurance for their employees.

Mr. GALLES. I would not favor mandating small business owners provide coverage. Small business owners are doing their level best to keep people employed in this country, and, in fact, President Clinton has focused on a distinction in his economic plan which would help, which is intended to help small businesses employ more people.

If we want small businesses to employ more people we should not make it more expensive for them to hire them in the first place.

Mr. MCCRERY. OK. But you think that universal coverage is important in any comprehensive health care reform effort?

Mr. GALLES. Yes, I do.

Mr. MCCRERY. And basically you would provide the bulk of that universal coverage for those who are not covered now with some broad based tax that would be returned to those individuals in the form of tax credits or perhaps expansion of Medicaid or something like that?

Mr. GALLES. Vouchers. But I would certainly focus on streamlining and reducing costs first before I would ever encumber more taxes.

Mr. MCCRERY. OK. Thank you.

Chairman STARK. Ms. Waxman, your testimony touches on some issues that are of concern to me. Unfortunately, unlike big aggregate numbers like the number of uninsured and the rising rate of health care inflation, I am afraid your testimony certainly is limited as to what I would suggest are anecdotal incidences. That is how we started out with ownership referral. A few anecdotes

turned out to be a rather substantial fraud as we began to collect it. I think we had a roomful of anecdotes before too long.

But you have suggested that under the headings of discouraging coverage, limiting coverage, that these are arbitrary barriers between the physician and the patient. Can you give us a few instances of this and tell us if this a practice that is limited to just technical fly-by-night, small insurance companies, or is it universal throughout the industry. I would also like to ask if States are doing something to stop it. And finally, could you perhaps tell us where we would get more information on the aggregate number of these problems?

Ms. WAXMAN. The problems you are talking about are relatively recent in that as competition among insurers has increased and the pressure has mounted in recent years, there have been more and more complaints from consumers of the kind that I have outlined here.

I don't know that there is anybody that has actually researched the aggregate number of complaints to be able to tell you how many of these problems there are, but I can tell you as an attorney who people turn to with their health insurance problems, that over the past few years the number of calls with people having some kind of hassle with their insurance company has just increased dramatically.

Chairman STARK. We heard from the earlier panel about the idea of stopping the issuance of a policy, so you isolate that group on which you can then increase the premium on that group and hold the lower rate for all new providers.

This came to my attention at the University of California, the Alumni Association. I was surprised how many there were. But they, some insurance provider, and I think this is referred to as association coverage, froze or offered an opportunity to all of the existing people insured in the group plan to apply for a new lower rate group plan but they had to submit a medical questionnaire, not even a very subtle way of risk selection. And they, of course, got all the healthy people who could pass the test into the new one and then raised the rate. And I think it went from, like, say, a couple hundred, $300 or $400 a month to $700, $800, or $900 on the group that were left behind, which did raise some objections from the university's alumni.

Do you know, does that kind of occurrence go on frequently? Do you hear much about that, or am I the only person in the country who has run into this type of thing?

Ms. WAXMAN. No. It is a really very common kind of problem. I mean, in fact, the reason I raise Family USA's own personal experience is because we were going to be in that boat too. Over time, of course people in our group got sicker and our premiums just went through the roof, so we shopped around for a new plan. If we were willing to exclude some of our employees from coverage, then we could have gotten a cheaper rate somewhere else, but then over time the same problem would happen. Our costs would go up and we would be back into the same old situation all over again.

It is something that does keep happening, either on an individual company basis or in the kind of situation that you are talking about, in association rates where the organization is looking for

ways to lower the costs. But lower rates are not available for everybody. The sick people are the ones that are kicked out.

Chairman STARK. How about in the area of utilization review? Have you heard of any egregious examples where people were injured by this practice. The most recent example I can think of was the H&H Music Co. case.

Can you think of any instances that you find are behind your scope.

Ms. WAXMAN. I don't really have any individual examples right off, but this is a problem that I hear doctors complaining about all the time, particularly that their judgment is superseded by a clerk that is in an office some 600 miles away and they find that, one, they can't provide the kind of services they want to, or two, that the responses they receive are very vague and so they are discouraged from providing care even though it might ultimately be covered, and on and on.

I am happy to look through our records and see if I have any anecdotes to add to the record.

Chairman STARK. I think it is time we start to collect them, because in the past what we have done is find a pattern and then that has been very helpful in giving the committee staff some basis on which to think about, areas in which we might think that Federal legislation might be necessary to protect the insured, and that would be of interest.

What vision, Mr. Smedsrud, do you have for us? How can we negotiate as well on behalf of the 35 million uninsured to get them a good deal as you seem to have done for the farmers?

Mr. SMEDSRUD. Let me make one interesting point regarding the pattern. If I am not mistaken, the University of California case, and if I am correct, on the H&H Music case, both were ERISA-exempt trusts operating through associations. I do not have any hard and fast scientific facts as to what the breakdown is but I would suggest if you look very carefully at anecdote after anecdote, you will see that more often than not the trail leads back to an ERISA-exempt situation.

There are all kinds and they go by lots of names. Among the things that we have done for our farmer members over the years, whether or not the same can be done for the 35 million Americans who do not have insurance, one of the things that we have done is to develop consumer education programs for our members. We have found ways to work with insurance companies to negotiate a 75 percent loss ratio for all farmers that are self-employed and are members through our association.

We have worked with the insurance company to have our members audit all their medical bills so that any time they find an error that the insurance company didn't catch, and believe me insurance companies don't catch a whole lot of errors, they receive a cash payment back from this insurance company for 50 percent of what the error was to a maximum of $750.

We have set up a program called Ask A Nurse where all the farmers can call a 1–800 number and talk to a nurse 24 hours a day. There are consumer oriented action steps that can be taken. Having said all that, it is getting very, very difficult for any national association to run a truly national program when we have

a plethora of State laws that are attempting to exert their own territoriality.

It is also becoming very difficult when there are a lot of competitive pressures, such as have been indicated earlier, that do the death spirals and all those types of things that momentarily have cheaper plans for individuals out there.

Chairman STARK. That may be of interest to the former president of the National Association of Insurance Commissioners who just quit and ran for Congress and is back here with us, so maybe that portends some change. I want to thank the panel.

Mrs. JOHNSON. May I?

Chairman STARK. Certainly, Mrs. Johnson.

Mrs. JOHNSON. I would like to state one closing comment. I would like to thank Ms. Waxman for her testimony and for the clarity with which you described the problems as they now have become very common and that we run into daily in our districts, but I did want to point out that every section that you describe, discouraging coverage, limiting coverage, claims harassment, utilization review, all those problems are increasingly true in Medicare as well.

I can't tell you the number of hours that I have worked with Medicare physicians who have been trying to bill Medicare and finally Medicare people will say to them, I don't know why we won't pay. There doesn't seem to be any reason, resubmit the bill again. With 10 or 12 resubmissions and months and months and months of drag, clearly doing it just to restrain the rate at which the money is going to flow out.

Utilization review, limiting coverage, the most recent reform that we adopted in Medicare—in the Medicare payment system, has resulted in now new definitions of what is not eligible anymore for coverage under Medicare. So I think the reason reform has to happen is because in the publicly paid for systems, you are seeing the same techniques used to stem the flow of dollars that you have seen earlier in the private sector.

So we really have to have the kind of systemic reform that will give us a different way to control costs because otherwise the gaming that you are familiar with and your employees, you will see absolutely in your mother's life as well. Thank you.

Chairman STARK. I concur with the gentlelady. I can only tell you that it is my hope that this new administration will change all of those problems in HCFA.

Mrs. JOHNSON. I am with you, Mr. Chairman.

Chairman STARK. I want to thank the panelists for their participation and call our final panel.

We will have Mary Nell Lehnhard, who is the senior vice president of Blue Cross and Blue Shield Association; and pinch hitting, I am led to believe for Linda Jenckes, senior vice president, Health Insurance Association of America, is Ed Neuschler, who is the director of policy development and research.

Welcome to the committee, and why don't you proceed to enlighten us. Tell us what is wrong and you can even hint as to what we might do to correct it.

STATEMENT OF MARY NELL LEHNHARD, SENIOR VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Ms. LEHNHARD. Mr. Chairman, members of the committee, I am Mary Nell Lehnhard, senior vice president for the Blue Cross and Blue Shield Association and we certainly appreciate the opportunity to testify today. We have been supporting fundamental reform of the insurance industry at the Federal level for almost 3 years now.

We have not viewed insurance reform as a strategy for controlling costs, rather we view it as a way to make the insurance market more equitable and more responsive to the needs of the public. However, having said that, we think that insurance reform is also the key to refocusing the energy and the creativity of the private sector away from competition based on selection of the best risks to competition based on management of health care costs.

Risk selection is an incredibly powerful cost containment tool for health insurers. For example, 4 percent of the population will generate 50 percent of the claims costs. It is much easier to keep your premiums competitive by avoiding that 4 percent through medical screening and pricing strategies than by truly managing cost.

My point here is that we shouldn't underestimate the change in behavior in the insurance industry that you will see once you close the door on that ability to select the best risk. Some carriers may leave the market. Those who remain will have to make an immediate and major commitment to working with hospitals and physicians and generating the data necessary to identify cost-effective and high quality practice patterns.

Let me turn now to the problems in the insurance market and hopefully the solutions, the rules for the insurance market. First, you heard today coverage is not now available to every individual and small group and the barrier of course is preexisting conditions. We believe insurers should be required to accept all applicants for coverage. Insurers also must be prohibited from dropping individuals and groups because of health status or claims experience.

These rules have to apply to self-funded trusts, MEWAs and self-funded employers. These self-funded entities now account for over 60 percent of the market in large part because they can now escape the types of reforms we are discussing today.

A key step in increasing the availability of coverage is to limit waiting periods for preexisting conditions. With universal coverage, they can be eliminated. In a voluntary market, waiting periods are necessary but should be limited to 6 months or conditions existing at the 3 months prior to enrollment. We also need to pay attention to the practice of some large group employers of reducing benefits for employees with high-cost conditions. This should be prohibited.

A second major problem is rating strategies that have the effect of pricing the sick out of the market. We support very strict rating limits on the individual and small group market. Based on work we just completed, we believe we can support moving to community rating in the small group market with very limited adjustments for demographics, primarily age.

We are currently analyzing what limits should apply in the individual market. I want to note, and you have heard this throughout the day today, that these rating reforms will cause rates for rel-

atively healthier groups to increase. After all, it is an averaging process. I believe we need to all work together to educate the public that this is a very necessary part of reform and in the long run it will serve us well. We urge you, however, at this point to keep the small group and individual rate pools separate, at least in the beginning. Combining them will only mean an additional bump in the rates for small employers.

A third problem is lack of portability. The public needs to be assured that their benefits are portable. Waiting periods should be eliminated when people move from one insurer to another. With universal coverage we can eliminate waiting periods entirely. The system is too complex and too costly. We need to move quickly to paperless claims for consumers, paperless claims as standard formats for providers.

In summary we agree that rules are needed for the private insurance markets and we are ready to work with the subcommittee on fashioning those rules.

Mr. LEWIS [presiding]. Thank you very much for your statement.

[The prepared statement follows:]

TESTIMONY OF

BLUE CROSS AND BLUE SHIELD ASSOCIATION
PRESENTED BY

MARY NELL LEHNHARD
SENIOR VICE PRESIDENT

Mr. Chairman, and members of the Committee, I am Mary Nell Lehnhard, Senior Vice President of the Blue Cross and Blue Shield Association. The Association is the coordinating organization for the 71 independent Blue Cross and Blue Shield Plans throughout the nation. Collectively, the Plans provide health benefits protection for nearly 70 million people. I appreciate the opportunity to testify on the important issues of reforming the private health insurance market.

There is a consensus across this nation and in Congress that insurance reform is an important step on the road to comprehensive health care reform. At the federal level, insurance reform is a key component of most of the major health reform proposals. At the state level, a total of 32 states have enacted some level of legislation to reform the small group health insurance market, and 4 states have enacted reforms in the individual insurance market. A number of additional states are actively considering insurance reform in their current legislative sessions. As Congress begins to consider health care reform legislation in the 103rd session, I cannot emphasize enough the importance of reforming the health insurance practices and the impact it will have on carrier practices and the market.

The Blue Cross and Blue Shield Association has been actively supporting insurance market reform at the Federal level and we have been working with the National Association of Insurance Commissioners to develop Model Acts to implement insurance reform proposals in the states. Our Plans also have been working proactively with their state legislatures to implement insurance reform.

The types of insurance reforms that I will discuss would move the market away from competition based on risk selection. Risk selection currently is the most powerful "cost containment" tool available to many insurers and HMOs -- they can hold down costs much more easily by screening out high risks than by trying to manage overall health care costs. Under these reforms, insurers no longer could use risk selection to maintain competitive prices. Instead, they would have to compete on the basis of their ability to manage costs.

Today, I will focus my testimony on the three biggest problems in the health insurance market -- availability of coverage, wide variations in premium rates and portability of coverage. I will discuss how these problems affect the three segments of the health insurance market (small group, individual and large group markets); then I will turn to reforms to address these problems and discuss some implementation issues that have come to light as a result of insurance reform legislation at the state level.

1. **Availability of coverage.**

Small group and individual markets: Many health insurers are very selective in the risks that they will accept in the small group and individual markets. In a competitive market, insurers that accept all risks, or have even marginally more liberal enrollment practices, find themselves with a worse mix of risks, and consequently, with higher premiums than insurers that have been more selective. These higher premiums reflect the fact that only a few high-cost enrollees can generate substantial claims costs. On average, only 4 percent of insured individuals generate 50 percent of claims expenses, while 20 percent of enrollees generate 80 percent of claims. Clearly, the insurer that can avoid the 4 percent or a significant share of the 20 percent will have lower premiums.

Insurers that enroll a disproportionate number of persons who are higher-risk than average (the 4 percent or the 20 percent) are said to have experienced "adverse selection." The risk of adverse selection influences insurers' ability to accept all applicants.

The problem of adverse selection is worse in the individual market. Individuals make choices about whether they need coverage and which type of coverage to buy based on their perceived need for medical care. Thus, individuals who have a known or anticipated need for medical care tend to choose the most comprehensive coverage available -- when they need it -- while healthy individuals either choose lower-cost coverage or no coverage at all. In contrast to the group market, high-risk individuals do not bring along with them healthy individuals who may help offset their costs.

As a result of adverse selection concerns, both in the small group and individual markets, it has become increasingly common for carriers to deny coverage to high-risk groups and individuals; to impose pre-existing condition waiting periods for those individuals with existing medical conditions; and to cancel coverage once an individual or group becomes a poor risk.

- Solution: 1) Guaranteed availability. Insurance reforms would assure that every small employer and every individual would have access to private coverage regardless of their health status.

  The approach that has received the most attention would require all insurers to offer coverage to all applicants on a guaranteed issue basis, that is, without regard to health status or claims experience.

The Blue Cross and Blue Shield Association strongly supports this approach.

For many insurers, support for the guaranteed issue approach to assuring availability is dependent upon the availability of a mechanism to spread the risk of accepting all applicants -- a private reinsurance mechanism or another type of program. A key issue is how such reinsurance programs are designed (e.g., whether by a carrier participation in reinsurance would be voluntary or mandatory). Under a voluntary approach, insurers willing and able to assume all costs associated with accepting all small employers would not be required to participate in any risk-sharing program. We believe that states should have the flexibility to design their own programs, if they choose to establish them, in a way that best meets the needs of their environments.

- **Solution: 2) Limits on Pre-existing condition waiting periods.** Carriers would be limited in their ability to impose pre-existing condition waiting periods on new subscribers. These waiting periods should be limited to 6 months for conditions existing in the previous 3 months.

- **Solution: 3) Guaranteed renewal.** Insurance reform also would prohibit carriers from cancelling coverage for reasons related to an individual or group's health status or claims experience.

- **Implementation issues:** Assuring that all entities financing insurance coverage are playing by the same rules is essential to the success of a guaranteed issue approach. Not only should all insured carriers (including Blue Cross and Blue Shield Plans, commercial carriers and HMOs) be included in any reform measures, but of particular importance is the inclusion of self-funded entities, including Multiple Employer Welfare Arrangements (MEWAs). In some states, these entities provide coverage to a substantial segment of the small group market. If they were not subject to market reforms along with other insurers, more and more of the insured small group market would be encouraged to move to these self-funded, unregulated entities, thereby, rendering any reform meaningless.

  A second implementation issue is the one-time higher overall costs that are likely to result from a guaranteed issue requirement. The trade-off for assuring access to coverage for high-risk groups and individuals is that the inclusion of these high-risks in the insurance pool will increase the cost of insurance somewhat for all groups and individuals.

Large group market: Most large employers do not purchase insurance; instead, they self-fund their health benefits. Although most large employers already provide health coverage for their employees without regard to health status, some troubling problems have emerged in recent years. For example, some self-funded employers have begun scaling back benefit packages for their employees who develop serious medical conditions. This practice is clearly illustrated in the H & H Music case where the employer reduced health benefits after an employee developed AIDS. (This practice is prohibited in the insured market through state insurance regulations).

In addition, some large employers try to lower their health care expenditures by "carving out" high-risk employees and dependents from their health care coverage, and paying premiums for these individuals to: (a) receive coverage through the state's high-risk pool or (b) through other guaranteed issue programs in a state. This practice shifts costs back into the insured market because: (a) risk pool losses are financed in most states by assessments on insurance carriers and (b) because high cost individual included in guaranteed issue proposals will increase the rates for that insured segment. The Employee Retirement Income Security Act (ERISA) protects self-funded employers from sharing in these costs.

- **Solution: 1) Minimum benefit package.** A requirement that large and small employers provide a minimum benefit package would prevent the scaling back of benefits by self-funded employers.

- **Solution: 2) Guaranteed eligibility.** A guaranteed eligibility requirement would ensure that employers who provide coverage, offer the same coverage to all eligible employees and dependents.

- **Implementation issues:** Most large employers self-fund their health benefits. It is, therefore, especially critical to ensure that any reforms in the large group market extend to employers who self-fund their benefits. If the reforms do not include these entities, it would provide incentives for more and more employers to self-fund to avoid these requirements, thereby undermining the effectiveness of reforms.

2. **Rating practices.**

Small group market: As competition increased in the small group market, many carriers began to move away from community rating, where an insurer

charges every subscriber in a given area the same price for coverage, and toward experience rating, where premiums for groups are based on those groups' own costs. This meant that lower-risk groups could purchase coverage from those carriers at premiums that more closely reflected the costs of their own employees. This practice also developed in response to employers' increasing unwillingness to subsidize the coverage of other groups and individuals.

Experience rating has resulted in two serious problems in the small group market. First, this practice has resulted in a wide range of premiums that can be charged to small groups based on their health status or claims experience. While wide rate spreads make coverage very affordable for low-risk groups, they also result in premiums for some groups that are unaffordable. Second, experience rating has caused steep and unpredictable premium rate increases for some groups.

- **Solution:** Strict rating limits. Strict rating limits on insurers would eliminate those rating practices that have had the most destabilizing effect on the small group markets. A small employer's rates would not skyrocket if an employee became seriously ill. Moreover, small groups would be able to rely on more predictable rate increases from year to year. The Association strongly supports such limits.

- **Implementation issues:** Strict rating limits would result in a redistribution of health care costs. Younger, healthier groups with lower medical costs would receive premium increases to subsidize the higher costs of older, sicker groups (whose rates would decrease). In addition, lower-cost areas such as Frederick, Maryland would be required to subsidize higher-cost areas like Washington, DC. While the premium increases of these low-cost groups would vary, the tighter the rating limits, the more dramatic their rate increases.

  In addition, since some groups may see substantial rate increases as a result of rating reforms, some of these groups may choose to drop insurance coverage if coverage remains voluntary. Younger, healthier groups are most likely to make this decision, since they would be hit hardest by the rate increases. To the extent that the groups do decide to opt out of the insurance pool, rates would increase for those groups remaining in the pool.

Individual market: The rating problems in the individual insurance market are similar to those in the small group market. A problem that is especially acute in the individual market has been described as a "death spiral." Some insurers group individuals into rating pools.

After 12 to 36 months of opening a new rating pool, these insurers close the pool to new entrants and open a new pool. As the people in the older pool age, the insurer dramatically increases their rates. The younger, healthy people exit the pool for cheaper coverage, leaving behind the older, sicker people. This drives up the premiums for those left in that pool even faster. As soon as the pool becomes unprofitable, the insurer cancels coverage in the pool completely.

- **Solution: Strict rating limits.** Rating limits similar to those proposed in the small group market will eliminate these problem practices.

- **Implementation issues:** Some have suggested combining individuals and small groups into the same rating pool. Such a step would result in even higher rates for small employers, because they would be required to subsidize the higher-risk, higher-cost individual market.

Large group market: When Blue Cross and Blue Shield Plans first began providing insurance coverage in the 1930s, all enrollees in a given area were charged the same price for coverage, regardless of whether they worked for a large or small employer or purchased coverage on their own. This practice kept the cost of coverage for groups and individuals with the poorest health risks at the most affordable level possible.

But, as competition increased in the insurance market, some carriers began to experience rate coverage for larger employers -- that is, they began to set premiums for large groups based on those groups' own costs. In part, this practice evolved in response to employers' increasing unwillingness to subsidize the coverage of others groups and individuals.

The phenomenon represented the first step toward segmentation of the health insurance market and the loss of subsidies for the less stable parts of the market, such as the small group and individual markets. The passage of the Employee Retirement Income Security Act (ERISA) in 1974 gave large employers another opportunity to lower their health benefit costs by providing incentives to drop insurance in favor of self-funding their health benefits. In this way, employers could avoid the costs of state regulation, including mandated benefit and provider laws, premium taxes and subsidies of state risk pools.

These incentives further segmented the health insurance market and eliminated almost all remaining cross-subsidies between large employers and smaller groups and individuals. Currently, fully 65 percent of the groups health insurance market is self-funded.

Because of the opportunities for lower costs that self-funding provides, smaller and smaller employers are beginning to move from insured to self-funded arrangements. In addition to further fragmenting the insurance market, this development raises concern because smaller employers are less able to bear the risk of self-funding than large employers. A single catastrophic claim could place a small employer in financial jeopardy. As a result, all employees could lose their health coverage and be at risk for unpaid health claims.

- **Solution: Limits on self-funding.** Rating limits in the small group and individual markets would address the problems of premium variations based on health status or claims experience, but these limits alone would not achieve wide-scale spreading of risk, because so much of the employment market is self-funded. Any proposal to expand community rating beyond the small group market must recognize that unless large employers are prohibited from self-funding, they will choose to self-fund rather than help finance coverage for smaller groups and individuals. As a result, the insurance market would be further fragmented, and smaller employers and individuals would not receive the cross subsidies anticipated under such reform proposals. For this reason, we recommend that any proposal that extends community rating into the large group market also prevent employers in those larger groups from self-funding to avoid the costs of reform.

3. Portability of coverage.

All markets: Both insurers and employers commonly impose pre-existing condition waiting periods for new subscribers to prevent individuals and employers from buying insurance only when needed and then dropping the coverage after that need is met. However, pre-existing condition waiting periods are imposed on individuals changing their insurance coverage (e.g., because of a job change), even when they have had continuous coverage. Some describe this problem as "job lock" because they feel they cannot leave their current job for fear of losing their health benefits.

- **Solution: Credit waiting periods satisfied under previous coverage.** To assure portability, carriers and employers should be required to honor waiting periods served under qualifying previous coverage, provided the break in coverage was no longer than 90 days. Carriers and employers should be prohibited from imposing new waiting periods on persons who have had continuous coverage, so long as they have

satisfied pre-existing condition waiting periods under their previous coverage.

- **Implementation issues:** Depending on the length of the transition period between coverage, there may be some higher costs associated with portability provisions. It will be important to balance the higher costs with the expanded availability that would result from assuring portability of coverage.

Conclusion

I would like to reiterate our strong belief that the insurance reforms would have a positive impact on the health care market. Reforms are needed to address the unavailabililty of coverage for employers that have an employee with a serious medical condition, the wide variation in premiums charged to groups based on their health status and the lack of portable coverage for individuals with existing medical conditions. Insurance reforms would address these problems and set the stage for comprehensive health care reform. While there would be some initial distortions as a result of these reforms, such as the redistributional effects of rating reforms, the overall impact of these reforms would be to assure access and to improve the fairness in the health insurance market. In addition, these reforms would be the building blocks for broader cost containment efforts by requiring insurers to compete on the basis of their ability to manage costs.

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STATEMENT ON BEHALF OF LINDA JENCKES, SENIOR VICE PRESIDENT, AS PRESENTED BY EDWARD NEUSCHLER, DIRECTOR OF POLICY DEVELOPMENT AND RESEARCH, HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. LEWIS. Mr. Neuschler.

Mr. NEUSCHLER. Thank you, Mr. Chairman and members of the committee. I would like to apologize for our senior vice president, Mrs. Jenckes, inability to be here today. She was called away Thursday on a family emergency and was unable to get back due to the weather. We have submitted a formal statement for the record and I was going to summarize that orally, but I find that the committee has gotten just some excellent testimony today that I think has really laid out the nature of the problems in the insurance business at the moment, and so I just would like to make, in view of the late hour, just a few highlight-type of comments.

As I said, I think you have gotten an excellent idea of the kinds of problems that happen out there in the insurance world today. I would like to focus your attention on the underlying cost reason for the development of those problems over the last 10 to 15 years. Basically, it has been a game in which everybody tries to look for the best price for themselves, and it is that kind of dynamic that has led to the fragmentation of the risk pools and all the kinds of abuses that are definitely out there and that you have heard about today.

The question is, how do we start to put the insurance market back together again in a way that will make things better and not worse in the short run. At the Health Insurance Association of America, we started to work on this problem as far back as 1988 when we recognized that, particularly in the small employer market, what was going on was dysfunctional and not in the long-run interests of our customers, and we began then to work on a set of reforms for the small employer market which, as Mr. Sutton mentioned earlier, those reforms or something like them have now been enacted comprehensively in more than 20 States and something over 30 States have done pieces of them.

Briefly, those reforms include guaranteed access to coverage so that no employer group can be turned down for coverage by an insurer, whole group coverage so that individuals who may have existing problems cannot be excluded from the group by either the employer or the insurer, guaranteed renewability of coverage so that an employer can't have their policy canceled because their experience has gone bad, continuity of coverage, that is, a limitation on preexisting condition exclusions so that coverage does become portable and people don't have to worry about job-lock, and premium pricing limits or rating limits, whatever you want to call them, that put some limits on how greatly rates can vary for similarly situated groups, that is, groups with similar age and sex, because we recognize that a guarantee of availability means little if the product is not affordable.

But I think there was another major point made in the various testimonies today and that is the absolute need for a level playing field. Whatever insurance reform rules we put in place over the next year or two have to be the same for everybody who is providing health benefits.

Earlier witnesses mentioned the problems of what happens when you have got loopholes and people can get out of one set of rules by moving under another, and that means that there has to be comprehensive reform that affects everybody and that gets us out of the ERISA regulation—or nonregulation—versus State regulation problem.

The other major point that was made is that the underlying problem is the affordability of health care. Health insurance premiums in large part—well, exclusively—are based on the underlying expected medical claims costs for the group that is being insured, and as one of the previous speakers pointed out, 9 out of 10 of the folks who are uninsured these days could get coverage at standard premiums.

The abuses we are talking about affect maybe 10, maybe 15 percent of the market. For the other 85 or 90 percent, the problem is that they cannot afford coverage even at favorable rates, and that is the issue that we are really going to have to tackle in order to make coverage truly affordable and available for the bulk of our citizens.

There are a variety of problems involved in this. The cost shifting for government programs is one of the problems, State limitations on managed care techniques is another, some difficulties in prosecuting fraud and abuse are others. But that is one of the underlying problems. I would also just like to mention in closing that while we started down our small group reform track 4½ years ago now, we recognized before too long that that wasn't going to do very much other than make the existing market fair so that everybody lived by the same rules.

Because of those cost problems, just reforming the insurance market is not going to significantly increase the number of Americans who do have coverage, and so over the last year, we have intensively been working on our own vision for health care reform. It calls for universal coverage. We think that a lot of the problems that we see now in the market, while they can be addressed in a voluntary environment, can really only be solved if we get to an universal environment.

So we have come up with a comprehensive set of recommendations which are attached to our written testimony that we believe can achieve universal coverage and cost control in the context of a viable private marketplace. We call for changes in the behavior of providers, payers, including insurers, and the public. The changes that we recommend are systemic and will emphasize the continued evolution of managed care.

We recognize that as part of the reform of the entire health care system, there must be a fundamental change in the way the insurance industry does business and we stand ready to work with President Clinton and the Congress to achieve these goals.

We are happy to answer any questions you may have.

Mr. LEWIS. Thank you very much, Mr. Neuschler.

[The statement of Linda Jenckes and attachment follow:]

STATEMENT OF LINDA JENCKES, SENIOR VICE PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA

I am Linda Jenckes, Senior Vice President, Health Insurance Association of America. The Health Insurance Association of America (HIAA) is a trade association representing many of the nation's leading commercial private health insurance companies.

I appreciate the opportunity to discuss with you developments in our health care system which are in part the impetus behind the current nationwide support for comprehensive reform of the health care system. No one segment of the health care industry is exclusively responsible for the current health care crisis. Problems exist in both the financing and delivery sides, in the litigious nature of society, and in consumer demand. My testimony today addresses issues related to the health insurance industry.

The Uninsured

Though the percentage of the American public that is insured, either privately or publicly, has increased dramatically from the time that health insurance began to be provided by employers as an employee benefit, we must now move forward to achieve universal coverage of all Americans.

In 1991, the latest year for which the Census Bureau has data, private insurers covered 72 percent of the population or 178 million out of 249 million Americans. Persons covered either by private or public health insurance totalled 212 million. There were approximately 37 million Americans not insured during that year.

Examination of the profile of the uninsured helps to explain this gap in coverage. In 1991, approximately 29 percent of the nonelderly uninsured were below the federal poverty level; 18 percent had incomes between 100 percent and 150 percent of poverty; 14 percent were between 150 and 200 percent; and 39 percent had incomes over 200 percent of poverty. Of the nonelderly with family incomes below the Federal poverty level, Medicaid reaches only 49 percent of them.

Escalating Costs of Medical Care

We all know that health care spending in the United States has been rising much faster than other costs, and faster than our total economic growth. Growth rates exceeding 10 percent per year are the norm; and the latest figures from the Health Care Financing Administration (HCFA) show rates of over 11 percent for the last two years (although private spending grew more slowly than public spending from 1990 to 1991). Invariably, though, HCFA attributes the growth in health care spending to 4 factors: population growth, general price inflation, additional price inflation specific to health care services, and greater utilization of services (volume and intensity) over time. The net cost of administering health benefits, which is insurance in the broadest sense, has tracked but has not contributed significantly to the growth of overall health spending.

In recent years, news reports have commonly cited premium increases for private insurance rates that exceed the annual increase in national health spending. In part, these higher rates are due to increased cost-shifting: as government has limited payments under Medicare and Medicaid, and as the number of uninsured Americans has grown somewhat, providers have had to charge private paying customers more every year to make up the difference.

Put simply, the cost of health insurance is the cost of the medical claims insurers pay plus the expenses of administering the insurance plan (including any profit). And the cost of the medical claims is determined by two factors: the number of services providers order (volume) and the price of those services.

In 1991, according to the HCFA, all private insurance arrangements (commercial insurers, Blue Cross/Blue Shield plans, HMOs and self-insured employers), taken together, paid out 85.6 percent of the premiums they received in medical benefits. Thus, the major factors driving health care spending are the price and volume of health care services, not the costs of administering health insurance plans.

Simply limiting health insurance premiums does not get at these underlying causes of high health care costs: high provider charges, provider specialization providers' tendency to order more care than is needed, and continued medical progress, which year by year creates new technology and procedures that can be brought to bear on patients' conditions (for a price, of course).

In summary, health insurance is expensive because health care is expensive.

Small Employer Market

Of workers without health care coverage, almost half (47.7%) work for employers with 25 or fewer employees or are self-employed. This is not surprising since only one in three firms with fewer that 25 employees offers health benefits. This market provides one of the most vivid examples of how health care cost inflation continues to afflict our financing system.

Small employers during the 1980s sought relief from rising health care costs by an aggressive search for the lowest possible price for health care coverage. Those with healthy employees were more likely to seek, and obtain, coverage at prices that reflect their low risk.

In turn, more and more insurers found that to be price competitive for these low-risk employers, they were less able to spread the costs of groups with employees at high risk of incurring large medical expenses broadly across the lower risk groups. (I should note, however, that this does not mean that insurers do not pool risks at all. In fact, in insured plans, 80% of the claims come from 20% of the people.) Until recently, this led to a growing number of higher risk employers that could not find coverage at an affordable price. Moreover, those employer groups that are lower risk initially, and thus obtain a lower premium, will eventually have employees or dependents that develop expensive medical conditions. When their experience deteriorates, those employers may face large premium increases.

In general, then, small employers have had greater difficulty than large employers in affording and sometimes even obtaining health coverage. Furthermore, the greater frequency with which small employers change carriers and their workers change jobs exposes individuals in this market to greater risk of being left out of the system. Finally, small employers are highly sensitive to very large, unanticipated premium increases and may fail to initiate or retain coverage in a marketplace where individual employer experience is highly unpredictable.

To address the problems which arose from these practices, in 1988, the Health Insurance Association of America was the first to develop a small group reform proposal. HIAA has aggressively pursued this proposal in the states. All competing entities in the small employer market, including non-insured benefit plans, would have to be bound by the same rules in order to prevent any company or segment of the market from being placed at a disadvantage. In the past several years, at least 20 states have enacted reforms that address all aspects of HIAA's proposals and will eliminate many of the problems for the small employer market. At least another dozen states have enacted partial reforms that will help a great deal.

Guaranteed Access to Coverage

One problem for small employers has been that they could be denied coverage entirely, because insurers could elect to cover only low-risk employees. This is a practice which has been referred to as "cherry-picking." Where HIAA's reform proposals have been enacted, all small employer groups are now able to obtain private health insurance regardless of the health risk they present. Twenty states have to date adopted guarantee issue requirements.

Coverage of Whole Groups

Leaving high-risk individuals out of group coverage has been one response to escalating costs. HIAA supports the requirement that coverage be made available to every employee in an employment-based group. No employer nor any insurer would be able to exclude from the group's coverage individuals who present high medical risks. Twenty-four states have to date adopted whole group coverage requirements.

Renewability of Coverage

Many employers have found that their coverage is not renewed because of a change in their workforce or their claims experience. HIAA supports the requirement that coverage will not be cancelled, terminated or not renewed based on the health status or claims experience of any individual or group. Thirty-four states have adopted renewability provisions.

Continuity of Coverage

Many employees are afraid to change jobs because they may be subject to new pre-existing condition limitations, a problem referred to as "job-lock." Or employees may be excluded from coverage if the employer changes carriers. Given the frequency with which small employers change carriers and employees in this market change jobs, individuals should have greater protection when making such moves. Under HIAA's proposal, once a person is covered in the employer market and has satisfied an initial plan's pre-existing condition restrictions, he or she would not have to meet those requirements again when changing jobs or when the employer changes carriers. Twenty-four states have adopted continuity of coverage provisions.

Premium Pricing Limits

Many small employers have experienced significant increases in premiums, which has led to excessive churning or dropping coverage altogether. To address this problem, HIAA supports limits on rating practices that would, absent reforms, create large rate differentials for small employer groups of similar age, sex, and geographic composition. We recognize that a pledge to issue a policy is meaningless if the rate charged is exorbitant. At the same time, there is a need to retain some rate variation based on risk because people will only pay for health insurance according to their own perceived risks. Even in a mandatory climate, insurers must be able to calibrate rates to risk. Otherwise, insurers that happened, by the luck of the draw, to cover a sicker population would not survive economically. Their rates would be non-competitive; they would attract no new customers; and eventually they would fail. We also believe that it is important to give employers incentives to promote healthy behaviors on the part of their employees. A limited degree of experience rating, particularly for medium and large employers, can serve that purpose.

To date, thirty-four states have adopted rating limitations for the small employer market.

Other Problems in the Health Insurance Industry

Some practices that have been perceived as abusive are necessary in a voluntary market. For example, pre-existing condition limits are necessary to guard against adverse selection in a voluntary market, particularly for individuals and small firms. (The risks are much lower for large firms.) Universal coverage, individual and employer mandates to purchase insurance, and guarantee issue of coverage, however, should make the use of pre-existing condition clauses obsolete in the future. During the transition and for those who do not comply with these mandates, however, the use of one-time pre-existing condition limits upon initial entry into the system may still be necessary.

A number of other problems for the industry contribute to the unpredictability of health care costs and result in considerable increase in premiums to the privately insured. "Cost shifting" by public payors contributes significantly to the cost of private insurance, raising hospital payments at least 28% above costs, for example. This "hidden tax" hits small employers especially hard.

The insurance industry has made demonstrable efforts to manage health care costs but many states have adopted or are considering anti-managed care laws which negate these efforts. As real access requires both availability -- which our reform proposals address -- and affordability, impediments to managed care systems are counterproductive.

Premium adequacy is critical. Efforts to set premiums through prior rate approval requirements or limits on increases in premiums without any guarantee that premiums will reflect health care cost could imperil insurer solvency.

The GAO estimates that between three and ten percent of total expenditures for health care in this country are attributable to waste, fraud and abuse. Waste, fraud and abuse affect both private and public payors, and we all share the responsibility to increase our deterrence and detection efforts. Waste, fraud and abuse deprive the American public not only of huge numbers of dollars but also of quality medical care. Strong federal legislation will assist all payors in this battle.

Medical liability contributes to escalating health care costs, which is then reflected in increased premiums, and is detrimental to quality medical care. Both the cost of medical insurance premiums and costs attributable to defensive medicine contribute to this problem. For example, Levin-VHI recently published its mid-range estimate of potential defensive medicine savings from comprehensive malpractice reform to be almost $36 billion dollars over five years.

The industry recognizes its responsibility to address its internal problems as well. The health insurance industry must devote considerable attention toward reducing our own administrative costs. The industry is actively engaged in developing electronic data processing systems -- with a rigorous self-imposed timeline. The benefits to the privately insured will be seen both in reduced costs and, for many equally important, simplification of the claims process.

HIAA Vision Statement

Mr. Chairman, though we are not here today to discuss the various comprehensive reform proposals which are being considered both by the Administration and Congress, I would like to mention the HIAA Vision Statement which contains a comprehensive set of recommendations that we believe can be achieved in the context of a viable private marketplace. HIAA's Vision calls for universal coverage for all through an essential package of benefits and changes in the behavior of providers, payors, including insurers,

and the public. These systemic changes when taken with our proposed insurance reforms in the health care financing and delivery systems will emphasize the continued evolution of managed care. We have attached a copy of this statement to our testimony. The insurance industry recognizes that, as part of the reform of the entire health care system, there must be a fundamental change in the way we do business. We stand ready to work with President Clinton and Congress to achieve these goals.

Mr Chairman, thank you for the opportunity to present the views of the Health Insurance Association of America on issues related to health care reform. I would be pleased to answer any question you or the Committee may have.

HIAA

Health Insurance Association of America

VISION STATEMENT

Our vision is a society of healthy individuals and communities. Our nation, through systemic change, will build upon our employer-based system to create a consumer-responsive, prevention-focused, affordable and cost-effective health system which fosters individual responsibility, human dignity, improved health status, and enhanced quality of life for all.

VISION GOALS

- *Promote a healthy and productive existence for all Americans, maximizing the dignity and quality of life for each individual.*
- *Recognize, as a society, that heroic efforts to extend life are not always appropriate or desirable. Dignity, quality of life, and the potential of returning to a healthy existence must be considered in treatment decisions and in the allocation of resources.*
- *Provide compassionate care to all people, especially to those who are chronically or terminally ill and cannot recover from their illnesses.*
- *Encourage Americans to take personal responsibility for maintaining good health regarding lifestyle factors within their ability to control.*
- *Stabilize health care costs as a percentage of individual financial capacity--earned income and other sources.*
- *Harmonize health care spending with other essential national requirements--the environment, education, the economy and security.*

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GUIDING PRINCIPLES

Reform of our health care system requires comprehensive change. Change must include a shift in emphasis away from sickness and repair and toward health and wellness. The principles below comprise a unified whole, not a cafeteria menu. All elements integral to universal coverage and cost containment must be implemented together, not piece-meal nor staged over time one state at a time. HIAA believes that reform of our system must be guided by the following principles:

1. Reform must rely on competitive, pluralistic, and flexible delivery and financing systems in which all players--public and private alike--abide by the same rules. Government should not anoint winners; winners should be determined by the marketplace--a marketplace free to abandon failures and embrace promising new ideas.

2. Universal, "cradle to grave" coverage must be achieved by requiring all employers and individuals to pay for an essential package of benefits which should include primary, preventive and catastrophic coverage. Government cannot shirk its role; it must help subsidize those employers and individuals who cannot afford to purchase an essential package.

3. Insurers and other private payors must issue and renew coverage for all. To protect insurer solvency and maintain employer incentives to control costs and promote employee wellness, insurers can, within limits, establish premium rates which reflect risk. Coverage must be portable; there must be no pre-existing condition limits once in the system; and the problem of "job lock" must be eliminated.

4. Reform must build on our employment-based system. Employers' active participation in financing, selecting, and administering an essential package of coverage is critical to maintaining an open, flexible, and innovative health care system. Given their significant financial commitment, employers must retain control over their employees' health care coverage. Therefore, requiring employers to participate solely through group purchasing pools would invalidate the cornerstone of our employer-based system.

5. Changing the delivery system is fundamental. Managed care should be the primary vehicle for achieving sustained systemwide cost savings; we must allow it to evolve and develop into its next generation, including full participation of Medicare and Medicaid beneficiaries in managed care systems. A defining element of managed care systems will be their ability to collect and publish data which allow purchasers to compare outcome and price information. Employers and managed care systems will also provide incentives that promote healthy lifestyles and

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personal responsibility. Managed care alone may not sufficiently control systemic health care costs. Therefore, alternative approaches (such as expenditure targets and provider rate regulation) should be explored as an additional means of controlling health care costs.

6. Government's role must be one of an enabler, not of a "doer". A primary and essential function must be to eliminate cost-shifting to private payors. Self-regulatory bodies will develop, implement and enforce rules of conduct for all players. These include rules of market behavior for all private and public payors, rules for providers to follow to ensure consistent payment levels which eliminate cost-shifting, and standards for electronic data interchange and for reporting outcome and cost information. Government-sanctioned self-regulatory bodies will also define essential package(s) of care, evaluate technologies for their cost-effectiveness, and establish a mechanism for pooling certain cost and utilization data. In addition, government must enact legislation reforming the malpractice adjudication system.

7. Tax preferences should be limited to the essential package of care, thereby motivating the public to seek the best value and providing additional revenue to finance expanded health care coverage.

CREATING A WORKING HEALTH CARE SYSTEM

We Americans have shorter life spans, higher infant mortality rates, and higher rates of violent death than do the citizens of other industrialized countries. Yet we pay more for health care per capita and more in total health costs--close to $900 billion a year--than does any other country in the world. Furthermore, an estimated 37 million people in the United States do not have health care coverage; if we as a society continue "business as usual," that number is expected to reach 40 million by the year 2000.

To make matters worse, the private sector has had to shoulder more than its fair share of the costs. The Prospective Payment Assessment Commission estimates that, in 1990, private payors paid $22.5 billion more than the costs incurred by their hospital patients to make up for losses hospitals experienced from the uninsured as well as Medicaid and Medicare patients. Put another way, private payors paid an average of 128 percent of actual provider costs; this amounts to almost a 30 percent "tax" on hospital costs paid by the nation's employers.

Clearly, these trends must be reversed. Over the last year, the Vision Committee of the Board of Directors of the Health Insurance Association of America (HIAA) met to discuss health care reform. The Committee members approached their task as

Americans who happen to know about health insurance rather than as health insurance executives who happen to be Americans.

HIAA's vision is a framework for comprehensive reform. Its underlying premise is that everyone with a stake in the success of American health care, including insurers, will have to do what it takes to create a working health care system. It reflects the conviction that the nation's health care needs can best be met by a competitive and pluralistic system, not a monolithic one, and that the private sector will continue to play a dominant role in financing health care. It calls for universal coverage for all and changes in the behavior of providers, payors, including insurers, and the public. It advocates that government be an "enabler," not a "doer," that it eliminate cost-shifting, and that it establish guidelines for everyone to follow. Our vision is premised on comprehensive reform; all initiatives central to its goal of universal coverage and cost containment must be implemented together, and in coordination with one another, to ensure maximum success.

Taken together, these reforms will lead to a sustainable reduction in the growth of health care costs and improve the health of the American people. We recognize, however, that these reforms will require significant new government spending. We have identified one possible revenue source--a limit to the tax preference employer-sponsored health insurance currently enjoys--but we recognize that other sources will be needed as well. It is critical that these newly generated tax dollars be applied only to building a health care system that will produce long-term sustainable savings; new revenues should not be wasted perpetuating the status quo.

The health insurance industry anticipates further discussion on many aspects of the system it proposes. Some areas need more thought, and some gaps need to be filled. As areas of uncertainty are clarified, this paper, which is not final, will be modified to reflect these changes. Some lack of specificity will have to be tolerated while we struggle to find solutions to difficult issues. (For purposes of this discussion, "health care" refers to services to prevent, diagnose or treat medical conditions. The reforms proposed here do not apply to coverage outside of the essential package, such as disability income, supplemental hospital indemnity, specified disease, Medicare supplement or long-term care insurance.)

COMPONENTS OF THE NEW SYSTEM

1. *Based on Pluralistic Financing and Delivery Systems*

Reform must rely on market-based pluralistic and competitive financing and delivery systems. Pluralism and choice are what engender competition--competition among ideas, among companies, among plans, and among values such as cost, quality and convenience. Only true competition can assure that our health

care system remains flexible and open to innovation, so that it will continue to evolve to better meet consumers' needs in the future. A system with many buyers and sellers will assure breadth and depth of services and responsiveness to consumers. Market forces must be allowed to determine which systems shall succeed.

Comprehensive health care reform will require an expanded federal role to eliminate costly variations in state regulation and assure uniform standards--a level playing field--for all public and private payors. It will also require that government remove barriers to the growth of pluralistic, competitive systems.

2. *Builds on an Employer-Based Foundation*

Employers have a unique interest in maintaining employee health--as it affects productivity. Therefore, employers must provide coverage for all their employees and dependents. Employers will pay for at least part of this coverage. Some employers will receive government assistance to help cover their employees.

All employers, regardless of their size, will select plans based on the performance of competing managed care systems. A system built on an employer base is categorically inconsistent with the concept of exclusive group purchasing that bypasses employers altogether, thus relieving them of their responsibilities. Purchasing pools, such as group association and multiple employer plans, are common methods of obtaining coverage. We have no objection to a variety of demonstrations and experimentation with other forms of purchasing pools provided employer participation is voluntary. In no case should employers be required to buy health insurance solely through group purchasing arrangements.

A competitive and pluralistic system should allow purchasing pools to exist side by side with other methods of arranging coverage. Insurance reform measures will prevent any one entity from bearing an inequitable share of risk because all payors will follow the same market rules to guarantee coverage.

In addition, employers should:

- be free to experiment with and invest in a variety of approaches in providing an essential package of coverage;
- provide incentives to promote healthy behavior; and
- have incentives to help restrain costs because some element of their experience is considered.

3. *Achieves Universal Coverage for an Essential Package*

All Americans will have continuous coverage for an essential package of primary, preventive, and catastrophic care. Achieving universal coverage will require a series of mandates--on government, employers, insurers and individuals. How to divide these responsibilities will probably be the most difficult and controversial aspect of health care reform. Ultimately, it will be a political decision, not a health care decision. Clearly governments--federal and possibly state--will bear the cost of covering low-income people. Employers, in our view, should at the very least be required to incur the costs of offering health insurance to their employees.

HIAA supports a requirement that employers help pay for coverage for their employees and dependents. Even a modest employer payment would heighten employer cost consciousness and help restrain health care inflation. So-called employer mandates, however, are in effect a mandate on employees as well as employers, since employee premium contributions are envisioned in virtually all employer mandate plans. We are reserving judgment on how the costs should be shared between employer and employee, recognizing that there are practical limits on the ability of both employers and employees to shoulder the financial costs of a health care mandate. It may be necessary--however the cost is divided--to phase in the mandates over a period of years, taking account of any other employer mandates--such as increases in the minimum wage--that may be imposed at the same time. If an employer mandate is phased in, it will be necessary to coordinate it with other aspects of health care reform. For example, certain aspects of insurance market reform are not feasible absent a mandate; the two reform measures must be synchronized.

To achieve universal coverage, the following steps must be taken:

- Government must require all employers to arrange and help pay for an essential package of coverage for their employees and dependents. All individuals--those employed and those not connected to the work force--are required to obtain such coverage.

- Government must help employers and individuals who cannot afford to purchase an essential package. (Certain employers receive financial help, but they cannot "opt out" by paying a tax instead.)

- All individuals--those employed and those not connected to the work force--must receive the same tax incentives to purchase an essential package.

- The essential package covers primary, preventive, and catastrophic care. Government will authorize an independent body of providers, payors, employers and consumers to define the essential package of coverage. The design of this package must be flexible to encourage cost-conscious

behavior; it must have inherent limits to prevent continuous expansion, recognizing that people's wants and desires may exceed society's resources; and it must not overlap or duplicate medical care coverage available elsewhere such as under workers' compensation and automobile insurance.

- There should be no difference in the essential package of coverage received by the poor and the non-poor. Government will finance coverage for low income individuals, but there will no longer be the need for a separate Medicaid program.

4. *Ensures Universal Coverage Through Market Reform*

Market reform must be premised on a government requirement that all individuals and employers purchase coverage. In this environment, all health plans will be subject to national rules of market behavior to guarantee universal and continuous coverage. The same rules will apply to all health plans, whether offered by commercial insurers, Blue Cross/Blue Shield plans, HMOs, self-insured employers, government, or any other entity. Problems such as "job lock" and lack of coverage for pre-existing conditions will be resolved. The rules of market behavior will:

- require that coverage be made available to every employee in an employment-based group;

- assure that every individual will be able to purchase the essential package, regardless of their health, financial or employment status;

- guarantee that coverage will not be cancelled, terminated or not renewed based on the health status or claims experience of any individual or group;

- prohibit insurer rating practices that create large rate differentials for groups of similar age, sex and geographic composition;

- maintain, at the same time, insurers' ability to calibrate rates to risk--pure community rating results in market disruption and works against cost containment in a variety of ways; and

- establish a form of reinsurance or risk-sharing to compensate for inequitable distribution of risk.

5. *Creates Sustained Cost Containment By Systemic Change in Financing and Delivery Systems*

Changing the health care delivery system is fundamental. The actual delivery of care must be substantially better organized than it is today to meet the needs of patients, purchasers, and providers. Therefore, managed care should be the primary vehicle

for achieving sustained systemwide cost savings, and must be allowed to evolve and develop to its next generation. Managed care systems will serve the health care needs of communities by offering essential packages of care; they may also offer supplemental coverage.

Different forms of managed care coverage will compete on a level playing field. These competing forms of coverage include plans employing managed care techniques such as utilization review as well as managed care structures such as HMOs, PPOs, other network-based health plans, and evolving models. However, a defining element of all managed care systems will be their ability to collect and publish data which allow purchasers to compare outcome and price information across managed care systems.

Managed care systems will be permitted to pay providers in a variety of ways that encourage cost-effectiveness and quality care, including physician risk-sharing incentives, so that providers are rewarded for the cost-effective use of medical resources. New payment systems should encourage greater provider autonomy in decision-making and reduce the "hassle factor" that now results from micromanaging by payors.

Managed care systems will be user-friendly, efficient, and paperless. Administrative costs, and waste and fraud, will be significantly reduced. Improved alliances between providers and insurers will promote enhanced financial and managerial control of managed care systems, timely and responsive customer service, quality assurance programs, and fraud prevention.

Both managed care systems and employers will provide incentives that promote healthy behavior including discounts, promotions, and education. These incentives will reduce health care costs related to unhealthy lifestyle choices and will promote personal responsibility for one's health.

Given government's enormous buying power and its ability to influence provider costs, there should be strong incentives, perhaps requirements phased in over time, that Medicaid and Medicare beneficiaries fully participate in managed care systems to eliminate cost-shifting and control costs and utilization.

As managed care continues to develop, it will result in significant cost containment. However, managed care alone may not sufficiently control systemic health care costs. Therefore, alternative approaches (such as expenditure targets and provider rate regulation) should be explored as an additional means of controlling health care costs.

6. *Controls Systemwide Costs Via New Government Role*

Government will establish an entity that oversees and relies on one or more self-regulatory bodies to develop, implement and enforce rules of conduct for all players in the health care system. The regulatory framework will include all interested parties in the health care system--providers, insurers, employers, government, and the public. One, or possibly several, self-regulatory bodies will perform the following functions:

- establish consistent rules of market behavior for all health plans--those provided by insurers, self-insured employers, HMOs, government, or any other entity (see point 4);

- define essential package(s) of coverage that is made available to all, regardless of their income, age or employment status (see point 3);

- establish rules for providers to follow which ensure that they set consistent payment levels for all public and private payors for the same service. These rules should:

    - recognize that different payors may use different payment methods; and

    - assure that payments reflect real economic costs and value to providers and payors (such as convenience, service, adherence to quality standards, cost-effective practice patterns, or meeting additional contractual obligations).

      (In no case, however, should the rules allow providers to grant discounts to one payor simply by increasing the cost to another payor. The most important outcome of these new rules is to eliminate government's chronic failure to pay the true costs of care for poor and elderly Americans. In other words, Medicaid and Medicare should no longer receive special deals with providers at the expense of the rest of the population.)

- develop standardized guidelines for electronic data processing and a nationally uniform claim form to achieve an efficient and paperless system;

- evaluate technologies (i.e., drugs, procedures, and equipment) for their cost-effectiveness; sanction clinical guidelines (developed by appropriate professions) that can be used as legal defense against malpractice claims; determine valid experimental treatments eligible for reimbursement through participation in clinical trials;

- establish standards for the reporting of outcome and cost information published by managed care systems;

- establish a mechanism for pooling certain cost and utilization data on a regional, state and/or national basis to assist all payors in controlling costs and utilization, to help managed care systems produce outcome and cost data, and to help the government-authorized entity to develop guidelines that ensure that providers set consistent payment levels;

- enact legislative reforms of the malpractice adjudication system;

- enact legislation that allows insurers to exchange information for the purpose of identifying fraudulent providers; and

- consider actions needed to change the mix and supply of physicians and to increase the supply of physicians in inner cities and rural areas.

7. *Establishes Equitable Rules for All*

Government will require all public and private payors to play by the same rules. To achieve this level playing field, the regulatory framework must:

- avoid duplicative or overlapping regulation among the states or between the state and federal levels;

- remove all state regulatory control over anti-managed care laws, mandated benefits laws, and provider contracting laws;

- prohibit states from mandating additions to the essential benefit package; and

- amend ERISA to allow this regulatory structure to successfully implement the above responsibilities.

8. *Promotes Equitable Tax Policy*

Government must implement tax policies that eliminate perverse incentives for health care spending.[1] An unlimited tax preference for employer-sponsored health benefits does not promote cost-consciousness among employees. Instead, tax preferences for the essential package of coverage should be:

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[1]As noted earlier, this vision addresses reform of the acute care medical system; it does not address long-term care financing reform. HIAA continues to support several recommendations in the latter area, including favorable tax treatment of long-term care insurance, on the grounds that the increased availability of affordable private insurance will have a significant impact on reducing future public (Medicaid) spending on long-term care.

- capped at a level equal to the essential benefit package;
- extended to the self-employed and to those who purchase the coverage outside of an employment setting;
- inapplicable to any premiums for health benefits in excess of the essential package; and
- inapplicable to cost-sharing requirements, such as deductibles and copayments, for the essential package.

Employers would continue to be allowed to deduct 100 percent of their contributions to employees' health coverage, even if their contributions are for coverage in excess of the essential package. (But employees are taxed on the excess.) In addition, the inequitable taxation of various payors must also be addressed to help level the playing field in the new system.

The revenues from these tax changes should be used only to help pay for health care reform. HIAA could not support these tax changes if cost-shifting is not adequately addressed or if the revenues generated from these changes are not specifically applied to health care reform.

SYSTEMIC FACTORS DRIVING COSTS ARE SLOWED

We have proposed many ways to create a sustained reduction in the growth of health care spending. Everyone will have continuous coverage so people will not wait until they are ill before seeking care. Managed care systems will discourage excess doctor visits, unnecessary hospital and specialist care, and technology use that is not cost-effective. Physicians will be empowered to practice effective, not defensive, medicine. Managed care systems will offer essential packages of care that will compete on price and value.

Providers will not be able to shift costs among payors, so true market competition will compel providers to become more efficient. A government-authorized entity will evaluate, and slow the use of, expensive technologies that are not cost-effective. Administrative simplicity, a paperless system, and standardized claim forms will save money and help control fraud and waste. Coverage of preventive care and incentives for healthy lifestyles will pay off over the long-run. Tax advantages will be limited to the value of the essential package of care, thereby motivating everyone to seek the best value.

Successful reform will yield measurable results and trends that will compare favorably to those of other nations on costs and on a variety of quality measures (such as mortality, percent who smoke, and height/weight standards).

HIAA will continue to refine its vision of health care reform. However, we are committed to achieving the objectives outlined.

Fixing the health care system will lift a sizable burden from our collective shoulders, yielding resources and liberating energies for other critical issues on the nation's social agenda.

SEPARATE ISSUE PAPERS

Additional issue papers are being developed on selected subjects. In some instances, these are descriptive papers discussing the pros and cons of the issue. In other cases, these are supplemental papers providing more detail than what is proposed herein. Topic areas include:

1. Price controls
2. Global budgets or expenditure targets
3. Extent of tax-favored treatment for health insurance
4. Precise nature of federal and state responsibilities
5. Cost estimates and revenue sources for reform
6. Implementation and enforcement of employer and individual mandates (including how much an employer contributes, which employees qualify under the employer mandate, and how a subsidy program could be structured)
7. Centrality of employers in providing coverage (including a discussion of the concept of group purchasing arrangements)
8. Insurance in the new market
9. Determining the essential package of coverage (including a discussion of supplemental coverages)
10. Medicare and Medicaid
11. Technology assessment
12. Tort reform
13. Individual responsibility, wellness and prevention
14. Measuring and assessing results with other nations
15. Medical care coverage under Workers' compensation and auto insurance

Mr. LEWIS. Ms. Lehnhard, as you are well aware, there are a multitude of insurance standards, it varies State by State. Wouldn't it be easier and more efficient to have a uniform set of Federal standards?

Ms. LEHNHARD. Yes. We are supporting detailed Federal standards for the insurance industry. We believe that some States should be able to apply stricter standards where they want to but we certainly support a uniform set of standards.

Mr. LEWIS. I understand that many commercial insurers are leaving New York. A recent Wall Street Journal article suggests that this is the result of the insurance reform enacted by that State. This may be occurring in some other States. Is it true that individuals and groups in New York will not be necessarily penalized because of the guarantee issue requirement now in place?

Ms. LEHNHARD. The question is, has it penalized companies?

Mr. LEWIS. Right.

Ms. LEHNHARD. Many of the companies that left New York, and Ed should answer this too, are the same companies that are supporting these types of reforms at the Federal level. You may want to respond, Ed.

Mr. NEUSCHLER. There are definitely companies who believe that they cannot survive economically in an environment that requires them to guarantee issue and flat community rate, which is what New York has placed on them, and so there are companies who are withdrawing from those markets.

I think it was also mentioned by one of the earlier speakers that it does become difficult to keep up with the reforms in 50 different States and so there is just a question of availability of staff time and the administration of the insurance company to deal with the individual States and that will become an increasing problem, I think, as we see different reforms on the State level.

Ms. LEHNHARD. I should clarify that the Blue Cross and Blue Shield plan was very supportive of these reforms, primarily because that is what they continue to do in New York and they couldn't survive unless other companies did the same.

Mr. LEWIS. Could you tell me what effect will community rating and the elimination of preexisting condition have on the ability of insurance companies to compete and prosper?

Ms. LEHNHARD. I think they are two separate issues. The preexisting conditions you need in a voluntary market. Even Medicare has a waiting period for preexisting conditions. If you don't have that, people wait to buy insurance until they are sick and then you really do have high costs because you are not spreading the costs among a lot of people who are paying their premiums and are healthy.

On the community rating issue, we have supported, as the commercials have supported, a narrowing of those rate bands over time. We have come to the conclusion that we can support community rating with a very narrow additional band based on demographics, no experience as a group, just single rate with some variation based on how old your group is.

We have concluded that we can compete with that kind of criterion. I believe many of the HMOs are supporting community rating.

Mr. LEWIS. Thank you.

Mr. NEUSCHLER. The problem with flat community rating is that if you happen to be an insurer who, when the requirement goes into effect, on average a sicker population than the population of the geographic area, State or whatever it may be, you are basically stuck. If you have to have one flat rate for all of your people and you are higher than the average, then you are never going to get any new folks into your pool and you go into one of these death spirals that Mr. Trapnell explained earlier. So our feeling is that in order to have viable competition in the marketplace, you have to have some flexibility on rates.

We had a proposal on the table in our State reform proposals that talked about demographics plus an allowance for health status. That is in the context of a voluntary market. It may be possible, if the assumption is universal coverage, it may well be possible to narrow that rate band a bit. That is an issue we are still looking at.

Mr. LEWIS. Thank you.

Mrs. Johnson.

Mrs. JOHNSON. Thank you. It was interesting to hear you reiterate something that was said earlier in the hearing, that 8 of the 10 people who don't have insurance today could qualify, they just can't afford it. And the big problem with moving to community rating is how many people are no longer going to be able to afford insurance.

One of the problems is, a year ago when we had these hearings, we asked witnesses how much of a premium increase he thought there would be moving to a community rating. Would each of you give us your best guess?

Ms. LEHNHARD. Mrs. Johnson, I can't respond directly to you and tell you the actual——

Mrs. JOHNSON. I am aware of that. What percentage of those currently insured in the small group market would experience a premium increase if we went to community rating?

Ms. LEHNHARD. We do have those numbers and I believe it is around 30 to 40 percent, but we are working doing a business analysis of how you can phase in that community rating so that it is not disruptive to the market. Small groups are used to a certain level of increases and we are working to—with our actuaries around the country, to see how slowly you have to phase it in so that small employers don't see a major increase in their rates.

Mrs. JOHNSON. Mr. Neuschler.

Mr. NEUSCHLER. Yes, Congresswoman. We did some work based on a sample of employer groups that we got from four or five member companies, a little model to see what might happen. When we play through in that model—and there are a range of companies that vary somewhat in their existing rating practices—when we play through a flat community rate in that kind of environment for small employers, that is, under size 25, we find that 69 percent of employers would have rate increases of 10 percent or more, and if you want to look at higher increases, we found that 30 percent of employers would have rate increases of over 35 percent with flat community rating.

Now, that is sort of the worst case. As you back off with community rating by class, you would get somewhat smaller numbers than that.

Mrs. JOHNSON. That does support the kind of testimony we got a year ago in which people agreed that about 70 percent of those currently with small group coverage would experience some increase just by going to community rating. That does deeply concern me. I think ultimately we can arrive at community rating, but I think if we go too fast, we run the risk of pushing a lot of people out of the market who are currently in the market.

The second thing is the solvency of the employers. I mean, if we set the premiums too low, we can make companies insolvent. We have set the premiums so low in Medicaid that we have created a very clear and direct cost shift onto the private sector. If the private sector weren't there, Medicaid would be bankrupt because it doesn't pay for the costs that it incurs.

The same is increasingly true of Medicare. So I think the solvency issue we proved in the private sector that you can bankrupt the insurer and in the public—we proved that in the public sector. In the private sector we do have to be cognizant, if you don't raise the premiums enough to cover costs, you bankrupt the providers. If you do raise it to cover costs without controlling costs, you push really an enormous number of people out of the system and that is the tension that we have to recognize and the balance that we are going to have to find a way to strike.

Would you agree that if we adopt the reforms that we currently associate with insurance reforms, that is, denying the right to exclude for preexisting conditions except for perhaps an initial waiting period, guaranteeing issue, not allowing the dropping of people because they have health costs, and limiting rate increases, increasingly severe over time, if we do those things, that we will accomplish a radical change in the focus of the industry?

I notice Ms. Lehnhard, that you led off with that, and I think that deserves a little more attention. You said that we shouldn't underestimate the change in behavior in the industry if you adopt these reforms that we commonly associate with health insurance reform. And since in the end we all agree that health care reform requires changing everyone's behavior in America, not just the providers, but the purchasers, and that in the end people are going to get less health care, not more, for less money, would you, either of you care to enlarge on that, what you think will happen if we just did the legal part of reform?

Ms. LEHNHARD. We think that there is such a consensus on reform that people are forgetting and not focusing on how much it will change behavior. We think as soon as Congress looks like it is about to enact the reform, you will see the industry reacting immediately. As I said, companies that don't want to compete based on management of costs will leave the market. We don't know how many that is, but other companies will move immediately to make that major capital investment in the information systems, the provider relations people to set up networks with hospitals and physicians.

We think it is a major reform focusing all that energy, again on risk selection to truly managing costs, and there is a lot of discus-

sion about loopholes today. I think that the industry, once Congress moves, will see that even if there are loopholes to be found, it will be a constant closing of those loopholes and companies will make this judgment since the Federal law is enacted that, do they want to put up with consecutive years of loophole closing or do they just want to move into P&C and life insurance and some other line of business.

And we think they should get out of the health business if they don't want to make that commitment.

Mrs. JOHNSON. That is an interesting point, capital investment required to make change.

Ms. LEHNHARD. That is why a number of companies over the last 12 months have dropped out. They have made a very conscious business decision not to make the capital investment.

Mrs. JOHNSON. Interesting.

Mr. NEUSCHLER. I think I can agree with everything Ms. Lehnhard said there. The other thing that we feel is going to be necessary in order to get the level playing field and get the competition focusing on managing care and controlling costs is some standardization of the benefit package.

In our vision statement, we are calling for what we call an essential package of care by which we mean to say it should be adequate for the needs of most Americans, and we haven't exactly reached closure yet internally on whether that should be a fixed package or whether there should be some degree of variability allowed within that.

But unless you get that kind of basic package there, it leaves room for other kinds of competition other than cost control.

Mrs. JOHNSON. Thank you very much.

Mr. LEWIS. Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman. Unfortunately I have to go with Mrs. Johnson to another meeting right now, but I was just wondering, Ms. Lehnhard, have you examined the HIAA proposal and if so, do you have any comments you would like to make on the merits of their proposal or——

Ms. LEHNHARD. I would be glad to get those to you. I think we are very close. We do not support provider rate setting. We think managed competition in a market with rules is far preferable, and I believe we are much tighter on our rating limitations, but other than that I think many of our reforms look the same.

Mr. MCCRERY. Thank you.

Chairman STARK. I apologize for missing the inquiries of my colleagues and if I am redundant, please just tell me it has already been answered and I will consult my colleagues. The HIAA testimony indicates that increasing premiums are due to high medical costs and there is some indication that small groups lack bargaining power so there are more large groups to pay higher prices.

Does this imply that the insurance industry would support regulations more across-the-board leaning toward an all-pay or containment or other type of price controls to protect these smaller groups?

Mr. NEUSCHLER. That is something we are looking at, Mr. Chairman. We haven't developed a firm policy internally on that yet.

Chairman STARK. We have heard that for a variety of reasons self-insurance looks like an attractive option and I suppose there is, as I recall, a fine line between a—back up a minute. If I heard the testimony of the actuaries earlier, once you have over 1,000 employees, you can self-insure and you are not buying into much more than just the risk of the cast of the die. But smaller firms get tempted to self-insure, probably because of some of ERISA's exemptions so they can get out of certain requirements. However, as the size of the firm decreases, arguably, they are accepting maybe more risk than they are able to understand.

What effect is this having on both of your clients? Are they finding that more and more of their customers who would be in the 100 to 1,000 group are starting to self-insure? Are you finding that?

Ms. LEHNHARD. We are. We are finding that the MEWAs are picking up a large number of the small groups, particularly in States where there has been insurance reform and the MEWAs can—are able to not comply with these insurance reforms, and I would make—one thing that is critical to us in Federal reform is that at a minimum, to the extent that you require community rating coupled with open enrollment, say groups of 1 to 50 or 100, those are the most important groups to not allow an opt out for the self-funded because if we are going to have community rated pools and people can come along and pick out people out of those pools and not do community rating and not do open enrollment, we haven't addressed the fragmentation of the market.

In fact we have made the whole problem worse, because we and the commercials are carrying a bigger burden and the self-funded have a bigger competitive advantage unless they are brought in.

Chairman STARK. The only advantage that I have been able to think of is that you put—let's say you went to no medical underwriting, community rating across-the-board, and that is pretty harsh but let's say we did it, that leaves the self-insured out of the box and my feeling is they would self insure when they started, the average age of the employee was 25; the minute the average age was 50, they would quickly throw it out to whatever public plan they could.

To level the playing field, you would have to do something like make the self-insured plans contribute to some kind of an age-related trust fund in cash that they could only pick up later as their beneficiaries age so they couldn't get out of the community rating. They would have to somehow pay a premium to the community related to age.

This is the reverse of what I would normally think, just so that they couldn't quit the plan. And let's say that the average age of their employees was 30. They just couldn't run the plan for 5 or for 20 years and then give us a bunch of people who they have been just costing them the 30-year rate and dump them all on us when they are 50. We would have to prevent that.

My theory is you would have to regulate them, the same way as you do through insurance companies, and if they think they can manage their books better than Blue Cross or Aetna or Pacific Mutual, go ahead, but they play under the same rules, whether it is a State or Federal insurance regulation.

Mr. NEUSCHLER. Mr. Chairman, we agree that playing under the same rules is absolutely critical to all of this, but I think the scenario you just described is an example of the kind of machinations you would have to get into if you do insist on flat community rating. We don't want to deny——

Chairman STARK. You wouldn't need that if you didn't let them operate at all. The easier step would be to say no more self-insured plans.

Ms. LEHNHARD. Even with just an open enrollment rule, you would have to do something about a closed group that has a much healthier group of people.

Chairman STARK. The easy way I can look at that is say you can't do it. Say you want to get licensed as an insurance company, then you have a little problem with the unions, saying that I could join the UAW plan, I might have a little problem.

I have a question for you, Mary Nell. Gordon Trapnell suggested—I will preface this. I am not so sure that there is any good way for risk adjusting right now. I mean maybe 20 percent of accuracy but that is the order of magnitude. I just don't think we know how to do it, and he said maybe it is 5 years away.

Do you think there is some way we could start in the next couple of years and start risk adjusting?

Ms. LEHNHARD. I know the reference he made earlier and we currently don't know of a very powerful risk adjustor. What we have suggested, we are very supportive of managed competition, but we have said——

Chairman STARK. Which managed competition?

Ms. LEHNHARD. Any of them. That we have said you can move ahead on five of the six key elements of managed competition. The HIPC which really does require a risk adjustor, we said you can phase in later as we develop a better risk adjustor, but all the other economic drivers you can move on, in fact, much faster if you don't wait for a HIPC infrastructure to be built every where.

Chairman STARK. I gather HIAA is still on the HIPC kick as well.

Mr. NEUSCHLER. We certainly are open to experimenting with it as a way of pooling purchasing power for small employers.

Chairman STARK. Very judicious hedge. I like that.

Mr. NEUSCHLER. We are against making them the only way that any class of employers would be allowed to buy insurance.

Chairman STARK. You just earned the enmity of Professor Enthoven on that, and my support. You talk about your vision and I don't know whether this is just probably some general oversight, but that you want market reform premised on, and I quote, "A government requirement that all individuals and employers purchase coverage." Then you go on to say you want us to require that coverage be made available and that every individual will be able to purchase and guarantee that coverage will not be canceled. But when you say that I should require all individuals and employers to purchase coverage, what do you do if they can't get it, the death penalty?

Mr. NEUSCHLER. Well, we are talking about underlying insurance reforms that would guarantee that folks have access.

Chairman STARK. What if they don't have any money? Put them in debtors' prison?

Mr. NEUSCHLER. No. There is no way that we are going to get universal coverage in this country without considerable cross-subsidization from the wealthier part of the population to the poorer part of the population. Fully 60 percent of the uninsured have family incomes below twice the poverty level. Obviously, those folks cannot afford to pay out of their own pocket.

We think we can get some of it from the employers, but we are quite sympathetic to the problems that small employers have meeting payroll at the moment. We don't want to place a heavy burden on them, so we are talking about a mandatory offering and some contribution, as yet unspecified, towards the cost. But you are going to have an individual mandate with that, and you are going to have to have fairly significant Government subsidies for the individuals, and for the employers as well.

Chairman STARK. Did you see the piece written recently to the effect that the last increase in the minimum wage had almost no effect on small business?

Mr. NEUSCHLER. No, I didn't. I didn't see that.

Chairman STARK. So if we assume that that was an accurate economic assessment, why would it be such a horrendous thing to have a 50-cent hit in the minimum wage, if it were in the form of a minimum benefit requirement? That is $1,000 a year for a minimum wage employee, at 2,000 hours; then that would be a generous contribution toward a minimum benefit package. And if all employers had to do it, at however many hours they had per person, and those who already had a benefit package would not have to, so you have sort of a substandard minimum wage; can you conceive that would really destroy small business?

Mr. NEUSCHLER. We haven't had the——

Chairman STARK. They gripe every time we raise the minimum wage and none of them go out of business.

Mr. NEUSCHLER. I would like to see an economic analysis of where they are at the moment before committing ourselves on that. But we clearly are on line with you in the sense that we believe they can afford something and that we are going to have to do that in order to move forward.

Chairman STARK. This is the last question I have, and I am afraid this is a conspiracy between you and Mary Nell. The worst kind of anti-Government, pro-private enterprises are former Government employees who escape, and you have here that Government which will establish an entity that oversees and relies on one or more self-regulatory bodies.

Now, self-regulatory means that I am going to establish the body to take away the jurisdiction of this committee, which I am sure is exactly what the framers of this HIPC have in mind. This is their way to shut us up and to put us out of business. I could be accused of just wanting to jealously hang on to my jurisdiction, and that is the only reason I don't like the idea of these so-called quasi-governmental bodies, but there really are a couple of other reasons that I think we shouldn't have them.

One, we already have them. We have HIPC, PPRC, ProPAC, and we had one setup for pharmaceuticals.

Chairman STARK. What if they don't have any money? Put them in debtors' prison?

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One, we already have them. We have HIPC, PPRC, ProPAC, and we had one setup for pharmaceuticals.

Secondly, and I think Mary Nell would agree, this isn't going to get scored. You can't have a body that does not have the effect of law setting a rate that CBO is going to score. We can't turn over to the Blue Cross Association the idea of setting a budget.

You tell us what it is and get it scored, because we have to have somebody doing it where you have the force of law, and we are not apt to turn that over to people who aren't elected.

The other issue is the one that was raised by CalPers. Do you really want somebody to set the benefits and/or the rules under which they will be priced, who represent someone other than the beneficiaries?

In other words, do you want the fox in the henhouse? Why should doctors or insurers be on the other side of the table from the insured, the beneficiaries of these plans?

Those are my three points. One, you put me out of business, we have a fight right from the get-go. But the other two are, that one, either you want us to regulate the rates, and that has been changing; your association, the Health Insurance Association, sort of changed their mind.

At first they wanted more Government regulation, then they weren't sure they wanted us to set rates, and now everybody seems to think there should be a body, but just not Government. I am out of business; two, if we are going to spend the money, we really have the responsibility to control it; and the third is that I don't think that providers and insurers and even employers, as good old warm feelings as they have for their employees, ought to dominate those boards.

It ought to be somebody representing the beneficiaries. They elect them, and that arguably would be Congress; how do you feel about that?

Mr. NEUSCHLER. Well, Mr. Chairman——

Chairman STARK. Do you want to back off of that?

Mr. NEUSCHLER. We are somewhat groping around here for the right structure as well, and what we have said is that we want some kind of a new regulatory paradigm here, that we don't see in the existing health care entities anyway, the right kind of structure. Now, as a person who was a HCFA employee for about 9 years, I might say that I am personally probably more interested in not having HCFA involved in this, than in not having this subcommittee involved. But——

Chairman STARK. We get the reverse from a lot of people, so that is all right.

Mr. NEUSCHLER. As we have thought about this, what we think needs to happen is that Government, meaning the Congress, has to set what the overall goals are. And where we have found difficulties is where we get entirely too much micromanagement from bureaucrats who aren't on the ground level trying to make this stuff work, so that you get unreasonable kinds of process requirements that are not the most effective way of meeting the goal.

So what we are groping for——

Chairman STARK. How how much of that micromanaging is really out of HCFA, and how much out of that is out of the Blues and Travelers and those in the intermediaries? Because I don't know as the intermediaries aren't given some bit of latitude.

Ms. LEHNHARD. I would say we have very little latitude. That has decreased substantially over the last few years.

Chairman STARK. You think under the previous administration they gave you less latitude?

Ms. LEHNHARD. I think you would have to go back several years.

Chairman STARK. I thought they gave you more pressure to perform, to keep turning down procedures, but I don't know as they gave you more specifics.

Ms. LEHNHARD. If you look at the volume of intermediary letters and instructions, it is very detailed at this point.

I would like to follow up on the comment of—we are very supportive of detailed Federal standards, and rather than a lot of flexibility on the part of these purchasing entities, we think the Federal Government should define the benefit package or packages. We think there should be multiple packages, like medigap, but define, the rating rules and the market conduct rules. Set up the rules for the marketplace.

The HIPC can enforce them or the insurance commissioner could enforce them, but they are very standardized, so they are the same from State to State, and the function of the purchasing entity is more a—is really to support individual choice, where you move ahead as a facilitator for people making individual choice, not regulating the market.

We think the Congress and the States should regulate the market and be the regulatory entity, and the HIPCs should be the facilitator.

Chairman STARK. I think that what you say is my understanding of what the public wants.

Mr. NEUSCHLER. My comments were going more to how those rules at the Federal level get developed, and I think our concern is that there be a large input from all the folks in the system who are affected, and that includes us and the employers and providers and consumers.

Chairman STARK. First of all, let me comment just on Mary Nell's last comment and come back to you what you were saying. What we have heard from our favorite pollster, or my favorite pollster, Glen Doan, is that is exactly what the public wants. They are very comfortable having the Federal Government be the watchdog and the policeman, but they don't want us to be the facilitator.

Ms. LEHNHARD. Regulate, not operate.

Chairman STARK. They want us in there very much. They really don't trust the insurance companies, doctors, or hospitals. But they don't trust us to run the system. They will trust us, however, to be very nasty, tough cops.

Ms. LEHNHARD. They want you to set strict rules.

Chairman STARK. I just wanted to share that with you.

Go ahead.

Mr. NEUSCHLER. Our own polling would back that up, that folks want Government to ensure that there is a fair game. I am talking more about how the rules get developed in the first place.

We think it is important to have participation from all the folks who are affected. That includes consumers, employers, insurers, and providers. I think, as I said, we are kind of groping for what would this look like exactly. We don't have a clear idea.

Ms. LEHNHARD. I would say we have very little latitude. That has decreased substantially over the last few years.

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I think the critical thing is that you don't have people setting the principles of the benefit package requirements without having some representation on there from the folks who are going to have to pay for it.

Chairman STARK. Or from the people who are going to provide it.

But it seems to me, we have two choices. Let's take Medicaid off the table. I think we and 50 Governors agree that Medicaid is not particularly a good example of how to run the show. But then, it seems to me, you have two choices, whether it is a benefits package, or whether it is a review or a bookkeeping package, or whether it is a price control package, you have Medicare or nothing.

Don't misunderstand me. I mean, adjust it, or you start from zero and try and build a book of regulations that will arguably be as thick as Medicare's regulations. What you will lack, however, is 25 years of people grumbling, moaning and complaining, and all the institutional memory of how, when we tried that and the podiatrists came off the wall and we were forced to change it; or remember how the inner-city hospitals or the rural hospitals—and for better or for worse, albeit for a limited segment of the market, we have gone through it. So while people know how to steal from it, we know how to arrest them.

There is not yet quite the equilibrium I would like to see in that particular segment, but why set up a new set of rules so the doctors and hospitals and others can steal from us. Then it is going to take 5 years until we figure out where they are gaming us. Now we know. We just started to bargain with the doctors.

Mary Nell, if you would have dreamed to hear Mary Nell, how many years ago, suggesting that maybe the medigap rules work OK. I think that is what you limited it at.

Now, that was a 5-year fight. So if we are not going to provide the ultimate package, and the HIPC people think we should, but the three of us know we aren't ever going to have a basic benefit package basic enough to satisfy the substantial number of Americans, there is bound to be something supplemental. That doesn't trouble me. We have had the fight. We can translate something like how we regulate medigap, and I will bet your members would buy it. Why should we go out and fight how to pay doctors. We don't know that the one system we have already bargained will hold, but we are trying to do that.

So all I am saying is, I didn't write Medicare. But we have been working with it. Why not start with that, even if it is only the benefit package for a minute?

We know what is there, we have a lot of history of how many people use it, and how much the services cost. Arguably it needs a little sweeping in the obstetrics area, and pediatrics, and a few other areas, but we have tremendous cost records, and you have tremendous experience with it.

How much should we expand it? It is there. You could run it.

I am just saying, I don't know what else is out there. What other model is there for us to start from scratch and build building a whole new model, or reworking this sort of American system that has been clunking around for 20 years, for better or worse.

Ms. LEHNHARD. Mr. Chairman, I think on the benefit package, I don't have any argument. That is really, I think, a debate for consumers and providers, and we are the financiers. I think we do have a role in shaping the coinsurance and deductibles, making sure they are flexible.

On the payment side, you made a good comment, Medicare has been clunking along. I think the private sector has made tremendous strides on innovating.

I will give you one example: In Minnesota, they had certain counties with extremely high rates of cesarean sections. They decided it was because they were paying more for C-sections. They said we are going to pay the same rates for C-sections as for normal deliveries, and the rates dropped 40 percent for C-sections.

Chairman STARK. You think their record was any better in C-sections than mine has been in cataracts?

Ms. LEHNHARD. I think the point is that a lot of innovation is going on in the private sector. This is one tiny example.

Chairman STARK. That is not innovation. That is cost cutting to the point where you cut the benefit.

Ms. LEHNHARD. I don't think Medicare would have used the data analysis to pick that up and gone out and visited with the physicians and gotten the consensus of the physician community to move on this.

Chairman STARK. What do you think we do in our hearings?

Ms. LEHNHARD. Well, in congressional hearings, but this is out in the local communities. I think there is a big difference.

Chairman STARK. So you would not trust the AMA to represent those physicians? You think we probably should go out and hear it for ourselves.

Ms. LEHNHARD. We hear it individually.

Mr. NEUSCHLER. The other thing on that, and I would like to follow up on what Mary Nell has just said. Yes, if you want to start talking about what is the benefit package, you can probably start with Medicare and start talking from there. But Medicare is fixed in the old fee-for-service mold, you know. When you try to squeeze down on the rates, the doctors try to figure out a way to unbundle or do more or whatever.

Chairman STARK. Absolutely.

Mr. NEUSCHLER. One of the things we think absolutely needs to happen in order to really reform health care——

Chairman STARK. Remember, we are assuming that this is universally applied. No more cost shifting by definition. All right; go ahead.

Mr. NEUSCHLER. And under that paradigm, Medicare will probably have to pay more than it does now. Anyhow, what we need to look for is more effective ways of managing care. And we have been, over the last 10 or 15 years, we have had things like utilization review and there are problems with that; the doctors feel like it is outside and some clerk, as they tend to put it, is looking over their shoulder, so obviously that will not be a long-term solution. But we need to move toward more integrated kinds of managed care, where there are more networks and integrated contracts with the providers.

Ms. LEHNHARD. Mr. Chairman, I think on the benefit package I don't have any argument. That is really, I think, a debate for con sumers and providers, and we are the financiers. I think we d have a role in shaping the coinsurance and deductibles, makin sure they are flexible.

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Chairman STARK. You have still not decided yet whether you want my price controls to make your managed care work, have you? Your small members cannot live with managed care unless they have me set price controls; me being the Government. We know that. That is your gripe right now with your membership.

The big five figure they will let the little companies take the high most. They are big enough to demand or to bargain for prices, but the Farmers Mutual of Richland Center, Wis., cannot get 10 cents off a bill if they happen to have somebody that moves to Minneapolis.

Mr. NEUSCHLER. On the price side, you are absolutely right.

Chairman STARK. But then why cannot—and that is really, save for purchasing on HMOs, about all Medicare does is set prices. There is nothing wrong—Medicare does not preclude HMOs or preferred provider, it just keeps a good one like Southern Cal Edison from shifting costs themselves.

There is some managed care people who shift a lot of costs to small groups in their own community. I don't know, as we are talking at cross purposes. You may go the other way. You may say, no, we don't need price controls. I don't know how else you stop the cost shifting without it.

Mr. NEUSCHLER. We are looking at different options on the price side of things. But, remember, this is a two-factor equation.

Chairman STARK. What are the options? Freeze? A new OPA, which we have not had since Nixon. We have a good guy to come back and run it again. Or we have Medicare.

Mr. NEUSCHLER. Yes, or some relationship to Medicare or some kind of cap related to Medicare with some flexibility under that.

On the price side, yes, but health care is a two-factor equation, price times quantity. And we think what the goal of managed care is is to manage the quantity.

Chairman STARK. I think as long—as somebody said earlier—that you don't mandate it; so that my mother doesn't have to join a HIPC. That would scare her just hearing it, without knowing what it is. And I don't know as you are going to take so-called managed care out of the loop.

There are some areas where it works very well, but it is not going to work in the District of Columbia. Our problem here is we have 150,000 people who are not in any system and there isn't anybody going to run—if I could talk Blue Cross into taking this system over, they could not talk the providers into moving in here to do it.

So there are some areas where we just don't have the luxury. Around the Bay area, where you have Hewlett-Packard competing with Apple, with—you know, and great HMOs and it is wonderful. They are getting very efficient at using high-tech stuff and slowing down on the overutilization of high-tech equipment. But that is not everywhere, and I guess that is the problem.

Well, thank you both for being here. When are you all going to decide in the new association what is going to happen? Do you expect to change your approach or rewrite your——

Mr. NEUSCHLER. Our vision statement, as you have obviously noticed, has some areas in which it is vague and we are working on further issue papers.

Chairman STARK. You are in good company.

Mr. NEUSCHLER. And the committee is meeting. There is another meeting this Thursday, as a matter of fact, and another one 3 weeks after that. So as we talk about these issues further, refinements will come out.

Chairman STARK. Do you want us to come down and help you? They are not calling us from the White House. We will come down. We are available.

Thank you both. And that concludes the hearing.

[Whereupon, at 5 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

A written statement to be included in the printed record of the hearing held on March 15, 1993, before the Subcommittee on Health, Committee on Ways and Means, US House of Representatives, The Honorable Pete Stark (D., California), Chairman:

A lack of standards is not the only aspect of the private health insurance industry that may be considered a travesty. The practices of contemporary health insurance companies have created an atmosphere of personal terror that rivals the aftermath of the World Trade Center bombing.

By now, most have heard about the case where two men went to jail for the crime of switching identities in order to make sure that one of them, who had been seriously injured, but did not have health insurance, had the opportunity to receive the medical treatment that he needed so desperately. This is but one example of torture many Americans are forced to endure as our health is held hostage by a health care system that is driven far more by profit than by any other consideration.

A few short years ago, a friend of mine was in labor with her third and, at this time, youngest child. Her due date was January 2nd of the following year. Her husband had recently been fired by his employer and his family health insurance expired at midnight on December 31st of that year. My pregnant friend's obstetrician planned to give my friend drugs to induce labor if she had not naturally gone into labor by December 29th -- not because it was medically necessary, *but so that my friend would be covered by insurance during the delivery.*

My family has been fortunate enough to be covered under *relatively* good health insurance throughout the past several years. However, there are many practices of my family's insurance company that have made the process of being ill even more hellish that it already is.

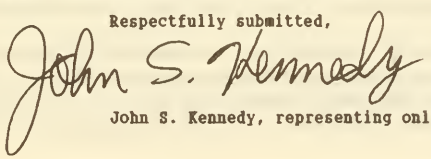
My grandmother has become very ill several times in the past few months. She has been hospitalized seven times in the recent past. Having a close family member seriously ill is horrible enough of an experience -- yet we must also endure the process of "medical pre-certification". In each case, when my grandmother was admitted on an emergency basis, we had to call and ask for the *permission* of her insurance company to allow her to stay in the hospital to receive the life sustaining care that she needed so desperately. On several occasions, after she got out of the hospital, we were forced to endure notices from the insurance company saying that some of the days that she was in the hospital were not considered "medically necessary". I have been told that such practices are meant to discourage the abuse of insurance companies, and I have no doubt that there have been abuses in the past. However, when insurance companies assume that *all* of their subscribers and their subscribers' doctors are attempting to defraud them, they are dangerously flirting with the wholesale abandonment of the concept of "innocent until proven guilty".

At the moment, I am covered by the same insurance company as my grandmother. I often wonder whether or not to instruct my friends and relatives that if I should ever become injured or seriously ill, to call my insurance company *before* they call 911.

The thirteenth amendment of the Constitution of the United States attempted to abolish the practice of slavery and involuntary servitude. However, so long as our present health insurance system exists, Americans will be held in slavery to their employers much as the ancient plantation owners held African-Americans as slaves. Those who have not found an employer with significant health benefits must endure the captivity of the constant terror of becoming seriously ill in a society where health care providers and insurance companies are more concerned about their profits than the health of their patients and customers. Most insurance companies refuse to sell significant health coverage to anyone with any significant pre-existing condition. I am such a person with a pre-existing condition. I look forward to a future of lousy health coverage, no health coverage, or working for companies that I am poorly suited for, not for career advancement, but simply to escape the never-ending terror of getting sick without insurance.

I, and millions of other Americans, would appreciate any action that the Congress can take in order to assure that *all* Americans are freed from the terror of being held hostage by our present health care system.

Respectfully submitted,



John S. Kennedy, representing only myself

A WRITTEN STATEMENT
BY LINDA REITER
IN RESPONSE TO THE
COMMITTEE ON WAYS AND MEANS,
U.S. HOUSE OF REPRESENTATIVES,
THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
HEARING ON HEALTH CARE REFORM:
ISSUES RELATING TO PRIVATE HEALTH INSURANCE REFORM
MARCH 15, 1993

This is a statement in response to the announcement of this hearing in which Chairman Stark said, "The lack of standards for private health insurance is a travesty. The widespread use of medical underwriting, experience rating and restrictions on enrollment have deprived too many businesses and individuals of affordable health insurance coverage". I, Linda Reiter, am writing this statement representing myself and other citizens of the United States, who are concerned about coverage denials, exclusions for preexisting conditions and exclusions based upon industry classification of groups; specifically for infertility patients.

I count myself as one of the 4.9 million people affected by infertility in this country. Before discussing insurance coverage for infertility I would like to dispel two myths which we as childless families are confronted with regularly as solutions to our problem. We either hear well-meaning comments envying our freedom or off-hand suggestions such as "Why don't you just adopt?". The options, other than infertility treatment, we as childless families face are to remain childfree or to adopt. To some people a childfree lifestyle is not an option because they believe a family with children is the basic foundation of our country and the most important thing in life. The desire for biological parenthood is seen as their right.

The adoption option is in theory a practical and humanitarian way to add children to a childless family. In fact there are 100,000 children waiting for homes. They are at least of school age, in sibling groups, are emotionally, mentally or physically handicapped or are racially different than the majority of adopters. However, in general, social workers feel that such children with special needs need special parenting skills; skills which are usually developed with experience. No one should consider adopting such a child because they have been incorrectly advised that such is "easy to get" or "all they can get" or "what they should do". This attitude reflects poorly as well on the children who wait; who deserve the dignity of being adopted as a first choice for themselves alone. Though some of these children will be placed with inexperienced first time parents, many of them will be adopted by families who already have children.

International, transracial adoption carries with it a different set of issues. Doing a good deed for a poor, homeless childby adoption, thinking that she/he will perhaps be more grateful to you when older than if he were your child by birth, is poor motivation for this type of adoption and not very realistic. An attitude of respect for the country and culture of the child is necessary as opposed to helping the child become absorbed into your culture at the expense of his own.

In the case of domestic adoption there are twenty five couples who wait an average of three to seven years for each baby who is available for adoption. Therefore, biological parenthood is the remaining viable option for most couples experiencing infertility. Further, a wide range of underlying diseases may cause or inhibit infertility and are treatable in 60-70% of cases, most often without expensive treatements.

Infertile people are discriminated against by insurance companies who refuse to pay for treatment, labeling infertility as an elective condition, while often providing full maternity benefits and paying for voluntary sterilization, both of which are elective conditions.

Some companies consider infertility as experimental, to quote a letter from my insurance company questioning the use of certain medications I had been using since 1989. It read, "Your Prescription Drug Program is designed to provide benefits for medically necessary care. After April 1, 1992, we will require prior authorization to

determine whether these medications are covered in accordance with your program. The Prior Authorization Unit reviews a patient's medical records to determine if the medication and therapy it is being used for meets the contractual requirements by your group program. Our policies exclude coverage for medications which are labeled experimental or investigational." At this time in the course of treatment we had already established a pregnancy using one of theadvanced reproductive technologies. This unfortunately resulted in an ectopic pregnancy situated in my fallopian tube which had to be surgically removed. The point being that these are not experimental procedures because of their success and they have been in existence since 1978. I stopped treatment in February 1992 for two reasons (1) fear that I would be denied coverage which I could not afford as a result of this letter and (2) the stress of undergoing seven years of physically and psychologically invasive treatment procedures. Fortunately my insurance paid most of the cost of my treatments up to 1992, denying payment for procedures which replace the specific act of natural conception.

Many health insurance plans simply do not provide coverage for infertility treatment. I have a friend who also has had years of treatment. She paid some of her costs out of pocket and eventually asked that her doctor write off some of a large balance she had accrued. This same friend finally began the adoption process and in two years has paid a few thousand dollars to wait another possibly two to three years. She is now 39 years old and is beginning her menopause prematurely, effecting the production and quality of eggs. She heard of a woman willing to donate eggs to anyone willing to pay for her treatment which would amount to from $8500 to $10000. She and her husband could claim none of this expense on their insurance making it necessary for them to take out a loan. She is at this time pregnant with her husband's sperm and the donor eggs, hoping that the pregnancy goes to full term. She pays $300 per month on this loan for the next three years, regardless of what happens with this pregnancy. This is a middle class family already struggling with finances who took a great risk to build a family with children.

For those who wish to or need to change jobs, many face preexisting condition clauses which preclude them from treatment. The insurance companies are thus in the position of deciding about our reproductive choices.

On the other hand, a typical day at the infertility clinic for a treatment cycle can be anywhere from $300 to $350. Last year Congressman Ron Wyden (D-OR) proposed legislation (HR 3940) which would require development of standards in quality assurance, records maintenance, and personnel qualifications and continued reporting of success rates. The Chair-person of the national Board of Directors of RESOLVE (a nonprofit organization for people with infertility problems) testified on its behalf, stating, "We view this bill as a cooperative effort between the physicians and government to assure the highest standards of care and information for infertile couples". There also needs to be a way to facilitate communication between care providers and insurance companies to keep costs competitive with continued quality care.

I left my last employment in May 1992 to pursue further education and therefore gave up my health insurance. We are at a point at which we face attempting further infertility treatment not knowing if my husband's insurance will cover and without my income to supplement the difference. Another option is to get on an adoption waiting list before I turn forty in December of this year, since this is the usual age limit for many agencies, and wait for three to six years. Or we decide that we will build a lifestyle without children. Whatever we decide my concern rests with the millions who have not had the opportunity for treatment that we have had and the millions still to face this issue in the future.

The following is a proposal for national health insurance with managed competition as outlined by Paul Starr in his publication entitled "The Logic of Health-Care Reform". Instead of acquiring health coverage through employers, consumers would choose a plan through a regional Health Insurance Purchasing Corporation (HIPC). The HIPC, a public authority set up under a state commission, would contract with various HMOs and other managed-care plans as well as one plan offering free choice of provider. These plans would be owned and run, as they are today, by insurance companies, provider groups, other corporations, or consumer cooperatives.

All revenue for health insurance goes into one pot making the pooling of risk community-wide. I am advocating that coverage for infertility treatment be included. This could be on the order which some states have already enacted through Family Building Acts. These states have mandated infertility treatment but for a limited number of treatments. Or some companies or individuals, using net after-tax income, may choose to buy supplementary policies, say, for uncovered infertility care.

National health insurance would also make exclusions for preexisting conditions unnecessary because health coverage would not be tied to one's employment. This would also allow for more mobility in the work force thus benefiting the economy by allowing workers to go where they can make greater contributions. And finally, this eliminates the intrusion by employers into employees' private choices about their health care. In this case it eliminates the need for employees with infertility problems to advocate with their employer to secure coverage for infertility. This would eliminate the need to expose private health issues to your employer except on a voluntary basis and in confidence.

This would also preserve a role for existing private health plans, but change how they compete. Using the staff expertise of the insurance industry to manage competition, it would ensure that no plan attempted to reduce its costs by inducing high-cost patients to leave. The threat to infertility patients, for example, to lose coverage during treatment would be avoided; thereby reducing some stress in these otherwise extremely stressful medical procedures. The HIPC would not deal directly with doctors or other health-care providers. Consumers would select one of several privately managed health plans. The doctors and health plans would work out the terms of their relationships with clearer expenditure limits than now exist. This brings us to the effects of this plan on the health-care providers.

Universal health insurance based on competing private plans would leave physicians with a variety of different practice options. This would avoid subjecting physicians to comprehensive all-payer fee regulation. Managed-care plans will not be in a position to dictate terms to doctors because they will need physicians' cooperation to control overall health costs. Thus, health-care providers will regain their autonomy in practice but by keeping down increases in their own fees and conserving healthcare resources. In this example, physicians will be able to determine the most appropriate infertility treatment. And consumers will be aware of the limits on the particular health plan they have chosen and will not be subject to unforeseen exclusions or denials of coverage in the middle of a treatment cycle.

While I am clearly in favor of a national health care system, some of the more popular reform plans diminish greatly or remove infertility treatment from coverage. For example, the Oregon model, in October 1992, listed medical treatments in order of importance and priority with infertility 602nd out of 709. As of last week they announced that infertility treatment will not be covered under their plan at all. The Board of RESOLVE adopted the following policy: "RESOLVE supports affordable, quality health care for all Americans. All such health care benefits should include pregnancy related benefits for the infertile and as a component thereof, coverage for all procedures and medication necessary to achieve and maintain a pregnancy". I support this policy within the guidelines as outlined above. This will include many people who have not had the opportunity for basic infertility treatment, but will also allow for the purchase of supplemental infertility coverage.

PHYSICIAN OWNERSHIP AND REFERRAL ARRANGEMENTS AND H.R. 345, "THE COMPREHENSIVE PHYSICIAN OWNERSHIP AND REFERRAL ACT OF 1993"

TUESDAY, APRIL 20, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to call, at 10 a.m., in room B–318, Rayburn House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing and a copy of the bill, H.R. 345, follow:]

FOR IMMEDIATE RELEASE
MONDAY, APRIL 12, 1993

PRESS RELEASE #11
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

**THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING
ON
HEALTH CARE REFORM:
PHYSICIAN OWNERSHIP AND REFERRAL ARRANGEMENTS AND H.R. 345,
"THE COMPREHENSIVE PHYSICIAN OWNERSHIP AND REFERRAL ACT OF 1993"**

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on issues relating to physician ownership and referral arrangements on Tuesday, April 20, 1993, beginning at 10:00 a.m., in B-318 Rayburn House Office Building.

The Subcommittee will focus on the effect that physician ownership and referral arrangements have on the health care system. The Subcommittee previously announced that the hearing scheduled for April 14, 1993, would include consideration of budget issues relating to physician ownership and referral arrangements. This issue will now be considered on April 20, 1993.

The hearing on Part B budget reconciliation issues relating to clinical laboratory services and durable medical equipment, previously scheduled for April 14, 1993, will also be held on April 20, 1993, in room B-318 Rayburn House Office Building, immediately following the hearing on physician ownership and referral arrangements. (See press release #9, dated March 26, 1993, and press release #9-Revised, dated April 12, 1993.)

Oral testimony will be heard from <u>invited witnesses only</u>. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

<u>BACKGROUND</u>:

Earlier this year, Chairman Stark introduced H.R. 345, "The Comprehensive Physician Ownership and Referral Act of 1993." H.R. 345 extends the current physician ownership and referral prohibitions beyond public health care programs and to additional services beyond clinical laboratory services.

In addition, on February 17, President Clinton announced his budget proposals for fiscal year 1994, which included recommendations to extend the current physician ownership and referral prohibitions to additional services. The Congressional Budget Office (CBO) has estimated that the President's proposal would save $350 million by extending the current physician ownership and referral ban to additional services.

<u>DETAILS FOR SUBMISSION OF WRITTEN COMMENTS</u>:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Tuesday, May 4, 1993, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

(MORE)

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

* * * * *

I

103D CONGRESS
1ST SESSION

H. R. 345

To amend title XVIII of the Social Security Act to extend and improve the ban on physician referrals to health care providers with which the physician has a financial relationship.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 5, 1993

Mr. STARK introduced the following bill; which was referred jointly to the Committees on Ways and Means and Energy and Commerce

---

A BILL

To amend title XVIII of the Social Security Act to extend and improve the ban on physician referrals to health care providers with which the physician has a financial relationship.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Comprehensive Physician Ownership and Referral Act of 1993".

SEC. 2. APPLICATION OF MEDICARE BAN ON SELF-REFERRALS TO ALL PAYORS.

Section 1877 of the Social Security Act (42 U.S.C. 1395nn) is amended—

(1) in subsection (a)—

(A) in paragraph (1)(A), by striking "for which payment otherwise may be made under this title" and inserting "for which a charge is imposed", and

(B) in paragraph (1)(B), by striking "under this title";

(2) by amending paragraph (1) of subsection (g) to read as follows:

"(1) DENIAL OF PAYMENT.—No payment may be made under this title, under another Federal health care program, or under a State health care program (as defined in section 1128(h)) for a designated health service for which a claim is presented in violation of subsection (a)(1)(B). No individual, third party payor, or other entity is liable for payment for designated health services for which a claim is presented in violation of such subsection."; and

(3) in subsection (g)(3), by striking "for which payment may not be made under paragraph (1)"

and inserting "for which such a claim may not be presented under subsection (a)(1)".

SEC. 3. EXTENSION OF SELF-REFERRAL BAN TO ADDITIONAL SPECIFIED SERVICES.

(a) IN GENERAL.—Section 1877 of the Social Security Act is further amended—

(1) by striking "clinical laboratory services" and "CLINICAL LABORATORY SERVICES" and inserting "designated health services" and "DESIGNATED HEALTH SERVICES", respectively, each place either appears in subsections (a)(1), (b)(2)(A)(ii)(I), (b)(4), (d)(1), (d)(2), and (d)(3), and

(2) by adding at the end the following new subsection:

"(i) DESIGNATED HEALTH SERVICES DEFINED.—In this section, the term 'designated health services' means—

"(1) clinical laboratory services;

"(2) physical therapy services;

"(3) radiology services, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services;

"(4) radiation therapy services;

"(5) the furnishing of durable medical equipment;

"(6) the furnishing of parenteral and enteral nutrition equipment and supplies;

"(7) the furnishing of outpatient prescription drugs;

"(8) ambulance services;

"(9) home infusion therapy services;

"(10) occupational therapy services; and

"(11) inpatient and outpatient hospital services (including services furnished at a psychiatric or rehabilitation hospital).".

(b) CONFORMING AMENDMENTS.—Section 1877 of such Act is further amended—

(1) in subsection (d)(2), by striking "laboratory" and inserting "entity",

(2) in subsection (g)(1), by striking "clinical laboratory service" and inserting "designated health service", and

(3) in subsection (h)(7)(B), by striking "clinical laboratory service" and inserting "designated health service".

SEC. 4. CHANGES IN EXCEPTIONS AND OTHER PROVISIONS RELATING TO COMPENSATION ARRANGEMENTS.

(a) MULTIPLE LOCATIONS FOR GROUP PRACTICES.—Section 1877(b)(2)(A)(ii)(II) of the Social Secu-

rity Act is amended by striking "centralized provision" and inserting "provision of some or all".

(b) TREATMENT OF COMPENSATION ARRANGEMENTS.—

(1) RENTAL OF OFFICE SPACE AND EQUIPMENT.—Paragraph (1) of section 1877(e) of such Act is amended to read as follows:

"(1) RENTAL OF OFFICE SPACE; RENTAL OF EQUIPMENT.—

"(A) OFFICE SPACE.—Payments made by a lessee to a lessor for the use of premises if—

"(i) the lease is set out in writing, signed by the parties, and specifies the premises covered by the lease,

"(ii) the aggregate space rented or leased is reasonable and necessary for the legitimate business purposes of the lease or rental,

"(iii) the lease provides for a term of rental or lease for at least one year,

"(iv) in the case of a lease that is intended to provide the lessee with access to the premises for periodic intervals of time, rather than on a full-time basis, the lease specifies exactly the schedule of such inter-

vals, their length, and the rent for such intervals,

"(v) the rental charges over the term of the lease are set in advance, are consistent with fair market value, and are not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties,

"(vi) the lease would be commercially reasonable even if no referrals were made between the parties, and

"(vii) the compensation arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

"(B) EQUIPMENT.—Payments made by a lessee of equipment to the lessor of the equipment for the use of the equipment if—

"(i) the lease is set out in writing, signed by the parties, and specifies the equipment covered by the lease,

"(ii) the equipment rented or leased is reasonable and necessary for the legitimate business purposes of the lease or rental,

"(iii) the lease provides for a term of rental or lease of at least one year,

"(iv) in the case of a lease that is intended to provide the lessee with use of the equipment for periodic intervals of time, rather than on a full-time basis, the lease specifies exactly the schedule of such intervals, their length, and the rent for such intervals,

"(v) the rental charges over the term of the lease are set in advance, are consistent with fair market value, and are not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties,

"(vi) the lease would be commercially reasonable even if no referrals were made between the parties, and

"(vii) the compensation arrangement meets such other requirements as the Secretary may impose by regulation as needed

to protect against program or patient abuse.".

(2) BONA FIDE EMPLOYMENT RELATIONSHIPS.—Paragraph (2) of such section is amended—

(A) by striking "WITH HOSPITALS",

(B) by striking "An arrangement" and all that follows through "if" and inserting "Any amount paid by an employer to an employee who has a bona fide employment relationship with the employer for employment, or paid by a hospital pursuant to an arrangement with a physician (or immediate family member) for the provision of administrative services, if",

(C) in subparagraphs (A), (B), and (D), by striking "arrangement" and inserting "employment relationship or arrangement", and

(D) in subparagraph (C), by striking "to the hospital".

(3) ADDITIONAL EXCEPTIONS.—Such subsection is further amended by adding at the end the following new paragraphs:

"(7) PAYMENTS TO A PHYSICIAN FOR OTHER ITEMS OR SERVICES.—

"(A) IN GENERAL.—Payments made by an entity to a physician (or family member) who is

not employed by the entity as compensation for services specified in subparagraph (B), if—

"(i) the compensation agreement is set out in writing and specifies the services to be provided by the parties, the compensation for each unit of service provided under the agreement, and the schedule for the provision of such services,

"(ii) the compensation paid over the term of the agreement is consistent with fair market value and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties,

"(iii) the compensation is provided pursuant to an agreement which would be commercially reasonable even if no referrals were made to the entity, and

"(iv) the compensation arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

"(B) SPECIFIED SERVICES.—For purposes of subparagraph (A), the services specified in this subparagraph are any of the following:

"(i) Consultative services that—

"(I) relate to results that have been obtained that are outside established parameters, or are specifically requested by the referring physician on a specified patient,

"(II) are furnished by a physician other than the referring physician (or by another physician who is a member of the same group practice), and

"(III) for which the physician furnishes a written report for that patient.

"(ii) Interpretation of tissue pathology or Pap smear slides or the provision of other cytology services.

"(iii) Phlebotomy services for paternity or toxicology testing where the services are furnished by a physician other than the physician referring the individual for such testing (or by another physician

who is a member of the same group practice).

"(iv) Employment-related health care services, including a payment by a self-insured employer for services rendered to employee applicants, employees, or their families under the terms of a health benefit plan.

"(v) Services as a clinical consultant to the entity as required for certification of the provider under section 353 of the Public Health Service Act.

"(vi) Services required by local, State, or Federal licensure, accreditation, or other health and safety provisions.

"(vii) Services billed in the name of a group practice provided by a physician under contract to the group practice for services not otherwise available directly through a physician who is a member of the group.

"(8) PAYMENTS BY A PHYSICIAN FOR ITEMS AND SERVICES.—Payments made by a physician—

"(A) to a laboratory in exchange for the provision of clinical laboratory services, or

"(B) to an entity as compensation for other items or services if the items or services are furnished at a price that is consistent with fair market value and are generally available to referrors and non-referrors alike on similar terms and conditions.

"(9) PAYMENTS FOR PATHOLOGY SERVICES OF A GROUP PRACTICE.—Payments made to a group practice for pathology services under an agreement if—

"(A) the agreement is set out in writing and specifies the services to be provided by the parties and the compensation for services provided under the agreement,

"(B) the compensation paid over the term of the agreement is consistent with fair market value and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties,

"(C) the compensation is provided pursuant to an agreement which would be commercially reasonable even if no referrals were made to the entity; and

"(D) the compensation arrangement between the parties meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.".

(c) TREATMENT OF GROUP PRACTICES.—

(1) USE OF BILLING NUMBERS, ETC.—Section 1877 of the Social Security Act is amended—

(A) in subsection (b)(2)(B), by inserting "under a billing number assigned to the group practice" after "member",

(B) in subsection (h)(4)(B), by inserting "and under a billing number assigned to the group" after "in the name of the group", and

(C) in subsection (h)(4)(C), by striking "by members of the group".

(2) TREATMENT OF CLINICAL LABORATORY SERVICES FURNISHED UNDER ARRANGEMENTS BETWEEN HOSPITALS AND GROUP PRACTICES.—

(A) IN GENERAL.—Section 1877(h)(4) of such Act is amended—

(i) in subparagraph (B) (as amended by paragraph (1)(B)), by inserting "(or are billed in the name of a hospital for which the group provides clinical labora-

tory services pursuant to an arrangement that meets the requirements of subparagraph (B))" after "assigned to the group";

(ii) by redesignating subparagraphs (A) through (D) as clauses (i) through (iv), respectively;

(iii) by inserting "(A)" after ".—"; and

(iv) by adding at the end the following new subparagraph:

"(B) The requirements of this subparagraph, with respect to an arrangement for clinical laboratory services provided by the laboratory of a group and billed in the name of a hospital, are that—

"(i) with respect to services provided to an inpatient of the hospital, the arrangement is pursuant to the provision of inpatient hospital services under section 1861(b)(3);

"(ii) the arrangement began before December 19, 1989, and has continued in effect without interruption since such date;

"(iii) the laboratory provides substantially all of the clinical laboratory services to the hospital's patients;

"(iv) the arrangement is pursuant to an agreement that is set out in writing and that specifies the services to be provided by the parties and the compensation for services provided under the agreement;

"(v) the compensation paid over the term of the agreement is consistent with fair market value and the compensation per unit of services is fixed in advance and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties;

"(vi) the compensation is provided pursuant to an agreement which would be commercially reasonable even if no referrals were made to the entity; and

"(vii) the arrangement between the parties meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.".

(B) CONFORMING AMENDMENT.—Section 1877(b)(2)(B) of such Act is amended by inserting "(or by a hospital for which such a group practice provides clinical laboratory services pursuant to an arrangement that meets the

requirements of subsection (h)(4)(B))" after "by a group practice of which such physician is a member".

(3) TREATMENT OF CERTAIN FACULTY PRACTICE PLANS.—The last sentence of section 1877(h)(4)(A) of such Act, as redesignated by paragraph (1)(A), is amended by inserting ", institution of higher education, or medical school" after "hospital".

(d) EXPANDING RURAL PROVIDER EXCEPTION TO COVER COMPENSATION ARRANGEMENTS.—

(1) IN GENERAL.—Section 1877(b) of such Act is further amended—

(A) by redesignating paragraph (5) as paragraph (7), and

(B) by inserting after paragraph (4) the following new paragraph:

"(5) RURAL PROVIDERS.—In the case of designated services if—

"(A) the entity furnishing the services is in a rural area (as defined in section 1886(d)(2)(D)), and

"(B) substantially all of the services furnished by the entity to individuals entitled to

benefits under this title are furnished to such individuals who reside in such a rural area.".

(2) CONFORMING AMENDMENTS.—Section 1877(d) of such Act is amended—

(A) by striking paragraph (2), and

(B) by redesignating paragraph (3) as paragraph (2).

(e) EXEMPTION OF COMPENSATION ARRANGEMENTS INVOLVING CERTAIN TYPES OF REMUNERATION.—Section 1877(h)(1) of such Act is amended—

(1) by striking subparagraph (B);

(2) in subparagraph (A), by inserting before the period the following: "(other than an arrangement involving only remuneration described in subparagraph (B))"; and

(3) by adding at the end the following new subparagraph:

"(B) Remuneration described in this subparagraph is any remuneration consisting of any of the following:

"(i) The forgiveness of amounts owed for inaccurate tests or procedures, mistakenly performed tests or procedures, or the correction of minor billing errors.

"(ii) The provision of items, devices, or supplies of minor value that are used to—

"(I) collect, transport, process, or store specimens for the entity providing the item, device, or supply, or

"(II) communicate the results of tests or procedures for such entity.

"(iii) The furnishing by an entity of laboratory services to a group practice affiliated with the entity, if the entity provides all or substantially all of the clinical laboratory services of the group practice.".

(f) MISCELLANEOUS AND TECHNICAL CORRECTIONS.—Section 1877 of such Act is amended—

(1) in the fourth sentence of subsection (f)—

(A) by striking "provided" and inserting "furnished", and

(B) by striking "provides" and inserting "furnish";

(2) in the fifth sentence of subsection (f)—

(A) by striking "providing" each place it appears and inserting "furnishing",

(B) by striking "with respect to the providers" and inserting "with respect to the entities", and

(C) by striking "diagnostic imaging services of any type" and inserting "magnetic resonance imaging, computerized axial tomography scans, and ultrasound services"; and

(3) in subsection (a)(2)(B), by striking "subsection (h)(1)(A)" and inserting "subsection (h)(1)".

SEC. 5. EFFECTIVE DATES.

(a) EXPANSION OF COVERAGE AND PAYORS.—The amendments made by sections 2 and 3 shall apply with respect to a referral by a physician for designated health services (as described in section 1877(i) of the Social Security Act) made on or after the first day of the first month beginning 2 years after the date of the enactment of this Act.

(b) CHANGES IN EXCEPTIONS, ETC.—The amendments made by section 4 shall apply to referrals made on or after January 1, 1992.

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Chairman STARK. Good morning. If our guests would get their testimony in silence, we will continue our hearings on health care reform. We will focus this morning on the ownership and referral in H.R. 345, a bill which I introduced along with Mr. Levin. In 1988 a form of the bill was introduced at the suggestion of HCFA and the inspector general's office, and the bill exists in some form today.

Since 1989 a number of studies have indicated that self-referral for types of services in addition to clinical labs are associated with higher utilization and increased costs. In particular a study conducted by the Florida Health Care Cost Containment Board has raised serious questions about self-referral to various types of medical facilities.

Earlier this year I introduced H.R. 345 to extend the current physician ownership and referral prohibitions beyond public health programs and to additional services. This bill was introduced because the evidence is clear that self-referrals drive up health care costs and result in unnecessary utilization of services. Others have joined in the desire to ban these referrals.

President Clinton's budget includes a proposal similar to the original legislation proposed in 1988, and the health care reform proposal introduced by the Republican task force includes a similar proposal.

Today we will hear the results of a study conducted by the GAO. At this committee's request they have examined physician referral behavior to determine if there were differences between the referral rates of owners and those of nonowners. It is my belief that this study strongly supports the contention that physician ownership and referral arrangements cost us wasted money.

The medical practice is far more commercialized and profit-oriented than before. This factor has led to an explosion in ownership of and investment in medical facilities by physicians. The nature of these arrangements may limit the doctor's ability to offer patients neutral advice about whether or not services are needed.

Only by enacting a comprehensive, across-the-board ban on referrals can we protect and improve the consumers' confidence in the health care system generally. I hope we can move forward on a bipartisan basis to enact a comprehensive reform ban on referrals this year.

[The opening statement of Chairman Stark follows:]

OPENING STATEMENT

THE HONORABLE PETE STARK

APRIL 20, 1993

This morning the Subcommittee continues its series of hearings on health care reform. These hearings are intended to lay the foundation needed to help us as we work with the President to enact health care reform legislation.

Today we will focus on issues relating to physician ownership and referral arrangements and H.R. 345, "The Comprehensive Physician Ownership and Referral Act of 1993", a bill which I introduced along with the Vice-Chairman of the Subcommittee, Mr. Levin.

In 1988, I introduced at the suggestion of HCFA and the Inspector Generals office the first bill focusing on physician self-referral. As a result of my proposal, the Congress enacted a law, which went into effect in 1992, prohibiting physicians who had a financial relationship with a clinical laboratory from referring to the laboratory for Medicare services.

Since 1989, a number of studies have indicated that self-referral for other types of services in addition to clinical laboratory tests are associated with higher utilization and increased costs. In particular, a study conducted by the Florida Health Care Cost Containment Board, raised serious concerns about self-referral to various types of medical facilities.

Earlier this year I introduced H.R. 345, "The Comprehensive Physician Ownership and Referral Act of 1993". This bill would extend the current physician ownership and referral prohibitions beyond public health programs and to additional services. I introduced this bill because the evidence is clear that physician self-referrals drive up health care costs and result in unnecessary utilization of services.

Others have more recently joined in the desire to ban referrals by physicians with a financial conflict of interest. President Clinton's Budget includes a proposal similar to the original legislation I proposed in 1988. In addition, the health care reform proposal introduced by the Republican Task Forces also includes a similar provision.

Today, we will hear the results of a study conducted by the General Accounting Office. At this Committee's request, GAO examined physician referral behavior to determine if there was differences between the referral rates of owners and those of nonowners. This study strongly supports what I have contended all along--physician ownership and referral arrangements cost all of us money.

Medical practice is far more commercialized and profit-oriented than ever before. This factor has lead to an explosion in ownership of and investment in medical facilities by physicians. The very nature of these arrangements undermine the doctor's ability to offer patients neutral advise about whether or not services are needed, which kinds are preferable and who should provide them.

Referrals by physicians with an ownership interest should be banned. Only by enacting a comprehensive, across-the-board ban on referrals can we protect and improve consumers' confidence in their physicians, as well as the health care system generally. We need to ensure that our physicians are providing not only the best care but also the most objective and cost effective advice. I hope we can move forward immediately on a bipartisan basis to enact a comprehensive ban on referrals this year.

Chairman STARK. I would like to recognize the distinguished ranking minority member, Mr. Thomas, for an opening statement.

Mr. THOMAS. Thank you, Mr. Chairman. I ask unanimous consent that my statement be placed in the record.

Chairman STARK. Without objection.

Mr. THOMAS. I don't think anyone is opposed to making sure the waste, fraud, and abuse is not in the system. I think you will find that it is relatively minor given the total dollar amount we are involved with. My concern is not so much in our ability to create a total ban in terms of self-referral structure, but what that total ban would do in some areas, principally rural areas, and that I am looking for testimony today that will allow us to do this in as reasonable a way as possible to make sure that as States are moving in this direction—and it is clear that they are—that we create a system in which we do not present regulatory burdens to professionals in terms of having to comply with State and Federal standards that differ in ways that require them to follow two paths for approval; or that the Feds create a controlled structure superimposing their position on the States that will make it more difficult under a proposal which currently reports indicate that the President's health care package will allow a great deal of flexibility for the States.

Frankly, one of the concerns I have is that without the willingness of doctors in rural areas to invest their own moneys in structures which will provide for newer technology and greater benefits for rural areas that we simply for the sake of uniformity create a ban which, in fact, denies opportunities for people in particular areas of the country that perhaps would prefer to say, if given a choice of no self-referral or self-referral, set up a structure which allows it to occur fairly without waste, fraud, and abuse.

Although I certainly understand the difficulties and the reason for a potential ban, I am looking for a position which is a reasonable one; one which makes sure that no one can unfairly advance themselves in the system, but which creates maximum opportunity for people who are willing to invest their own funds to provide technology and services that would otherwise be unavailable, Mr. Chairman.

[The prepared opening statement of Mr. Thomas follows:]

OPENING STATEMENT OF HON. BILL THOMAS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Chairman, there are several anecdotal examples of physicians improperly referring a patient to a lab or clinic in which the physician has an interest. If we are to get a handle on runaway medical costs, it is clear that such abuses of the system must be stopped.

My primary concern, however, is that in our attempt to stop fraud and abuse, we must not strictly prohibit legitimate and necessary investment in new technologies and services, especially in rural areas. There are many small towns in my district which have only a couple of physicians, and in the past these physicians have been the only source of investment for new clinical and lab services. Failure to take such situations into account could result in reduced accessibility to adequate health care.

I also have concerns about the effect a ban will have on the financial health of referral services. As the Subcommittee develops legislation, we must remain aware of the effect the new regulations will have on the overall availability of services and on the competitiveness of these services in the health care market.

I am hopeful that today's hearing will provide guidance on how to address the problem of inappropriate physician referral, while preserving the ability of areas

with limited investment capability to expand medical services, and how to effectively and fairly implement regulations.

Chairman STARK. Are there other statements?

Mr. Lewis.

Mr. LEWIS. Mr. Chairman, I want to thank you for holding this hearing. I have reviewed the testimony from the GAO, and I believe that the issue of self-referral is a serious problem that we must and can address. I look forward to hearing the testimony from our witnesses. I thank you again, Mr. Chairman.

Chairman STARK. Thank you. I would just suggest that today we have a long day of hearings and the Chair will run the clock both for the pain of the witnesses and the members to give us time to inquire. We will waive that as we usually do for the administration, and with unanimous consent all witnesses' statements will appear in the record in their entirety. The record will be held open for subsequent submission of questions or statements for 5 days, and we will then proceed to hear from Janet Shikles, the Director for Health Financing and Policy Issues, the General Accounting Office. Accompanying Janet is William Rice, the senior evaluator of the Boston regional office, and Herman Jenich, who is the evaluator of the Human Resources Division.

I apologize for the crowded conditions for our guests, but I would ask that those near the doors keep the doors closed if they can. It is not easy to hear in this room for witnesses, the reporter, or the members, and to make it more comfortable for everybody we will ask—also if guests standing kind of in the aisle around the edges of the room, they may find some more comfort or tables to perch on and there are a few chairs up here. I am trying to accommodate as many of you as we can.

Janet, welcome back to the committee.

STATEMENT OF JANET L. SHIKLES, DIRECTOR, HEALTH FINANCING AND POLICY ISSUES, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Ms. SHIKLES. Thank you.

Chairman STARK. I look forward to your testimony. Why don't you proceed in any manner you are comfortable.

Ms. SHIKLES. Thank you. Mr. Chairman and members of the committee, we are pleased to be here today to discuss the effect on health care utilization and costs when physicians invest in medical facilities and then refer their patients to those facilities, a practice known as self-referral. Our testimony today will focus on diagnostic imaging services, including high-technology, high-cost radiology services such as MRI.

Several studies have indicated that self-referral for services is associated with higher utilization and increased costs. These studies have generated debate about financial and professional ethics considerations within the medical profession as well as within Congress and State legislatures.

In previous testimony before this committee several physician associations have challenged these studies. They believe that the research has not shown a difference between the referral rates of physician-owners and nonowners. In addition, they believe that

when a difference has been found that it has not adequately adjusted for physician specialty.

What I will be reporting on today will be the results of our work from an ongoing study that we are doing for this committee that focuses specifically on physicians. Our objective was to determine if physician-owners, that is, physicians who invest in a particular facility or service, refer their Medicare patients for more imaging services than physicians who are not investors. For our methodology we were able to use survey information gathered in 1989 and 1990 on owners of Florida imaging facilities by Florida State University researchers, and physician information from Florida Blue Cross and Blue Shield Medicare files.

Overall, our analysis included almost 1.3 million claims representing over 55 percent of all referred Medicare part B imaging services for Florida in 1990. What did we find? In 1990 there were at least 39 freestanding centers providing MRI services in Florida, some within blocks of each other or across the street, and physicians had invested in all but one of these facilities. We identified almost 3,000 Florida physicians who had a financial interest in at least one freestanding imaging center. Furthermore, about 18 percent of these physician owners had a financial interest in more than one, and we identified one physician owner who had invested in seven.

Of most significance we found that physicians with a financial interest in freestanding imaging centers had higher referral rates for imaging services than other physicians. Moreover, the differences in the referral rates were greatest for costly, high technology imaging services. As shown in this chart that, I think, is right in front of you, the referral rates of owners were 54 percent higher than nonowners for MRI scans, 28 percent higher for CAT scans, and 25 percent higher for ultrasound and echo-cardiograms.

Now, because some specialties make greater use of imaging services than others, we also compared the referral rates of owners and nonowners within each of 49 practice specialties. For MRI referrals the differences between owner and nonowner referral rates varied widely among the specialties, but MRI owners referred more often than nonowners in each of the 18 specialties with the most MRI referrals.

This second chart over here summarizes our findings for the six specialties with the most MRI referrals. On the left you see we analyzed those specialties that normally have low referral rates—internal medicine, general practice, and family practice—and you can see that MRI owners in each specialty had referral rates from 35 to 181 percent higher than nonowners in the same specialty.

Then on the right, you can see that these are specialties where they typically do refer for a lot of MRI scans—neurologists, neurosurgeons, and orthopedic surgeons. Here MRI owners in each specialty had referral rates from 32 to 57 percent higher than nonowners.

In summary, we believe our study results provide strong evidence that physician ownership arrangements are associated with higher utilization of health care facilities and higher costs. Because our findings are based on a large-scale analysis of physician referral practices, they provide, we believe, important new information

for the Congress as it considers legislation to extend current restrictions on physician self-referrals.

Mr. Chairman, this concludes my statement, and we would be pleased to answer any questions.

[The prepared statement follows:]

Statement of Janet L. Shikles, Director
Health Financing and Policy Issues
Human Resources Division

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the effect on health care utilization and costs when physicians invest in medical facilities and then refer their patients to those facilities--a practice known as self-referral. Our testimony will focus on diagnostic imaging services, including high-technology, high-cost radiology services such as magnetic resonance imaging (MRI).

Preliminary results from our ongoing analysis of Florida's 1990 Medicare claims show that physicians with a financial interest in freestanding (nonhospital) imaging facilities refer their patients more frequently, for more expensive imaging services, than do other physicians. The differences were greatest for MRI referrals by MRI owners and nonowners: overall, MRI owners referred their patients for MRI scans twice as often. Furthermore, in each of the top 18 specialties, accounting for 93 percent of all the Medicare MRI referrals, MRI owners referred their patients for MRI scans more frequently than other physicians in the same specialty. For example, MRI owners in general practice referred their patients for MRI scans almost three times as often as all other physicians in general practice.

Our study results to date provide evidence that physician ownership arrangements are associated with higher utilization of health care facilities and higher costs. Because our findings are based on a large-scale analysis of physician referral practices, we believe they provide important, new information for the Congress as it considers legislation to extend current restrictions on physician self-referral.

BACKGROUND

In June 1989, we found that physician owners of clinical laboratories tended to order more laboratory tests, and more costly types of tests, than nonowners.[1] Later in 1989, the Congress enacted legislation restricting physician owners of clinical laboratories from referring their Medicare patients to those laboratories. Since 1989, several studies have indicated that self-referral for services other than clinical laboratory tests is also associated with higher utilization and increased costs. These studies have generated debate about financial and professional ethics considerations, within the medical profession as well as in the Congress and state legislatures.

In particular, a 1991 report on Joint Ventures Among Health Care Providers in Florida by the State of Florida Health Care Cost Containment Board and Florida State University raised serious concerns about self-referral to various types of medical facilities, including freestanding diagnostic imaging centers. That study compared the utilization and charges of physician-owned imaging centers with other imaging centers, but it did not examine physician referral behavior to determine if there were differences between the referral rates of owners and nonowners. Therefore, this Subcommittee asked us to use the information gathered for the Florida study--the only statewide information then available on physician financial interests in medical facilities--to determine if physician owners refer their Medicare patients for more imaging services than other physicians.

Using survey information gathered in 1989 and 1990 from Florida imaging facilities by Florida State University and physician information from Florida Blue Cross and Blue Shield Medicare files, we identified the Medicare provider numbers of almost 3,000 Florida physicians with a financial interest in

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[1]Medicare: Referring Physicians' Ownership of Laboratories and Imaging Centers (GAO/T-HRD-89-26, June 8, 1989).

Florida freestanding imaging centers. I will refer to these physicians as "owners" of freestanding imaging centers.[2]

While we did not independently verify the accuracy of the Florida State survey, we reviewed selected survey responses, met with the principal researchers, and matched selected information from the surveys with physician data from Florida Blue Cross and Blue Shield. The number of physician owners we used in our analysis is a conservative estimate of the total number of Florida physicians with a financial interest in imaging facilities in 1990. Some of the imaging facilities that responded to the Florida State survey acknowledged that they were owned by physicians, but they refused to identify those physicians. For other physician owners, we did not have sufficient information to determine their Medicare provider numbers. Thus, our "nonowner" physician groupings include some owners, which tends to understate the differences in referral rates by owners.

To calculate physician referral rates, we used a database of all the 1990 Medicare Part B claims processed by Florida Blue Cross and Blue Shield.[3] We used all imaging services that identified the referring physician and for which we could confirm, from Medicare claims, that the patient had a recent office visit with that physician. We also used imaging services where the referring physician was not identified but where Medicare claims showed the patient had a recent office visit with only one potential referring physician. We visited several Florida imaging centers to review original billing and medical records to test the accuracy of our data and methodology and found that we had correctly matched imaging services to their referring physicians in over 96 percent of our test cases. Our analysis included almost 1.3 million imaging services, representing over 55 percent of all referred Medicare Part B imaging services for Florida in 1990.

To compare the referral practices of physicians who invested in freestanding imaging centers with those who did not, we calculated physician referral rates on the basis of the number of imaging referrals per 100 office visits. We did not review the medical necessity of the imaging services ordered by physicians. We did, however, analyze the referral rates of owners and nonowners by physician specialty, by type of imaging service, and by type of facility owned, to identify variations in the referral rates that might be associated with those factors.

FLORIDA HAS MANY FREESTANDING IMAGING CENTERS AND PHYSICIANS OWN ALL BUT ONE OF THE CENTERS PROVIDING MRI SERVICES

Freestanding diagnostic imaging centers have proliferated in many parts of the country and are also among the most popular types of physician-owned joint ventures. As discussed in a May 1992 GAO report to this Subcommittee,[4] freestanding imaging centers have been especially prevalent in states like Florida that did not restrict the growth of health care facilities in freestanding (nonhospital) settings and had relatively high Medicare payment rates for services such as MRI scans. In 1990, there were at least

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[2]In some cases, a physician's financial interest may have been through a member of his or her immediate family or through investment in a partnership or corporation with a parent or subsidiary relationship to the facility that actually provided the imaging services.

[3]The analysis presented in this testimony does not include inpatient imaging services or those imaging services performed in doctors' offices.

[4]Medicare: Excessive Payments Support the Proliferation of Costly Technology (GAO/HRD-92-59, May 27, 1992).

39 freestanding centers providing MRI services in Florida--some within blocks of each other--and physicians had invested in all but 1 of those facilities.

Almost 3,000 Florida physicians had a financial interest in at least 1 freestanding imaging center. Furthermore, about 18 percent of these physician owners had a financial interest in more than one imaging center, and one physician had an interest in seven imaging centers.

MOST PHYSICIAN OWNERS OF IMAGING FACILITIES REFERRED MEDICARE PATIENTS FOR IMAGING SERVICES

Of the almost 3,000 physician owners of freestanding imaging centers, 2,510 physicians, or almost 84 percent, referred Medicare patients for imaging services in 1990. While these physician owners constituted about 14 percent of all the Florida physicians who referred Medicare patients for imaging services, they accounted for 22 percent of all the imaging referrals and 34 percent of all the MRI referrals for Florida Medicare patients in 1990.

Physician owners were represented in most of the specialties that referred Medicare patients for imaging services. The three specialties with the highest MRI referral rates were neurological surgery, neurology, and orthopedic surgery. As shown in chart 1, physicians in these specialties with a financial interest in an MRI facility constituted 24, 21, and 16 percent of all the physicians in that specialty, respectively. Thus, physician investment in an MRI facility is most prevalent among the specialties most likely to refer their patients for MRI scans.

PHYSICIAN OWNERS REFERRED THEIR PATIENTS MORE FREQUENTLY, FOR MORE EXPENSIVE IMAGING SERVICES, THAN NONOWNERS

In 1990, Florida physicians with a financial interest in freestanding diagnostic imaging centers had higher referral rates for imaging services than other physicians. Moreover, the differences in the referral rates were greatest for costly, high-technology imaging services. As shown in chart 2, the referral rates of owners were 54 percent higher than nonowners for MRI scans, 28 percent higher for CT scans, and 25 percent higher for ultrasound and echocardiography.[5]

We further analyzed the differences in referral rates to determine if they varied by the type of imaging facility. We found, for example, that physicians with a financial interest in an MRI facility referred their patients for MRI scans twice as often.

Because some specialties make greater use of imaging services than others, we also compared the referral rates of owners and nonowners within each of 49 practice specialties. For MRI referrals, the differences between owner and nonowner referral rates varied widely among the specialties, but MRI owners referred their patients for MRI scans more frequently than other physicians in the same specialty in each of the 18 specialties with the most MRI referrals.[6] Chart 3 summarizes our findings for the six specialties with the most MRI referrals: in specialties with relatively low MRI referral rates--internal medicine, general practice, and family practice--MRI owners had referral rates from

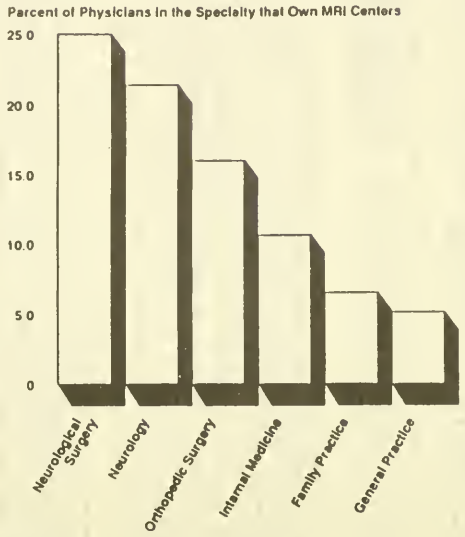
[5]Owners' referral rates for simple x-rays were only 3 percent higher than nonowners, but this could be affected by the use of x-rays taken in physicians' offices. Most freestanding facilities make greater use of more complex imaging machines such as CT and MRIs. We are planning additional analyses that will include in-office imaging services.

[6]Taken together, these 18 specialties accounted for 93 percent of all Medicare MRI referrals.

Chart 1

MRI Ownership is Most Common in High Use Specialties

Physician Ownership in MRI Centers



MRI Referral Rates

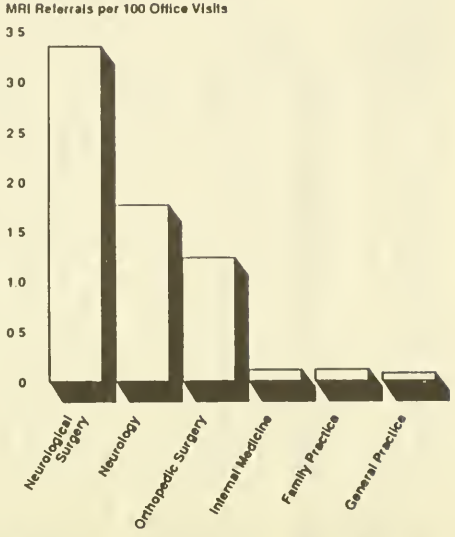
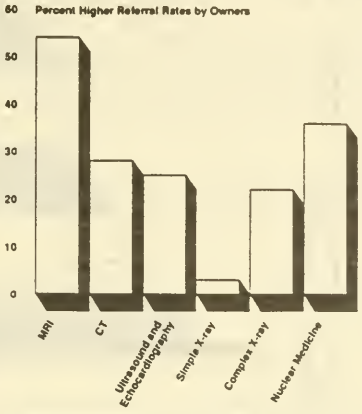


Chart 2

Referral Rates of Owners Exceed Nonowners For All Imaging Services



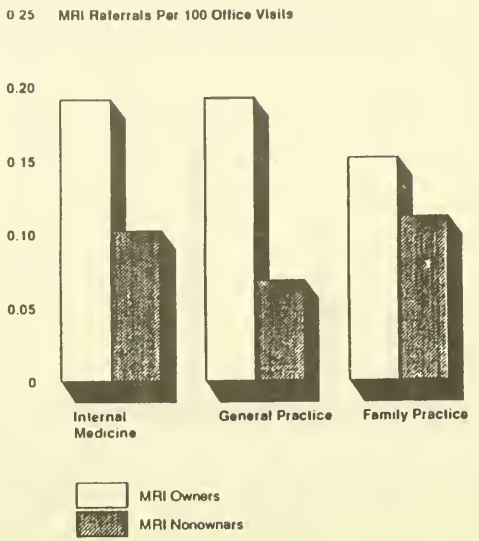
The percentages for each type of imaging service are based on referral rates for each physician specialty, weighted by the proportion of imaging referrals made by that specialty

This analysis does not include imaging services performed by physicians in their offices

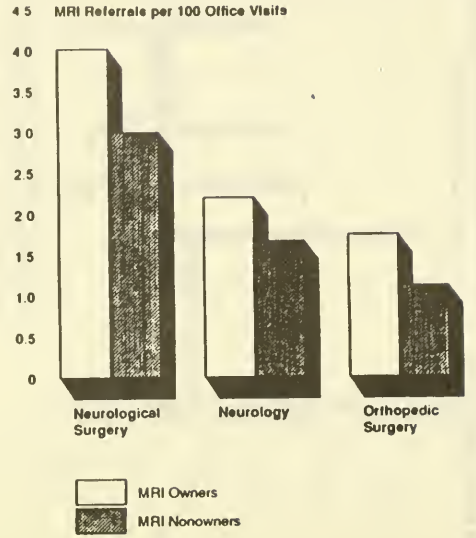
Chart 3

MRI REFERRALS FOR MRI OWNERS AND NONOWNERS

Low Use Specialties



High Use Specialties



35 to 181 percent higher than nonowners. Among neurologists, neurosurgeons, and orthopedic surgeons--which are the highest-use specialties--the MRI owners had referral rates from 32 to 57 percent higher than those for nonowners.

We believe this analysis of referral for imaging services, together with our earlier analysis of referral patterns for clinical laboratory services, illustrates a broad potential for higher use and higher costs through self-referral.

* * * * * * *

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you may have at this time.

Chairman STARK. Thank you.

Janet, did you collect any information on the unit cost or the unit price between facilities that had physician owners and facilities or had outside investors, if you will, and facilities that were just operated by a professional without outside investment?

Ms. SHIKLES. No, we didn't look. We were focusing on what Medicare reimburses for each of these referrals because we were particularly interested in what the impact is on the cost to the Medicare program.

Chairman STARK. But if, in fact, there were a consistent pattern of a higher price charged by a facility with referring investors or whatever we want to call them, wouldn't that just exacerbate your finding?

Ms. SHIKLES. Yes, I think so. Right.

Chairman STARK. Make it even more skewed. OK. The study conducted by the Florida Cost Containment Group was criticized due to their use of the Baltimore area as a comparison group, and the study found that physicians who owned imaging centers in Florida had higher utilization rate than nonowned imaging centers in Baltimore. Is that a concern, and has your study showed us anything that other studies haven't?

Ms. SHIKLES. No, it is not a concern. The reason the Florida researchers used Baltimore for comparison is because they didn't have access to the data that we have. Our findings just reinforced the findings of the Florida study. We were able to have access to Medicare data, so we were able to compare every physician referral based on whether he or she was an owner or not. They just didn't have access to that data, so we totally reinforced their findings.

Chairman STARK. You also suggest that your estimate of the number of physician owners is conservative. Why do you suggest that?

Ms. SHIKLES. Yes, and that means our findings of the differences between owner and nonowner referral rates are conservative. We were able to identify about 3,000 physician owners in these freestanding facilities, but as part of the Florida survey when they were trying to get at who are the owners, investors in these facilities, some of the facilities said that they were physician-owned, but they wouldn't give the Florida researchers the names.

Chairman STARK. I thought they had a big fine in Florida if they didn't.

Ms. SHIKLES. They just didn't enforce it. I think they had a lot of difficulty. They were very aggressive in trying to get the information, but with some facilities refusing to give the names of the physician investors, we had some difficulty—we have spent a year trying to match this data, and we had a lot of difficulty matching some of the physician investors to Medicare provider numbers. If we weren't confident that we had a good match, we didn't include it. We are estimating that we are missing up to 800 physician owners.

What that means is that in our nonowner data, which has lower rates of referral, we have got 800 owners. If we had been able to tease that out, I think while our results are dramatic, they would have even been more startling.

Chairman STARK. OK. You also note there are 38 freestanding MRI joint venture operations in Florida in addition to those operated in hospitals. Do you have any comment on whether that is a reasonable number or a large number?

Ms. SHIKLES. I think it is probably on the high side, and it has something to do—California, some other States probably have a high number of facilities. It has to do with these practices that we are having the hearing on this morning. It also has to do with Medicare payment rates that have been very high that have encouraged this kind of investment.

Chairman STARK. Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

Not discounting anything that has been said, one of the things that I find most fascinating about this place sometimes is the methodology associated with studies to prove one thing or another. I don't think anybody can dispute the higher use rate of facilities owned by physicians. Was there any base drawn prior to going into this in terms of the knowledge of the equipment? It would seem to be a given that people who have investigated and decided to spend money in it would probably have a higher knowledge of its uses and potentials than those who haven't vested in it and that therefore as a diagnostic tool they might see it as more useful.

Was there any base laid down in terms of a comparison of knowledge between owners and nonowners of the equipment? Was that included as part of the methodology?

Ms. SHIKLES. It wasn't included as part of the methodology, but that is why we went through each of 49 specialties and compared just within that specialty physician referrals by their colleagues to try to get at this issue. The other issue is that most of the investment——

Mr. THOMAS. The question was did you establish any base line on the knowledge and understanding and use of the equipment as a diagnostic tool between those who owned and those who didn't?

Ms. SHIKLES. No, we didn't.

Mr. THOMAS. Did you determine the total cost to the patient of beginning to end, including the use of the equipment between those who made self-referrals and those who didn't? That is, as a total cost to the patient, did you compare and were they higher to those who self-referred on the total cost to the patient?

Ms. SHIKLES. I would guess based on our results they would be——

Mr. THOMAS. I would rather you didn't guess when you are making flat out statements about what was and was not done. Was there any comparison in terms of the total cost to the patient from those who used the equipment on a higher referral rate, those who had more knowledge of the equipment, those who were owners versus the other group?

Ms. SHIKLES. We have data on the cost of imaging services and we can run that analysis, and I can provide you with that information.

Mr. THOMAS. Similarly patient recovery rate in terms of time is money, was there any comparison of a recovery rate between those who did and those who didn't?

Ms. SHIKLES. No.

Mr. THOMAS. So all we did was look at whether or not the equipment was utilized more frequently? We didn't determine whether it produced a patient who got handled differently than a patient who wasn't treated using the equipment, and therefore there could have been potential overall costs, there could have been fewer patient days, there could have been a number of other factors that perhaps would be relevant to the overall care of the patient and the costs that weren't used to compare those who referred to the equipment and those who did not; is that a generally acceptable statement in terms of the study that you have given us?

Ms. SHIKLES. That is accurate. We compared referral rates by physicians.

Mr. THOMAS. So we really didn't look into those measurable comparisons that would determine whether or not it, in fact, was a good idea to do this on either patient time, patient care, choice of—the efficacy of various care choices that would be available to the physician based upon the utilization of this technology or not? We only know from your study that those who owned them and presumably had more knowledge about the use of this equipment tended to use them more often. That is basically what we can take away from your study?

Ms. SHIKLES. We can take away from our study that physicians who are investors referred at a much higher rate. Typically they are limited partners so they have no knowledge of the operations of these facilities.

Mr. THOMAS. On what basis do you make that statement?

Chairman STARK. Would the gentleman yield?

Mr. THOMAS. Certainly.

Chairman STARK. We have probably 300 or 400 joint venture agreements, and I don't know that this appears in every agreement, but I would submit that in almost every agreement the limited partners, the joint venture investors are prohibited from having any professional or business say in the operation of the joint venture.

Now, I think that is to cover their butts for a lot of reasons, but almost universally I would submit to the gentleman that that is the structure of these.

Mr. THOMAS. I understand the structure, but it seems to me that if someone is asked to put money into a new technology, as anyone does, they take a prospectus or they investigate a little bit more in detail what it is that they are putting their money into, and inevitably you learn more about what it is that you are putting money into. This happens to be a new technology which provides you with images which other machinery, if we are talking about MRIs, can't provide you with.

My only concern, and I said at the outset I don't dispute anything that has been laid out in terms of the dollars and cents. My quarrel is with the methodology that is utilized sometimes because it seems to me the most meaningful statement coming out of a study of this sort would be that the choices between those who utilize the equipment and didn't did not result in any care differences between the patients and that the overall cost to the patient was, the total cost to the patient was higher utilizing this equipment than those who did not.

If that statement could be made, I would feel much more comfortable about leaping into a ban for these kinds of structures, but until and unless you can link those, it seems to me that it is a little premature to automatically ban it simply because one graph is higher than another on utilization. It might, in fact, prove if we looked at it, that we would be getting more bang for our buck if we utilized it. I am certainly open and willing to look at any information that you can cross-reference or cross-tab that you have that would increase my comfort level that a ban would, in fact, prove that patients would get better care cheaper.

Thank you very much, Mr. Chairman.

Chairman STARK. Mr. Lewis.

Mr. LEWIS. Thank you, Mr. Chairman.

Janet, it is good to see you.

Ms. SHIKLES. Thank you.

Mr. LEWIS. Based on your study and investigation, can you think of any legitimate reason to allow physician self-referral?

Ms. SHIKLES. No. We have been opposed to this issue since we did research in about 1988 or 1989. The major reason that we and other researchers and professional associations have found that physicians invest in this is for financial gain. We think it is a conflict of interest and jeopardizes the relationship between the physician and the patient.

It also raises concerns about access and quality and contributes significantly to increased health care costs.

Mr. LEWIS. Since your study and investigation in the State of Florida, are you familiar with any changes or did the State pass a law to curtail or prohibit this from continuing?

Ms. SHIKLES. The State, based on the Florida legislature's study, passed a law to try to ban most of these referrals—the referrals in physical therapy, freestanding imaging services, laboratory services, and I think radiation therapy.

Mr. LEWIS. Do you see any type of movement on the part of State legislatures in other States to move in this direction?

Ms. SHIKLES. I think there are about 30 State legislatures that are concerned that this has caused problems in terms of access, quality, and higher costs for the State and are moving to ban these arrangements.

Mr. LEWIS. Thank you.

Thank you, Mr. Chairman.

Chairman STARK. Mr. McDermott.

Mr. MCDERMOTT. No questions.

Chairman STARK. I wanted to thank the witnesses. Do we have or did you have and I presume we have the Florida study that was done in their State legislature?

Ms. SHIKLES. Yes.

Chairman STARK. Then did you do a study in a couple of States independent of the Florida study?

Ms. SHIKLES. Previously, several years ago we did work in Maryland and Pennsylvania, and then the inspector general, and I know you will be hearing from him next, did a study in 10 States, and there have been studies.

Chairman STARK. HCFA is the one who did it in the 10 States.

Ms. SHIKLES. That is right.

Chairman STARK. Yours was just two, and then if you add Florida.

Ms. SHIKLES. Right. People have had difficulty in doing research in this area because owners have not wanted to be identified, so we have not been able to get information.

Chairman STARK. I was surprised to learn the Florida study had something like a $1,000-a-day fine for physicians who didn't provide the information and that the Florida study was supposed to cover every doctor in the State.

Ms. SHIKLES. Right.

Chairman STARK. Which made it far more comprehensive than any of the studies you had done or that actually HCFA had done. Then you are telling me that even with that threat that the data wasn't complete.

Ms. SHIKLES. That is right. It is the most comprehensive study that has been done in the United States, the Florida one, but even with those threats and the power of the State legislature behind it, they still had a lot of difficulty getting some of these arrangements to identify who the owners were. That is why it has been difficult, Congressman Thomas, to get at issues like quality because we have invested a year trying to match, to make sure that we were being very fair about just the match rates, and Herman and Bill were down in Florida a lot going through medical records at these clinics, making sure we didn't attribute a referral to a physician that wasn't there.

That is why you have had limited research in this area.

Chairman STARK. Also, my guess would be that all of these centers, whether they were owned or not owned, met the same kind of licensure standards in Florida. In other words, there had to be a radiologist involved and licensed technicians and all of that, so that the only difference ostensibly would be the ownership structure; is that a fair assumption?

Ms. SHIKLES. Actually that is not true. Some of these don't have to be licensed, so the imaging facilities that we looked at that did not provide x-ray services did not have to be licensed by the State. That is typical around the country with new MRI technology, that the State legislatures are behind in requiring licensure for a lot of the freestanding ambulatory centers, cancer centers, which raises concerns about quality and access issues.

Chairman STARK. I was not aware of that.

Ms. SHIKLES. Right. Some States they require licensing, and then you would be correct that the only difference should be the ownership, but in Florida you need to be worried about——

Chairman STARK. You mean Congressman Thomas and I could go down and start one of these operations and not get a license?

Ms. SHIKLES. Actually that is what happened.

Mr. THOMAS. I am fairly familiar with the machinery, so——

Chairman STARK. I have warm hands. We might make a hell of a team.

Mr. THOMAS. I have a cold heart they tell me, so we should make a good pair.

Chairman STARK. Thank you very much for your testimony. We appreciate it. We will continue with——

Mr. THOMAS. Mr. Chairman, just let me, so no one misunderstands my line of questioning and where I was going, was that these are the kinds of comments that are going to come up when you present these kinds of studies, and I know it makes it difficult to do these other things, but if you would at least take it into consideration or perhaps include it in a summary in terms of the obvious deficits of a study such as this and that the goal is to try to find these sorts of things, it makes it a whole lot easier on those of us who are faced with these kind of graphs to be able to make flat out statements.

It apparently is easier for you to make a flat out statement than it is for me based upon my understanding of methodology and what I consider to be the most important factor, and that isn't that some are using them more than others, but the bottom line that the patients are treated differently and it is cheaper. If neither of those can be proven, then that graph, to me, is more important.

Ms. SHIKLES. We can certainly address the cost issue for the patient for you.

[Questions for the record from Mr. Grandy and answers from Ms. Shikles follow:]

Subcommittee on Health
Hearing on Physician Ownership and Referral
April 20, 1993

Questions for Submission to Janet Shikles (Mr. Grandy)

1. Are there differences between urban and rural areas regarding the availability of services being discussed?

   GAO's study of physician ownership interests in diagnostic imaging facilities[1] does not address access to health care in rural or underserved areas. The scope of the study is limited to determining the effect of ownership interests on physician referral rates.

2. What is the prevalence of such services in rural areas and what is the typical ownership arrangement?

   Information regarding rural joint ventures is limited. A 1991 study of Florida joint ventures found that none of the joint venture health care facilities were located outside of metropolitan statistical areas. Furthermore, with the exception of some non-joint venture hospitals and nursing homes, there were few health care facilities located in rural areas of Florida.[2,3]

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[1]Medicare: Physicians Who Invest in Imaging Centers Refer More Patients for More Costly Services (GAO/T-HRD-93-14, April 20, 1993).

[2]State of Florida Health Care Cost Containment Board, Joint Ventures Among Health Care Providers in Florida, Vol. II (September 1991).

[3]Jean M. Mitchell, PhD, and Elton Scott, PhD, "New Evidence of the Prevalence and Scope of Physician Joint Ventures", Journal of the American Medical Association, Vol. 268, No. 1 (July 1, 1992), pp. 80-84.

Chairman STARK. Thank you again.

We will now hear from Larry Morey, who is the Deputy Inspector General for Investigations in the Department of Health and Human Services. No pictures?

Mr. MOREY. No pictures. I have let you down, Mr. Chairman. I have some information, though.

Chairman STARK. Welcome back, Mr. Morey. Why don't you proceed in any manner in which you are comfortable.

STATEMENT OF LARRY D. MOREY, DEPUTY INSPECTOR GENERAL FOR INVESTIGATIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. MOREY. As I said, good morning, Mr. Chairman and members of the committee. Thank you for the opportunity of testifying this morning concerning self-referrals by health care providers. I am Larry Morey, the Deputy Inspector General at the Department of Health and Human Services. I have submitted my written statement and would request that it be entered into the record.

I might mention that our overall experience with self-referrals has not been promising and it has not really been a positive experience. As the Department's investigator for Medicaid and Medicare, we have spent millions of dollars tracking down fraudulent abuse in our health care programs. In addition to the fraud, overutilization is one of the most frequent things we find, and as an investigator I find it hard to say which is harder, to find the element of fraud or to find the element of overutilization in our health care programs.

The Office of the Inspector General is aware that proliferation of arrangements between those in a position to refer businesses such as physicians and those providing items of services for which Medicare or Medicaid pays. We have investigated those activities, those joint ventures by using indicators of potential unlawful activity. Those indicators concern the examination of investors' interest, the examination of business structure, and the examination of the financing and the profit distribution.

In 1989 at the request of this subcommittee we undertook a study of the financial relationships between physicians and health care businesses. Basically we found that patients of referring physicians who own or invest in independent clinical laboratories received 45 percent more clinical laboratory servicing than all Medicare patients in general. We also concluded that patients of physicians known to be owners or investors in independent physiological laboratories used 13 percent more physiological testing services than all Medicare patients in general.

Other studies also support our initial work in this area. An article in the New England Journal of Medicine in 1990 found that self-referring physicians use imaging examinations at least four times more frequently than radiologists and that the charges are usually higher than the imaging that is done by the self-referring physicians. Congress and the Department have reacted by enacting more restrictions upon providers who do self-referring. However, as new laws are passed, new loopholes are created.

The safe harbor regulations have also slowed down the investigation of self-referrals. Not only does the investigator and the pros-

ecutor have to determine if there is a violation of the Medicare, Medicaid antikickback statute, but it must also be determined if the joint venture falls within the safe harbor regulations. The more safe harbors that exist, the more complicated the investigation and prosecutions will become.

One example of these complex investigations concerns an individual who owned six home health agencies. This individual purported to sell the six companies to a friend to make it appear that he no longer owned the companies. The subject then proceeded to set up other sweetheart companies to refer patients, supplies, sell insurance and lease vehicles. The scheme defrauded the Medicare and Medicaid program of $2.8 million during a 4-year period. Six individuals were convicted for submitting false cost reports for several home health agencies.

In addition, the two physicians were indicted for receiving kickbacks for referrals of patients to the six home health agencies.

Let me give you one other example. It has a different twist to it, but it involves a chiropractor who devised a scheme to defraud both the private insurance and Medicare by involving his employees and patients. No service was rendered to the patients and the patients received one-third of the amount billed. We have 58 patients who have been indicted to date with more indictments anticipated. The chiropractor and his wife have been convicted and over $3 million was fraudulently obtained in this self-referral scheme. We certainly have other investigations and there is much more that needs to be done in this area, but that would conclude my testimony at this time. I am available for any of your questions.

[The prepared statement follows:]

STATEMENT BY

LARRY MOREY
DEPUTY INSPECTOR GENERAL FOR INVESTIGATIONS
OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good morning Mr. Chairman and Members of the Subcommittee. I am Larry Morey, Deputy Inspector General of the Office of Inspector General (OIG). We appreciate the opportunity today to address the problem of self referral in the health care industry. First of all, Mr. Chairman, we applaud your leadership on the issue of physician self referral, and the success you have had in keeping the issue before the public eye.

Created in 1976, the OIG is statutorily charged to protect the integrity of departmental programs, as well as promote their economy, efficiency and effectiveness. We meet our challenge through a comprehensive program of audits, inspections, program evaluations, and investigations. In FY 1992, we imposed 1,739 administrative sanctions on individuals and entities who defrauded or abused the Medicare and Medicaid programs or their beneficiaries. That is more than 44 times the level we reported in 1981. Successful health care prosecutions in the criminal courts have also dramatically increased, from 20 in 1982 to 168 in FY 1992. In fact, FY 1992 marked our 12th consecutive increase in successful prosecutions.

Much has been accomplished and much has been learned since 1989, when the issue of self referral became a matter of attention by this Committee and the Congress, and by the OIG. Since then, it is clear that a bipartisan, public consensus has been building, supported by OIG studies as well as in professional literature, that self referral has become increasingly prevalent problem in our health care system, and that action needs to be taken to address it.

Overall Concerns with Self Referral

The overall concern here is that health care decisionmaking should be free of the profit motive. Patients want to be assured that financial interests are not affecting the decisions about their medical care. This concern breaks into three basic categories: overutilization, patient choice, and competition. The overutilization issue relates to the items and services ordered which would not have been ordered if the physician had no profit motive. The patient choice concern relates to the steering of patients to a less convenient, lower quality or more expensive provider, just because that provider is sharing profits with the doctor. And lastly, where referrals are controlled by those sharing profits, the medical marketplace suffers since new competitors can no longer win the business with superior quality, service or price.

The Beginning of Enforcement Against Self Referral in 1989

As you well know, as of early 1989, the only statute available at that time to attack self referral abuses was the Medicare and Medicaid Anti-Kickback Statute, 42 USC §1320a-7b(b). This a broadly-worded, criminal statute, which requires proof of intentionally paying anything of value in exchange for the referral of Federal program business. The statute is also a basis for exclusion from Medicare and Medicaid.

As of 1989, this statute had never been applied to the area of physician investment in ancillary facilities where the physician was referring patients, and the promoters of various investment schemes were doubting that the statute applied at all. Nevertheless, in April 1989, we issued a Fraud Alert on Joint Venture Arrangements, which specified those types of investment interests between physicians and the providers of ancillary medical facilities which we considered to clearly violate the anti-kickback law. This Fraud Alert was intended as the first shot across the bow of those engaging in self referral schemes, and we mailed a copy to each and every provider of health care services to the Medicare program.

In 1989, OIG commenced a landmark test case, the Hanlester Network case, in order to establish the legal proposition that payment of dividends to referring physicians can simply be a form of illegally paying kickbacks, at least in some circumstances.

In May 1989, OIG published the first study of the effect of ownership by physicians on their referral patterns. The study found that patients of referring physicians who own or invest in independent clinical laboratories received 45 percent more clinical laboratory services than Medicare patients in general, regardless of place of service. Financial Arrangements Between Physicians and Health Care Businesses, OAI-12-88-01410 (OIG, 1989).

Based in part on the results of this study, and under your leadership Mr. Chairman, in November, 1989, Congress passed Section 1877 of the Social Security Act, better known as the Stark Amendment. Section 1877 prohibits Medicare payment for clinical laboratory services where the physician who orders the service has a "financial relationship" with the lab.

Studies of the Effect of Self Referral

Since OIG's initial study in 1989, seven more major studies have appeared in the New England Journal of Medicine, the Journal of the American Medical Association, and an additional, quite comprehensive study published in September 1991 by the Florida Health Care Cost Containment Board supporting our original findings. Among other things, this latter study found that 93 percent of diagnostic imaging facilities in Florida are joint ventures with physicians. It also found that compared to non-doctor affiliated facilities of the same type, doctor-affiliated clinical labs, diagnostic imaging facilities and physical therapy facilities (1) performed more procedures on a per-patient basis, (2) charged higher prices, and (3) were NOT located in rural or urban-underserved areas.

One of the other studies deserves special mention too, since one hears criticism of the studies in general from time to time that they all consist of statistical comparisons of the number of services rendered between physician-owner groups and non-owner groups. Although the physician-owner groups generally show higher utilization, there were no specific findings of excess utilization, so the criticism goes. However, an article in the New England Journal last November showed that California physician-owners of MRI facilities ordered medically inappropriate MRI scans at a rate about one third higher than physician non-owners. As a result, the study estimated that where referring physicians own MRI facilities, the costs to the health care system of this expensive technology goes up by 31 percent. ("Increased Costs and Rates of Use in the California Workers' Compensation System as a Result of Self-Referral by Physicians"; Swedlow A, Johnson G, Smithline N, Milstein A: New England Journal of Medicine, 1992; 327; 1502-1506)

These studies support the proposition that many physicians respond to financial incentives. It is this simple truth which probably accounts for the skyrocketing popularity of self referral schemes in the late 1980s, as providers have attempted to lock in maximized flows of referral business by sharing profits of ancillary medical providers with referring physicians.

Developments in Anti-kickback Law

Since 1989, OIG has been largely successful in shaping the law under the anti-kickback statute with respect to how the statute applies to self referral schemes. The Hanlester Network test case I referred to earlier concerned dividends paid to doctors by joint ventures. The case involved three clinical laboratories in California. The managers who set up the labs only solicited investors who were high users of clinical lab services. The minimum investment was nominal -- $1,500 -- and the returns to the doctors were extraordinary -- up to 65 percent per year. Some doctors were even loaned the money for their initial investment on a non-recourse basis, so they had no investment risk at all. The managers called physicians on the phone to badger more referrals. Some doctors who did not refer very much got a check for their investment back in the mail.

Although we have obtained a successful result (nine exclusions from Medicare and Medicaid), this case has been very expensive in terms of resources devoted to it, and has generated almost 300 pages of judicial opinions in the administrative review process. On Feb. 10, 1993, a ruling from the U.S. District Court found in OIG's favor and the case is now before the Ninth Circuit.

In the regulations arena, Congress addressed the fact the anti-kickback statute is so broadly worded that it potentially covers arrangements which are non-abusive and only technical violations of the statute. The Medicare and Medicaid Patient and Program Protection Act of 1987 (P.L. 100-93) required the Department to publish "safe harbors," which by regulation would immunize non-abusive arrangements from enforcement action under the anti-kickback statute.

In July 1991, OIG published eleven final "safe harbors," several of which addressed ownership and compensation arrangements between physicians and entities where they refer business. I wish to emphasize that the safe harbors are narrowly drafted to prevent abusive arrangements from slipping into protected status. They reflect our continuing concern that self referrals should be blessed only in narrow, carefully thought-out circumstances. It should be noted that even though the safe harbors are narrow, they have a chilling effect on prosecutors, who may be reluctant to take a case which may involve a colorable claim that a safe harbor applies.

Actions by States and Other Federal Agencies

In recent years, other federal agencies and many states have become active in the self referral area. In November, 1991, the Internal Revenue Service ruled that tax-exempt hospitals risk losing their tax status if they participate in net revenue joint venture schemes with physicians which violate the anti-kickback statute. This type of scheme involves a hospital selling shares in the future income of its surgical department to surgeons and

other potential referrers. Although this ruling was limited to net revenue joint ventures, it has implications for tax exempt hospitals anytime they unlawfully attempt to share profits with referring physicians.

In addition, over the last year and a half, the Federal Trade Commission has taken a much tougher stance in examining the damage to the health care marketplace which results from the "locking up" of referrals effect of self referral arrangements.

The states of New Jersey, Michigan, Illinois, New York, Virginia, Maryland, and Florida have enacted tough restrictions on physician referrals to entities where they own a piece of the action. At last count, the legislatures of at least 29 states were actively considering restrictions in the self referral area.

The New AMA Ethical Rule

In December 1991, the Council on Ethical and Judicial Affairs of the American Medical Association reversed the old ethical rule that self referral was acceptable, as long as there was disclosure of the financial relationship to the patient. (We know from experience, by the way, that such a "disclosure" by the physician is often turned into a positive testimonial about the entity where the patient is being sent.) Under the new ethical rule, physicians should not refer patients to a facility outside their office where the physician has an ownership interest, except in very limited circumstances, i.e., that there is a demonstrated need in the community for the facility and alternative sources of financing are not available. Even then, the facility would have to meet a list of safe harbor-like requirements. This new ethical rule was reaffirmed by the Council in December 1992.

Bush and Clinton Administration Positions

In the last year, both the Bush and Clinton Administrations have endorsed expansion of the Stark Amendment to services in addition to clinical laboratories. In February 1992 and again just before

it left office, the Bush Administration stated that, "Reform legislation should consider prohibiting Medicare payment in areas such as radiology, radiation therapy, durable medical equipment, home health, physician therapy, and rehabilitation when abuses have been found." Soon after taking office, the Clinton Administration advocated extension of the Stark Amendment to "additional services, such as physical and occupational therapy, durable medical equipment, and parenteral/enteral nutrition equipment and supplies."

All these events taken together indicate that a broad consensus has been building for expansion of the Stark Amendment. The only question to be decided is exactly how and when. Soon, there will be a proposal for a massive overhaul of the entire system for the delivery and financing of health care in the United States, and expansion of the Stark Amendment from Medicare to all payors should be taken up as an issue in the debate regarding this new system.

At the same time, it is appropriate to take a hard look at the exceptions which currently exist in the Stark Amendment, in view of the experience gained in the self referral area since the Amendment was passed in November 1989. We look forward to providing Committee staff with advice on improvements to the exceptions.

A word of caution is appropriate here. Some special interests will assert entitlement to an exception in the Stark Amendment, probably on the grounds that what they want is a necessary part of health care reform. Underlying some of these proposals, however, one may find a desire to lock up referrals from physicians by sharing profits with them. Thus, proposals to expand existing exceptions or create new exceptions should be scrutinized very carefully.

This concludes my testimony, and I would be happy to answer whatever questions you may have.

Mr. LEWIS [presiding]. Thank you very much, Mr. Morey. Let me ask you the same question I asked a previous witness. Based on your investigation, based on your study, can you think of any legitimate reason to allow physicians to continue the practice of self-referral?

Mr. MOREY. I think the basic answer is we find it unhealthy for the health care programs to have self-referrals. Certainly there are occasions when a physician can have a laboratory in his office, a small one doing minimal services. In that case we find it acceptable, but generally we think that self-referrals are not helpful.

Mr. LEWIS. Do you see any need to exclude any specialist in the banning of self-referrals?

Mr. MOREY. I have reviewed the list of recommendations, and we think that we ought to expand that to all services and that we shouldn't get into the exception area because when we get there everybody wants the exception. We would like to see that cover all health care services.

Mr. LEWIS. Thank you.

Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

On the question of exceptions, that is to specialties and you want it across the board. In your studies was there any attempt to look at or did anything jump out at you in regard to geographic distribution of owner sponsors and referrals? I am thinking perhaps along the line that it seems that more of them were in areas in which there were already adequate facilities, in urban areas versus rural areas or could you make that statement?

Mr. MOREY. I think our study was basically a statistical sample. We certainly have considered the problems that rural areas have, but generally that was a statistical sample. It involved some rural areas, urban areas.

Mr. THOMAS. But there was no purpose for breaking out or comparison in terms of population or geography in examining the frequency and use of self-referral and owner——

Mr. MOREY. I think that is true, Mr. Thomas. I think it was just a statistical sample on how they selected that.

Mr. THOMAS. Do you think information of that nature would be helpful in guiding people who are being told now that what we want is an all out ban across the board and that it might be useful to have knowledge of the way, of the geographic location of these kinds of activities and a comparison on the basis of geography of self-referral and ownership structures as in rural as defined areas versus urban areas, do you think that might be a useful piece of information in guiding us?

Mr. MOREY. Yes, I do. I don't think we can generally say that in all cases self-referrals should be exempted, we shouldn't have them. I think we need to consider not just what you said, but take a look at the whole picture to make sure we are coming up with the right answer here.

Mr. THOMAS. Well, under the Stark legislation there is a provision for waivers licensing in rural areas. My concern is that intuitively we decide that that makes sense, and it seems to me that there are several other ways you could slice that intuition, because what sometimes seems to be common sense is refuted by facts, and

that I would much prefer to move into a ban in terms of choices available to professionals on the basis of knowledge rather than intuition.

Is the material that you have susceptible to manipulation on the basis of geography and that it just wasn't done or would it require going back into the field and collecting materials in a different way?

Mr. MOREY. I think we would probably have to go back and recalculate that study and probably do different samplings if we wanted to expand our scope.

Mr. THOMAS. It just seems to me that the logical way to look at it would be availability of similar services regardless of who owned them, and that where there was availability it wouldn't make sense to allow someone to go ahead and duplicate it simply because they owned it, but where there were no facilities and we ban the ability of someone to provide those facilities, that seems to me not the best way to deliver health care to all Americans. Perhaps those from urban areas believe that that might be an appropriate way, but I can assure you those of us from rural areas are going to make sure that the structure provides at a reasonable cost adequate care, and this may or may not be an option that should be utilized.

I just want to make sure that when we pass legislation we don't create all or nothing options in ways that deny us the most rational use of technology and services available.

Thank you for your testimony.

Mr. MOREY. Let me assure you that I am from the State of Wyoming, that is pretty rural. I appreciate the problem.

Mr. THOMAS. By definition it is.

Chairman STARK [presiding]. Mr. McDermott.

Mr. MCDERMOTT. What further measures can we pursue to take fraud and abuse out of the system?

Mr. MOREY. Are we talking maybe about the self-referral itself, how we can have a self-referral and maybe make it more plausible without fraud, waste and abuse? The profit incentive in a self-referral scenario is probably the driving force. It is pretty hard to pick out the fraud or the waste or the abuse if the whole system is driven with the profit incentive.

I guess one line of reasoning, if we don't have the self-referral and you eliminate the need for profit, then we would knock out the overutilization. To be able to give you a list of safeguards, I could only refer you to the safe harbor regulations. There are 11 on the books, and we have about 9 more that will be coming out. If we look at those, they spell it out about as clear as we can to eliminate what we think would be the fraud in that area, Mr. McDermott.

Mr. MCDERMOTT. The reason I ask the question is we have moved toward a national health plan. Whether it is a single-payer system or managed competition, it seems to me there are going to be some changes in the way referrals are made or in which money is allocated to specific sectors of health care, and I wonder how the cost of laboratory services or the use of technology is going to be controlled in that system?

Mr. MOREY. I don't have the great solution to that. I can just refer you back if you look at the safe harbor regulations where it spells out what we think would be a reasonable way to distribute

the profits of a joint venture. If profits were distributed in that manner it cuts down the incentive to refer patients because you wouldn't be getting profits based on referrals. You are going to be getting profits on the amount of your investment.

Mr. MCDERMOTT. My feeling always has been that one of the problems in dealing with health care costs has been the lack of a real database. It seems to me that without an adequate database it is impossible to find the people who are doing this. How did you go into the pool? How did you discover these cases you described?

Mr. MOREY. We had the same problem as GAO coming up with the information on who were the owners where, who owns the joint ventures, and a lot of them are very difficult to uncover. Basically we sent a survey out to the provider, and if they answered the survey, then we were able to use their own information in coming up with our study. If they didn't answer the survey, then, of course, that information was not used, we didn't have it.

Mr. MCDERMOTT. What kind of return did you get on your survey?

Mr. MOREY. We thought that was pretty high, quite frankly. As I remember it was about 60 percent.

Mr. MCDERMOTT. So 40 percent of the people chose not to answer the survey. It was a voluntary survey, no tie on licensure or anything else?

Mr. MOREY. That is correct.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Chairman STARK. Mr. Grandy.

Mr. GRANDY. Thank you, Mr. Chairman.

I wonder if I might be permitted to submit a question in writing for GAO.

Chairman STARK. Certainly, without objection.

Mr. GRANDY. Thank you. Just one question for you, Mr. Morey. When the original prohibition on physician self-referral was implemented in 1989, why wasn't it made broader then? Do you know?

Mr. MOREY. Are we talking about just the fact that it only covered clinical laboratories?

Mr. GRANDY. Yes.

Chairman STARK. Would the gentleman yield?

Mr. GRANDY. I would be pleased to yield to the Chairman.

Chairman STARK. At that time when we were marking up the bill, we only had good empirical evidence on the higher utilization for the diagnostic labs, and many of these studies weren't completed then, and so we decided just to limit the referrals in those areas where we had, I don't want to say proof, but we had substantial data available to us. The other data wasn't in yet, and we are now at that point where we said, well, we will wait until we see what these other studies show and if they show in other areas that there is a need for this, we will expand the legislation. So that was a decision that this subcommittee made actually.

Mr. GRANDY. Thank you for your response, Mr. Morey.

Mr. MOREY. Well, I am in agreement with it. That is how I understand it.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. I have no questions, Mr. Chairman.

Chairman STARK. Mr. Morey, do you think that what we are doing here—you have had a chance to review the legislation.

Mr. MOREY. Yes, I did.

Chairman STARK. Do you think it is tight enough to prohibit basically a variety of kickback schemes from continuing?

Mr. MOREY. I think you might have been out when I made one general statement. We are of the opinion that if we even expanded the list to more health care providers and more services, that we would do ourselves a favor in the long run. We will just have to add more to the list later as new things develop.

Chairman STARK. It has also been brought to my attention that the case which is referred to in the gossip tax trade as the Facey Medical Foundation case portends loopholes being created before this legislation even gets reported out. But basically what they are attempting to do is set up corporations and boost the value of so-called intangibles which are defined as patient lists, and somehow a promise by physicians to continue referring in exchange for a contract of some questionable value with the new tax-exempt corporation that is being organized.

Are you aware of these schemes?

Mr. MOREY. I have to admit that you are a step ahead of me, Mr. Chairman.

Chairman STARK. Well, there is somebody in your organization who handles tax issues. He raised an issue of—I will find his name in a minute, D. McCarty Thornton, Associate General Counsel of the Health and Human Services, IG.

Mr. MOREY. Yes, he is our General Counsel.

Chairman STARK. Well, he has suggested that where valuation of intangibles is used as a disguise to cover up the intent to purchase the future flow of referrals, that is illegal. I hope that you would encourage him to submit to this committee any indications that he has. There is evidently some small dispute here between you and the IRS, but I suspect we could straighten that out legislatively and see that as we try and contain this situation that we contain as much of it, any prospective loopholes as we can, so your help in doing that would be appreciated, as I am sure the committee would not want to revisit this again and again and again as the medical entrepreneurs dream up new loopholes to keep us going. You guys will make a career out of closing up MRI scams.

I have some information that I will submit, and your help would be appreciated.

Mr. Thomas.

Mr. THOMAS. Mr. Chairman, briefly, in terms of your examination of the States as they move to put legislation in place to control this, are there any States that have legislation currently on the books comparable to H.R. 345, or is that more comprehensive than what States are doing?

Mr. MOREY. I think there are a few States out there that have tried to address this. I am really not familiar with all of them, Mr. Thomas, or what they have to offer, but I do know that there are eight or nine States out there that have certainly got restrictions against self-referrals.

Mr. THOMAS. Mr. Chairman, it seems to me that as States are moving to control self-referral that this is a laboratory that would

be useful for us to examine. What the States are doing, the degrees that their statutes conform to what we are trying to do, and the problems that they anticipate, I don't know who the watchdog would be to monitor that, but if they are moving as rapidly—I mean we are obviously at the cutting edge here. It has just been a year or so since the States began doing it.

As we move forward with the legislation, I would really like to learn from the experience of the States so we at the Federal level are able to correct the problems that have been made or offer suggestions in which they can continue to be laboratories for us. I thank the Chairman.

Chairman STARK. Mr. Levin.

Mr. LEVIN. No questions. Thank you.

Chairman STARK. As I say, this gets often into the issues of intent and how you get criminal prosecutions or how you stop a practice without the death penalty, somewhere between there and the death penalty there ought to be some tools that your office can use to slow this down, and we certainly would appreciate any suggestions. Your office got us into this business in the first place, now you have got to help get us out of it, OK?

Mr. MOREY. We will try. Thank you.

Chairman STARK. Thank you very much for your testimony.

We will continue with testimony from Prof. Marc A. Rodwin, who is associate professor at the School of Public and Environmental Affairs at Indiana University at Bloomington.

Dr. Rodwin, welcome to the committee. We are happy to have you enlighten us in any manner you are comfortable.

STATEMENT OF MARC A. RODWIN, J.D., PH.D., ASSOCIATE PROFESSOR, SCHOOL OF PUBLIC AND ENVIRONMENTAL AFFAIRS, INDIANA UNIVERSITY, BLOOMINGTON, IND.

Mr. RODWIN. Good morning, Chairman Stark and members of the committee. My name is Marc Rodwin. I am associate professor of the School of Public and Environmental Affairs at Indiana University in Bloomington. Before assuming this position I practiced law and worked as a health care consultant, and that is where I first encountered conflicts of interest of professionals and learned how incentives for doctors can distort their judgment.

Over the last 5 years I spent a considerable amount of my time researching and writing about physicians' conflicts of interest, particularly physician self-referral. I have included as an appendix to my testimony two articles I have written, and excerpts from my book, "Medicine, Money and Morals: Physicians' Conflicts of Interest", which will be published by Oxford University Press in 2 weeks' time.

That study examines several aspects of the problem. One, it examines how over the last 100 years the medical profession has addressed conflicts of interest.

Second, it compares the conflicts of interest of doctors—and how government has addressed them—to the conflicts of other professionals—lawyers, public servants, financial professionals and business.

And finally it looks at the range of conflicts of interest in medical practice today.

I would like to discuss briefly key points from my study.

Before doing so let me just state briefly the nature of the problem. Physician self-referral is a classic conflict of interest. It compromises the loyalty of the doctor to the patient. It compromises the ability of doctors to exercise independent judgment on behalf of the patients, and it is inconsistent with traditional medical ethics which expects that doctors act for the benefit of patients. It also prevents a doctor from being an effective advocate for patients because conflicted doctors have a financial tie that prompts them to provide for more care than necessary or delegate particular providers.

My study found several things. One, physicians' conflicts of interest are not new. This problem existed at least since the 1890s, and it is well documented in the records of the reports of the American Medical Association, other medical organizations, and the medical press. Conflicts such as self-referral, kickbacks, ownership of pharmacies and the like, are long standing.

Second, these problems are not confined to a few areas of practice. They are widespread today. My research shows that there is practically no specialty in medicine and no area of the country that has not been touched by self-referral and similar conflicts of interest.

Third, the medical profession's response to this problem has become weaker as the problem has grown worse. Early in the century the medical profession had strict guidelines that considered unethical kickbacks, self-referral, dispensing drugs, and many other practices. But starting in the mid-1950s, the American Medical Association chipped away at these guidelines. In place of prohibitions, it substituted subjective standards, merely asking doctors to act in the interest of patients.

Since December 1992, the AMA has toughened its stand a little bit, but it still has not returned to its position of the 1950s. And I believe that the AMA will testify today that it wants a number of modifications in H.R. 345 that, in my opinion, would undermine the value of that bill, which is to have a bright line rule. The AMA speaks about exceptions where there is a community need for the physician to own and self-refer. The problem is there is no workable way to define such a need.

Fourth, current institutions are not designed to address conflicts of interest. The Medicare antikickback law really addresses only kickbacks and is not designed to address self-referral.

Fifth, practically every other professional group that I have mentioned—lawyers, government officials, financial professionals—is subject to much stronger prohibitions and regulations with respect to conflicts of interest. The SEC regulates the conflicts of interest of broker dealers, investment advisers, money managers. Public servants in the executive branch, as you know, are prohibited from participating in a decision that might influence their own financial interest, and lawyers are also subject to conflict-of-interest regulation by courts.

Chairman STARK. Go ahead. I don't know where we got the bell.

Mr. THOMAS. We have stiff penalties here.

Mr. RODWIN. There are obviously a number of ways to address such conflicts as self-referral, but a prohibition will be the least

costly, most effective, and easiest to administer. I can elaborate on these, the problems with the other approaches if you wish.

[The prepared statement follows:]

TESTIMONY OF
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Hearing On Health Care Reform: Physician Ownership and Referral Arrangements and H.R. 345, "The Comprehensive Physician Ownership and Referral Act of 1993" Before the Committee on Ways and Means, Subcommittee on Health, U.S. House of Representatives, April 20, 1993

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I speak today not as a representative of any association or group that has interests in legislation on self-referral, but as a scholar who has spent much of the last five years studying and writing about physicians' conflicts of interest and self-referral. Before accepting an appointment at the School of Public and Environmental Affairs, Indiana University, I practiced law and worked as a health policy consultant. That is where I first faced conflicts of interest as a professional and observed how financial incentives were affecting the practice of medicine.

Appendices to the record will include two articles that I have written plus a short excerpt from my book, *Medicine, Money and Morals: Physicians' Conflicts of Interest*, which will be published by Oxford University Press in two weeks.[1] I have made my study available to the Committee. I know of no other book on physicians' conflicts of interest. After brief introductory comments on the nature of the problem I will summarize the aim of my study, what I found, and some of the implications for policy.

From my practice of law I was aware of the well-developed institutions and laws to oversee the conduct of lawyers, including court rules, statutes, and mechanisms to enforce codes of ethics such as barring attorneys with certain conflicts from representing clients and imputing the conflicts of one attorney to others working in the same firm. What surprised me when I examined medical practice and institutions was that there was very little institutional leverage to hold doctors accountable for their conflicts of interest. Nor was the subject discussed much in medical ethics.

Many doctors now own shares of limited partnerships or corporations that operate free-standing imaging centers, home health

care services, diagnostic laboratories, medical equipment companies, pharmacies, nursing homes, out-patient facilities, dialysis centers, the practices of other doctors, and other facilities. Even hospitals are selling partnership shares to local doctors in order to attract referrals from investing physicians. Physician investors have a strong incentive to refer patients to such facilities. By doing so they protect their investment and increase the likelihood they will reap profits. They have no responsibility for day to day management of such centers, bear no risk of liability beyond the money they invest and can increase their income merely by making referrals. They have no greater clout in demanding that such facilities provide high quality of care than referring doctors who are not owners. Nothing is wrong with doctors profiting from investments. But the kind of physician self-referral I have described compromises the patient-doctor relationship, places patients at risk, and increases medical costs. It is contrary to the traditional aims of medical ethics, and allowing such conflicts to proliferate is bad public policy.

Self-referral compromises one of the doctor's main roles, namely to use his or her independent judgment to advise patients on what course of medical treatment is most appropriate and which medical personnel or institutions are the most suitable providers. It also undermines the doctor's ability to act as a strong advocate for the patient because the doctor's financial well-being is tied to recommending the use of services. It encourages doctors to recommend patient use of designated providers based on the doctor's financial ties rather than on the patient's best interests. Individual doctors may resist the temptation, but self-referral creates perverse incentives that compromise the doctor.

Substantial evidence from dozens of studies shows that doctors with ownership interests recommend services in which they have an interest more often than doctors without such ties. Even if the service is needed, doctors may recommend their own centers when others would be better or less expensive. (These findings are consistent with over twenty years of health services research that show that financial incentives affect the clinical choices of doctors in many settings.) With limited exceptions, self-referral provides no benefits to patients or society that would make its risks worth bearing.

Two examples illustrate the kind of practices involved. The case of the Georgia physical therapist, Walter Ford and his physician colleagues Drs. William Cabot and Sylvia Urratia, illustrates how self-referral can be used to disguise kickbacks. Ford alleges, in court documents, that he paid Cabot and Urratia 45% of his fees in kickbacks over four years for patient referrals. Later, fearing legal

liability, these individuals "formalized" their agreement by setting up a partnership arrangement. The doctors and their families invested a total of $3,000 and became limited partners earning 45% of the income generated by Ford's practice. The payments for referrals continued, only using the limited partnership arrangement. Were the referrals based on the mutual confidence these parties had in the professional skills of the other? Apparently not. When changes in Georgia law forced Ford to cease making such payments, Cabot and Urratia stopped all referrals and Ford's physical therapy practice went out of business.[2]

A second example is the intravenous treatment facility that was operated by Tri-State Home Therapeutics, Inc. of Cincinnati, Ohio, a subsidiary of the national firm T2 (pronounced T-Squared) Medical Management, Inc. The firm's plan was set forth in a 1987 Private Placement Memorandum.[3] Tri State sought 15 to 35 investors to purchase shares at $15,000 each. Investors had to put up $100 each and could borrow up to $14,900 from a bank at 1% above the prime interest rate and relend the funds to Tri State on the same terms. T2 only sought investors in Cincinnati, i.e., those in a position to steer patients to the facility. The prospectus makes clear that this was the intent. It states "The Organizers believe that a physician will be more likely to refer patients to the Corporation if the physician owns an interest in the Corporation." The prospectus acknowledged that referrals from physician investors were necessary for the firm to succeed. It states that "The ability of the Corporation to compete successfully with the other entities [competing firms] will depend upon the Corporation's ability to secure a large number of referrals from physician-investors."

In the last two years many firms have been more cautious in establishing physician ownership arrangements due to some well-publicized prosecutions by the Office of the Inspector General under the Medicare and Medicaid anti-kickback statute. Although these new arrangements are set up in ways that make it less likely that they will be prosecuted, they still give financial incentives for doctors to refer patients. The antikickback statute does not eliminate the problem.

The Aims of My Study

My book examines the range of financial conflicts of interest that exist in medical practice today, how they affect patients and the public, and how the medical profession and society address them.

It compares current medical practices and society's response with those of the medical profession in the past and with the practices of other professional groups--lawyers, federal government officials, and financial professionals working in business (such as money managers, broker dealers, pension fund managers and corporate officers and directors).

It also examines the role of law, ethics, and institutions in holding doctors accountable to patients and explores a range of ways to address conflicts of interest.

Findings

1. **Physicians' financial conflicts of interest exist in nearly every area of medical specialization and nearly every section of the country.** My study provides examples and statistics that document these conflicts. The text is supported by over one hundred pages of citations to cases, financial documents and published studies. Physicians' conflicts of interest are pervasive and go far beyond the few "bad apples" often acknowledged by the organized medical profession.

2. **Physicians' conflicts of interest are not new.** Many similar conflicts existed as far back as the 1890s, including kickbacks, self-referral, dispensing of drugs, and ownership of pharmacies and other products. But the commercialization of medicine in the latter half of the 20th century has made the problem worse.

3. **The medical profession's stance on these issues has become weaker as the problem has become more serious.** Although the organized medical profession did not address conflicts of interest as a generic problem until recently, its ethical codes did include prohibitions on a range of practices including fee-splitting, commissions, physician ownership of pharmacies and ancillary medical facilities, gifts from medical suppliers, and practices similar to self-referral. But starting in the mid-1950s these policies were progressively weakened. The American Medical Association (AMA) replaced clear prohibitions with subjective standards (such as stating that doctors should act in the interest of patients) and allowed self-referral and other practices if they were disclosed to patients.

The AMA has still not returned to its stronger 1950s position on conflicts of interests. As of December 1992, AMA policy has

considered self-referral presumptively unethical. However, AMA ethical guidelines contain loopholes. Doctors can self-refer when in their opinion there is no adequate alternative provider within the vicinity. There is no AMA guidance on what constitutes an adequate alternative facility or the area within which a doctor is supposed to look in comparing his facility to alternatives. The AMA still does not support a legal ban and not surprisingly so. The record shows that the AMA has spoken out against self-referral only after Congress and states enacted prohibitions and more restrictive legislation was on the horizon.

Today the AMA believes that conflicts of interest should be addressed through its voluntary code of ethics even though it has not been effectively enforced over the last century and probably cannot be enforced in the future due to the organizational structure of the AMA. Since less than half of American physicians are AMA members, society cannot rely on the AMA or other medical associations alone to address these problems effectively.

4. **Doctors are less accountable to patients than they are to hospitals, medical suppliers, insurers and other groups.** Although doctors profess loyalty to patients and have a noble tradition of ethics, today most medical providers and insurers have much more leverage over doctors' behavior, through financial incentives and organizational ties, than do patients. These third parties target doctors because their clinical decisions are responsible for allocating approximately 70% of health care expenditures. Firms offer doctors financial incentives to practice medicine in ways that promote their firms' interests.

Many patients may consult a specialist only once or infrequently. Their decision to choose another doctor has only a small influence on that doctor's income. Institutions, on the other hand, work with doctors on an ongoing basis and have many more opportunities to influence their judgement. Thus, part of the disparity between patients' influence and institutions' influence over doctors can not be easily overcome. But there is no reason to encourage bias in favor of institutional interests. Permitting doctors to self-refer to joint ventures they share with hospitals promotes such bias. Instead we should seek ways to make doctors accountable to patients.

5. **Other professional groups are subject to much stricter conflict-of-interest regulation than doctors.** Those who say that a Congressional ban on self-referral would restrict the economic liberty of doctors compared to other professionals have it backwards. It

matters not whether one views doctors as akin to public servants who work without profit, or as business professionals who promote their own interests, or as learned professionals, such as lawyers. Whichever occupation or profession is considered most similar to doctors, the lesson is the same. Society has used institutions to hold them accountable. The law has held each of these professional groups to fiduciary standards with respect to their conflicts of interest as a way to insure they act for the benefit of the individuals they are supposed to serve. But the law has not yet held doctors to such standards. This is a peculiar gap in the law.

For each of these professionals, government has intervened in three ways. It has prohibited professionals from entering into conflict-of-interest situations as a preventive measure. It has regulated or supervised the conduct of professionals to remove discretion that may be abused. It has used sanctions and restitution as a deterrent in the event that professionals engage in misconduct despite the use of these other measures.

Many institutions help to hold these other professionals accountable to the parties which they are supposed to serve. Government officials are strictly regulated by numerous federal statutes overseen by the Office of Governmental Ethics. They are prohibited from participating in decisions that affect their personal financial interests. Executive branch employees may not receive gifts over $20 offered because of their official position. The source and amount of income they may receive outside of government employment is restricted. In business, self-dealing is either prohibited, restricted or subject to court or independent review. The Securities and Exchange Commission exercises broad investigatory and supervisory powers over the securities industry. It sets standards and restricts practices of broker-dealers, investment advisors, and others. It has the power to license and revoke the licenses of broker-dealers and advisers; to set the range of permissible prices; and to establish the manner and timing of advertising and sales of securities. Pension fund managers are subject to strict conflict-of-interest standards by the Employee Retirement Income Security Act (ERISA) and the Department of Labor. They can not self-deal except in limited situations. Lawyers' conflicts of interest are addressed through rules of court and common law. Lawyers must always disclose conflicts and in many situations they are precluded from representing a client even if the client is informed of the conflict and consents.

Is there any compelling reason to treat doctors differently from other professionals with respect to conflicts of interest? I have found

none. Other professionals have thrived despite being held to fiduciary standards. The same is likely to be true for doctors. Indeed, holding doctors to fiduciary standards would enhance their status as professionals, protect patients, and improve the quality of medicine.

6. **There are several examples of successful government action to address conflicts of interest of doctors.** Federal regulations have required that institutions receiving federal funds must create institutional review boards to address conflicts stemming from doctor's divided loyalties as providers of patient care and researchers. Today there is broad support for these regulations. This experience shows that the federal government can effectively protect the public. Doctors working for the Veterans Administration are subject to very strict conflict-of-interest regulations as are other federal employees. Such regulations also have benefitted the public and serve as a useful model. The restrictions on self-referral for clinical labs, passed as part of the Omnibus Reconciliation Act of 1989 (OBRA 1989), were another useful beginning in addressing physicians' conflicts of interest, but they only address a small part of the problem, and do not apply to all doctors or patients.

7. **Several measures can be used to address conflicts of interest, including broader prohibitions, regulation or oversight, and penalties for misconduct.** The approach used should depend on the particular circumstances. If the conflict presents no irreparable harm should a breach of duty occur and if the risk of a breach is low and easy to detect when it occurs, then penalties for misconduct are usually sufficient. However, if it is difficult or costly to detect misconduct and the harm involves health rather than just money (which can be recouped through restitution), then regulations or prohibitions may be more appropriate.

The choice between prohibitions and regulation should turn on the costs and benefits of monitoring or regulating the parties involved compared to the costs and benefits of prohibitions. The experience with utilization review and quality assurance programs shows that often it is very costly to monitor the conduct of doctors and it is not particularly effective where there is medical uncertainty or where doctors make subtle judgements. In such cases it may be more appropriate to prohibit entering into conflict-of-interest situations, especially if there would be no significant social loss.

8. **Current institutions and laws alone are not effective.** Several institutions address physicians' conflicts of interest *indirectly*. Medicare and Medicaid have an anti-kickback statute. There is a Medicare ban on self-referral, but it is only for a few medical services and includes many loopholes. Other federal programs also bear on the problem. These include programs fostering utilization review and quality assurance, IRS policy on payments by non-profit hospital to doctors, federal antitrust laws. Some state laws restrict self-referral or require disclosure. These laws form a patchwork of regulation that is ad hoc, inconsistent and incomplete. They are implemented by institutions that have missions other than addressing physicians' conflicts of interest and they do not effectively cope with the problem.

9. **For physician self-referral, the most effective, least costly and easiest approach is to enact a broad federal prohibition such as that proposed in H.R. 345.** Extensive monitoring of doctors through utilization review and quality assurance programs would be very costly and not a particularly effective way to cope with conflicts of interest. Disclosure would do more to protect doctors than patients.[4] Using penalties for misconduct to deter improper actions would offer little protection to patients because of the difficulty of detecting and prosecuting suits, and detection would be costly, too. This holds whether the sanctions are for violating the Medicare anti-kickback statute, antitrust laws, state laws or other legislative and common law prohibitions.

10. **To achieve workable health care reform, the United States will need to adopt new policies and institutions for physicians' conflict of interest.** Our system of financing and organizing medical care has led to uncontrolled increases in medical spending and a large ineffective utilization review bureaucracy. These problems are exacerbated because we have tolerated, even encouraged, perverse financial incentives for doctors. Physicians' conflicts of interest go far beyond issues of professional ethics. They are a central part of why our health care system needs to be reformed. Addressing such conflicts is an integral part of the federal government's responsibility to protect patients, ensure access to health care, control costs and promote quality. If the committee is interested in physicians' conflicts of interest other than self-referral and a range of alternative measures to address them, they can consult my book. I would be happy to answer questions about these issues.

Recommendations

1. Congress should enact broad prohibitions on physician self- referral as proposed in H.R. 345. It should consider eliminating certain exceptions proposed in H.R. 345, such as the exclusion for referral to hospitals in which doctors have a financial interest.

2. Congress should address other physician conflicts of interest and consider enacting broad bans on physician dispensing of drugs and the receipt of gifts from medical suppliers.

3. Some proponents of national health care reform who favor managed competition have suggested the creation of various national health boards to oversee market competition. If Congress passes such reform legislation it should specify that such boards have jurisdiction to oversee the financial conflicts of interest of doctors and the practices of other medical providers that contribute to such conflicts of interest by doctors.

4. Congress should fund studies of physicians' conflicts of interest and ways to cope with them by such health related agencies as the Agency for Health Care Policy and Research, the National Institutes for Health, the National Science Foundation, the Physician Payment Review Commission, the Veterans Administration, the Congressional Budget Office, the General Accounting Office, and the Department of Health and Human Services Office of the Inspector General. These studies should go beyond measuring medical care utilization and examine the role of institutions and laws in addressing these problems.

[The appendices referred to in the beginning of this statement are being retained in the Committee files.]

Notes

1. Rodwin, Marc A. 1989. "Physicians' Conflicts of Interest: The Limitations of Disclosure." *The New England Journal of Medicine* 321(20):1405-1408.

Rodwin, Marc A. 1992. "The Organized American Medical Profession's Response to Financial Conflicts of Interest: 1890-1992." *Milbank Memorial Fund Quarterly* 70(4):703-741.

Rodwin, Marc A. 1993. *Medicine, Money and Morals: Physicians' Conflicts of Interest.* New York: Oxford University Press.

2. Rodwin, Marc A. 1993. *Medicine, Money and Morals: Physicians' Conflicts of Interest.* New York: Oxford University Press. p. 66, 94-95.

3. Information drawn from Tri-State Home Therapeutics, Inc., and Ohio Corporation. July 15, 1987. Confidential Private Placement Memorandum. The facts are discussed more fully in Rodwin, Marc A. 1993. *Medicine, Money and Morals: Physicians' Conflicts of Interest.* New York: Oxford University Press. 77-78.

4. Rodwin, Marc A. 1989. "Physicians' Conflicts of Interest: The Limitations of Disclosure." *The New England Journal of Medicine* 321(20):1405-1408.

Chairman STARK. Well, thank you. I agree with you. I think the members should know that your book and your writings have become important resources for people who are interested in this whole area. I am not a lawyer, but it just seems that as we have fussed with this issue over the last 4 or 5 years now that the creative mind of the entrepreneur doesn't rest, and the only way it appears that you can prevent this ownership is, as you call it, a bright line.

It just seems to me to make it very simple and very direct that you won't have an ownership in any entity to which you refer, and every time we start making exemptions from that, six law firms and three accountants dream up new ways to get around it, and the fact is that it is very profitable for people selling machines or tests or equipment or whatever they sell, and it is usually not the physician that dreams these things up. It is somebody who is trying to peddle the equipment or the service, and they need the physician to supply them their revenue, and at perhaps a greater rate than they are used to getting.

I think we will hear more about it today, that all of these exemptions will do nothing but lead to a series of loopholes, and we will have the whole problem come back at us. I hope that the members will have a chance to review your complete prepared testimony and get some idea of both the concerns and the anecdotal approach you bring. People told me originally that we had anecdotal evidence. I think we now have enough anecdotes to fill a room about this size with a variety of prospectuses.

As I would remind the members, if you borrow those prospectuses, if you addressed in them that Dr. McDermott will have you before the ethics committee for accepting a bribe, they are so generous, and you can't buy them unless you are a physician. Do you own any, Dr. McDermott? But it is a problem, and I certainly appreciate your bringing it to us in layman's language.

Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman. I, too, want to applaud your background, although lawyer and Ph.D., the teacher in you came out marvelously in the way in which you presented this. It isn't that we can't ferret out the points in most of the testimony, it is just that it is a whole lot easier if it is done as clearly as you have done it, and I appreciate it.

On page 9, one of your recommendations seems to say that the higher good is no exception and that, as the chairman has indicated several times, the fertile mind of entrepreneurs, whether they be in law, medicine, or any other area, when driven by the profit motive are superior to those folks who are trying to plan to stop them from making an unfair profit.

Do you really believe that an outright ban has a higher priority than trying to provide services in rural areas that would otherwise be not provided if we didn't allow some of the professionals to invest their own money, or can we carve out some minor, very clearly understood restrictions that you would find acceptable?

Mr. RODWIN. First, I am not against the profit motive for doctors. I just don't want direct incentives that affect which service is used. There certainly are cases where there may be appropriate exceptions to a ban. The one most frequently mentioned is for rural

areas. I would suggest that if the exception is made there, there should then be some burden put upon the physician that engages in such schemes to show that there is a need for the activity.

Simply because an area is rural does not mean there is a need for services or self-referral. Take the use of imaging equipment, for example. There are all sorts of mobile imaging centers which allow access to services in rural areas even if there is no local facility

Mr. THOMAS. Just looking for, and obviously we will have various findings of fact that need to be present for the exceptions, but you don't believe the higher calling is a ban versus well thought out, clearly enforceable criteria that need to be met, because what I was getting was that no exceptions whatsoever was the preferred position, but you state that as a kind of an overstatement and then we will work down from there.

It seems to me also that from an enforcement point of view sometimes when you make it an outright ban that people who are bound and determined to carry it out are clearly carrying it out illegally, but that sometimes they are more enthusiastic about doing that under an outright ban than if there are clear criteria which allow us to say this is allowed and this is not, and, in fact, enforcement sometimes is easier when there are clearly areas in which you can do it and therefore this didn't meet those criteria and it is not allowed. Clearly the intent of Congress, whether we allow for exceptions, is easier to understand.

Have you had any feeling for that kind of an approach?

Mr. RODWIN. In terms of exceptions being easy to understand, the current exceptions in the Medicare fraud and abuse law—the so-called safe harbors—are very hard to understand. I have talked to many lawyers that make their living advising clients on such matters, and we have long discussions about what kind of venture would fit in particular safe harbors.

I think one has to consider the value of the activity that may be restricted. If there is some kind of value for the activity, some benefit you can't get otherwise, I would be very reluctant to restrict it in any way. Many conflicts of interest fall into that category. But I think with self-referral that is generally not the case. You have some kind of rule and there is going to be some costs either way. However, I think the net benefit and gains are going to favor a clear prohibition with a few limited exceptions.

Mr. THOMAS. Thank you for that clarification because clearly I, too, am one who wants just explicit, very carefully guarded and completely proven criteria for exceptions, but it seems to me that when you are talking about having particular services available or not that the choice of those two requires us to look at some possibilities that perhaps in other areas we wouldn't allow areas being geographic primarily and where services are clearly available that ultimately the delivery of that care, with price being secondary, sometimes needs to be considered versus not having that service at all, and it is going to be one we are going to wrestle with as we go through. And given your background experience, I would appreciate it if you would indicate that as you are going around with your book tour that you would provide some time for us to use you as a sounding board as to whether or not these seem to be reasonable criteria based upon your experience and background.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Lewis.

Mr. LEWIS. Thank you, Mr. Chairman.

Dr. Rodwin, I appreciate your moving statement. I look forward to reading your book, and I appreciate all of your research and study and various statements on this whole issue. I think the essence of what you stated to the committee is summarized on page 6 of your testimony. Maybe it is the essence of this issue.

At the bottom of the page, you raised a question and you give us an answer. The question is very simple. "Is there any compelling reason to treat doctors differently from other professionals with respect to conflict of interest?" You answer, "I find none." I think that is the issue with this legislation and issue before this committee.

Mr. RODWIN. I think you are right. For a long time many physician entrepreneurs have asked, why should we hold doctors to different standards or higher standards than others? After all, medicine is becoming more business-like, and Government policy promotes competition in medical care markets. But the simple fact is, if we want to treat doctors like other professionals, we have to subject them to the same standards. Even in the stock market, even in the hurly-burly world of business there are strict prohibitions on certain kinds of activities. These haven't always worked. There are problems. We may need more, but the legal standards are clear. Other professionals are held to fiduciary standards, and there is no equivalent, nothing near an equivalent for doctors.

Mr. LEWIS. Thank you.

Thank you, Mr. Chairman.

Chairman STARK. Mr. McDermott.

Mr. MCDERMOTT. Mr. Chairman, thank you. I guess I want to raise a question with you. I think that it is possible to draw the conclusion from your testimony that all physicians are involved in this, and I think it is important just to provide some perspective.

I was reading your article in Milbank here and noticed that in Chicago where I trained, Loyal Davis was censured or they attempted to censure him for speaking out against fee splitting. I think there have been a number of physicians who fought very hard against these kinds of abuses in the profession, but it strikes me that probably the only effective way to deal with this kind of abuse is a single-payer system where you have all the money on the table and physicians have to look one another in the eye and talk about what is actually going on inside the profession.

It strikes me that we up here will never be fast enough on our feet to figure a way to prevent people from finding some way to create a scheme by which money is passed on the basis of a conflict of interest. I know my profession well enough. I know my colleagues well enough, and we are no better, no worse than all the rest of the people in the United States in an entrepreneurial society. If there is an open-ended system as there has always been in our health care system, the motivation is always to figure out how to get more out of the system, and that has led to a large part of the cost explosion in this country. I don't foresee a way of writing a conflict of interest law that says there will be an absolute prohibition, but I just know people well enough that they always find a way to circumvent the rules.

It seems to me those kinds of things will proliferate. The only thing that is going to stop it is when there is no more money and people have to look at each other and say I know what you are doing and you are going to stop it because we are not going to reimburse that next year. It can't be effectively policed by people from the outside because they will never know what is going on on the inside. I really despair of trying to write a rule or a regulation or a law that will stop it. I think the only thing that is going to stop it is when doctors are looking at each other.

I would like to hear your response to that. Do you think you can write a law as an attorney that will prevent it?

Mr. RODWIN. Well, I think it is an important aim to try to do what is possible, even if you don't solve the whole problem. If you can make some progress, that should be done. On the issue of self-referral, I think that can be easily dealt with through legislation; namely by prohibition. There are other conflicts of interest, many, and I deal with them in my book. For those I think you need to develop new institutions and processes. These might be addressed as an integral part of the health care reform that is coming. And in fact, it needs to be addressed because as long as we have skewed incentives we are going to have problems with cost and having inappropriate care, and for too long we have not looked at how incentives might distort the clinical judgment of doctors.

Mr. MCDERMOTT. I would agree with you. I think you can do the limitations on self-referral. It is fairly straightforward on the face of it, but even that gets more complicated when you look at what has gone on in this Facey Medical case. You then begin to say, well, I wonder if it is possible even in what seems like a circumscribed area to write laws. I think it is a terribly complicated thing that needs to be addressed as a part of the overall Health Care Reform Act.

Thank you, Mr. Chairman.

Chairman STARK. Thank you. I intend to recognize Mr. Grandy, but before I do that I wanted to just welcome, if the committee will indulge me—I have several young people here in Close-Up who are from the Fremont, Calif., School for the Blind, and they wanted to hear a hearing today, so we have them with us in the audience, and I hope that perhaps they can make some sense out of Dr. Rodwin's inserts and all of ours as they observe our hearing today. I just wanted to welcome them here with their Close-Up group and their teachers.

Mr. Grandy.

Mr. GRANDY. Thank you, Mr. Chairman.

Dr. Rodwin, you were saying, you testified that there are some limited exceptions to the self-referral prohibition. What would they be in your rule?

Mr. RODWIN. Well, I will tell you one that I wouldn't have that is currently in the bill, the exception for hospitals.

Mr. GRANDY. I gathered that. But what are the ones that you would allow?

Mr. RODWIN. I would think there needs to be some kind of modified rule made for rural areas.

Mr. GRANDY. OK. I was hoping you would say something like that because it seems to me if there is going to be some kind of

carve out that it should relate to access, and I am curious about this because obviously both Mr. Thomas and I represent rural areas, but as we watch the health care debate distill down from the task force to the committee and then out to America, the managed competition model which has been popular, and I think it is losing steam right now from what I read, but it is kind of mutating into managed cooperation. I think that is the right term, isn't it, Mr. Chairman?

Chairman STARK. I don't know what it is today.

Mr. GRANDY. Well, as of last week, it was managed cooperation, but anyway that is kind of the distant cousin of managed competition in rural areas, and as I understand it, only dimly, this would allow physicians and providers and hospitals to kind of pool resources which I would assume would include some self-referral. Now, is that a possibility for an exception under your otherwise broad prohibition, and if so, how would you monitor that?

What is the determining factor that guarantees access without lewd entrepreneurialism taking place? I like that term, don't you? You might want to put that in your book if you do a volume 2.

Mr. RODWIN. Too late.

Mr. GRANDY. OK. I assume you feel the screen rights will not be——

Mr. THOMAS. A revised edition. You have got to think ahead.

Mr. GRANDY. Anyway, I mean, how do you draw that line? If you want to ensure access and of course we do, and you know there are delivery systems out in rural areas and frontier areas where you don't have a lot of choices and you have to have cooperation, then is there a way you could measure access to allow that to be excepted under your rule.

Mr. RODWIN. One shouldn't assume, I think, that rural areas don't have access to needed facilities and therefore services can only be provided by self-referring doctors. The evidence from the Florida Cost Containment Board study, and other studies as well, suggests that that is not where most of these limited partnerships are locating. There is a legitimate need to consider the special problems of rural areas, but I don't think this should be overemphasized.

I would suggest some kind of modified rule under which self-referral is allowed if certain other criteria were met. There should be some finding by a neutral agency that there was no alternative.

Mr. GRANDY. Would you allow community governments to perhaps, petition, if they could demonstrate the need or the lack of access if self-referral is not permitted in their managed cooperation corner of the health care grid?

Mr. RODWIN. That would be one approach. I would think it might be useful to have some national group that oversees such a waiver process.

Mr. GRANDY. I don't disagree with that. I guess what I would like to hear is the ability for communities to petition the Federal Government, assuming that is the managing agency here, the managing entity to say, look, we have got a clear need here. We have a hell of a time recruiting physicians. We have a hell of a time maintaining services. We are down to our last few options, and this hap-

pens to be one; I mean, an allowable exception to what you are talking about in terms of expanding H.R. 345?

Mr. RODWIN. It all depends on how it is done. If a patient has to drive 20 minutes or 30 or 45 to receive services, I am not sure that is always a bad thing. Studies have shown that it is much better in terms of quality and cost to choose facilities that perform services frequently and have expertise. The idea that one needs to have one of each kind of facility, lab, CAT scan center in everyone's backyard, I think, is wrong.

Mr. GRANDY. I understand that, but the areas that I think Mr. Thomas is referring to, and I would refer to, would probably in some cases involve a helicopter flight or distances that would be measured in the hundreds of miles and not 20 or 30.

Mr. RODWIN. I am just suggesting we start with the presumption that self-referral is inappropriate or not needed, and then as the need arises or is shown one certainly should make exceptions.

Mr. GRANDY. OK. All right. I think we have reached some conclusion on this.

Mr. RODWIN. I might be able to answer two of the questions that Mr. Thomas asked of another witness if that is not inappropriate.

Chairman STARK. Certainly not.

Mr. THOMAS. Were they good questions?

Mr. RODWIN. One dealt with the issue of limited partners and what role they might have in day-to-day management of facilities. I am not an expert in partnership law, but my understanding is partnership law prohibits a limited partner from engaging in day-to-day management, and if they do that, the limited partnership would collapse. That raises an interesting point. These centers are often set up so the physicians don't have roles in day-to-day management, don't have any liability, don't bear any of the usual risks that owners usually would.

You also asked about what prospectuses say and whether investors could renew them and decide if these were good facilities. That is certainly possible. However, my reading of several hundred prospectuses suggests that they usually provide mainly information on financial projections or rates of return. They mention the likely profits physician investors will receive.

I have a quote from one prospectus that I would like to read. It is from Tri-State Home Therapeutics Inc. of Cincinnati, Ohio, a subsidiary of T^2 (T-squared). This firm's private placement memorandum of 1987 solicited funds to set up an intravenous facility. Physician investors would invest $15,000, but they only had to put up $100. The rest of the money came from a bank loan at 1 percent above the prime. The doctors relent that money to the facility.

Here is what the prospectus said, and I quote: "The organizers believe that physicians will be more likely to refer patients to the corporation if the physician owns an interest in the corporation." Then the prospectus goes on and says, "the ability of the corporation to compete successfully with other entities will depend upon the corporation's ability to secure a large number of referrals from physician investors."

Now, the recent prospectuses I have seen are a little bit more careful in the language they use, but the financial incentive to refer patients is still there, although sometimes muted.

Mr. THOMAS. A brief response. That, to me, would almost seem to be self-evident in terms of someone involved in these kinds of operations. My only point in that regard was that it makes sense that if you are going to make the flat-out statements that were made, based upon the other presentation, that you ought to have the ability to indicate that they had no knowledge of the equipment any more so than anyone else, or at least establish a baseline on that so that you could take that argument away if you wanted to, and to the degree the methodology does not consider those alternative options, it simply weakens the position of that direct linkage. Also it was quite clear that limited partners cannot participate in the daily running of it.

My question was that someone who was going to invest, do they know and understand the usefulness of the equipment, and the fact that doctors would tend to utilize it if they knew more about it. That would obviously be a secondary point, but it seems to me you ought to knock those down in your pursuit of a clear legislative relationship between investment and use. You are familiar with methodology. I just think it makes sense to knock those down on the way.

Mr. RODWIN. Yes, but the studies I have seen by Bruce Hillman and others on radiology services suggested that when the radiologists made referrals and didn't have an interest, they referred less frequently. And when general practitioners and others who had less expertise had an ownership interest, they referred more frequently. These studies show knowledgeable professionals often use services less than physicians who self-refer. Those are good methodological points.

Mr. THOMAS. I need to look at those before I am able to jump on a ban. Thank you very much.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Thank you, Mr. Chairman. I was struck, Mr. Chairman, as we listen to the testimony and ask questions, that there really has been a great shift in a relatively few years. You, I think, put it very well that the presumption we should start with is that there should be a prohibition—a presumption against the practice of self-referral—and I think that many are now at that point. I think not too many years ago the presumption was the other way, and I think it is in part due to the leadership within government, to the chairman's leadership, and to some shift within the medical profession.

You say on page 4 of your testimony, the medical profession's stand on these issues has become weaker as the problem has become more serious. I think yes and no. Yes, if you go back far enough, and also if you don't take into account recent, more recent statements, but it is interesting, for example, in the testimony that will come after you, from the AMA testimony, we are really now talking about what conditions or what exceptions should be set, and it is true some people might try to make the exceptions so broad they would ruin the presumption, but I don't think that is going to happen. I mean, for instance, we are now talking about how long a divestiture period should be.

Looking at it objectively, the argument between 4 and 2 years is not going to destroy the presumption. The same in terms of the

rural exception. I think there would be rather broad agreement where there was an absolutely clear proof of need for an exception because of the size of the community that there should be such an exception, but the burden should be on those who want to amend the presumption, get out from under it, so I think in a relatively short period of time—indeed I think in the time I have sat on this subcommittee—there has been a rather substantial shift, and the working presumption now is that this kind of an interlocking mechanism should be prohibited.

I don't know if you want to comment on that, but I think there has been this rather substantial change, and for those who think that we would allow the exceptions to undermine the presumption, they should think twice.

Mr. RODWIN. I agree with what you are saying and want to elaborate on a few points you have made. The medical profession, particularly the AMA, has taken a stronger stance if one looks at the short term, but it has consistently followed the lead of Congress and State laws. The record shows that as legislation is proposed that would have greater restrictions, the AMA comes around to propose something slightly less than that. I would like to congratulate this committee for taking the lead because the organized medical profession, or certain elements of it, have not done so.

Second, on the issue of divestiture, I am not aware of any problems that arose in Florida or are arising in Florida or in other States that have recently enacted prohibitions. Certainly one wants to allow reasonable time to divest. However, many of these activities were potentially liable under the Medicare and Medicaid antikickback statute. This was made clear by courts in the decisions of *Greer* (760 F.2d 1985), *Hanlester* (CCH Medicare & Medicaid Guide, ¶40,064) and several other cases. So there has been adequate notice that self-referral is not risk free. I think anyone in the last 4 or 5 years starting these schemes has had notice that there is some risk of legal liability and regulatory restrictions. Second, if there is a legitimate need for these services, if they don't run mainly on self-referral, then shares of those limited partnerships will sell for a reasonable market price, and there won't be great hardship by selling them. There may be some small loss because limited partnerships are not as liquid as shares purchased in the stock market. But this loss will be small and necessary for the public interest.

It is mainly if these limited partnerships can't be sold in a competitive market, when the self-referral incentive is eliminated, that the physician investors will loose substantially when selling their shares. If that is the case I am a little less worried that there will be some loss of the original capital that was invested, especially since many such investors have recouped this capital many times over the past few years. I am in favor of an orderly divestiture. The 2-year period specified in the bill strikes me as reasonable. The 4-year period proposed by the AMA is probably more than necessary.

Mr. LEVIN. I agree. I didn't mean to minimize the difference between 2 and 4. Indeed, I would say, I think the whole trend line here is to be tough, and the tough approach has gained more and more understanding and acceptance that we should cut this nexus, and anybody who wants to come within an exception has the clear

burden of proof, and those exceptions have to be very, very carefully drawn. Thank you.

Thanks very much.

Mr. LEWIS [presiding]. Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman. I want to follow up on your reply to Mr. Grandy's question when you were talking about the need for exceptions for access. You mentioned the Florida study and whether joint ventures there were located in areas that were medically underserved. I am wondering whether you could elaborate as to whether the joint ventures that were created in Florida actually helped the access in underserved medical areas. One of the reasons we are given for allowing physicians to invest is that otherwise we would not get medical services in certain areas. Do we have any evidence that joint ventures helped underserved areas in Florida?

Mr. RODWIN. Well, the Florida study and the subsequent articles by Prof. Jean Mitchell, Elton Scott, and Dr. Sunshine suggest quite clearly that these facilities have not improved access, not for the uninsured, not for the Medicaid population, and or for rural areas. In Florida, these centers are located in urban areas and have taken the cream of the crop in terms of payers, either private insurance or Medicare. I believe earlier reports by the inspector general suggested similar trends, too.

Mr. CARDIN. So that if we carve out an exception it is going to have to be very carefully worded to have some type of an objective body make a determination that, in fact, it will improve access and that access is not otherwise available in the underserved community.

Mr. RODWIN. That is what I would suggest. The other fuzz area is going to be what counts as a rural area.

Mr. CARDIN. An underserved area I think is more——

Mr. RODWIN. Underserved area or rural area. Maybe underserved with respect to one facility or problem or others. However, if you are really concerned about underservice, financing for the people who lack insurance will do wonders. When there is money, the facilities will come. Perhaps there needs to be some kind of payment differential for physicians in rural areas. But one has to be very careful with the underserved area exception to self-referral or it might swallow the rule.

Mr. CARDIN. I thank you, Mr. Chairman.

Chairman STARK [presiding]. Mr. Andrews.

Mr. ANDREWS. Thank you, Mr. Chairman. I just want to mention that much like Sandy Levin, my own thinking about this has evolved since I have been in the Congress. I really think what Sandy said earlier is right on point, and I agree with his remarks about this issue. We don't always agree on health care issues. In fact, we respectfully disagree on many of them, but on this particular point I think he is absolutely correct.

The chairman wants to know what Sandy said. I didn't say I agreed with the chairman, just with Sandy. Only spoken in jest, Mr. Chairman. I really do think that the present system is fraught with danger, not just for the general public but for physicians in general, and that there may be the need for exceptions, but like

Mr. Levin said, I think the burden should fall on those seeking the exception.

Fred Grandy mentioned rural problems, and there are real rural problems and not just on the plains of Iowa, but in south Texas and other places, and I think we have to look at those in a realistic, very pragmatic way to be sure we can deliver health care, but that is not the primary problem. The primary problem is abuse and the opportunity for abuse and what will not only cause problems among doctors and other providers but also help ratchet up the cost.

I have a good friend who is an anesthesiologist in the Texas Medical Center at Houston. We went to college together. He was an outstanding Phi Beta Kappa student, and is now one of the foremost lecturers around the world on his specialty. He has written two or three books on anesthesiology. He told me a few weeks ago that the present system is indefensible, that doctors game the system and send their patients to their own anesthesiologist, making money off their practice in that regard except when they had a family member that needed the best anesthesiologist, and he said quite modestly, then they came to see him. That is exactly a reason why, one of the reasons why I think we need to change the system.

The Congress changed the honoraria system a year or so ago. We eliminated it, not because there was rampant abuse, but because there was the opportunity for abuse. There was the clear perception that there could be abuse in the system, and ethical problems, and I see some similarities here. I think we need, for the sake of the medical profession and the best providers, to make this very stringent. I am anxious to hear what some of the institutional groups here have to say about guidelines.

Frankly, again, I want to be very clear about my view about this. I think that it is not necessarily guidelines we are looking for, but exceptions to prohibition that should be acceptable to the Congress, and the more that you think through this—I am anxious to see your book, read your book. I wish you would give us some thoughts a little more in depth about, for instance, the query that Mr. Grandy made about rural health care and how to deal with that particular problem.

Thank you, Mr. Chairman.

Chairman STARK. Thank you. Do any members have further inquiry——

Mr. RODWIN. I want to make one point clear. I don't blame doctors for most of these problems. They are caught in the middle. A lot of these conflicts of interest arise because of the actions of institutional providers. They know that doctors control 70 percent of the medical care expenditures through their clinical decisions. Organizational providers are the ones that often promote these self-referral schemes. One can look at this as this system reform, to protect doctors, to help them practice good medicine, to minimize microlevel management, such as utilization review. If we can reduce the role of perverse incentives, doctors can exercise their best clinical judgment subject to fewer limitations.

Mr. ANDREWS. Mr. Chairman, could I just ask one brief question.

Chairman STARK. Please.

Mr. ANDREWS. Give us your thoughts, please, about this concept of managed competition and how you think these kinds of changes will fit into that process. Will this make us more effective or less effective?

Mr. RODWIN. Well, it depends on which managed competition proposal you talk about. It all depends on how managed competition is set up. I don't think the problem will be necessarily eliminated under all forms of managed competition. The answer lies in what the Congress does and how they set up managed competition plans.

Mr. ANDREWS. It is not inconsistent, is it, to have a managed competition concept, a managed competition marketplace where this kind of practice is outlawed? There is no reason, and I don't mean to retrack Mr. Grandy's question, but it is not necessary that there be this kind of self-dealing in a managed competition approach.

Mr. RODWIN. I would argue even more strongly. You need to restrict self-referral to really get competition. Prof. Alan Enthoven, one of the original proponents of managed competition, has spoken out against self-referral, too. In fact, I would think some self-referral schemes are violations of antitrust law. They are tie-ins. Self-referral schemes do not promote classic market competition because the doctor in a sense is cutting out competing sources. They are in charge of whether the service is needed, providing the service, recommending the service, so if one is a proponent of competition, one would particularly want to get rid of self-referral.

Mr. ANDREWS. Thank you.

Chairman STARK. Is that in your book, too?

Mr. RODWIN. Yes.

Chairman STARK. He will buy a bunch of copies. Thank you, Professor. I appreciate very much your——

Mr. THOMAS. Do you have a copy of his new book? Is it under $25?

Mr. RODWIN. $24.99.

Mr. THOMAS. I don't want to get you off track, but it seems to me there might be some useful place for several copies.

Mr. RODWIN. I have made advance copies available to the staff and I would certainly be happy to——

Mr. THOMAS. Excuse me, the staff already?

Mr. RODWIN. I believe members of the staff received advance copies so they could look into my research.

Chairman STARK. Do you want to read just the back, reverse cover. There is an admirable quote here if you can make it part of the record. Go ahead.

Mr. RODWIN. You want me to read it? Your quote?

Any American concerned about skyrocketing health care costs will want to read this book. Understanding that some physicians earn disgraceful profits through self-referral and learning how to stop them is one of the keys to getting health care costs under control.—Congressman Pete Stark.

Chairman STARK. Do you still want to read the book?

Mr. THOMAS. No, I just want a free copy. Constantly being put on the same level of staff around here, it is very, very difficult.

Chairman STARK. Thank you for your unbiased testimony today.

Mr. RODWIN. I heard earlier today that some people thought that I was biased, and I want to point out one thing, except for the Government agencies testifying here, I am the only one testifying today that does not have any financial tie or stake in this legislation. I received no outside funds for producing this book except that I have received Freedom of Information Act waivers from the Government, and that is a form of subsidy in doing research.

Chairman STARK. Let the record so state. Thanks a lot.

We will continue now with testimony from Dr. Nancy W. Dickey, who is a member of the board of trustees of the AMA; Mr. Frederick Entin, who is a senior vice president for legal affairs for the American Hospital Association; and Dr. Frank Riddick, who is president and chief executive officer of the Alton Ochsner Medical Foundation. We welcome the witnesses to the committee and would let you proceed, if you will, in the order that we called you. I would also suggest to the members and our guests and our future witnesses that it is the intention of the Chair to work on through.

He would appreciate it if some of the members would stagger their luncheons or meetings. We have ongoing hearings at the completion of these, and having said that, Dr. Dickey, why don't you lead off.

STATEMENT OF NANCY W. DICKEY, M.D., MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Dr. DICKEY. Thank you, Mr. Chairman and members of the committee. I am Nancy Dickey, a physician from Richmond, Tex., with a practice in family medicine. I am also a member of the AMA board of trustees. The AMA is pleased to have the opportunity to testify before you today concerning physician ownership of medical facilities and self-referral to these facilities. Even before H.R. 939 was introduced in 1989 by Chairman Stark, the AMA was actively working to establish our policy on ownership and referral.

The AMA is ready to work with the chairman and the subcommittee in creating acceptable physician ownership and self-referral guidelines. The AMA believes that when adequate alternative facilities exist, self-referral is presumptively inconsistent with physicians' fiduciary duty to their patients. However there are certain situations where self-referral is appropriate and even necessary to properly serve patients' needs.

For physicians, the highest priority is and must always be the needs of our patients.

In brief, the AMA, through Report C of the AMA Council on Ethical and Judicial Affairs, recommends that physicians should not refer patients to a health care facility outside their office practice in which they do not directly provide the care or services when they have an investment interest in that facility. The only exception to this prohibition is if there is a demonstrated need in the community for the facility and alternative financing is not available. Furthermore, even if this exception is met, the self-referring physician must comply with further ethical requirements relating to the marketing efforts of the facility, referral requirements, return on investment, noncompetition clauses, disclosure to patients, and utilization review. We believe the publicity in recent years concerning this issue, the fact that many patients are becoming part

of managed care, the AMA's educational efforts in State legislative activity have caused many physicians to reexamine their self-referral practices.

As health system reform evolves over the next few years, we expect that the practice of self-referral may greatly diminish. Health care delivery will probably be done by integrated systems for efficiency purposes in order to compete on cost and quality. With the modification of fee-for-service arrangements, incentives for the practice of self-referral will probably decrease.

In this new health care environment, physicians will be less likely to control where their patients acquire ancillary health care services. Those decisions might be made by managed care entities, third party payers, or others. In light of this rapidly changing environment, it is especially difficult to craft effective Federal legislation. As you know, the Comprehensive Physician Ownership and Referral Act of 1993, H.R. 345, introduced by Chairman Stark, would expand the current Medicare prohibition against self-referral to a clinical laboratory to nearly all health-related facilities and to all payers. Exceptions would be created for services provided personally by the physician or under the supervision of the physician, including other physicians in a group practice as well as for ancillary services provided by the physician or member of the group.

The AMA believes that H.R. 345 as drafted would establish an overly broad prohibition. The AMA would find the bill more acceptable if modified to meet certain conditions. For instance, this legislation would be effective 2 years after enactment. We believe that a 2-year divestiture period is too short. In order for physicians and facilities to have sufficient time to modify existing financial arrangements, the AMA supports a divestiture period of at least 4 years.

Although H.R. 345 provides for a rural exception as defined by the Medicare program, the AMA supports inclusion of exemptions for community need where no financial investors are available other than referring physicians. We commend the chairman for language included in H.R. 345 that clarifies group practice exemptions, but we also support an exception for situations in which physicians share facilities, such as laboratories outside of the formal group practice arrangement. We have attached our specific suggestions for modification of H.R. 345 to our written statement as attachment 3.

In conclusion, the AMA is supportive of efforts to control physicians' unethical ownership of and self-referral to health care facilities outside the physician's practice of medicine. However, we urge the subcommittee to be cautious in attempting to legislate an ethical issue. Many facilities would not be available in some communities but for physician ownership. Patient benefit and patient access to health care facilities must be of primary concern in enacting self-referral legislation.

We are available to respond to your questions and look forward to working with the subcommittee on this issue. Thank you.

[The prepared statement and attachments follow:]

Testimony

to the

Subcommittee on Health

Committee on Ways and Means

Presented by

Nancy W. Dickey, MD

RE: Physician Ownership and Referral

April 20, 1993

Introduction

The American Medical Association (AMA) is pleased to have the opportunity to testify before you today concerning physician ownership of medical facilities and "self-referral" to these facilities. Even before Chairman Stark (D-CA) introduced legislation on this issue in 1989, the AMA was actively working to establish our policy on ownership and referral. The AMA is ready to work with the Chairman and the Subcommittee on HR 345 to create acceptable physician ownership and self-referral guidelines. The AMA believes that when adequate alternative facilities exist, self-referral is presumptively inconsistent with the physicians' fiduciary duty to their patients. However, there are certain situations where self-referral is appropriate and even necessary to properly serve patients' needs. For physicians, the highest priority is and must always be the needs of our patients.

In brief, the AMA recommends that physicians should not refer patients to a health care facility outside their office practice at which they do not directly provide care or services when they have an investment interest in the facility. The only exception to this prohibition is if there is a demonstrated need in the community for the facility and alternative financing is not available. Furthermore, if this exception is met, the physician must comply with further ethical requirements relating to the marketing efforts of the facility, referral requirements, return on investment, noncompetition clauses, disclosure to patients and utilization review.

Background

As a result of the interest in the self-referral issue, the AMA Council on Ethical and Judicial Affairs (CEJA) appointed an expert advisory panel to examine the issue. The panel members consisted of Russel Patterson, MD, Chief of Neurosurgery at Cornell University, New York and a former Chairman of the Council, Newton M. Minow, senior partner in the law firm of Sidley & Austin, former FCC Chairman, Trustee Emeritus of the Mayo Clinic, Director of the Rand Corporation and Director of the Annenberg Washington Program of Northwestern University, and Robert Veatch, PhD, Director of the Kennedy Institute of Ethics. The Panel studied the data and other evidence with regard to physician self-referral and reviewed CEJA's prior reports and opinions.

The panel made no formal recommendations to CEJA but assisted in establishing a framework for analysis of the issue. The panel identified several considerations of particular significance:

- The medical profession's ability to preserve autonomy and the nature of the physician-patient relationship during periods of transformation have succeeded in large part due to the profession's lack of tolerance for "commercialism" in medicine.

- Government policies toward the profession have been contradictory and have contributed significantly to the rise of commercialism in medicine. The Federal Trade Commission has made unfettered competition a priority in medical practice and has seen physicians primarily as businesspeople. The Commission has acted against certain professional regulatory efforts, in particular, self-imposed restraints on advertising and fees. In contrast, Congress and the Health Care Financing Administration have established an extensive system of oversight and controls that places restrictions on physician practices which are often at odds with the Commission's free market approach. The only consistent theme of government policies is their treatment of physicians as entrepreneurs rather than professionals, with little value being given to physicians' fiduciary obligations.

The treatment of the self-referral question has important symbolic significance for the public and policymakers with regard to which of two alternative conceptualizations of the physician's role--that of professional or that of entrepreneur--the medical profession will move toward in the era of health care reform.

A New Approach Recommended by the Council

In 1990, CEJA determined that it was necessary to strengthen its 1986 opinion on self-referral. The underlying ethical stance of CEJA is that physicians in general can be trusted to deal appropriately with the conflicts presented by self-referral. Indeed, the CEJA believes that physician investment and self-referral have, on balance, been positive for patients and the nation's health care system.

In addition, CEJA recognized the change in our nation's health care priorities, and in particular, of our patients' expectations about physicians. In the 1990s and beyond, the growth in the costs of health care is likely to be the dominant concern of our patients. The nation has today, and is likely to continue to have, unparalleled availability of health care facilities and technology of all varieties.

Thus, CEJA issued what has become known as Report C (see attachment I). In general, Report C states that physicians should not refer patients to a health care facility outside their office practice in which they do not directly provide care or services when they have an investment interest in the facility.

The AMA House of Delegates adopted this report at the 1991 Interim (December) meeting. Although a subsequent resolution on the issue that seemingly expressed a contrary opinion was adopted by the AMA House of Delegates at the 1992 Annual (June) meeting, Report C was never reversed. In fact, the report was reaffirmed at the AMA's 1992 Interim meeting.

CEJA Report C

Through CEJA Report C recommendations on self-referral, the AMA is establishing new and stricter formal guidelines for those physicians who, in order to serve their patients, invest in outside facilities and refer. Physicians who do not personally provide services to their patients in facilities outside their practice in which they have an investment interest should not self-refer unless they can demonstrate both the absence of adequate alternative facilities--a plain medical need--and the absence of alternative financing. However, if this exception is met, the physician also must comply with the following further ethical requirements:

a. Individuals who are not in a position to refer patients to the facility must be given a bona fide opportunity to invest in the facility, and they must be able to invest on the same terms that are offered to referring physicians. The terms on which investment interests are offered to physicians must not be related to the past or expected volume of referrals or other business from the physicians.

b. There is no requirement that any physician investor make referrals to the entity or otherwise generate business as a condition for remaining an investor.

c. The entity must not market or furnish its items or services to referring physician investors differently than to other investors.

d. The entity must not loan funds or guarantee a loan for physicians in a position to refer to the entity.

e. The return on the physician's investment must be tied to the physician's equity in the facility rather than to the volume of referrals.

f. Investment contracts should not include "noncompetition clauses" that prevent physicians from investing in other facilities.

g. Physicians must disclose their investment interest to their patients when making a referral. Patients must be given a list of effective alternative facilities if any such facilities become reasonably available, informed that they have the option to use one of the alternative facilities, and assured that they will not be treated differently by the physician if they do not choose the physician-owned facility. These disclosure requirements also apply to physician investors who directly provide care or services for their patients in facilities outside their office practice.

h. The physician's ownership interest should be disclosed, when requested, to third party payers.

i. An internal utilization review program must be established to ensure that investing physicians do not exploit their patients in any way, as by inappropriate or unnecessary utilization.

j. When a physician's financial interest conflicts so greatly with the patient's interest as to be incompatible, the physician must make alternative arrangements for the care of the patient.

Report C is based on a number of observations. It was recognized that there are circumstances under which patients may be deprived of the best health care if physicians cannot refer patients to facilities in which the physician has an investment interest. Physicians have often been exclusively motivated by the important needs of their patients in becoming involved in such arrangements. Clearly, blanket bans on self-referral are inappropriate. Also, investing and referring when it is a direct extension of a physician's commitment to serve patients' needs is both ethical and desirable. This recognizes, however, that those needs must not be marginal or rationalized needs, or secondary to a profit motive, and non-physician or non-referring physician investment for developing ancillary health care facilities and services should be explored and exhausted.

Communication Campaign

The AMA believes that organized medicine should effectively communicate the profession's ethical guidelines. Hopefully, these guidelines will do more than just serve as a beacon for physicians. The medical profession has to be certain that its relevant standards--in particular its own ethical code--is the directive for these financial arrangements.

Compliance with these new guidelines, as well as other CEJA standards, will be enhanced by an increased focus on education and enforcement by the AMA and the state and local medical societies.

To address this problem, CEJA took two actions:

1. A communication campaign to educate physicians about the ethics of self-referral. The primary elements of CEJA's opinion was communicated to physicians through: 1) an individual mailing to all members through AMA's Member Matters newsletter, 2) a special bulletin in American Medical News, 3) a description of the opinion in the Journal of the American Medical Association, and 4) a special segment on American Medical Television.

2. An enforcement program to require compliance with the code of ethics. CEJA is asking all state, county and specialty societies, through their grievance and discipline committees, to actively investigate reports of abuse or non-compliance with the ethical opinion, and CEJA will itself solicit, review and/or refer to the appropriate professional association any complaint involving self referral. CEJA asks physicians and the public to refer any questionable arrangements to it or to their local medical society.

A current AMA Socioeconomic Monitoring System (SMS) survey (see attachment II) on physician ownership indicates that the propensity of physicians to own or invest in health care facilities has declined steadily since 1988. Recent figures from the 1992 survey indicate that only about 8 out of every 100 physicians had an ownership or investment interest in a health care facility. This represents a decrease of 1.3 percentage points from the 1988 level. In 1988 three-fourths of all physicians who owned facilities also referred patients to these facilities. By 1992, however, less than two-thirds of physician owners indicated that they self-referred their patients.

We believe that the publicity in recent years concerning this issue, the fact that many physicians are becoming part of the "managed care" movement, the AMA's educational efforts and state legislative activity, have caused many physicians to re-examine their self-referral practices. As health system reform and managed competition evolve over the next few years, we expect that the practice of self-referral will greatly diminish, or it will be done by integrated or other delivery systems for genuine efficiency purposes in order to compete on cost and quality. With the modification of fee for service arrangements, the self-referral concerns will become irrelevant. In this new health care environment, physicians will be unable to control where their patients acquire ancillary health care services. That decision will be made by the managed care entity. Thus, the AMA believes that federal legislation enacted at this time also will quickly become irrelevant.

AMA Position on H.R. 345

The Comprehensive Physician Ownership and Referral Act of 1993 (H.R. 345), introduced by Chairman Stark, would expand the current Medicare prohibition against self-referral to a clinical laboratory to nearly all health related facilities and to all payers. Exceptions would be created for services provided personally by a physician or under the supervision of a physician including other physicians in a group practice as well as for ancillary services provided by the physician or member of the group.

The AMA believes that HR 345, as drafted, would establish an overly broad prohibition. The AMA would find the bill more acceptable if modified to meet certain conditions. For instance, this legislation would be effective two years after enactment. We believe that a two-year divesture period is too short. In order for physicians and facilities to have sufficient time to modify existing financial arrangements, the AMA supports a divesture period of at least four years. Although HR 345 provides for a rural exception as defined by the Medicare program, the AMA supports inclusion of exceptions for "community need" where no financial investors are available other than referring physicians. We also support an exception for situations in which physicians share facilities, such as laboratories, outside of a formal group practice arrangement. We commend the Chairman for language included in HR 345 that clarifies group practice exemptions. We have attached our specific suggestions for modification to HR 345 as attachment III.

Conclusion

In conclusion, the AMA is supportive of efforts to control physician unethical ownership of and self-referral to health care facilities outside the physician's practice of medicine. However, we urge the Subcommittee to be cautious in attempting to legislate an ethical issue. Many facilities would not be available in some communities but for physician ownership. Patient benefit and patient access to health care facilities must be of primary concern.

We are available to respond to your questions and look forward to working with the Subcommittee on this issue.

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ATTACHMENT I

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

Report: C
(I-91)

Subject: Conflicts of Interest: Physician Ownership of Medical Facilities (Resolutions 137 and 188, A-90)

Presented by: Oscar W. Clarke, MD, Chairperson

Referred to: Reference Committee on Amendments to Constitution and Bylaws (Jerome K. Freedman, MD, Chairperson)

Introduction

At the 1990 Annual Meeting, the House of Delegates referred two resolutions to the Board of Trustees regarding physician ownership of medical facilities. Resolution 137, introduced by the American Society for Therapeutic Radiology and Oncology, called for reconsideration of the Association's guidelines on passive investments in radiation therapy facilities by physicians who refer patients to those facilities. Resolution 188 requested the Council on Ethical and Judicial Affairs to declare it unethical for physicians to refer patients to a medical facility if the physicians or their families hold a financial interest in the facility and the facility is outside of the sphere of the physicians' medical expertise.

The Council presented an Interim report in response to these resolutions at the Annual Meeting in 1991 which called for aggressive enforcement by state and county medical societies of the Council's existing guidelines on conflicts of interest. This report responds to the substantive issues raised by the resolutions. The Council is recommending a change in the Association's approach to the question of self referral.

Background

The Council issued a major report on conflicts of interest in the practice of medicine in 1986. The Council's view then was that conflicts are inherent in the practice of medicine and that the problem of referral of patients to outside facilities in which physicians have an investment ("self referral") was not significantly different in principle from other conflicts presented by fee-for-service medicine. In a report in 1988 the Council also identified the patient conflicts presented by certain managed care arrangements, particularly HMOs which reward physicians for providing less care.

With all of these arrangements, the Council's primary guidance was to remind physicians that the profession of medicine is unique and that physicians are expected to put their patients' interests first. Thus, where a physician's financial interest may conflict with the best interests of a patient, it is assumed that the physician will not take advantage of the patient.

The Council did recognize that some arrangements may present too great a conflict to be appropriate, but with regard to self-referral the Council issued a list of safeguards to help ensure that the patient's interests would not be jeopardized. That list was most recently updated in 1988.

Since these reports and opinions were issued, several studies have been performed analyzing self-referral and drawing conclusions with regard to increased utilization and cost of the practice.

At the request of the Council, the AMA's Center for Health Policy Research reviewed this evidence. The review focused on the three studies that provide original data and analyses on the effects of self-referral on utilization and costs: (1) Financial Arrangements Between Physicians and Health Care Facilities, a 1989 report by the Office of the Inspector General of the Department of Health and Human Services; (2) Joint Ventures Among Health Care Providers in Florida, a recently completed study issued by the Florida Health Care Cost Containment Board; and (3) "Frequency and Costs of Diagnostic Imaging in Office Practice - A Comparison of Self Referring and Radiologist-Referring Physicians," an article by Bruce J. Hillman and others that appeared in the New England Journal of Medicine (December 6, 1990).

Although the Center found that all of these studies have flaws, several important points could be made with regard to their findings:

- In the neighborhood of 10% of physicians nationwide have ownership interests in health care entities that have been associated with potential self-referral issues. However, not all of the physicians with such ownership interests engage in self-referral, so other motivations exist for physicians to make such investments. Moreover, there is significant geographic variation in the extent of physician ownership of health entities that is not readily reconciled with differential opportunities to self-refer.

- For several important classes of services for which physicians make referrals, patients of physicians who self-refer have higher utilization rates than other patients. None of the studies, however, examined the appropriateness of the utilization levels of physicians who self-refer and those who refer to other sources.*

- There is no evidence in these sources on the extent to which physicians may profit from self-referrals, so the degree of the conflict is not known, except anecdotally.

The Advisory Panel

The Council also appointed an expert advisory panel to assist it. The panel members consisted of Russel Patterson, MD, Chief of Neurosurgery at Cornell University, New York and a former Chairman of the Council, Newton M. Minow, senior partner in the law firm of Sidley & Austin, former FCC Chairman, Trustee Emeritus of the Mayo Clinic, Director of the Rand Corporation and Director of the Annenberg Washington Program of Northwestern University, and Robert Veatch, PhD, Director of the Kennedy Institute of Ethics. The panel studied the data and other evidence with regard to physician self-referral and reviewed the Council's prior reports and opinions.

The panel members met with the Council and provided an important perspective on the issue. The panel made no formal recommendations to the Council but assisted the Council in establishing a framework for analysis of the issue. The panel identified several considerations of particular significance:

- The medical profession's ability to preserve autonomy and the nature of the physician-patient relationship during periods of transformation have succeeded in large part due to the profession's lack of tolerance for "commercialism" in medicine.

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* The HHS study found that self-referring physicians referred patients for clinical lab testing at a 45% higher rate than non-investing physicians; the Florida study concluded that physicians' utilization of clinical labs, diagnostic imaging centers, and PT/Rehabilitation Centers was "significantly higher" where physicians are owners; the Hillman study concluded that physicians with a financial interest in diagnostic imaging facilities referred patients at a rate of 4-4.5 times that of non-investing physicians.

- Government policies toward the profession have been contradictory and have contributed significantly to the rise of commercialism in medicine. The Federal Trade Commission has made unfettered competition a priority in medical practice and has seen physicians primarily as businesspeople. The Commission has acted against certain professional regulatory efforts, in particular, self-imposed restraints on advertising and fees. In contrast, Congress and the Health Care Financing Administration have established an extensive system of oversight and controls that place restrictions on physician practices which are often at odds with the Commission's free market approach. The only consistent theme of government policies is their treatment of physicians as entrepreneurs rather than professionals, with little value being given to physicians' fiduciary obligations.

- The treatment of the self-referral question has important symbolic significance for the public and policymakers with regard to which of two alternative conceptualizations of the physician's role -- that of professional or that of entrepreneur -- the medical profession will move toward in the era of health care reform. Although physicians will unquestionably continue to be forced into business oriented behavior, and market forces will have an important function in controlling health care costs, the Association should make clear what balance will be maintained with the profession's unique ethical traditions.

A New Approach Recommended by the Council

The Council believes that it is necessary to strengthen its opinion on self-referral. It believes that physicians in general can be trusted to deal appropriately with the conflicts presented by self-referral. Indeed, the Council believes that physician investment and self-referral have on balance been positive for patients and the nation's health care system. But anecdotes of excessive profit and utilization have been widespread, and the formal studies which have been done strongly suggest, although they do not actually prove, inherent problems with the practice.

In addition, the Council takes notice of the change in our nation's health care priorities, and in particular, of our patients' expectations about physicians. In the 1990s and beyond, the growth in the costs of health care is likely to be the dominant concern of our patients. The nation has today, and is likely to continue to have, unparalleled availability of health care facilities and technology of all varieties.

In this environment, the Council believes that the issue of self-referral is a part of the larger issue of physicians' commitment to professionalism. As professionals, physicians are expected to devote their energy, attention and loyalty fully to the service of their patients. This does not mean they cannot have outside investments and activities or that they should not invest in health care facilities. It does mean that, to the extent possible, physicians should not be in the business of profiting purely from their ability to refer patients to outside facilities. Such a practice is fundamentally different from deriving financial reward from treating patients in their offices or in outside health care facilities they have invested in at which they care for or provide services to their patients.

At the heart of the Council's view of this issue is its conviction that, however others may see the profession, physicians are not simply businesspeople with high standards. Physicians are engaged in the special calling of healing, and, in that calling, they are the fiduciaries of their patients. They have different and higher duties than even the most ethical businessperson. This is the teaching of the Hippocratic oath and of the great modern teachers of ethical behavior. There are some activities involving their patients which physicians should avoid whether there is evidence of abuse or not.

Patient Need and New Guidelines

The Council recognizes that there are circumstances under which patients may be deprived of the best health care if physicians cannot invest and self-refer. Physicians have often been exclusively motivated by the important needs of their patients in becoming involved in such arrangements. Blanket bans on self-referral are inappropriate. Investing and referring when it is a direct extension of a physician's commitment to serve patients' needs is both ethical and desirable. But those needs must not be marginal or rationalized needs, or secondary to a profit motive, and where non-physician or non-referring physician investment is available those sources should be explored and exhausted first.

By recognizing this patient service aspect of physician investment as a basis for ethical self-referral, the Council appreciates that the effectiveness of its general proscription against self referral for profit may be weakened. Guidelines which do not effect a change in behavior or which are unenforceable because of their vagueness or breadth of exceptions do little to enhance professionalism. Indeed, they

reduce the public's confidence in the profession's ability to regulate itself.

The Council does not believe that will occur here. In addition to announcing a shift in its view about self-referral -- one that finds the practice presumptively inconsistent with the physician's fiduciary duty when adequate alternative facilities exist -- the Council is also establishing new and stricter formal guidelines for those physicians who, in order to serve their patients, invest in outside facilities and refer. Only where physicians can demonstrate both the absence of adequate alternative facilities - a plain medical need - and the absence of alternative financing should self-referral take place.

Compliance with these new guidelines, as well as other Council standards, will be enhanced by an increased focus on education and enforcement by the American Medical Association and the constituent state and local societies. The commitment to greater education and enforcement is discussed in a report of the Board of Trustees at this meeting.

Recommendations

Accordingly, the Council on Ethical and Judicial Affairs recommends:

1. Physician investment in health care facilities can provide important benefits for patient care. However, when physicians refer patients to facilities in which they have an ownership interest, a potential conflict of interest exists. In general, physicians should not refer patients to a health care facility outside their office practice at which they do not directly provide care or services when they have an investment interest in the facility.

2. Physicians may invest in and refer to an outside facility, whether or not they provide direct care or services at the facility, if there is a demonstrated need in the community for the facility and alternative financing is not available. There may be situations in which a needed facility would not be built if referring physicians were prohibited from investing in the facility. Need might exist when there is no facility of reasonable quality in the community or when use of existing facilities is onerous for patients. In such cases, the following requirements should also be met:

a. Individuals who are not in a position to refer patients to the facility must be given a bona fide opportunity to invest in the facility, and they must be able to invest on the same terms that are offered to referring physicians. The terms on which investment interests are offered to physicians must not be related to the past or expected volume of referrals or other business from the physicians.

b. There is no requirement that any physician investor make referrals to the entity or otherwise generate business as a condition for remaining an investor.

c. The entity must not market or furnish its items or services to referring physician investors differently than to other investors.

d. The entity must not loan funds or guarantee a loan for physicians in a position to refer to the entity.

e. The return on the physician's investment must be tied to the physician's equity in the facility rather than to the volume of referrals.

f. Investment contracts should not include "noncompetition clauses" that prevent physicians from investing in other facilities.

g. Physicians must disclose their investment interest to their patients when making a referral. Patients must be given a list of effective alternative facilities if any such facilities become reasonably available, informed that they have the option to use one of the alternative facilities, and assured that they will not be treated differently by the physician if they do not choose the physician-owned facility. These disclosure requirements also apply to physician investors who directly provide care or services for their patients in facilities outside their office practice.

h. The physician's ownership interest should be disclosed, when requested, to third party payers.

i. An internal utilization review program must be established to ensure that investing physicians do not exploit their patients in any way, as by inappropriate or unnecessary utilization.

j. When a physician's financial interest conflicts so greatly with the patient's interest as to be incompatible, the physician must make alternative arrangements for the care of the patient.

3. With regard to physicians who invested in facilities under the Council's prior opinion, it is recommended that they reevaluate their activity in accordance with this report and comply with the guidelines in this report to the fullest extent possible. If compliance with the need and alternative investor criteria is not practical, it is essential that the identification of reasonably available alternative facilities be provided.

4. That the remainder of this report be filed.

Self-Referral Clarifications

Recommendations

Accordingly, the Council on Ethical and Judicial Affairs recommends:

1. Physician investment in health care facilities can provide important benefits for patient care. However, when physicians refer patients to facilities in which they have an ownership interest, a potential conflict of interest exists. In general, physicians should not refer patients to a health care facility outside their office practice at which they do not directly provide care or services when they have an investment interest in the facility.

   Clarification of Recommendation 1:

   Facilities in which the physician directly provides care or services. Under the guidelines, physicians may refer their patients to facilities in which they have an ownership interest if the physician directly provides care or services. The Council drew a distinction between the physician who benefits financially from services that the physician actually provides and the physician who benefits purely from the ability to refer patients for services. Thus, for example, a surgeon may operate on a patient at an ambulatory surgical facility in which the surgeon has an investment interest. [While self-referral is permissible, there is still an obligation to comply with recommendations 2.b. through 2.j.]

   The requirement that the physician directly provide the care or services should be interpreted as commonly understood. The physician needs to have personal involvement with the provision of care on-site.

2. Physicians may invest in and refer to an outside facility, whether or not they provide direct care or services at the facility, if there is a demonstrated need in the community for the facility and alternative financing is not available. There may be situations in which a needed facility would not be built if referring physicians were prohibited from investing in the facility. Need might exist when there is no facility or an inadequate number of facilities of reasonable quality in the community or when use of existing facilities is onerous for patients. In such cases, the following requirements should also be met:

a. Individuals who are not in a position to refer patients to the facility must be given a bona fide opportunity to invest in the facility, and they must be able to invest on the same terms that are offered to referring physicians. The terms on which investment interests are offered to physicians must not be related to the past or expected volume of referrals or other business from the physicians.

b. There is no requirement that any physician investor make referrals to the entity or otherwise generate business as a condition for remaining an investor.

c. The entity must not market or furnish its items or services to referring physician investors differently than to other investors.

d. The entity must not loan funds or guarantee a loan for physicians in a position to refer to the entity.

e. The return on the physician's investment must be tied to the physician's equity in the facility rather than to the volume of referrals.

f. Investment contracts should not include "noncompetition clauses" that prevent physicians from investing in other facilities.

g. Physicians must disclose their investment interest to their patients when making a referral. Patients must be given a list of effective alternative facilities if any such facilities become reasonably available, informed that they have the option to use one of the alternative facilities, and assured that they will not be treated differently by the physician if they do not choose the physician-owned facility. [These disclosure requirements also apply to physician investors who directly provide care or services for their patients in facilities outside their office practice.]

h. The physician's ownership interest should be disclosed, when requested, to third party payers.

i. An internal utilization review program must be established to ensure that investing physicians do not exploit their patients in any way, as by inappropriate or unnecessary utilization.

j. When a physician's financial interest conflicts so greatly with the patient's interest as to be incompatible, the physician must make alternative arrangements for the care of the patient.

Clarifications of Recommendation 2:

Demonstrated need. Demonstrated need might exist (a) when there is no facility of reasonable quality in the community or (b) when use of existing facilities is onerous for patients.

No facility of reasonable quality. Self-referral cannot be justified simply if the facility would offer some marginal improvement over the quality of services in the community. The potential benefits of the facility should be substantial to justify assuming the risks of self-referral. The question is whether the community has facilities that can provide medically appropriate services.

The community. The community should be defined liberally since concerns about patient convenience are included in the next criterion. Thus, the community would be the metropolitan area for a city, or the county for a rural area.

Use of existing facilities is onerous. This guideline permits newer facilities when use of existing facilities creates a hardship for patients. This might occur, for example, if existing facilities are so heavily used that patients face undue delays in receiving services. A delay would become undue if putting off the service could compromise the patient's care, i.e., it would affect the curability or reversibility of the patient's condition. There would also be a hardship if patients had long travel times that made it difficult for them to receive services. The appropriateness of the travel time would depend in part on the frequency of the service. Longer travel times would be acceptable if patients tended to use the facility rarely, while longer travel times would be unacceptable if patients tended to use the facility more regularly.

Alternative financing. The requirement that alternative financing not be available carries a burden of proof. If the facility serves a real need and is financially viable, then capital should generally be available to support it. The burden on the builder of the facility is to show that adequate capital could not be raised without turning to self-referring physicians. As to the kind of efforts that must be made to secure alternative financing, the builder would have to undertake the usual steps that entrepreneurs undertake, including efforts to secure funding from banks, other financial institutions, and venture capitalists.

3. With regard to physicians who invested in facilities under the Council's prior opinion, it is recommended that they reevaluate their activity in accordance with this report and comply with the guidelines in this report to the fullest extent possible. If compliance with the need and alternative investor criteria is not practical, it is essential that the identification of reasonably available alternative facilities be provided.

Clarification of Recommendation 3:

Previous investments. Physicians who invested in facilities under the Council's prior opinion and who complied with the opinion should not be damaged by retroactive application of the Council's new opinion. To the extent feasible they should, however, begin to comply with the new opinion. If the investor were able to recover his/her initial investment, plus a reasonable rate of return, there would appear to be no loss or hardship. The Council expects that physicians could achieve full compliance within three years of the issuance of the guidelines, January, 1995.

When immediate compliance with the need and alternative investor criteria is not practical and therefore full compliance is delayed, there is still an obligation to comply with recommendations 2.b. through 2.j.

ATTACHMENT II

American Medical Association
Physicians dedicated to the health of America

Physician Marketplace Report

Trends in Physician Self-Referral

by David W. Lee, PhD

Self-referring physicians have an ownership interest in an ancillary health care facility and refer their patients to that facility for treatment. Current American Medical Association (AMA) policy considers self-referral to be unethical unless "there is a demonstrated need in the community for the facility and alternative financing is not available."[1] In addition, several states have enacted laws that restrict the ability of the physician to self-refer. These restrictions usually require the physician to disclose any ownership interest in a facility to which a patient is referred.

This report presents trend data on physician ownership and self-referral patterns since 1988. These data were collected in AMA's Socioeconomic Monitoring System (SMS) surveys conducted in the fall of 1988 and the spring of 1989, 1990, and 1992. In each survey, physicians were asked the following question:

Excluding your own practice, hospitals, HMOs, and publicly owned firms, do you or does any member of your immediate family have an ownership or investment interest in a private facility that provides health care services?

Those answering in the affirmative were also asked if they referred any of their patients to that facility for treatment. Note that the wording of the question is important because it explicitly excludes ownership or self-referral involving hospitals, HMOs, and other health care facilities considered by the physician to be within his or her practice. Thus, the types of ownership arrangements captured by SMS are those in which the physician could be expected to exert some control over the operation of the ancillary firm.

Trends in the proportion of all physicians who had an ownership interest in a health care facility and those owners that self-referred are displayed in Figures 1 and 2, respectively. Although data for 1991 were necessarily imputed, the propensity of physicians to own or invest in health care facilities appears to have declined steadily since 1988. The most recent figures from the 1992 survey indicate that only about eight out of every 100 physicians had an ownership or investment interest in a health care facility. This represents a decrease of 1.3

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[1]1992 AMA Policy Compendium 140.961.

percentage points from the 1988 level. Self-referral had also become less common among owners. In 1988, about three-quarters of all physicians who owned facilities also referred their patients to these facilities. By 1992, however, less than two-thirds of physician owners indicated that they self-referred their patients.

Tables 1 and 2 summarize physician ownership and self-referral patterns by a variety of physician characteristics. When examined by specialty, surgical specialists were the most likely to own or invest in a health care facility and they were also the most likely to self-refer. In 1992, 78.4% of these physicians who had an ownership interest in a health care facility also self-referred, compared to 57.7% of physicians in general/family practice, 75.5% of medical specialists and 20.8% of physicians in other specialties. The largest decline in both ownership and self-referral rates were seen among physicians in general/family practice. Between 1988 and 1992, the ownership rate fell from 10.1% to 6.0% while the self-referral rate dropped from 100% to 57.7%.

Other highlights from these tables indicate that:

- Self-employed physicians were the most likely to own and self-refer among employment categories. However, the propensity to own declined consistently over time among these physicians;

- Board-certified physicians were more than twice as likely as non-board-certified physicians to have an ownership interest in a health care facility in 1992. Self-referral rates declined for both groups between 1988 and 1992, but the reduction was more pronounced among non-board-certified physicians;

- In 1992, physicians who were members of the AMA were more likely to have an ownership interest in a health care facility compared to non-members. Additionally, ownership rates and self-referral rates fell more rapidly among non-member physicians relative to physicians who were members of the AMA; and

- Ownership rates fell consistently across rural and small metropolitan areas in the years studied. In 1992, ownership was most common in metropolitan areas while physicians in rural and small metropolitan areas were the most likely to self-refer.

Several states have passed laws that restrict self-referral.[2] Prior to 1992, Arizona, California, Delaware, Florida, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, Pennsylvania, Virginia, Washington and West Virginia had passed restrictions on self-referral. In 1992, Connecticut, Missouri, Florida, Illinois and New York also passed laws restricting self-referral. The SMS data from 1992 indicate that physicians practicing in states where self-referral laws were enacted prior to 1992 were more likely to have an ownership interest and physician owners in these states were more likely to self-refer. Physicians practicing in states where self-referral restrictions were enacted in 1992 had a lower

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[2]Information on states with self-referral restrictions was obtained from an unpublished report by the AMA's Department of State Legislation entitled, "Physician Self-Referral: A Summary of 1992 State Legislative Activity on the Issue" (December 1992).

propensity to invest in a health care facility and were less likely to self-refer than physicians in states without self-referral restrictions or physicians in states with self-referral restrictions established before 1992.

In summary, these data indicate that the magnitude of physician ownership and physician self-referral is both small and in decline. Variations in the propensity to own and self-refer across physician characteristics do exist, however, with the most marked differences observed between specialties and between employment categories. Future data should provide important insights into the effects of recent state restrictions on physician ownership and self-referral behavior.

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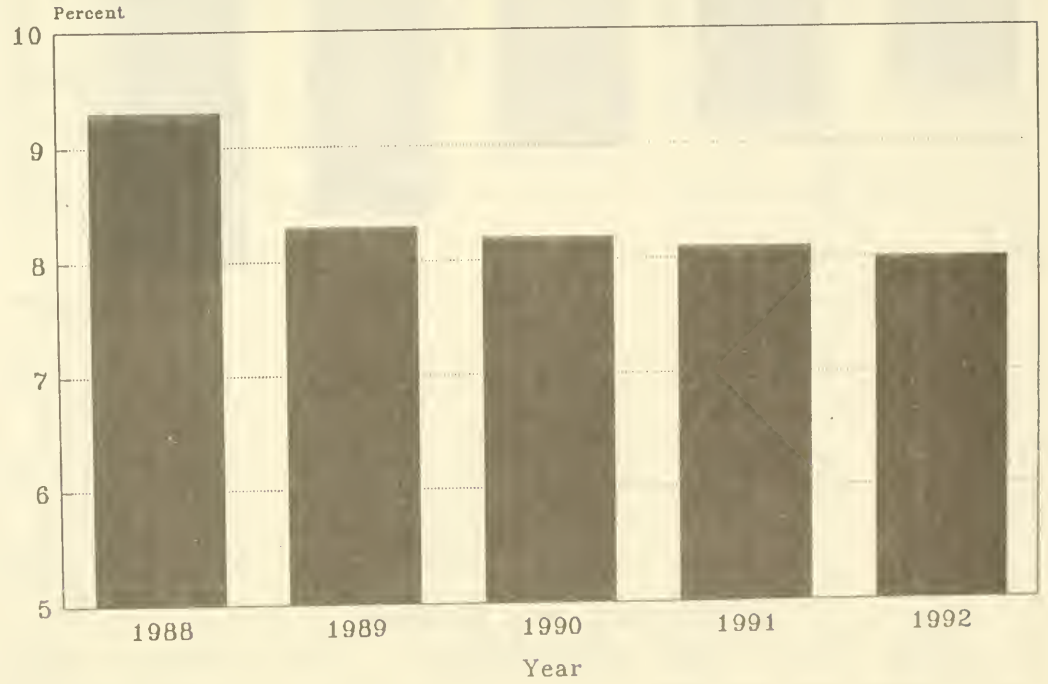
Figure 1

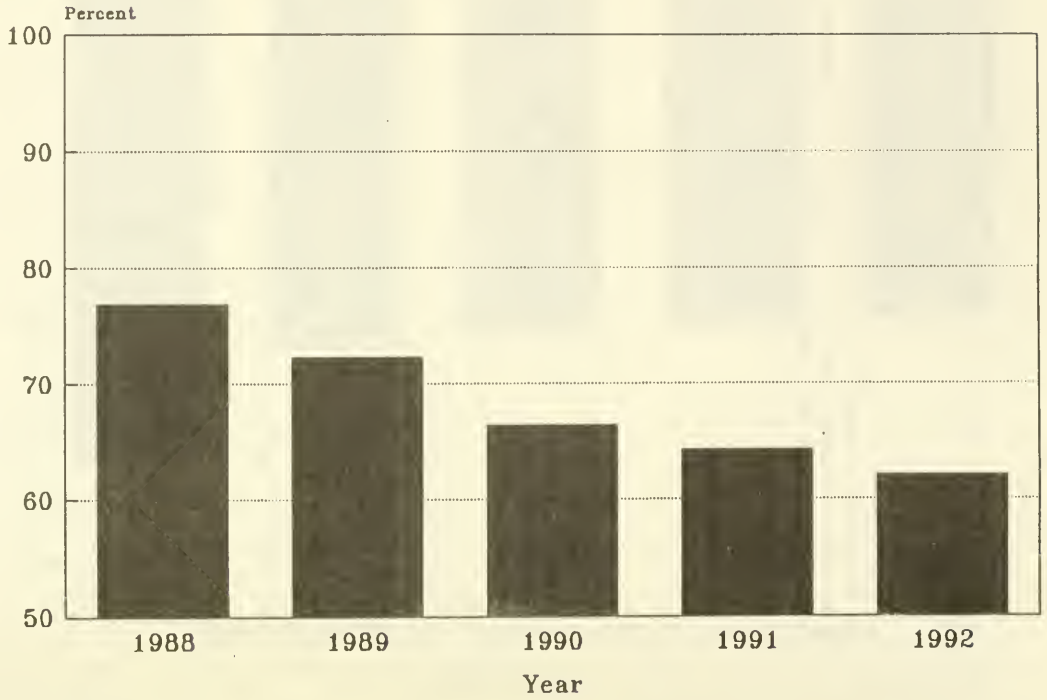
Ownership of Health Care Facilities



1991 Value Imputed

Figure 2

Owners Who Self Refer



1991 Value Imputed

TABLE 1: PROPORTION OF PHYSICIANS WITH AN OWNERSHIP INTEREST IN A HEALTH CARE FACILITY

PHYSICIAN CATEGORY	1988	1989	1990	1992
ALL	9.3%	8.3%	8.2%	8.0%
SPECIALTY				
GENERAL/FAMILY PRACTICE	10.1	5.5	6.7	6.0
MEDICAL SPECIALTIES	8.5	9.0	6.7	6.7
SURGICAL SPECIALTIES	12.1	11.8	11.7	11.9
OTHER SPECIALTIES	6.7	6.1	7.1	6.5
EMPLOYMENT TYPE				
EMPLOYEE	2.4	2.3	3.7	3.0
SELF-EMPLOYED	11.7	10.9	10.3	10.0
IND. CONTRACTOR	6.9	4.5	4.7	8.2
BOARD CERTIFICATION				
NOT CERTIFIED	8.1	6.1	5.8	4.2
BOARD CERTIFIED	9.8	9.3	9.1	9.2
MEMBERSHIP STATUS				
NON-MEMBER	9.0	6.4	7.2	5.7
MEMBER	9.5	10.3	9.3	10.7
LOCATION				
RURAL	9.3	6.7	6.2	5.8
SMALL METRO.	11.1	10.0	8.5	8.4
LARGE METRO	8.0	7.9	8.8	8.3
STATES W/ SELF-REFERRAL LAWS				
NO LAWS	9.5	8.6	7.6	8.3
LAWS ENACTED PRIOR TO 1992	11.8	9.8	9.8	8.7
LAWS ENACTED IN 1992	3.0	3.7	5.3	5.1

TABLE 2: PROPORTION OF PHYSICIANS WITH AN OWNERSHIP INTEREST IN A HEALTH CARE FACILITY THAT SELF-REFER

PHYSICIAN CATEGORY	1988	1989	1990	1992
ALL	76.9%	72.3%	66.4%	62.1%
SPECIALTY				
GENERAL/FAMILY PRACTICE	100.0	89.0	72.8	57.7
MEDICAL SPECIALTIES	95.8	83.4	75.3	75.7
SURGICAL SPECIALTIES	77.4	80.7	86.7	78.4
OTHER SPECIALTIES	25.3	34.4	26.0	20.8
EMPLOYMENT TYPE				
EMPLOYEE	49.0	26.9	26.2	30.8
SELF-EMPLOYED	79.7	76.9	73.8	69.7
IND. CONTRACTOR	43.9	42.3	9.4	11.5
BOARD CERTIFICATION				
NOT CERTIFIED	92.3	74.5	64.7	59.5
BOARD CERTIFIED	71.7	71.7	66.7	62.5
MEMBERSHIP STATUS				
NON-MEMBER	83.3	72.0	58.1	60.0
MEMBER	71.0	72.5	73.4	63.4
LOCATION				
RURAL	58.3	66.2	67.5	64.2
SMALL METRO.	75.9	72.8	58.6	68.2
LARGE METRO.	86.0	74.1	71.7	56.8
STATES W/ SELF-REFERRAL LAWS				
NO LAWS	74.5	79.3	63.3	63.0
LAWS ENACTED PRIOR TO 1992	78.8	68.0	68.6	63.5
LAWS ENACTED IN 1992	77.7	62.7	66.6	52.3

ATTACHMENT III

AMA MODIFICATIONS TO THE
H.R. 345 (THE COMPREHENSIVE PHYSICIAN OWNERSHIP
AND REFERRAL ACT OF 1993)

H.R.345 would establish an overly broad prohibition. The ethical standard and AMA policy also support exceptions for community need and where financial investors other than referring physicians are unavailable. The AMA has developed potential modifications to H.R. 345 that take these additional considerations into account and that are aimed at preserving access to ancillary services.

- Modification A would create an exception for valuable community services. The Secretary would issue a Statement of Exception where the facility demonstrates that it offers an increase in the quality of medical care in the community or provides a valuable and necessary service the absence of which would jeopardize the patients' ability to receive beneficial health care within the community.

- Modification B would recognize a "shared" facility. This exception uses the definition of "shared health facility" currently contained in the Medicare statutes at Section 1101(a)(9). This definition, among other things, would include an arrangement where two or more health care practitioners practice at a common location and share common waiting areas, examining rooms, treatment rooms, or other space, services of support staff or equipment. This would eliminate potential confusion and recognize a common practice.

- Modification C would recognize and provide an exception for facilities where services are personally provided by physicians for their patients in an ancillary facility such as an ambulatory surgical center, Comprehensive Outpatient Rehabilitation Facility (CORF), lithotripsy center or dialysis center.

- Modification D would add the definition for "facility services" as used in the Medicare statutes in regard to outpatient surgery. This definition would be extended to all other health care facilities through regulations promulgated by the Secretary.

- Modification E would add several new provisions --

    1. The Secretary would be authorized to issue a Statement of Exception to a qualified requesting facility indicating that the facility meets the exceptions under this Act.

    2. A facility receiving a Statement of Exception would be deemed to be

within a OIG "safe harbor".

3. The Secretary would be required to complete and submit a study to "Congress and the public no later than two years after the date of enactment as to the costs for health services before and after this Act.

4. Facilities would have five years from the date of enactment to divest. Facilities would be required to disclose the physician's ownership interest during the divestiture period. The Secretary could grant an extension of this time period if a patient hardship was shown.

Modification A

EXCEPTION FOR VALUABLE COMMUNITY SERVICES

Exceptions - 1877(b) - Add in and renumber accordingly -

(5) EXCEPTION FOR VALUABLE COMMUNITY SERVICES - (a) The Secretary shall issue a Statement of Exception in the case of services provided by a facility which has demonstrated to the Secretary that: the facility offers an increase in the quality of medical care in the community, or provides a valuable and necessary service to the community the absence of which would jeopardize the patients' ability to receive beneficial health care within the community. Other conditions may be established in regulations promulgated by the Secretary.

Modification B

EXCEPTION FOR A SHARED FACILITY

Exception - 1877(b) - Add in (Renumber all)

(3) SHARED HEALTH FACILITY SERVICES - In the case of services -

(A) that are furnished by a shared health facility as defined in Section 1101(a)(9).

Modification C

EXCEPTION FOR PERSONALLY PROVIDED SERVICES

1) Amend - 1877(b)(1)

(a) add "(a)" after "SERVICES ---"

(b) add a new (b) as follows--

In the case of facility services (such as, but not limited to, ambulatory surgical center, Comprehensive Outpatient Rehabilitation Facility (CORF), lithotripsy center or dialysis center) where the physician is actually providing physician services for the patient who is the recipient of the facility services.

Modification E

ADDITIONAL NEW PROVISIONS

Add after 1877(g) the following new provisions--

(i) STATEMENT OF EXCEPTION--The Secretary shall issue a Statement of Exception to all requesting facilities that meet the standards for exceptions in this Act. The Secretary also shall issue general guidelines, as well as written advisory opinions upon request, to aid in determining whether a potential facility falls within the exceptions authorized pursuant to this Act.

(k) "SAFE HARBOR" PREEMPTION--A facility receiving a Statement of Exception under this Act shall be deemed to have complied with the "safe harbor" regulations at 42 CFR Part 1001.

(1) STUDY OF COSTS - The Secretary shall conduct a study of the changes in costs for the designated health services before and after implementation of this Act. The Secretary shall issue this report to Congress no later than two years after the implementation of this Act.

(m) EFFECTIVE DATE - Facilities shall have five years from the date of enactment to comply with this Act. Disclosure of the physician's ownership interest in the facility to the patient shall be required during the divestiture period. The Secretary shall grant an exception to this provision if the facility demonstrates that a patient hardship would result from complying and that patients would not be exploited.

Modification D

DEFINITION OF FACILITY SERVICES

Section 1877(h) should be amended to add in additional definitions --

(8) FACILITY SERVICES - The term "facility services" is defined as used in Section 1833(i)(1) in regard to outpatient surgery. The Secretary shall promulgate regulations extending this definition to all other health care facilities.

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Chairman STARK. Mr. Entin.

STATEMENT OF FREDERIC J. ENTIN, GENERAL COUNSEL AND SENIOR VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. ENTIN. Thank you, Mr. Chairman. I am Fred Entin. I am general counsel and senior vice president of the American Hospital Association. I appreciate the opportunity to be here today on behalf of our approximately 5,300 institutional members.

Four years ago, the American Hospital Association supported adoption of the Ethics in Patient Referral Act of 1988 as it applied to clinical laboratory services. We continue to oppose referral of patients to an entity, facility, or venture where the referral is motivated by economic gain rather than patient needs. We support expansion of the ban as contained in H.R. 345 with certain clarifications, particularly addressing the issue of compensation arrangements, and certain limited exceptions.

A few prefatory remarks, if I may. We are on the verge of comprehensive health care reform, as many here have remarked today. That is because there is consensus that our current health care system is seriously flawed. It costs too much and it cares for too few. At the root of this unacceptably inefficient system are conflicting and perverse financial incentives. Certain of these inappropriate incentives cause the problems H.R. 345 and the current law on physician referral seek to address. But an absolute ban on all financial relationships involving referrals could conflict with other important policy objectives.

AHA appreciates the fact that the law as currently written and H.R. 345 do contain exceptions, recognizing the need for some flexibility. The health care system is restructuring itself in response to demands for greater efficiency and access. The system is moving toward more collaborative health care delivery, and this restructuring complements the objectives of the expansion of the self-referral ban. Both the restructuring and the ban will result in significant savings and a reduction of wasteful and unnecessary care.

In our written testimony, we make a number of specific suggestions regarding current law and H.R. 345 to make the ban more workable in this context. I will touch on a few. Specifically we have pointed out the need to clarify the expansion of the law which now includes hospital inpatient and outpatient services as designated health services. When read literally, that designation would encompass virtually all hospital services and thus could prohibit many necessary compensation or ownership arrangements between hospitals and physicians. We do not believe that this was the intention in drafting the law, and we seek clarification.

There has been comment earlier today, here in the hearing, about an exception regarding essential services in communities that need those services. We note that the law as written does have such an exception for rural communities. We would point out that the same problems of access to manpower and capital may exist in other medically underserved areas, such as inner cities, and AHA recommends consideration of the creation of a parallel exemption for medically underserved inner city areas, with the same requirement currently in the law that substantially all services be provided in that area.

Because of the expanded list of designated health services in H.R. 345, there is a need for simplification and clarification of exceptions for compensation arrangements. Congress must be careful that the expansion of the ban recognizes changes already underway and the need to accommodate a field that is dramatically and dynamically trying to respond to concerns over inefficiencies and wastes. More and more hospitals have abandoned competitive strategies. Instead they are seeking ways to work together to collaborate to deliver care more efficiently and avoid expensive duplication of services and technology.

In order to cooperate, hospitals must establish certain compensation arrangements with other providers, including physicians, to furnish health care services, and with the expansion of the list of designated health services, it must be clear what can be done. In our written testimony, AHA suggests ways in which the compensation arrangement issue can be simplified and clarified. We have a suggestion that would be applicable both to the employed physician and the nonemployed physician.

Rather than end up with a law, as has already been remarked here, that becomes ever expanding and ever complex, we think the law should set up some criteria generally applicable to compensation arrangements which ensure that incentives to overutilize will not be present. We see these criteria already in the law. The criteria would require that the arrangements not take into account volume or value of referrals and instead, require that those compensation arrangements be commercially reasonable, even if no referrals were made, and meet the standard test of fair market value.

The law must also be examined in the broader context of health care reform. The trend in health care delivery is toward integrated delivery systems. Indeed, the American Hospital Association's proposal for reform is based on the creation of community care networks or, as some have remarked, accountable health partnerships. Current law recognizes and makes some exceptions for alternative forms of delivery such as prepaid health plans and group practices, but we believe that those exceptions are not broad enough to encompass the broader concept of integrated delivery.

For example, in California and other States where there is a strong corporate practice of medicine doctrine, integrated delivery systems are forming along the lines of a foundation model. It is not clear if those models would be exempt. In many communities the entities with the commitment to organize providers into integrated delivery systems will be hospitals. Just as the law is flexible enough to allow referrals within group practices, we would hope that it also allows hospitals to develop referral relationships with physicians if the objective is coordination of care, reduction of costs and integration.

The suggestions we have made in our testimony would provide much of that flexibility. A health care system based on networks would encourage providers to collaborate with one another. In the AHA vision, networks would be paid on a capitated basis. Thus, the incentives to duplicate services and provide unnecessary care would be reversed. Only that care that is really necessary would be provided in a capitated arrangement. Inherent, however, in the

formation of networks will be the need for agreements regarding the referral of patients within the network.

We urge consideration of an exception to the law for accountable health partnerships or networks, if national health care policy sets us on that course. This would not compromise the spirit or intent of the physician referral law. We believe there is compatibility between the aims of this law to limit inappropriate referrals based on economic incentives and the overall goals of health care reform. We look forward to working with you and the committee as the future of health care delivery unfolds.

Thank you.

[The prepared statement follows:]

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Statement
of the
American Hospital Association
before the
Committee on Ways and Means, Subcommittee on Health
of the
United States House of Representatives
on
Health Care Reform:
Physician Ownership and Referral Arrangements and H.R. 345,
"The Comprehensive Physician Ownership and Referral Act of 1993"
April 20, 1993

Mr. Chairman, I am Fredric J. Entin, General Counsel and Senior Vice President of the American Hospital Association (AHA). On behalf of AHA's approximately 5,300 institutional members, I am pleased to testify on H.R. 345, a bill to amend Section 1877 of the Social Security Act to extend the ban on physician referrals to health care providers and entities with which the physician has a financial relationship. AHA supports the bill, with minor modifications and suggestions for flexibility which will be needed to accommodate efforts at health care reform.

BACKGROUND

This country is on the verge of comprehensive health care reform. As we move toward reform, we are faced with the challenge of finding an acceptable balance between providing greater access to health care services and conserving health care resources. To meet this challenge, there is a growing concern that the current health delivery system is fundamentally flawed and that we will need to change the way health care services are delivered. Although, the United States has unsurpassed ability to diagnose and treat disease, our current delivery system has certain conflicting and perverse financial incentives for providers that are at the root of an inefficient system.

One example of inappropriate financial incentives is the problem that H.R. 345, by amending current law on physician self-referral, seeks to address. Indeed, Congressional Budget Office estimates for the fiscal year 1994 budget include a total of $350 million in Medicare program savings by 1998, to be achieved by extending the current ban on physician self-referral. These estimates presumably are based, in part, on various federal and state studies of cost and utilization patterns for certain health care services when physicians own and refer to the entity where those services are provided. The evidence supports the conclusion that physician ownership can lead to conflicts of interest which affect the frequency and intensity of the provision of health care services. By amending current law, H.R. 345 would reduce the risk of unnecessary utilization or unethical referrals that exists when physicians (or their immediate family members) own an entity to which the physician refers.

The intent of the self-referral law is to address physician behavior; however, hospitals are pulled under the law by virtue of the various arrangements necessary to ensure furnishing of necessary services. Hospitals by their nature are a collection of health services, offering a continuum of care. Most hospitals are governed by community boards, whose goal is to ensure that the hospital fulfills its mission and meets the needs of its

community. Hospital activity is subject to oversight by a variety of sources including the Department of Health and Human Services (particularly, the Health Care Financing Administration and the Office of Inspector General), the Federal Trade Commission, the Department of Justice, and in most cases, the Internal Revenue Service. Both as a matter of financial pressure and public policy, hospitals continue to explore ways to contain costs and avoid duplication of services and equipment within a community. (See AHA Testimony before the Senate Judiciary Committee, Subcommittee on Antitrust, Monopolies and Business Rights, March 23, 1993)

Four years ago, AHA supported the original legislation addressing physician self-referrals for clinical laboratory services, the "Ethics in Patient Referral Act of 1988." The rationale for the legislation was to protect vulnerable Medicare patients from receiving unnecessary care or being improperly referred to certain providers. In addition, the bill sought to prevent over-utilization of Medicare services spurred by the prospect of financial gain. AHA opposes referral of patients for health care to an entity, facility, or venture in which the referring individual or an immediate family member has an ownership interest or from which compensation is received, except in limited circumstances.

An absolute ban on all financial relationships involving referrals, however, would conflict with other important public policy goals. Restructuring the delivery system and rearranging financial incentives will require flexibility for the development of new and innovative relationships among providers. Section 1877, as amended by H.R. 345, already contains various exceptions to address specific arrangements. AHA believes that the modifications discussed below, particularly in light of extending the ban from clinical laboratory services only to a variety of designated health care services, would help make the ban on referrals more workable. In addition, AHA notes that as the delivery of health care moves towards more integration among providers, reconsideration or restructuring of the referral ban may be necessary.

SPECIFIC MODIFICATIONS TO H.R. 345

AHA suggests consideration of the following modifications to H.R. 345:

(1) "Inpatient and Outpatient Hospital Services"

One main goal of the legislation is to expand Section 1877 to include a ban on referrals for a variety of "designated health services," in addition to clinical laboratory services. Section 3(a) of the bill adds a list of additional services, including:

> (11) inpatient and outpatient hospital services (including services furnished at a psychiatric or rehabilitation hospital).

Given the broad definition of "financial relationship" (which triggers the ban) contained in the law, along with existing operational practices between hospitals and physicians, numerous arrangements for furnishing inpatient and outpatient care could fall within subsection (11) and not qualify for an exception.

Proposed subsection (11) read literally would encompass all hospital inpatient and outpatient services and prohibit almost any type of compensation or investment relationship between hospitals and physicians (unless it fell within an existing exception). AHA suggests reconsideration of the specific goal of this subsection, and appropriate clarification of the legislative language.

It is possible that the language in subsection (11) is meant to prohibit referrals by a physician to hospital units or outpatient facilities in which the physician has a financial stake. This problem, however, is at least partially addressed in current law. Section 1877(d)(3) excepts services provided by a hospital if, "the ownership or investment interest is in the hospital itself (and not merely in a subdivision thereof)." By implication, ownership in a subdivision of the hospital, whether for the furnishing of inpatient or outpatient care, would prohibit referrals to the subdivision. Compensation arrangements, however, are not covered by section 1877(d)(3). If the goal of subsection (11) is to cover hospital "subdivisions," one approach would be to clarify the 1877(d)(3) exception and make it applicable to both ownership and compensation arrangements. A simpler approach would be to more clearly draft subsection (11) in H.R. 345, to address inpatient and outpatient hospital services rendered in units or freestanding facilities with which the referring physician has a financial relationship (if indeed this is the intent of subsection (11)).

(2) Exception for Unrelated Financial Relationships

Under current law, hospital financial relationships unrelated to the provision of clinical laboratory services are specifically excepted from the ownership and compensation arrangement prohibitions. (Section 1877(b)(4)) This exemption was provided to make clear that a physician's financial arrangement with a hospital for other than clinical lab services would not prevent that physician from referring patients for clinical lab services. H.R. 345 would expand the list of services covered by the law and amend the "unrelated services" exemption to read as follows:

> (4) HOSPITAL FINANCIAL RELATIONSHIP UNRELATED TO THE PROVISION OF DESIGNATED HEALTH SERVICES.--In the case of a financial relationship with a hospital if the financial relationship does not relate to the provision of designated health services.

This proposed language could be read to not except financial relationships with the hospital if the relationship is related to any of the designated health services being added to the law. Given the scope of the list, and in particular if "inpatient and outpatient hospital services" are added as a broad category, most if not all relationships will relate to some designated health service. AHA suggests that the language be clarified to note that arrangements unrelated to the specific designated health service for which the referral is being made are exempt from the prohibition. This drafting change would make the exception consistent with the law, as amended with additional designated services.

(3) Essential Services

Where essential services would not otherwise be available to a community, an exception to the financial relationship prohibitions should be made. Current law addresses this issue in the rural setting by exempting rural providers from the ownership prohibition. (Section 1877(d)(2)) H.R. 345 would amend the rural exception to apply for purposes of both the ownership and compensation arrangement prohibitions, and to require that substantially all of the services furnished by the entity are furnished to individuals who reside in the rural area.

AHA believes that providers in inner city areas often face similar difficulties obtaining essential services as providers in rural areas. Hospitals in medically underserved areas generally have trouble attracting health manpower and capital. We suggest, therefore, that H.R. 345 include a parallel exception for inner city providers, with a similar requirement that substantially all of the services are furnished to residents of the inner city area.

COMPENSATION ARRANGEMENT ISSUES

As health reform proceeds and varying models of integrated delivery systems emerge, hospitals, physicians, and other providers will need to collaborate, consolidate and establish innovative relationships for furnishing care. At the same time, H.R. 345 would expand the Section 1877 prohibition beyond clinical laboratory services to include a wide variety of services, and extend the ban beyond Medicare to all payers. As amended, Section 1877 would both preclude payment by federal and state payers for prohibited referral services and protect other payers from liability for such claims--meaning that providers risk payment denial from all payers.

AHA supports expansion of the prohibition, as qualified by the discussion of hospital inpatient and outpatient services above. Expanding the relatively narrow current prohibition, however, raises various issues with regard to compensation arrangements between providers. These issues should be clarified and simplified, if possible, to ensure that public policy goals are met, sufficient flexibility exists for providers to move forward with health care reform, and adequate clarity exists in the law.

Hospitals must establish compensation arrangements with various providers for the furnishing of health care services to patients. These arrangements can be in the form of either employment relationships or contracts (non-employment) for services. Either financial arrangement could trigger the prohibition on referrals.

Section 1877 contains various compensation arrangement exceptions drafted to accommodate a prohibition on referrals for clinical laboratory services. Because H.R. 345 expands the list of designated health services, the exceptions will need to be adapted. AHA believes that the compensation arrangement exceptions could be simplified by generally creating one exception for employment relationships and another exception for non-employment relationships. Both exceptions would include criteria which must be met to be exempt, and would apply to all entities or employers, including hospitals.

An exception exists in current law for "Employment and Service Arrangements with Hospitals." Section 4(b)(2) of H.R. 345 would amend that provision to create an exception for amounts paid where a bona fide employment relationship exists, or amounts paid by a hospital pursuant to an arrangement with a physician for the provision of administrative services. The amendment appears to intend to apply to (1) employment relationships for all services, and (2) service arrangements for administrative services. As written, however, the new exception could be read to cover employment for only administrative services. This language should be clarified to reflect that employment relationships for other than administrative services are exempt, as long as they meet the specified criteria.

In any case, AHA believes that a simpler approach to the employment exception would be to make section 1877(e)(2) apply only to employment relationships, and to cover non-employment service arrangements--for any services, including administrative services--in proposed section 1877(e)(7).

The proposed legislation would create a new paragraph 1877(b)(7) to exempt certain payments by an entity to a physician who is not employed by the entity for "other items or services." (See section 4(b)(3) of H.R. 345) As proposed, the new exception would apply only to a list of "specified services," mostly relating to the furnishing of clinical laboratory services. Note that if H.R. 345 expands the list of designated health services covered by the law, it is likely that a need will develop to expand the "specified services" in exception (e)(7) to accommodate the unique characteristics of each designated health service. The exception for other items and services furnished by non-employed physicians would almost certainly become unwieldy.

AHA suggests another approach to covering payments to physicians not employed by the entity. If proposed exception (e)(7) applied to payments "to a physician (or family member) who is not employed by the entity as compensation for administrative or health care services" in general, and if the specified services in proposed section (e)(7)(B) were deleted (or placed elsewhere in the law), the result would be a general exception for payment by an entity to a physician not employed by the entity for services. The criteria listed in proposed section (e)(7)(A) would still apply, including the requirement that compensation not take into account the volume or value of referrals.

These changes would create an exception for employment subject to the criteria listed in section (e)(2), including the requirement that employment compensation not take into account volume of referrals, and another exception for non-employment relationships. Hence, any compensation arrangement not exempted elsewhere in the law could only be exempt if it met specific criteria, and the expanded list of designated health services to which the law will apply would be accommodated. If the changes described above are made, current section 1877(e)(3), "Other Service Arrangements," may no longer be necessary because arrangements with entities other than hospitals presumably would be covered under either new section (e)(2) for employer payments to employees, or new section (e)(7) for entity payments to non-employees.

Simplifying the compensation arrangement provisions will also help resolve difficulties related to the section 1877(f) reporting requirement contained in current law which imposes an ongoing reporting requirement on participating providers. HCFA forms 96 and 97 require reporting of "financial relationships," including compensation arrangements. Exempt compensation arrangements must be indicated although not listed specifically. Simplifying the exemptions for compensation arrangements in the law will in turn simplify regulatory reporting.

THE FUTURE OF HEALTH CARE DELIVERY

AHA believes that the prohibitions in Section 1877 and the proposed amendments in H.R. 345 must also be viewed in the broader context of federal health care reform. AHA and others envision a future health care delivery system based on Community Care Networks℠, or what some call accountable health plans or partnerships (AHP's). Limited exceptions to the ban on physician self-referral can provide flexibility for the creation and operation of these networks, without compromising the spirit or intent of the self-referral prohibitions.

Current exceptions exist under Section 1877 for prepaid health plans and payments within group practices, but those exceptions would not necessarily encompass the broader concept of an integrated network of providers. For example, it is not clear that the "foundation model" currently being explored and implemented in California would be exempt from the ban on referrals. In many communities, the entities with the commitment to organize providers into integrated networks will be hospitals. Just as current law permits flexibility for group practices, the law should be flexible enough to allow hospitals to develop referral relationships if the objective is integration and coordination of care. Note, too, that the unintended consequences of a broad group practice exception may be duplication of services and equipment in a community, or fragmentation of care, rather than integration of care.

One objective of a network or AHP is to ensure a continuum of care. Networks invariably will seek to provide one or more of the proposed services defined as a "designated health service" in H.R. 345. There likely will be many cases where one or more designated health services could legally be provided by a physician or pursuant to a physician's order because a Section

1877 exception exists. However, those same physician services or orders might be prohibited if provided through a network or hospital. This result only exacerbates fragmentation of our health delivery system and unnecessarily restricts legitimate business arrangements among providers.

Accommodation of otherwise prohibited referrals in certain situations is not without precedent. Many states (most recently, Maryland) already have enacted all payor self-referral legislation with various statutory exceptions, including exceptions for certain financial arrangements between physicians and health maintenance organizations, group practices, or where health care services are provided through or by certain health care entities. These statutory exceptions reflect the legislators' conclusion that the referrals likely to occur within these newer, non-traditional health delivery settings are unlikely to pose a high risk of unnecessary or unethical care.

AHA REFORM VISION

AHA's vision for health reform calls for universal access to a basic set of health care benefits. The package of basic benefits would cover the full range of services from preventive care through long term care. Universal access would be provided by means of a pluralistic system of financing -- a combination of private workplace coverage and a new public program consolidating and expanding Medicare and Medicaid. Employers would be first encouraged and ultimately required to provide coverage for their workers and dependents.

AHA's vision of networks is one of providers working together to furnish patients with integrated care organized at the community level. These networks would include institutional providers, physicians and allied health care professionals, insurers, employers, unions and other groups. Networks would be responsible for providing all the covered health care services for their enrolled populations and would coordinate comprehensive patient care over time and across various provider settings.

Networks would receive risk-adjusted capitated payments from purchasers of health care and would create incentives for providers to conserve health care resources by providing only appropriate and necessary care. Networks also would encourage providers to collaborate with one another to avoid duplication and fragmentation of services. Inherent in the formation and operation of an integrated network will be agreements regarding the referral of patients to providers within the network. Such agreements likely will require ownership interests and compensation arrangements to create and maintain a viable network.

AHA urges Congress to consider an exception to Section 1877 for AHP's or networks, if indeed federal health care reform includes a role for these entities. The precise exception, of course, could not be established until networks or AHP's are defined.

If, as AHA envisions, providers are integrated within a network which receives capitated payments for services provided, financial incentives would be altered to encourage the delivery of necessary care in the most efficient way possible and discourage over-utilization of services. Consequently, there should be less concern over the risk of compromising patient care due to unnecessary or unethical referrals within a network setting. AHA's vision for reform would create a new health delivery system operating in a manner that is consistent with the spirit of the physician ownership and referral prohibitions.

CONCLUSION

The "Comprehensive Physician Ownership and Referral Act of 1993" presents an important opportunity for Congress to both address abusive patient referral practices and provide flexibility for providers to organize more efficiently. As reform of our health care delivery system evolves, additional consideration will need to be given to exemptions for integrated networks of providers. AHA looks forward to working with Congress and the Subcommittee to achieve these goals.

Chairman STARK. Thank you.
Dr. Riddick.

STATEMENT OF FRANK A. RIDDICK, JR., M.D., PRESIDENT, AMERICAN GROUP PRACTICE ASSOCIATION, AND CHIEF EXECUTIVE OFFICER, ALTON OCHSNER MEDICAL FOUNDATION, NEW ORLEANS, LA.

Dr. RIDDICK. Mr. Chairman, members of the committee, on behalf of the American Group Practice Association, I want to thank you for the opportunity to comment on the Comprehensive Physician Ownership and Referral Act of 1993. I am Frank Riddick, president of the American Group Practice Association and chief executive officer of the Alton Ochsner Medical Foundation and former medical director of the Ochsner Clinic in New Orleans, La. I am a practicing endocrinologist.

AGPA represents large multispecialty group practices that provide hospital and clinic service in integrated delivery systems, as well as smaller multi and single specialty group practices. Current and proposed legislation directed at physician ownership and self-referral directly affects the continued viability of these integrated group practices. The self-referral legislation is intended to eliminate opportunities for overutilization of health care services driven by economic incentives rather than by medical necessity.

We join Congress in condemning the unethical practice of physicians who abuse their patients' trust for personal financial gain. I ask, however, that you not lose sight of the fact that the vast majority of physicians do not fall into that category, and that these many physicians continue to place their duty to their patients above any personal concerns. Both the existing legislation and H.R. 345 would prohibit many valid and beneficial arrangements undertaken by physicians concerned about their patients' welfare that pose no risk of patient or payer abuse.

I speak to you today on behalf of those physicians about such arrangements. The existing statute exempts physicians in group practices that own clinical laboratories and individual physicians providing in-office ancillary services through their own laboratories. Because of the diversity in organizational and legal structure of group practices and the multiplicity of means by which these group practices provide services to their patients, many groups found themselves out of compliance with the technical requirements of the statute, as in the instance of my own institution. Group practices with shared laboratory facilities, under arrangement contracts with hospitals, with satellite facilities, and with part-time and independent contractor physicians were among those unprotected by the ancillary services exception. H.R. 21 corrects the inconsistencies in the existing self-referral statutes that affect group practices. AGPA supports this practice—correction, supports its passage.

H.R. 345 significantly expands the scope of physician self-referral prohibition to include a wide range of health care services and all payers. It carries over the exceptions to the existing physician referral legislation as well as some of the exceptions proposed in H.R. 21. The H.R. 21 exceptions, however, are limited to clinical laboratory services and do not address the myriad of problems that arise

from the expansion of self-referral prohibitions to other health care services.

H.R. 345 provides for an exemption for employment relationships and certain limited compensation relationships related to administrative services. AGPA asks that Congress draw a distinction for purposes of the self-referral prohibition between passive ownership and investment interest on the one hand and legitimate compensation arrangements, including both contractual and employment relationships that are not based on the volume or value of referrals.

Group practice represent a unique and rapidly growing mode of medical practice, offering high quality, cost-effective, coordinated care to patients and providing a professional environment that fosters medical excellence. AGPA recommends that as long as a group practice is a legally constituted integrated group practice and financial relationships are not based on referrals, affiliations with independent physicians or other group practices should not affect the group practices' exemption from the self-referral prohibition.

H.R. 345, unlike the original statute, provides an exception for under arrangements agreement for laboratory services between hospitals and group practices that operate clinical laboratories. AGPA applauds Congress' willingness to accept this new exception. We ask that if the self-referral proscription is expanded to other health care services, such as radiation therapy and radiology, the under arrangements exception also be expanded, and we have provided suggested language in our written testimony.

H.R. 345 does not provide an exemption for shared facilities. This constraint on shared facilities inhibits beneficial cost-effective collaborative activity. We ask that the exception apply to facilities shared by hospitals or foundations and group practices.

AGPA is honored to have been asked to testify before the committee. We support Congress' efforts to curtail abusive and unethical physician ownership and a referral practice, but we ask that in the effort the committee guard against unintended effects that the legislation may have on nonabusive beneficial practices. Thank you.

[The prepared statement follows:]

Testimony to the
Subcommittee on Health
Committee on Ways and Means

Presented By

Frank A. Riddick, Jr., M.D.

Re: Physician Ownership and Referral
April 20, 1993

Mr. Chairman and members of the Committee, on behalf of the American Group Practice Association, I want to thank you for this opportunity to comment on the Comprehensive Physician Ownership and Referral Act of 1993. I am Frank A. Riddick, Jr., President of the American Group Practice Association ("AGPA"), Chief Executive Officer of the Alton Ochsner Medical Foundation, and former Medical Director of the Ochsner Clinic in New Orleans, Louisiana and a practicing endocrinologist. The AGPA represents large multi-specialty group practices that provide hospital and clinic service in integrated delivery systems, as well as smaller multi- and single specialty group practices. Some of our member groups provide services through a single point of service, some have large networks in a single city, and some have multiple sites in several cities and states. We believe that group practices should be encouraged as a means of improving access to and coordination of care, reducing the administrative costs of health care delivery, and monitoring both the quality and cost of health care services. Current and proposed legislation directed at physician ownership and self-referral directly affects the continued viability of these integrated group practices.

The self-referral legislation is intended to eliminate opportunities for over-utilization of health care services driven by economic incentives rather than by medical necessity. We join Congress in condemning the unethical practices of physicians who abuse their patients' trust for personal financial gain. I ask however that you not lose sight of the simple truth that the vast majority of physicians do not fall into that category and that these many physicians continue to place their duty to their patients above any personal concern. Both the existing legislation and H.R. 345 would unintentionally prohibit many valid and beneficial arrangements, undertaken by physicians concerned about their patients' welfare, that pose no risk of patient or payor abuse. I speak to you today on behalf of those physicians about such arrangements.

<u>Background Information on Physician Ownership and Self-Referral</u>

As part of the Omnibus Budget Reconciliation Act of 1989, Congress enacted Section 1877 of the Social Security Act to prohibit physicians from making referrals to

an entity for the furnishing of clinical laboratory services for which Medicare would otherwise pay if the physicians or a member of their family have a financial relationship with that entity. Financial relationships include ownership and investment interests, as well as compensation arrangements. The law also prohibits an entity from submitting claims for Medicare payment for clinical laboratory services furnished under a prohibited referral. The statute exempts physicians in group practices that own clinical laboratories and individual physicians providing in-office ancillary services through their own laboratories. Because of the diversity in organizational and legal structure of group practices and the multiplicity of means by which those group practices provide services to their patients, many groups found themselves out of compliance with the technical requirements of the statute. Group practices with shared laboratory facilities, "under arrangements" contracts with hospitals, satellite facilities, and with part-time and independent contractor physicians were among those unintentionally left unprotected by the in-office ancillary services exception.

During the final days of the 102nd Congress, the Senate completed work on a comprehensive slate of non-controversial Medicare amendments which were attached to the H.R. 11, otherwise known as "the tax bill". H.R. 11 contained provisions that would correct technical problems with the physician ownership and self-referral statute to accomplish Congress' purpose to exempt physicians in group practices and individual physicians providing in-office ancillary services. These amendments and the problems they were intended to resolve were identified by group practices nationwide. In the absence of the clarifications provided by these amendments, many group practices presumed to be exempt from the prohibition on physician self-referral will be unable to achieve compliance with the statute without significant restructuring.

H.R. 11, which was reintroduced in the 103rd Congress and designated H.R. 21, includes fifty-five Medicare provisions that were originally set forth in last year's tax bill. In addition to clarifying physician ownership and self-referral provisions affecting group practices, provisions of H.R. 21 would restore Medicare payments for the interpretation of EKGs and repeal provisions that reduce Medicare payments to new physicians. Some of the amendments related to physician self-referral for clinical laboratory services are also included in H.R. 345.

The AGPA supports the passage of H.R. 21 to correct the inconsistencies in the existing self referral statute.

Comprehensive Physician Ownership and Referral Act of 1993

The Comprehensive Physician Ownership and Referral Act of 1993, H.R. 345, significantly expands the scope of the self-referral prohibition enacted as part of the Omnibus Budget Reconciliation Act of 1989. H.R. 345 would extend the physician self-referral prohibition to include physical and occupational therapy services, radiology services (including magnetic resonance imaging, computerized axial tomography, and ultrasound), radiation therapy services, the furnishing of durable medical equipment, parenteral and enteral nutritional equipment and supplies, outpatient prescription drugs,

ambulance services, home infusion therapy, and inpatient and outpatient hospital services, as well as clinical laboratory services. Further, H.R. 345 would apply to any referral made by a physician for designated health care services regardless of the source of payment.

H.R. 345 carries over the exceptions to the existing physician self-referral legislation as well as some of the exceptions proposed in the 102nd Congress in H.R. 11 and in the 103rd Congress in H.R. 21. The proposed exceptions contained in H.R. 21 and included in H.R. 345 are limited to clinical laboratory services and do not address the myriad of problems that arise from the expansion of the self-referral provisions to other health care services.

Financial Relationships

We ask that you distinguish between passive ownership arrangements, which are a potential source of abuse, and non-abusive, reasonable compensation arrangements that have been in place for many years. H.R. 345 provides for an exemption for *bona fide* employment relationships and certain, limited compensation arrangements related to administrative services. Employment of physicians, however, is not an option in many states as a result of statutes prohibiting the corporate practice of medicine. That doctrine proscribes employment of physicians by non-profit or business corporations, thereby limiting their employment to physician partnerships or professional medical corporations. As a result of state law constraints, the component parts of many integrated health care delivery systems must be established as separate legal entities. In California, for example, state law which prohibits the employment of physicians permits the operation of a tax exempt clinic that provides services to patients through a contract with a multi-specialty group practice. These "Foundation" model clinics share the concerns of the more traditional model group practices. The financial relationships between the physician component and the foundation or hospital component of these delivery systems are based upon *bona fide* compensation arrangements for professional physicians services, as well as for administrative, supervisory and in some cases teaching services. The self-referral legislation will preclude referrals within these integrated delivery systems.

H.R. 345 includes an exemption for compensation arrangements consisting of payments to a group practice for pathology services provided to an affiliated non-profit entity or hospital. AGPA recommends expansion of that exemption to the other designated health care services.

AGPA also recommends that a distinction be drawn between passive ownership and *bona fide* compensation arrangements that are not based on the volume or value of referrals as well as employment relationships.

In-Office Ancillary Services

The Comprehensive Physician Ownership and Referral Act of 1993 continues the exception for in-office ancillary services that was intended to provide an exception from

the self-referral prohibition for services offered by group practices when specific standards are satisfied. AGPA's principal concern is that this exception not be so narrow as to exclude valid and non-abusive practice arrangements that serve the objective of superior care at competitive prices in the best interests of patients and payers. Based on that objective, we believe three issues must be addressed: the definition of group practice, the use of shared facilities, and the provision of reference services.

Definition of Group Practice

The in-office ancillary services exception depends in the first instance on the definition of group practice. The current statutory definition of group practice requires each member of the group to furnish substantially the full range of services that physicians routinely provide within the group's legal structure. H.R. 345 creates an additional exception that presumably would permit groups to obtain services of physicians on a part-time or independent contractor basis to furnish care to the group's patients. This exception is particularly important to groups operating in rural and inner-city areas where certain subspecialty physicians may not be readily available or where their services might not be required on a full-time basis. AGPA supported this additional exception and appreciates Congress' responsiveness to our members' concerns.

The group practice definition, however, does not permit affiliations between or among group practices. Group practices represent a unique and rapidly growing mode of medical practice, offering high-quality, cost-effective coordinated care to patients and providing a professional environment that fosters medical excellence.

AGPA recommends that as long as a group practice is a legally constituted, integrated group practice whose financial relationships are not based on the volume or value of referrals, affiliations with independent physicians or other group practices should not affect the group practice's exemption from the self-referral prohibition.

Shared Facilities

The in-office ancillary exception does not provide an exemption for shared facilities. Shared facilities can take at least two forms: first - facilities jointly owned or operated by a group practice and an affiliated entity, such as a foundation or hospital, or by several group practices; and second - facilities owned solely by a group practice or an affiliated entity but used by both. This constraint on shared facilities inhibits beneficial, cost-effective collaborative activity. It is also inconsistent with earlier federal and state initiatives, such as certificate of need laws, that encouraged shared facilities and established barriers to duplication of costly facilities.

H.R. 345 and H.R. 21, unlike the existing statute, provide an exception for "under arrangements" agreements for laboratory services between hospitals and group practices that operate clinical laboratories. AGPA applauds Congress' willingness to adopt this new exception. We ask that if the self-referral proscription is expanded to other health care services, such as radiology and radiation therapy, the "under arrangements" exception also be expanded. We also ask that the exception apply to facilities shared by hospitals

or foundations and group practices. Shared facilities utilized by more than a single group practice or by group practices and entities with which they are affiliated pose no more risk of abuse than the more traditional in-office ancillary facility.

AGPA recommends that the "under arrangements" exception be expanded to include all designated health care services and that facilities shared by group practices with affiliated foundations or hospitals be exempt.

Reference Work

Finally, in-office ancillary services should not lose their protection because they are made available to providers that are not part of the group practice. The acceptance of outside referral work does not pose a potential for abuse. A narrow interpretation of the statute serves no discernible purpose and encourages the existence of wasteful excess capacity.

AGPA recommends that the Committee provide a flexible definition of group practice to permit integration and affiliation, endorse an exception to permit shared service arrangements under circumstances that satisfy the intent of the law, and clarify that the performance of reference work does not affect the in-office ancillary exception.

Integrated Health Care Delivery Systems

The physician ownership and self-referral legislation contemplates an environment in which physicians have few, if any, formal affiliations with other physicians or institutional providers. That environment is not one in which large multi-specialty group practices find themselves. Rather, many group practices provide the physician component of a complex, integrated health care delivery system that has evolved over many years to serve the health care needs of large population groups. These systems have been created in response to changes in the health care environment and expectations of patients. They provide the training ground for the physicians of tomorrow and the laboratory for the future's medical and scientific advances. No exception is proposed for integrated health care delivery systems. Yet, referrals between and among the components of integrated systems are intrinsic to the concept. The development of shared services and facilities to avoid duplication and to conserve scarce resources is the cornerstone of an integrated health care delivery system, but the use of these facilities might be curtailed be the proposed legislation. We ask that in your attempt to curtail the activities of physicians who are not deserving of their patients' trust that you not effectively ban entire delivery systems that provide forums for collaboration and innovation in patient care and training and research that will benefit future generations.

Conclusion

The AGPA is honored to have been asked to testify before the Committee. We support Congress' efforts to curtail abusive and unethical physician ownership and referrals practices, but we ask that in the effort the Committee guard against the unintended effects that the legislation has on non-abusive, beneficial practices.

Attachment A

1. Section 1877(e) of the Social Security Act (42 U.S.C. & 1395nn(e)) is amended to restate subsection (9) as follows--

"(9) PAYMENTS FOR SERVICES TO A GROUP PRACTICE -- Payments made to a group practice for professional, supervisory, administrative or teaching services provided by physicians in the group practice under an agreement if --

"(A) the services are furnished to an entity exempt from taxation under section 501(c)(3) of the Internal Revenue Code and physicians in the group practice constitute all or substantially all of the active medical staff of said entity,

"(B) The agreement is set out in writing and specifies the services to be provided by the parties and the compensation for services provided under the agreement.

"(C) The compensation paid over the term of the agreement is consistent with fair market value and is not determined in a manner that takes into account the volume or value or any referrals or other business generated between the parties,

"(D) The compensation is provided pursuant to an agreement which would be commercially reasonable even if no referrals were made to the entity; and

"(E) The compensation arrangement between the parties meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse."

2. Section 1877 (h)(1)(B)(iii) of such Act is amended as follows -

"(iii) The furnishing by an entity of designated health services to a group practice affiliated with the entity, if the entity provides all or substantially all of the designated health services of a group practice."

Attachment B

PROBLEMS FOR GROUP PRACTICES CREATED BY PROVISIONS OF SECTION 1877 OF THE SOCIAL SECURITY ACT

1. Part-time and Independent Contractor Arrangements. Many group practices, generally those in smaller communities, arrange for specialists, usually from other communities, to provide services to the group practices' patients on a part-time basis, usually as independent contractors. Typically the specialists are either already members of other groups or have their own practice entity or may have similar arrangements with several smaller group practices and, therefore, would not find it practical to become employees of other group practices. When these specialists provide services in the group practice's facilities under the independent contractor arrangement, the group bills for those services as services of the group. It should be noted that such arrangements are consistent with the Medicare limitations on reassignments by a physician of his or her right to receive payment found in S. 1842 of the Social Security Act. Under the Stark legislation and unofficial interpretations received from HCFA staff, the statute can be interpreted such that independent contractors are not members of the group practice and, therefore, would not be able to write orders for laboratory tests for group practice patients they are treating. In addition, under the legislation and the leaked regulations, even if such individuals were employees, the group would not meet the definition of a group practice because not every member of the group would provide substantially all of his or her professional services through the group. As long as the group practice itself is a legitimate group practice, there would appear to be no reason why the nature of the physician's contractual relationship or the extent of the individual's practice conducted with the group should be controlling as to whether the entity should qualify as a group practice for purposes of the Stark legislation and the exceptions thereunder. Indeed, a requirement of an employment relationship would be unduly restrictive, since some group practices may be organized as partnerships of individuals or perhaps of professional corporations. Further, if the Stark legislation is interpreted as precluding a group which has part-time physicians as employees or independent contractors from operating a laboratory, there could be a significant adverse affect on access to specialist services in rural areas and smaller communities. Group practices with part-time or independent contractor relationships with physicians that operate laboratories would be forced to make the difficult choice of either discontinuing operation of the laboratory or terminating the relationship with such physicians.

2. Provision of Reference Laboratory Services. A number of group practice laboratories have qualified to accept and perform reference work from outside sources (e.g., hospitals and physicians offices). Under an advance copy of draft implementing regulations, HCFA at one time considered precluding a group practice from protection under the "in-office ancillary" exception if the group practice's laboratory is authorized to accept reference work from outside sources. This interpretation serves no discernible policy purpose and should be overruled by a clear statement of legislative intent.

3. "Under Arrangements" Contracts. A number of group practices operate full-service laboratories and contract with hospitals and other providers to furnish clinical laboratory services to hospital and provider patients under arrangements as described in Social Security Act S 1861 (w). These arrangements have been in place for a number of years and many predate the Medicare program. Since the Medicare unbundling rules require the hospital to bill the Medicare program for these services, these arrangements are precluded from protection under the in-office ancillary exception to Section 1877.

The imposition of the S. 1877 prohibition to these type arrangements would prove particularly burdensome. The hospital or other provider would be required, prior to the end of December, 1991, to establish, equip, and staff a clinical laboratory duplicative of that operated by the group practice. The hospital would incur significant capital costs and the group practice would be forced to reduce the size of its clinical laboratory to reflect the reduced volume of business, which would result in termination of certain group practice laboratory personnel and eliminate the continued feasibility for the group practice laboratory to perform certain low volume, esoteric tests.

These arrangements should be protected by a new "under arrangements" exception.

4. Related Entities. Group practices often have affiliated property companies which are owned by members of the group practice and which lease facilities and equipment to the group practices. These arrangements are more common in older established group practices and were established primarily as vehicles for creating retirement income in an area in which self-employed individuals were not able to establish, on a tax deferred basis, retirement programs. Over the years as the tax laws have changed and group practices are now able to have retirement programs, the interest of new physicians in investing in these property companies has diminished. As a consequence there is frequently a lack of congruence between ownership interests in the property company and in the practice company. Technically the lease of equipment by the property company to the practice company which operates a clinical laboratory is a compensation arrangement for which there is no exception under the Stark legislation. Based upon informal discussions with HCFA staff, it appears that HCFA would view the above described arrangement as a problem because of the lack of identity of ownership interests between the two entities. This arrangement should not be viewed as presenting potential for abuse under the Stark legislation so long as the property company is owned exclusively by a subgroup of the physician members of the group practice.

5. Satellite Facilities. A number of group practices own and operate satellite facilities in communities other than the community in which the main clinic facility is located. The physicians who staff satellites are members of the group practice and the employees who assist the physicians are employees of the group practice and the employees who assist the physicians are employees of the group practice or a wholly-owned subsidiary of the group practice. The satellite facilities operate small laboratories which provide a limited range of clinical diagnostic laboratory testing but refer more complex tests to the main clinic laboratory. In some instances the main clinic laboratory will bill the patient and in other instances the originating satellite will bill the patient. In each instance, though, the bills are submitted under a provider number assigned to

the group practice (although in certain cases the groups have been assigned separate billing numbers for each location). The language of the Stark legislation, as well as informal interpretations received from HCFA staff, support the conclusion that the legislation contemplated group practices having a single "centralized" laboratory facility. Since there would not appear to be any potential for abuse or evasion of the Stark bill by permitting group practices with multiple locations to have multiple laboratory sites or to have more than one location through which centralized laboratory services are furnished, the law should be changed to permit such practices.

6. Shared Services Laboratories. A number of group practices and the hospitals with which they are affiliated have for a number of years operated a laboratory facility which serves both hospital inpatients and the group practice's office patients. Under the terms of the agreement between the group and the hospital, the laboratory is a shared services arrangement, rather than a true joint venture. The revenues, costs and, therefore, profits/losses derived from services to hospital patients belong to the hospital and, conversely, the revenues, costs and profits/losses of services provided to the group practice's patients belong to the group. This arrangement provides no more potential for abuse than does the more conventional group practice laboratory. Although the group practice is located in a rural area and is organized as a not for profit corporation without owners, the arrangement is a potential problem under the Stark legislation because the compensation received by the group practice from the laboratory operation is arguably not covered by any exception under the Stark legislation. This type arrangement should be protected by expanding the "rural provider" exception for ownership and investment interests to also protect compensation arrangements.

Chairman STARK. Thank you. We have a journal vote so we will recess for 10 minutes and reconvene if you can wait.

Mr. Thomas, go ahead.

Mr. THOMAS. I apologize, but I have a meeting that I have to go to. I only want to ask two questions.

Dr. Dickey, the comment made by Sandy Levin which is clearly one that shows the change in attitude in Congress over about a 5-year period from an understanding and exception that it should be done, to a position that it should not be done, that it should not be done unless there is some indication. The AMA has been changing its position; do you believe the transition that has occurred on this committee is one that is generally shared and reflected among the doctors in the AMA?

Is that a fair statement to make?

Dr. DICKEY. Yes, I think that is a fair description, Mr. Thomas. We have watched changes in the AMA's ethical guidelines dating back to the mid-1980s. As demonstrated by our house action, with a better understanding of the potential for abuses, the majority of physicians who are AMA members have changed their minds on the issue.

Mr. THOMAS. So the learning curve that clearly has been established in Congress is present within the AMA as well in an understanding of exactly what is occurring as it unfolds?

Dr. DICKEY. I think that is a fair statement.

Mr. THOMAS. As we move into this brave new world in terms of health care structure, do you feel that it is appropriate if we set up a divestiture structure that at the same time in meeting some of the needs that we are going to have to face, it makes sense to include a comprehensive review of the antitrust laws? We keep talking about criteria and the question of physicians and hospitals. It just seems to me that we have to clear up this business of not allowing professionals who have patient care as their primary goal, and if we are not going to allow them to make money in these other areas, we have got to enlist the professionalism as to how you structure it, and clearly once you begin that you bump into antitrust laws, and that, I think, needs to be an integral and comprehensive part of any change that we deal with.

Any reaction from any of you on that?

Dr. DICKEY. I would applaud everything you have just said. The AMA has recognized that without antitrust changes, it will be very difficult for physicians to either proceed or to know how they can proceed without the threat of antitrust either from the Justice Department or FTC.

Mr. ENTIN. I would just say I testified 3 weeks ago before the Senate Judiciary Committee on the issue of antitrust and the issue of health care reform. You are absolutely right this is not just an issue that can be dealt with by looking at the self-referral issue. You must look at all of the laws that have an impact on the way in which relationships between providers are structured in order to really get a sensible delivery system in place.

Mr. THOMAS. Thank you very much. Thank you, Mr. Chairman.

Chairman STARK. We will recess for 10 minutes. Thank you.

[Recess.]

Chairman STARK. If we could resume, the Chair apologizes for the delay and also apologizes to those of you who are hungry. If I try and crowd in a little lunch between witnesses here, will the witnesses excuse me?

Dr. DICKEY. Absolutely.

Chairman STARK. I had just a couple of questions.

Dr. Dickey, in the area of the extension, as you know we started doing battle with the AMA over this issue back in 1988, so for at least 4 years it should come as no surprise to physicians who one would presume are in what we would call an illegal relationship, you might or might not call it unethical, and I had to swallow hard to give them 2 years to quit doing something which I have always felt is illegal anyway, and so I thought the 2-year divestiture was rather generous.

What possible good could there be in giving them more than 2 years except to let them make more money?

Dr. DICKEY. I think we do have to recognize, Congressman, that many of these physicians are not abusing the ownership of their facility. They have been waiting, I think, to see what the prohibitions would be. I feel sure that many of those individuals are providing a community service. Once we put an effective date on when they must divest their interest, we create almost a fire sale mentality. Potential purchasers know that the physicians are going to have to sell their interest in the facility, and the purchaser can easily wait until the end of the 2 years to make the physicians offers that cannot be refused.

Chairman STARK. What if I said I would give them their net out-of-pocket investment back? The fact is, and I think the evidence shows this, that very few of them have invested any cash. All they have really done is receive more or less reimbursement for referrals over the period they have owned these, and we could easily determine whether that was not the case, so in a case where there was no at-risk investment, and I use "at-risk" as we do in the Tax Code so that, in effect, the only thing the physician has been doing is collecting a share of the income over a period of time. Why would there be any reason to extend that procedure?

Dr. DICKEY. The AMA is concerned that the group that really did make a true investment should have at least the opportunity to realize that investment and whatever reasonable profits society deems is there. If we can guarantee to protect that, then the number of years assigned to divestiture is much less at issue.

Chairman STARK. Then the only other issue that you raised—and this is more or less of a challenge. You guys challenged me years ago to find the fact that there were any statistics to show that there was overutilization, and we finally did. Now, you are suggesting to me that many facilities would not be available were it not for physician investment, and I think we have had the testimony of the largest manufacturer, perhaps the sole source of MRI equipment, which arguably is perhaps the most capital intensive sort of a facility that people are investing in, saying that they know of not one case where adequate capital was not available without any input from physicians in the area.

Do you suppose you could find us a case that would either prove the rule or show? My guess is that the physicians in very rare—

the same case where I said I would be willing to consider extending, that really their capital was nothing more than the promise of a referral.

Now, that might have induced others to invest some money, but do you think that you know of some cases, even anecdotal, to show where and under what circumstance because while I doubt it, I don't think any of us want to deny the citizens access, and if there were cases where that——

Dr. DICKEY. Mr. Chairman, while I can't provide you with statistics, I think I can provide you with anecdotes and we would be happy to do so in writing.

Chairman STARK. That would help us design whatever kind of exemptions we were going to make.

Dr. DICKEY. In fact, I would suggest perhaps to the MRI manufacturer that if you go back to when the technology was new, it was physicians who recognized what a tremendous impact this would have on our diagnostic abilities. Once a technology is proven that indeed it will be extremely effective and can be utilized in many instances, the risk of investment is now gone and there are lots of investors lining up. The question is whether they were willing to put their money where their mouth was early on.

Chairman STARK. The reason these joint ventures are so rich is they don't do it then. They know better.

Dr. DICKEY. But many physicians did. But I would be happy to get you some anecdotes at least.

Chairman STARK. Thanks.

Dr. RIDDICK. Mr. Chairman.

Chairman STARK. Sure, I was about to ask you something about that anyway, Dr. Riddick, so why don't you ask me.

Dr. RIDDICK. I can at least let you know in the early days, not of MR, but of CT scanning, the trustees of our foundation felt it was an iffy proposal, and if it was necessary—if the physicians in the group practice felt it were going to improve patient care so much and improve things, that we should be the ones that ponied up for it, and we did, we got the sixth, I think the sixth MR machine—the sixth CT machine in the United States.

After about 3 years the foundation took it off our hands, after we had depreciated the thing.

Chairman STARK. Dr. Riddick, I do not mean at all by this question to include your foundation in this suggestion, but as more and more people call to our attention the arrangements which are made to, I suppose, in anticipation of more restriction on ownership, we are learning about what is referred to as clinics without walls, basically a group of solo or small group who get together to accomplish through some kind of a phantom group structure what they perhaps would be prohibited from doing if this legislation becomes law.

Maybe you are aware of some of those arrangements. Is it your understanding that there are indeed some sort of phantom group organizations that are created for no other reason than to share a billing and cross-billing sort of arrangement, and would you be willing to help us make sure that the exception for group practice doesn't foster that sort of loophole?

Dr. RIDDICK. I would certainly not want to include groups that are created for the purpose of evasion of the law or for gain. I think that there are some so-called groups without walls that have perfectly legitimate reasons for doing so if to capture some of the cost savings of aggregating it into groups without the necessity for doing it. I think that I would personally hate to try to govern one of those, but in the case of our foundation, which has existed for 50 years, it is set up as a legitimate 501(c)(3) organization and all financial arrangements with the physician group have got to be approved by lay trustees.

Chairman STARK. As I say, I wanted to make clear that I felt that I was not addressing that question to your foundation.

Mr. McDermott.

Mr. MCDERMOTT. No questions.

Chairman STARK. Mr. Andrews.

Mr. ANDREWS. Let me ask the first two witnesses, Nancy, it is nice to see you, almost a constituent of mine, Mr. Chairman. She lives and works close to my district. I would like to ask both of you to tell me once again, do you support this bill?

Dr. DICKEY. Yes, the AMA supports the bill, but would like to have you consider some of the specific exceptions that we have outlined for you. We have concerns of having too much rigidity in the bill. There may well, as you know, be areas of your constituency that happen to be underserved, although distances may not be a problem there, but may well be in south Texas or west Texas. Our exceptions that we have outlined for you are there intending to improve patient care, Congressman, and not to enhance the profit sharing of physicians. If you are willing to look at those, we would be delighted. We do support the concepts of the bill.

Mr. ANDREWS. So when you mentioned in your earlier testimony that you thought the marketplace and the evolution of the medical practice would diminish this kind of commercialism, you didn't mean to suggest that this bill wasn't necessary?

Dr. DICKEY. I think as you and I have discussed before, while there is a great deal of activity on health system reform right now. However, we have little knowledge of how long or what exactly is going to happen. To ignore the issues that you are addressing here because of what might happen in the short term or a much longer term might not be the most effective solution. We simply want to point out the fact that the entire environment may well change. This subcommittee obviously will want to continue to watch what happens as the health care environment changes to be sure that the language continues to address the problems that concern you.

Mr. ANDREWS. But you, as a representative of the American Medical Association, endorse the Stark bill?

Dr. DICKEY. We endorse the Stark bill, Congressman, but we would like to have the exceptions——

Chairman STARK. Did you ever think you would hear the day when those words would be taken down in this committee?

Dr. DICKEY. Mr. Stark, I can't tell you how many times we have said the same thing. Did you ever think you would see the day?

Mr. ANDREWS. How about the American Hospital Association, do you support this bill?

Mr. ENTIN. Yes, we do, Congressman. We support the bill. We have raised some questions and concerns, which we have set forth in our written testimony and which I have tried to address briefly in my oral comments. Our questions mainly focus on the issue of compensation arrangements, which we believe the law does allow, but we are concerned about how the exceptions are crafted.

Mr. ANDREWS. You mean the Stark bill allows?

Mr. ENTIN. The Stark bill, yes. And we are just concerned that we have adequate clarification of the issues we have raised; but, we believe this bill is appropriate. It is necessary, and we do support it.

Mr. ANDREWS. Thank you.

Thank you, Mr. Chairman.

Chairman STARK. Thank you. I want to thank the witnesses for their garnered support. It will probably fail on the floor now after that. Thank you very much. We will need to work very closely with all of you as we try and mark this up in final form, which the Chair hopes to do in advance of other parts of the major reform issues. It has been suggested that this is one of those areas that we could mark up in its final form without prejudicing any of the other reform issues, so that we will be looking forward to working with you on it.

Thank you.

Our next panel consists of Ms. Hope Foster, the general counsel for the American Clinical Laboratory Association; Mr. Richard Geier, the executive director of Quality Imaging Association; Dr. Carl Wallace, who is chairman of the board of chancellors of the American College of Radiology; Mr. David Krause, who is chancellor and member of the Government Relations Committee of the American College of Radiation Oncology Division. It is Dr. Krause, I apologize.

Hope, we will let you lead off and if the others would like to follow in the order their names were called, you can proceed to summarize or expand on your prepared testimony which will appear in its entirety in the record.

Thank you.

STATEMENT OF HOPE S. FOSTER, GENERAL COUNSEL, AMERICAN CLINICAL LABORATORY ASSOCIATION

Ms. FOSTER. Thank you, Mr. Chairman and members of the committee. My name is Hope Foster. I am general counsel of the American Clinical Laboratory Association, an organization of federally regulated independent clinical laboratories. I am pleased to appear here today to offer unqualified, unambiguous support for H.R. 345. We urge its prompt enactment.

Since the early 1980s, ACLA has advocated a Federal prohibition on self-referral in the laboratory context. In 1989 when this subcommittee considered enactment of a Medicare self-referral ban, we testified before you and strongly supported your efforts to end this practice, and I might add that it has been fascinating to sit here today and compare the difference between this hearing and the 1989 hearings.

We sought and continue to seek the elimination of self-referral because it has been shown in study after study to cause escalated

utilization and pricing, factors that have contributed to the serious problems that now plague our health care delivery system. You have heard a great deal about these pernicious consequences today. In addition, self-referral arrangements inappropriately act to channel referrals, injuring healthy competition and threatening the viability of those providers that are unwilling to engage in such practices.

In 1989 you enacted a Medicare laboratory self-referral prohibition. It became effective on January 1, 1992. As we are the only provider category that has been subjected to a Federal bar, our experience may be of interest to you.

While there have, of course, been implementation issues and some minor amendments should be adopted, our overall view is that the prohibition has had the salutary effects that its framers intended and has not created the problems envisioned by opponents to the provision.

For example, during the 1989 debates on the provision, it was suggested that without laboratory self-referral arrangements, some Medicare beneficiaries would be denied access to needed services. We have seen no evidence that such consequences have occurred. We also heard that self-referral arrangements were needed to assure high quality. However, quality has not suffered. Moreover, since that time, the Clinical Laboratory Improvement Amendments of 1988 have been implemented, offering further protection against inferior quality.

We applaud your efforts to end harmful arrangements like self-referral, which distort health care delivery. Based on our experience, we support H.R. 345's plan to expand the Federal self-referral ban beyond both Medicare and laboratories. Non-Medicare payers need to be protected as Medicare has been.

We would note, however, that there are other arrangements that are closely related to self-referral that cause the same results. Thus, as you consider health care reform and the inclusion of H.R. 345's provisions, we hope that you will include a national direct billing mandate for laboratory services. Such a mandate would prevent those who order tests from buying them and then marking them up when billing patients and insurers. The profits derived from such markups are analogous to the financial benefits earned from self-referral and not surprisingly the effects of markup and self-referral mirror each other.

In an independent study conducted by the Center for Health Policy Studies, which compared lab charges and utilization in direct billing and nondirect billing States, the Center found that charges for laboratory services were 8.4 to 9.6 percent higher in nondirect billing States, per enrollee laboratory utilization was 28.3 percent higher in nondirect billing States, and laboratory charges per privately insured enrollee were 40.6 percent higher in nondirect billing States.

A copy of this report is appended to our written testimony. Please note that the report estimates annual savings from direct billing of between $2.4 and $3.2 billion, with a 5-year savings of between $12 and $16 billion.

Thus, direct billing mandates carry the same benefits as self-referral bans—lower prices and less utilization. These findings

should surprise no one as markup invites the same financial responses to profit incentives as self-referral. Because of these benefits you have already mandated laboratory direct billing for Medicare just as you have previously banned laboratory self-referral for Medicare.

Therefore, we implore you to look at the big picture and pass a self-referral ban and a direct billing mandate applicable to all payers. Provide all payers with the same lab safeguards that now protect Medicare. Thank you.

[The prepared statement and attachment follow:]

acla AMERICAN CLINICAL LABORATORY ASSOCIATION
1919 Pennsylvania Ave., Suite 800, Washington, D.C. 20006/(202) 887-1400

TESTIMONY OF THE AMERICAN CLINICAL LABORATORY ASSOCIATION BEFORE THE SUBCOMMITTEE ON HEALTH WAYS AND MEANS COMMITTEE

Physician Ownership and Referral Arrangements and H.R. 345

"The Comprehensive Physician Ownership and Referral Act of 1993"

April 20, 1993

The American Clinical Laboratory Association (ACLA), an organization of federally regulated, independent clinical laboratories is pleased to appear here today in support of H.R. 345, "The Comprehensive Physician Ownership and Referral Act of 1993." We urge its prompt enactment.

Since the early 1980s, ACLA has advocated a federal prohibition on self-referral in the laboratory context. In 1989, when this Subcommittee considered enactment of a Medicare self-referral ban, we testified before you and strongly supported your efforts to end the practice.

We sought, and continue to seek, the elimination of self-referral because it has been shown, in study after study, to cause escalated utilization and pricing, factors that have contributed to the serious problems that now plague our health care delivery system. You have heard a great deal about these pernicious consequences today. In addition, self-referral arrangements inappropriately act to channel referrals, injuring healthy competition and threatening the viability of those providers that are unwilling to engage in such practices.

In 1989, you enacted a Medicare laboratory self-referral prohibition; it became effective on January 1, 1992. Thus, laboratories have 15 months of experience with the ban. As we are the only provider category that has been subjected to a federal bar, our experience may be of interest to you.

While there have, of course, been implementation issues and some minor amendments should be adopted, our overall view is that the prohibition has had the salutary effects that its framers intended and has not created the problems envisioned by opponents to the provision.

For example, during the 1989 debates on the provision, it was suggested that without laboratory self-referral arrangements, some Medicare beneficiaries would be denied access to needed services. We have seen no evidence that such consequences have occurred. We also heard that self-referral arrangements were needed to assure high quality. However, quality has not suffered. Moreover, since that time, the Clinical Laboratory Improvement Amendments of 1988 have been implemented, offering further protection against inferior quality.

We applaud your efforts to end harmful arrangements, like self-referral, which distort health care delivery. Based on our experience, we support H.R. 345's plan to expand the federal self-referral ban beyond both Medicare and laboratories. Non-Medicare payors need to be protected as Medicare has been.

We would note, however, that there are other arrangements that are closely related to self-referral that cause the same results. Thus, as you consider health care reform and the inclusion of H.R. 345's provisions, we hope that you will include a national direct billing mandate for laboratory services. Such a mandate would prevent those who order tests from buying them and then marking them up when billing patients and insurers. The profits derived from such mark-ups are analogous to the financial benefits earned from self-referral and not surprisingly the effects of mark-up and self-referral mirror each other. In an independent study conducted by the Center for Health Policy Studies (CHPS), which compared lab charges and utilization in direct billing and non-direct billing states, CHPS found that:

- Charges for laboratory services were 8.4 to 9.6 percent higher in non-direct billing states.
- Per enrollee laboratory utilization was 28.3 percent higher in non-direct billing states.
- Laboratory charges per privately insured enrollee were 40.6 percent higher in non-direct billing states.

A copy of this report is attached hereto.

Thus, direct billing mandates carry the same benefits as self-referral bans -- lower prices and less utilization. These findings should surprise no one as mark up invites the same financial responses to profit incentives as self-referral. Because of these benefits, you have already mandated laboratory direct billing for Medicare just as you have previously banned laboratory self-referral for Medicare.

Therefore, we implore you to look at the big picture and pass a self-referral ban and a direct billing mandate. Provide all payors with the same lab safeguards that now protect Medicare.

Thank you.

Appendix 1

IMPACT OF DIRECT BILLING REQUIREMENTS FOR LABORATORY TESTS ON LABORATORY CHARGES, UTILIZATION AND COSTS

March, 1993

Prepared by:

Zachary Dyckman, Ph.D.
Center for Health Policy Studies
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For the

American Clinical Laboratory Association

EXECUTIVE SUMMARY

The Center for Health Policy Studies (CHPS) has been asked to study the impact of the enactment of a national direct billing law for laboratory testing; i.e., a law requiring the laboratory that performs the testing also to bill for that testing. Such a requirement would eliminate the current practice which permits physicians to mark-up testing, other than Medicare testing, that they do not perform.

CHPS has determined that laboratory charges and utilization are higher in states that do not require direct billing. It appears likely that enactment of a national direct billing law could substantially reduce health care expenditures, by between $2.4 and $3.2 billion per year, due to the lower laboratory prices and reduced utilization of laboratory testing that would result from such a provision.

Under the current system, laboratories often contract with physicians to provide laboratory testing services. In most states, physicians can then mark up this testing when they bill third party payors and patients. This ability to mark up prices creates strong financial incentives for physicians to order additional testing, thereby increasing laboratory costs. The purpose of this study is to determine how a direct billing requirement affects laboratory prices and utilization.

CHPS has performed an analysis of Medicare and Blue Cross and Blue Shield claims experience, including laboratory prices (charges per test), utilization and total charges

per enrollee. CHPS determined that each of these measures is higher in states that did not require direct billing. The primary findings of the study are:

- Laboratory charges per test are higher in non-direct billing states than in direct billing states -- 8.4 to 9.6 percent higher.

- Laboratory utilization per enrollee is higher in non-direct billing states than in direct billing states. For tests reimbursed by Medicare, utilization is 6.5 percent higher. For tests reimbursed by private payors it is 28.3 percent higher.

- Laboratory charges per enrollee under private health insurance programs, which reflect both utilization and price differences, are 40.6 percent higher in non-direct billing states.

Therefore, it appears likely that if a national direct billing law were enacted, substantial savings could be achieved in health care expenditures, as a result of reduced utilization and lower prices. As noted above, CHPS estimates that these savings would be between 2.4 and 3.2 billion dollars a year.

IMPACT OF DIRECT BILLING REQUIREMENTS FOR LABORATORY TESTS ON LABORATORY CHARGES, UTILIZATION AND COSTS

INTRODUCTION

The purpose of this study conducted by the Center for Health Policy Studies (CHPS) is to investigate the impact of provider direct billing requirements for laboratory tests on charge levels, utilization and total costs for laboratory tests. If a cost impact is determined to exist, an additional study objective is to estimate potential cost savings if direct billing requirements were to be required for all payers in all states.

Since July, 1984, Medicare has not allowed physicians to bill Medicare for laboratory tests that were performed by other providers, e.g. physician billing for a test when the test was actually performed by an independent laboratory. In most states, there are no direct billing requirements for services paid for directly by the patient or through private health insurance. It is common practice in these states for laboratories to contract with physicians to provide laboratory testing services under monthly billing account arrangements. There is active price competition for physician accounts and prices offered are usually substantially below "retail laboratory prices" -- prices charged by physicians and laboratories to patients and private health insurers. Physicians typically bill and receive fees for laboratory tests which are well in excess of the prices they pay independent laboratories for the tests.[1] This ability to mark up prices for laboratory tests can create strong financial incentives for physicians to order unnecessary tests. Thus, the absence of direct billing requirements can result in an increased number of tests and in higher prices being paid for these tests, by patients and by private health insurers.

In several states, physicians are prohibited from billing for tests that are performed by other providers. In these states, when tests are ordered from independent laboratories, physicians do not have financial incentives to order increased testing. As a result, laboratory service utilization rates can be expected to be lower in states with direct billing requirements than in states without such requirements. Moreover, laboratory test prices may be lower in these states than in states without direct billing requirements because there may be more price competition focused on the patient in direct billing states than in non-direct billing states. In non-direct billing states, much of the competition among laboratories is focused on obtaining physician business.

There is an extensive body of research to support the conclusions that physicians: 1) are aware of financial incentives affecting their practices, and 2) respond to financial incentives in their practice and billing behavior. These studies, which have examined utilization and cost experience for laboratory, radiology and other diagnostic services, have produced findings of additional medical care costs from 40 percent to over 500 percent attributable to financial incentives to perform or order more tests.[2] Within the past year, several studies have been published which focus on the cost impact of physician self-referral practices.[3] While these and earlier studies did not focus explicitly on the cost impact of physician mark-up of laboratory tests, their findings suggest that the strong financial incentives related to the opportunity of physicians to mark-up prices of tests performed by others can be expected to result in increased utilization, higher charge levels and higher claims cost.

Study Research Issues

The following specific research issues are addressed in this study:

1. Are laboratory test prices (charges per test) higher in states with no direct-billing requirements (non-direct billing) than in direct billing requirement (direct billing) states?

2. Do laboratory test prices increase more rapidly in non-direct billing states than in direct billing states?

3. Are laboratory utilization rates higher in non-direct billing states than in direct billing states?

4. Are laboratory claims costs higher in non-direct billing states than in direct billing states?

5. What is the estimated national cost impact and potential cost savings (if any) of a change to direct billing requirements for laboratory tests for private pay patients in all states?

OVERVIEW OF STUDY METHODOLOGY AND DATA SOURCES

The methodological approach used includes a comparison of health insurance claims experience in non-direct billing and direct billing states. Ideally, only private payer experience would be analyzed, as the research issues relate explicitly to laboratory services provided under self pay and private insurance programs. However, only limited private claims experience is available for both non-direct billing and direct billing states which can be used to address the research issues identified above. Two data sets are used in this study.

- Medicare Part B Medicare (BMAD) claims data
- Blue Cross and Blue Shield private program claims data.

The two data sets and methodology used with each are described briefly below.

Medicare Data

The BMAD data used reflect claims experience by Medicare carrier area for a sample of laboratory test procedures for 1988 and 1990. Not included in the data set are hospital inpatient and hospital outpatient claims, which are processed under the Medicare Part A program.

The BMAD data set has the advantages of reflecting national experience for a standard benefit program with demographically similar enrollees in all Medicare carrier localities. Moreover, unlike most other health insurance data sets, reliable data are available on enrollment which allows analysis of utilization and claims cost on a per enrollee basis.

The BMAD data does have one significant disadvantage from the perspective of the research issues being addressed in this study. Because providers are not permitted to bill under Medicare for tests they did not directly perform, regardless of the existence or absence of state direct billing requirements for laboratory tests, one may not observe higher Medicare utilization experience in non-direct billing than in direct billing states, even if utilization rates are higher for the non-Medicare population in non-direct billing states. This deficiency does not affect the analysis of laboratory prices, as submitted charges for specific tests would be expected to be the same for self-pay and privately insured persons as for those covered under Medicare.

Described below are the primary components of the study methodology used in the analysis of Medicare claims experience.

Select sample of laboratory procedures for analysis. A sample of laboratory procedures was selected from a larger list of frequently performed tests under Medicare. The sampled procedures, shown in Exhibit 1, include both those commonly performed in physicians' offices as well as those commonly performed by independent laboratories.

Obtain Medicare claims data. BMAD claims data for 1988 and 1990 were obtained from HCFA for the laboratory procedure codes in the study sample for each of the 56 Medicare carrier areas. The BMAD data includes number of services, submitted charges and allowed charges, by provider type. Medicare Part B enrollment by carrier area was also obtained from HCFA.

Identify states in two direct billing requirement categories: direct billing requirement states, and no direct billing requirement states. There are two states, New York and Rhode Island, which prohibit providers from billing for tests they did not directly perform. New York and Rhode Island are designated as direct billing states. In three other states, Connecticut, Michigan and Pennsylvania, a Blue Shield plan with 50 percent or more of the private health insurance market does not pay for laboratory tests which are billed by a provider that does not directly perform the test. Because of their large market shares, the provider payment practices used by these Blue Shield plans can be expected to exert substantial influence on provider practice and billing behavior. Connecticut, Michigan and Pennsylvania have been designated as direct billing states in the analysis. All other states, in which physicians are not restricted from billing for tests they did not perform directly, are designated as non-direct billing states.

EXHIBIT 1

STUDY SAMPLE OF LABORATORY PROCEDURES*

80012 - Automated multichannel test, 12 chemistry tests
81000 - Urinalysis
82150 - Amylase, serum
82270 - Blood; occult, feces, screening
82550 - Creatine phosphokinase (CPK)
82565 - Creatinine; blood
82643 - Digoxin, RIA
82746 - RIA
82947 - Glucose
84478 - Triglycerides
85031 - Blood count, complete CBC
85650 - Sedimentation rate (ESR)
87205 - Smear, with interpretation
88150 - Cytopathology (PAP Smear)

*80019 - Automated multichannel test, 19 or more chemistry tests, was also included in the procedure sample. However, claims data for this code were inadvertently not included in the HCFA data set provided to CHPS.

Analyze Medicare charge and claims experience. Medicare charge and claims data are combined within each of the two billing restriction categories of states. This is done for each of the 14 laboratory procedure codes in the study sample and for the total of all procedure codes combined. Comparisons are then made between the two categories of states, of charges per test, number of tests per 1,000 enrollees, number of tests per 1,000 office visits and total charges per 1,000 enrollees.

Blue Cross and Blue Shield Data

The second data source used is Blue Cross and Blue Shield claims data which CHPS has access to as a result of an ongoing Multiplan Study of physician costs. Eleven Blue Cross and Blue Shield plans contracted with CHPS in 1991 to conduct a comparative analysis of their charge, claims cost and utilization experience. Claims data were collected and analyzed for a sample of approximately 130 frequently used procedure codes. Among the Blue Cross and Blue Shield (BCBS) plans which participated in the study are Blue Cross and Blue Shield of Rhode Island and Pennsylvania Blue Shield. As noted above, Rhode Island is a direct billing state and Pennsylvania Blue Shield does not pay a physician for a laboratory test unless the physician has actually performed the test. Rhode Island and Pennsylvania are designated as direct billing states in the analysis. The remaining BCBS plans are located in non-direct billing states and allow payment to physicians for laboratory tests if the tests are performed by independent laboratories. The complete list of study plans is provided below:

Direct billing Environments

- Blue Cross and Blue Shield of Rhode Island
- Blue Shield of Pennsylvania

Non-direct billing Environments

- Blue Shield of California
- Blue Cross and Blue Shield of Indiana
- Blue Cross and Blue Shield of Iowa
- Blue Cross and Blue Shield of Kansas
- Blue Cross and Blue Shield of Kansas City
- Blue Cross and Blue Shield of Massachusetts
- Blue Cross and Blue Shield of New Hampshire
- Blue Cross and Blue Shield of Oklahoma
- Blue Cross and Blue Shield of Texas

Included among the study sample procedures are seven frequently performed laboratory procedures. The seven laboratory procedures are:

- 80019 - Automated chemistry tests, 19 or more tests
- 81000 - Urinalysis
- 82947 - Glucose
- 85031 - Blood count (complete CBC)
- 87060 - throat or nose culture
- 88150 - Cytopathology (PAP smear)
- 88304 - Surgical pathology, level III

The BCBS claims data for the eleven study plans enables us to compare submitted charges per test, number of tests per enrollee (covered person) and submitted charges per

enrollee in 1990 between BCBS plans in direct billing environments and BCBS plans in non-direct billing environments.

The Medicare data is used primarily as a source of information on relative charge patterns between non-direct billing and direct billing states. While information is contained in the BMAD data set on utilization and total charges per Medicare enrollee, a direct billing requirement exists under Medicare in all fifty states. Differences which may be found in utilization and total charges between non-direct billing and direct billing states may reflect a spillover effect of financial incentives which exist for private pay patients, i.e., the financial incentive that exists for non-Medicare patients "spills-over" and affects physician behavior for Medicare patients. The Blue Cross and Blue Shield claims experience is used as the primary source of information on relative utilization and total cost experience between non-direct billing and direct billing states.

STUDY FINDINGS

The results of the comparative analysis of Medicare claims experience are summarized in Exhibit 2. Laboratory prices (laboratory charges per test) are 8.9 percent greater in non-direct billing states than in direct billing states. Between 1988 and 1990, charges per test increased more rapidly in non-direct billing than in direct billing states, 11.9 percent compared to 8.4 percent. These total charge per test comparisons include the effects of relatively small differences in distribution of tests between direct billing and non-direct billing states, i.e., there is a slightly more intensive mix of laboratory tests in direct billing than in non-direct billing states. For the same distribution of tests, total charges per test are 8.4 percent greater in non-direct billing states than in direct billing states.

EXHIBIT 2

COMPARISON OF MEDICARE LABORATORY CHARGE, UTILIZATION AND COST EXPERIENCE, DIRECT BILLING (DB) STATES AND NON-DIRECT BILLING (NDB) STATES

	DB States (NY, RI, MI, PA, CT)	NDB States (All Other States)	(NDB-DB)/DB
Lab charges per test*, 1990	$ 11.96	$ 13.03	8.9 %
Percent Change, 1988-90	8.43%	11.92%	
Lab charges per test for same distribution of tests**, 1990	$ 12.02	$ 13.03	8.4
Lab tests per enrollee, 1990	1.23	$ 1.31	6.5
Percent Change, 1988-90	6.28%	5.03%	
Lab tests per 1000 Office visits, 1990	277	322	16.2
Percent Change, 1988-90	-14.42%	-3.97%	
Lab charges per enrollee, 1990	$ 14.72	$ 17.02	15.6
Percent Change, 1988-90	15.24%	17.55%	

*Includes affects of differences in test distributions between NDB and DB states.

**Assumes same distribution of tests in DB as in NDB states.

CENTER FOR HEALTH POLICY STUDIES

Also shown in Exhibit 2 are differences between non-direct billing and direct billing states in utilization of laboratory tests per Medicare enrollee and per 1,000 medical office visits. Number of laboratory tests per enrollee and per 1,000 office visits are, respectively, 6.5 percent and 16.2 percent greater in non-direct billing states than in direct billing states. The higher differential between non-direct billing and direct billing states in laboratory tests per 1,000 medical office visits than in tests per enrollee implies a greater number of medical office visits per enrollee in direct billing than in non-direct billing states. The higher rate of visits in direct billing states is likely related to greater relative physician supply in these states. The number of non-Federal physicians per 100,000 civilian population in 1990 is 284.7 in the combined group of direct billing states.[4] This figure is 25.4 percent greater than the number in non-direct billing states (227.1). The finding of 16.2 percent more laboratory tests per 1,000 visits in non-direct billing states than in direct billing states clearly demonstrate that the higher volume of laboratory tests per enrollee in non-direct billing states than in direct billing states is not caused by a possible higher number of patient visits (or proportionately more physicians) in non-direct billing states. Rather, the observed higher laboratory utilization per enrollee in non-direct billing states occurs despite visits per enrollee being lower in non-direct billing than in direct billing states. Given the higher physician population ratio and associated greater number of visits per enrollee in direct billing than in non-direct billing states, we would expect laboratory tests per enrollee to be greater in direct billing states as well. That the reverse is true adds further credence to the view that it is the lack of direct billing requirements that causes higher laboratory utilization rates in non-direct billing than in direct billing states.

As indicated earlier, the higher laboratory test utilization rates in non-direct billing than in direct billing states likely do not fully reflect differences that would be observed for private pay patients, because laboratory tests in all states are subject to direct billing requirements under Medicare. Rather the laboratory utilization rate differential may reflect only the spillover effect from financial incentives that exist for private patients which can affect physician practice behavior for Medicare patients as well.

The last row in Exhibit 2 provides data on total laboratory charges per enrollee for the 14 laboratory procedures in the Medicare study sample. These figures combine the effects of submitted charges per test and number of tests per Medicare enrollee. Total charges per enrollee are generally in excess of amounts actually paid on average for laboratory tests, because maximum fee levels are often less than amounts charged by providers. However, previous research indicates that differences in total charges for laboratory tests between localities are good proxies for differences in amounts actually paid by private payers for laboratory tests between those localities.[5] Thus, the existence of high or low laboratory charge levels in a specific locality is generally a good indicator of whether actual fees received by laboratories from private payers are, respectively, relatively high or low in that locality.

Total laboratory test charges per enrollee is $17.02 in non-direct billing states, or 15.6 percent higher than in direct billing states. It is important to also note from the figures shown in Exhibit 2 that over the 1988-1990 period, percentage changes in laboratory charges per test, laboratory tests per 1,000 medical office visits and laboratory charges per enrollee are each higher in non-direct billing states than in direct billing states. Thus, there is

evidence that cost differences between non-direct billing and direct billing states are increasing over time.

As discussed above, the Blue Cross & Blue Shield data are better suited to developing estimates of the impact of direct billing requirements on utilization of laboratory tests than the Medicare data, because the financial incentives affecting physician laboratory test ordering patterns apply to private insurance covered services and not to Medicare covered services. Findings from the Blue Cross & Blue Shield laboratory claims analysis are summarized in Exhibit 3. Laboratory charges per test are 9.6 percent higher in non-direct billing states than in direct billing states. This figure is approximately one percent higher than the 8.4 percent charge per test differential computed based on the Medicare data. Laboratory charges are higher in non-direct billing states than in direct billing states, even though the cost of living is lower on average in the non-direct billing states than in the direct billing states.

Total tests per enrollee are 36.9 percent greater in non-direct billing states than in direct billing states. However, after adjusting for differences in distributions of tests between direct billing states and non-direct billing states, the difference in number of tests per enrollee between non-direct billing and direct billing states is reduced to 28.3 percent. This figure compares to an estimate of 6.5 percent differential under Medicare, which is interpreted as a spillover effect from financial incentives affecting physician laboratory test ordering patterns for private pay patients. The last row in Exhibit 3 shows the differential between laboratory charges per enrollee in non-direct billing and direct billing states.

EXHIBIT 3

COMPARISON OF BLUE CROSS AND BLUE SHIELD CHARGE, UTILIZATION AND COST EXPERIENCE, IN DIRECT BILLING (DB) AND NON-DIRECT BILLING (NDB) STATES

	DB States	NDB States	(NDB-DB)/DB
Lab charges per test, 1990*	$ 19.05	$ 20.88	9.6 %
Lab tests per enrollee, 1990	.300	.411	36.9
Lab tests per enrollee adjusted for intensity, 1990**	.320	.411	28.3
Lab charges per enrollee, 1990	6.33	8.90	40.6

*Computed using same distribution of tests in DB as in NDB states.

**Differences between NDB and DB states in adjusted lab tests per enrollee (28.3%) are computed by netting out effect of difference in average charges per test between NDBR and DBR states (9.6%) from difference in lab charges per enrollee (40.6%).

Laboratory charges per enrollee are 41 percent greater in non-direct billing than in direct billing states.

NATIONAL COST IMPACT OF DIRECT BILLING REQUIREMENTS

The final research objective of this study is to estimate the National cost impact in 1992 dollars of a change to direct billing requirement in all states. The underlying assumption of the estimation approach used is that cost and utilization experience in non-direct billing states would be the same as in direct billing states if direct billing requirements were to be imposed at the national level. The estimation methodology used is outlined below:

Step 1. Estimate existing laboratory expenditures. An estimate is developed of private payor (health insurer and consumer pay) laboratory expenditures for laboratory tests performed outside of the hospital setting. It is assumed that government laboratory costs and costs of tests performed for hospital patients would not be affected by change from non-direct billing to direct billing status for tests performed for private pay patients outside of the hospital setting. The estimation methodology requires the following steps:

- Obtain HCFA estimate of private insurance and direct consumer expenditures for physician and other professional services for 1992: $135.2 billion[6].

- Estimate laboratory expenditures as a proportion of total Blue Cross and Blue Shield expenditures for physician and other professional

services. The ratio of Blue Cross and Blue Shield plan laboratory charges to total physician charges is 9.3 percent.

- Multiply $135.2 billion by 9.3 percent -- $12.57 billion. This figure is towards the low end of the range of estimates of expenditures for laboratory services outside of the hospital setting[7].

Step 2. Determine the resident populations in direct billing and non-direct billing states. The 1991 resident population of direct billing and non-direct billing states is computed from data contained in the 1991 Statistical Abstract[8].

- direct billing states (NY, RI, MI, PA, CT) -- 43,457,000
- non-direct billing states (all other states) -- 205,253 million

Step 3. Compute per capita laboratory costs in direct billing and non-direct billing states. Using basic algebra, we compute the average cost per capita in direct billing and non-direct billing states based on the following findings from the analysis of Blue Cross and Blue Shield claims experience: total laboratory charges per covered person are 40.6 percent greater in non-direct billing states than in direct billing states[9].

Average per capita private pay laboratory costs for tests performed outside of the hospital setting are estimated to be:

non-direct billing states -- $53.22
direct billing states -- $37.86

Difference -- $15.36 (41 percent).

Step 4. Compute estimates of national cost impact of adopting national direct billing requirements. The final step in the estimation process is to multiply the non-direct billing-direct billing per capita cost differential by the population in non-direct billing states. The resultant estimates of cost savings which could result from a national change to direct billing is: 205,253,000 x $15.36 = $3.15 billion.

This estimate is appropriate if there are no price controls or national fee schedule for laboratory tests, which could substantially reduce or possibly eliminate price differences among laboratories. However, if some form of price controls or a national fee schedule is adopted, the estimate of potential cost savings resulting from imposition of direct billing requirements may be too high, because it incorporates the effects of both laboratory test utilization and price differences between non-direct billing and direct billing states. A more conservative estimation approach, which is based only on estimated differences in utilization between non-direct billing and direct billing states (28.26 percent), results in a projected savings from adoption of direct billing requirements at the national level of $2.377 billion[10].

CONCLUSION

The analysis of Medicare and private insurance claims experience yield similar findings regarding the impact of direct billing requirements for laboratory tests on charge and utilization patterns:

- Laboratory charges per test are higher in non-direct billing states than in direct billing states: 8.4 – 9.6 percent higher.

- Laboratory utilization rates are higher in non-direct billing states than in direct billing states: 6.5 percent higher under Medicare and 28.3 percent higher under private insurance.

- Laboratory charges per enrollee are substantially higher in non-direct billing than in direct billing states: 15.6 percent higher under Medicare and 40.6 percent higher under private insurance.

In addition, analysis of Medicare trend data indicate more rapid growth between 1988 and 1990 in non-direct billing than in direct billing states for all of these variables. It is also of interest in interpreting the study findings that the direct billing states, New York, Rhode Island, Michigan, Pennsylvania and Connecticut, are characterized by, on average, higher costs of living and higher physician-population ratios than the non-direct billing states. Because of these factors, we would expect, in the absence of any effects of direct billing requirements, laboratory charge levels and utilization rates to be higher in direct billing states than in non-direct billing states. Study findings which indicate the reverse to be true provide substantial support for the view that it is the direct billing requirement that is the cause of higher charge and utilization experience in non-direct billing states, rather than other factors.

The national cost impact of lack of direct billing requirements for laboratory tests and potential savings which could result from adoption of direct billing requirements in all states is estimated to be in the range of $2.4 - $3.2 billion. We believe that these estimates are reasonable, but rough approximations of expected cost savings. Under direct billing requirements, we can reasonably expect reduced incentives to perform unnecessary tests.

This should result in a reduced volume of tests. We can also expect more competitive pricing for tests as the locus of price competition among independent laboratories changes from that of the wholesale market -- physicians' monthly billing account business, to that of the final product market -- consumers and health insurers,
who pay for medical care services on their behalf.

FOOTNOTES

1. Anderson, J. Case Studies of the Clinical Laboratory Services Market, Center for Health Policy Studies, 1986. (prepared under HCFA contract No. 500-85-0052.) General Accounting Office, Medicare -- Payments for Clinical Laboratory Test Services Are Too High, June, 1991.

2. Dobson, R., J. S. Todd and B. Manuel. "Conflicts of Interest and the Physician Entrepreneur." New England Journal of Medicine Vol. 314 (1986): 250-3. Hillman, A. M. "Financial Incentives for Physicians in HMO's: Is there a Conflict Interest?" New England Journal of Medicine, Volume 317, No. 27 (1987): 1743-1748. Hillman, A. M., M. V. Pauly, J.J. Kerstein. "How do Financial Incentives Affect Physicians' Clinical Decisions and the Financial Performance of Health Maintenance Organizations? New England Journal of Medicine, Volume 321, No. 2 (1989): 86-92. Hillman, B. J., C. A. Joseph, M. R. Mabry, J. H. Sunshine, S. D. Kennedy, and M. Noether. "Frequency and Costs of Diagnostic Imaging in Office Practice - A Comparison of Self-Referring and Radiologist-Referring Physicians." New England Journal of Medicine, Volume 323, No. 23 (1990): 1604-1608. Morreim, E. H. "Conflicts of Interest: Profits and Problems in Physician Referrals," Journal of the American Medical Association, Volume 262, No. 3 (1989): 390-394. Relman, A. M. "Dealing with Conflicts of Interest," New England Journal of Medicine, Volume 313, No. 12 (1985): 749-751. Relman, A. M. "Economic Incentives in Clinical Investigation," New England Journal of Medicine, Volume 320, No. 14 (1989): 933-934. Stark, F. H. "Physicians' Conflict in Patient Referrals," Journal of American Medical Association, Volume 262, No. 3 (1989): 397. U.S. Department of Health and Human Services, Office of Inspector General, "Financial Arrangements Between Physicians and Health Care Businesses." May 1989.

3. Hillman, B.J., Olson, G.T., Griffith, P.E. et. al. "Physicians' Utilization and Charges for Outpatient Diagnostic Imaging in a Medicare Population." Journal of the American Medical Association, Volume 268, No. 15 (1992): 2050-2054. Florida Health Care Cost Containment Board. Joint Ventures Among Health Care Providers in Florida, 1991. Dyckman, Z. Impact of Physician Joint Venture Activity on Medical Care Costs in Florida, Center for Health Policy Studies, February, 1992.

4. Computed from data in American medical Association, Physician characteristics and Distribution in the U.S., 1992, Table A-11.

5. Dyckman, Z. Multiplan Study of Physician Claims Experience, Center for Health Policy Studies, January, 1993, Chapter 3.

6. Sonnenfeld, S.T., Waldo, D.R., Lemieux, J.A. and McKusick, D.R. "Projections of National Health Expenditures through the Year 2000," Health Care Financing Review, Volume 13, No. 1 (1991), 1-29.

7. For example, one industry publication suggested that independent laboratory revenues were about $9.9 billion and physician office laboratory revenues were about $5.0 billion, for a total of $14.9 billion. See "Washington Insider's Focus, " National Intelligence Report, January 30, 1992. However, there are widely varying estimates for the size of the market. Id.

8. U.S. Bureau of the Census. Statistical Abstract of the United States - 1991, (111th Edition), 1991. Ideally, the population figures that should be used are total population, less those covered under Medicare, Medicaid, CHAMPUS and other government health benefit programs. However, the ratio of population in non-direct billing to direct billing states does not differ markedly if total population is used instead.

9. Solve for X = Per capita laboratory expenditures in direct billing states.

```
205,253,000 x 1.4057X + 43,457,000X = $12.57 billion
                      331,981,000X = $12.57 billion
                                 X = $37.86
                            1.4057X = $53.22
Per capita difference between
 non-direct billing and direct billing states          = $15.36
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10. Solve for X = Per capita laboratory expenditures in direct billing states.

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205,253,000 x 1.2826X + 43,457,000X = $12.57 billion
                      306,715,000X = $12.57 billion
                                 X = $40.98
                            1.2826X = $52.56
Per capita difference between
non-direct billing and
direct billing states               = $11.58
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Chairman STARK. Thank you.
Mr. Geier.

STATEMENT OF RICHARD E. GEIER, EXECUTIVE DIRECTOR, QUALITY IMAGING ASSOCIATION

Mr. GEIER. Thank you,. Mr. Chairman, members of the subcommittee. I am Richard Geier, executive director of the Quality Imaging Association. I am pleased to testify today before the subcommittee in strong support of a Federal ban on physician self-referral. QIA is a nonprofit trade association of large and small operators of freestanding MRI diagnostic imaging centers. Collectively, QIA members have diagnostic imaging facilities in 30 States and operate over 350 MRI scanners out of 3,000 scanners nationwide.

QIA members offer a unique perspective on the detrimental effects of the referral by physicians to facilities in which they have an ownership interest. When MRI was an emerging technology, most association members formed joint ventures with physicians to secure necessary funding from lenders and to gain acceptance from physicians. In some situations our members have discovered that physician investment actually interferes with, instead of promotes, the provision of high quality MRI services. Physician investment in the delivery of health care services has unfortunately created perverse financial incentives that a few physicians have allowed to unduly influence the decisions they make concerning patient care.

Accordingly, physician self-referral must be outlawed and the sooner the better. Moreover, this ban should apply to services furnished by all payers and not just Medicare.

Briefly, MRI uses a large magnet that surrounds the patient, coupled with radio frequencies and a computer, to produce exceptionally detailed, noninvasive images of soft tissue. Because MRI uses no ionizing radiation, it presents absolutely no known risks to adults or children. Moreover, it is well-documented that MRI has improved and saved countless lives.

Accordingly, QIA urges the subcommittee to keep in mind that with self-referral outlawed and through the development of practice guidelines, appropriate use of MRI scans can, in fact, save health care dollars through the avoidance of more costly surgery or testing and from the early detection and treatment of disease.

Results of recent studies have shown that approximately two-thirds of the MRI scanners in 1991 had ownership structures involving physicians. As numerous studies, as well as firsthand experience of QIA members can attest, this physician ownership has led to increased utilization of MRI services. The Florida Health Care Cost Containment Board, as you have heard, has found that MRI centers with physician owners had from 14 to 65 percent more referrals, depending on locality, than non-physician-owned centers. In addition, a recent study by Bruce Hillman on utilization of diagnostic imaging services found that the rate of referral by self-referring physicians was 70 to 670 percent greater than when nonowner physicians referred patients.

The costs to our health care system of this overutilization caused by physician ownership are indeed great. QIA commissioned former HHS Inspector General Richard Kusserow to prepare a report estimating the additional health care costs created by overutilization

of physician investors. This report, which has been provided to all members of the subcommittee, estimated that in 1992 alone at least $258 million in expenditures for excess MRI services were charged as a result of the financial incentives of self-referral. And this is a very conservative estimate.

Perhaps even more startling than this estimate is the actual experience QIA members have had with physician ownership. A few physicians have made it perfectly clear to personnel of QIA members that they would refer patients only if they were given financial incentives to do so. Centers operated by QIA members have been told that the quality of services they offered was irrelevant because the physician would refer only to the facility in which he had an ownership interest. In addition, QIA members have seen prospectuses for physician joint ventures where the annual income of the physician partners was directly explained in terms of how many referrals per week the physician might make. While the explicit nature of such marketing efforts may be changing, physician investment is continuing, and, in the experience of our members today, it is growing.

Successful marketing of these ventures continues to occur today since many physicians still are keenly aware that both the ventures and their own fortunes will flourish if they keep up their referrals. Our members can and do want to compete based on the quality and price of our services. However, we simply cannot compete with joint venture facilities which have a captive stream of referrals from physician owners.

Not only does QIA support the Chairman's bill to eliminate physician self-referral, but we believe that the objectives of the bill can be significantly enhanced by accelerating its 2-year delayed effective date. In States that have passed laws banning physician ownership, QIA.members have witnessed existing joint ventures using the window before the law becomes effective to increase utilization and thereby enhance immediate revenues and possible sale valuation. In addition, QIA members are aware of new joint ventures that are being developed even in the face of knowledge that this bill, the Stark bill, may soon become law.

The promoters of these ventures brag about the ability of physician investors to receive a large return on their investment even over the short 2-year period before the law would kick in. While QIA recognizes the need to give physicians some time to sell their ownership interests, we recommend that the ban on physician self-referral go into effect as soon as possible, perhaps as soon as 6 months after the date of enactment.

In conclusion, QIA reiterates its strong support for a Federal ban on physician self-referral. QIA members believe in the value of MRI as a diagnostic tool of significant medical value that has saved countless lives and can, when used appropriately, reduce health care costs. We hope that the Chairman and members of the subcommittee recognize that while overutilization of MRI services must be eliminated through the banning of physician self-referrals and the implementation of appropriate practice guidelines, adequate reimbursement levels for medically necessary MRI scans must be protected.

Mr. Chairman, we hope that we can abolish physician self-referral and develop appropriate practice guidelines. We also expect that you can restore confidence in the many valuable clinical applications of MRI.

Thank you for the opportunity to present our views to the subcommittee. We stand ready to work with the Chairman and other members of the subcommittee for swift enactment of an all-payer, physician self-referral ban. I would be happy to answer your questions.

[The prepared statement follows:]

STATEMENT OF
RICHARD E. GEIER,
EXECUTIVE DIRECTOR,
QUALITY IMAGING ASSOCIATION
BEFORE THE HEALTH SUBCOMMITTEE
OF THE WAYS AND MEANS COMMITTEE
U.S. HOUSE OF REPRESENTATIVES
APRIL 20, 1993

Mr. Chairman and Members of the Subcommittee, I am Richard Geier, Executive Director of the Quality Imaging Association ("QIA"). I am pleased to testify today before the Subcommittee in strong support of a federal ban on physician self-referral. QIA is a nonprofit trade association of large and small operators of freestanding MRI diagnostic imaging centers. Collectively, QIA members have diagnostic imaging facilities in 30 states and operate over 350 MRI scanners out of an estimated total of 3,000 scanners in operation nationwide in 1992.

QIA members offer a unique perspective on the detrimental effects of the referral by physicians to facilities in which they have an ownership interest. When MRI was an emerging technology, most Association members formed joint ventures with physicians to secure necessary funding from lenders and to gain acceptance from physicians. While QIA recognizes that most physicians act in an ethical manner concerning treatment decisions, in some situations our members have have discovered that physician investment actually interferes with, instead of promotes, the provision of high quality MRI services. Physician investment in the delivery of health care services has unfortunately created perverse financial incentives that a few physicians have allowed to unduly influence the decisions they make concerning patient care.

Accordingly, self-referral must be outlawed and the sooner the better. Moreover, this ban should be applied to services furnished by all payers and not just Medicare. QIA members have witnessed firsthand how some physician joint ventures have led to the steering of patients to facilities in which the physician has a financial interest and to the overutilization of diagnostic imaging services. Unfortunately, we also have witnessed how MRI, as a result, has become synonymous with all that is wrong with our health care system, rather than all that is right.

I would like to begin by providing the Subcommittee with a brief overview of the benefits of appropriately used MRI services and then describe the current make-up of the industry, focusing on physician ownership interests and how these interests have needlessly increased utilization and decreased quality in some instances. I will close by explaining why QIA believes that federal legislation is urgently needed.

Clinical Applications of MRI

Magnetic resonance produces high-resolution "slice" studies of the body. MRI uses a large magnet that surrounds the patient, coupled with radio frequencies and a computer, to produce exceptionally detailed images of soft tissue normally hidden by bone. Because MRI uses no ionizing radiation, it presents absolutely no known risks to adults or children. With its clarity of images, MRI is particularly useful in detecting previously undetectable problems in the brain,

neck, and spinal cord. It is also increasingly useful in evaluating joint and muscle injuries.

MRI has improved and saved countless lives. As just one of many examples, I know of a California woman who had suffered from numbness and pain on the right side of her face for more than a year, but physicians could find no explanation. Finally, an MRI scan revealed a tumor near her eye, dangerously close to her brain. With the MRI results, physicians were able to operate and successfully remove the tumor, restoring the woman to her previously healthy condition and saving her life. That woman's experience could occur to any of us or to one of our loved ones.

Appropriate Use of MRI Can Reduce Health Care Costs

QIA's experience, which I will relate shortly, is that overutilization through physician investments has, indeed, caused needless health care spending. However, QIA urges the Subcommittee to keep in mind that with self-referral outlawed and through the development of practice guidelines, appropriate use of MRI services can, in fact, save health care dollars through the avoidance of more costly surgery or testing and from the early detection and treatment of disease. As just one example, a spinal MRI often can take the place of the more expensive, more risky, more painful myelogram, which requires the injection of contrast media into an area dangerously close to the spinal cord. While a spinal MRI takes about an hour and costs approximately $650, the myelogram costs $2,000 and can cause the patient to suffer from nausea or headaches and create a two-day inpatient recovery period.

Overutilization and Other Problems Created by Physician Investment

Results of Recent Studies

Various studies have been conducted recently to determine the extent of physician ownership of diagnostic imaging facilities. The most extensive survey in this area was conducted by SMG-Marketing, an independent company that performs annual surveys of outpatient diagnostic imaging centers. In 1991, SMG-Marketing surveyed diagnostic imaging facilities and found that approximately 66.7%, or two-thirds, of the MRI scanners had ownership structures involving physicians. Comparable figures were found in a 1989 SMG-Marketing survey where physician-ownership was involved with 71.3% of the scanners.

Another study, conducted by the Florida Health Care Cost Containment Board in 1990, found that physician investors had a financial interest in over 90% of the 160 Florida imaging centers surveyed. Jean Mitchell and Elton Scott, JAMA, "*New Evidence of the Prevalence and Scope of Physician Joint Ventures*," Vol. 268, pp. 80-84 (October 21, 1992).

As numerous studies, as well as firsthand experience of QIA members, can attest, this physician ownership has led to increased utilization of MRI services. The Florida Health Care Cost Containment Board found that MRI centers with physician owners had from 14%-65% more referrals, depending on locality, than non-physician-owned centers. State of Florida Health Care Cost Containment Board, "*Joint Ventures Among Health Care Providers in Florida*," vol. II, p. IV-6, September 1991. A recent study by Bruce Hillman on utilization of diagnostic imaging services found that the rate of referral by self-referring physicians was 70%-670% greater than when non-owner physicians referred patients. Bruce Hillman, *et al.*, JAMA, "*Physicians' Utilization and Charges for Outpatient Diagnostic Imaging in a Medicare Population*," Vol. 268, pp. 2050-2054 (October 21, 1992).

The costs to our health care system of the overutilization caused by physician ownership are indeed great. QIA commissioned former HHS Inspector

General Richard Kusserow to prepare a report estimating the additional health care costs created by overutilization of physician investors. This report, which has been provided to all Members of the Subcommittee, estimated that in 1992 alone at least $258 million in expenditures for excess MRI services were charged as a result of the financial incentives of self-referral. Strategic Management Associates, Inc., "*Magnetic Resonance Imaging (MRI): Added Costs Resulting from Self-Referral*" (March 31, 1993). Please bear in mind that this is a very conservative estimate that does not include deductibles paid by consumers or any factor for the higher prices which the Florida study suggested are often charged by physician-owned ventures. The report also uses a relatively low estimate of the rate of excess referrals among physician owners.

Experience of QIA Members

Perhaps even more startling than this estimate is the actual experience QIA members have had with physician ownership. The fact of the matter is that MRI facilities are dependent on physician patronage. To perform an MRI scan a facility must have an order from a physician. While QIA recognizes that many physicians do not let financial interests influence their health care decisions, QIA members have encountered situations all across the country where physicians have used their referral power for their own financial gain at the expense of patient care and, literally, at the expense of all of us who pay for health care.

Physicians often have made it perfectly clear to personnel of QIA members that they would refer patients only if they were given financial incentives to do so. Centers operated by QIA members have been told that the quality of the services they offered was irrelevant, because the physician would refer only to the facility in which he had an ownership interest. In one case with which a QIA member is familiar, the physician's ownership interest was in a mobile scanner located in a large trailer. A patient told this physician that she suffered from claustrophobia and did not want to undergo an MRI in the cramped trailer. When she informed him that she wanted to go to a larger freestanding facility that was nearby, the physician refused to refer her to this facility and even stated he would terminate treating her if she insisted on going there.

In addition, QIA members have seen a few prospectuses for physician joint ventures where the annual income of the physician partners was directly explained in terms of how many referrals per week the physician might make. While the explicit nature of such marketing efforts may be changing as a consequence of the rulings in the *Hanlester* decision, physician investment is continuing and, in the experience of our members, growing. In *Hanlester*, the joint venture promoters who had expressly tied physician investment to referrals were found to have violated the anti-kickback law. However, successful marketing of these ventures today does not require such express linkage -- some physicians still are keenly aware that both the ventures and their own fortunes will flourish if they keep up their referrals.

While independent imaging facilities without physician owners are struggling with low or negative profit margins because of the continued decline in reimbursement levels, those centers with a captive stream of referrals from physician owners continue to provide these physician owners with incredible returns on investments. For example, QIA is aware of one MRI joint venture with 50 limited partners consisting mostly of neurosurgeons, neurologists, and orthopedic surgeons who were asked to contribute an initial $20,000 each. From this initial $20,000 investment, each physician investor is averaging an income of $90,000 per year for the past five years -- or a 450% return on investment each year. Such is definitely not the case for those independent facilities without the captive market of patients created by physician investors.

The fact that overutilization resulting from physician financial interests has defrauded state workers compensation funds has been widely publicized. This past February, PrimeTime Live exposed on television a scam, engaged in by numerous California physicians, to order needless MRIs, charge workers compensation, and obtain a financial gain either through kickback arrangements or through the direct ownership of facilities providing the MRI services. Moreover, a recent study appearing in the New England Journal of Medicine found that of MRI scans ordered by self-referring physicians of patients whose care was covered by workers compensation in California, 38% were found to be medically inappropriate. Alex Swedlow, et al., NEJM, "*Increased Costs and Rates of Use in the California Workers' Compensation System as a Result of Self-Referral by Physicians*," vol. 327, pp. 1502-1506 (November 19, 1992).

Need for Federal Legislation

Several states already have followed Chairman Stark's lead by enacting their own physician self-referral bans covering diagnostic imaging, as well as other health care services. Despite this activity at the state level, QIA believes there continues to be a pressing need for the adoption of federal legislation. Because of the financial impact of physician self referral on federal health care costs, this issue is one of paramount federal concern. The Congressional Budget Office has estimated that $350 million in federal spending could be saved over a four-year period if the current physician ownership ban is extended to additional services, such as diagnostic imaging.

Moreover, the specific terms of state laws vary significantly, and with many health care companies being national in scope, such a hodgepodge of state rules is confusing and frustrating. QIA believes it is appropriate and necessary for the federal government to establish the basic restrictions applicable to the area of physician self-referral. States could then choose to enact legislation that is even more restrictive than the federal law, if they desire.

In addition, the Safe Harbor regulations in and of themselves are not sufficient to prohibit physician self-referral. Joint ventures outside the safe harbors are not necessarily unlawful. Therefore, a more specific and definitive federal prohibition in this area is vitally necessary.

While the QIA applauds the recent stand of the American Medical Association ("AMA") against physician ownership in health care facilities to which they refer patients, we believe that voluntary ethical guidelines that provide no enforcement mechanism are insufficient to prevent abuse. Moreover, while the federal government's role is not to determine or legislate professional ethics, its economic interests, at a time when health care costs are driving the budget deficit, dictate that the federal government must act and act now.

It has been suggested that physician ownership increases access to MRI services for medically-underserved patient populations such as Medicaid recipients or in medically-underserved locations, such as inner cities or rural areas. Experience has not proven this to be true. Many physician joint ventures exclude Medicaid patients by explicit agreement or otherwise, while the Florida study concluded that few physician-owned facilities were located in rural or underserved areas. Florida Study, vol. II, p. v.

Arguments also have been made that physician ownership assures quality services. The experience of QIA members refutes this notion, however. As described above, physician ownership promotes the steering of patients to facilities regardless of whether the facility best meets that patient's needs, and sometimes even regardless of whether the patient needs the service at all. Clearly, the best assurance of quality is through a healthy, competitive marketplace not distorted by physician ownership. Only in such a market can one be assured that physicians

will refer patients to centers based strictly on quality, unbiased by financial self-interest.

QIA strongly urges that the federal ban be extended to all payers, and not just Medicare. Otherwise, providers can simply choose not to serve Medicare patients. Certainly, for physicians treating predominantly workers compensation patients, or those in sports medicine, giving up Medicare patients would be little sacrifice. To achieve the full cost savings that are possible under a self-referral ban, the ban must be all inclusive.

Recommendation to Improve Existing Language in H.R. 345

Not only does QIA support the Chairman's bill to eliminate physician self-referral, but we believe that the objectives of the bill can be significantly enhanced by accelerating its effective date. As currently drafted, the ban would go into effect two years after date of enactment. In states that have passed laws banning physician ownership, QIA members have witnessed these joint ventures using the window before the law becomes effective to dramatically increase utilization.

In addition, QIA members are aware of many brand new joint ventures that are being developed even in the face of knowledge that your bill may soon become law. Promoters of these joint ventures brag about the ability of physician investors to receive a large return on their investment even over the short two-year period before the Stark law would kick in.

While QIA recognizes the need to give physicians some time to sell their ownership interests, we recommend that the ban on physician self-referral go into effect as soon as possible, perhaps as soon as six months or one year after the date of enactment. The balance of the transition period could then allow for a more limited business relationship with physicians in the form of structured debt unrelated to referrals for any buy-outs that may occur.

QIA would also request that the language of the Chairman's bill be specific enough to prohibit hospitals from "purchasing" ongoing physician practices with an understanding that part of the compensation for the buyout, as well as subsequent payment for the physician's services, is for prospective referrals to the hospital once the physician is employed. These business arrangements are prone to all of the same abuses that we have seen with physician self-referrals to joint venture facilities. We hope that the Chairman will be vigorous in ending overutilization and the perverse financial incentives in the area of hospital acquisition of physician practices as well.

Conclusion

In conclusion, QIA reiterates its strong support for a federal ban on physician self-referral. QIA members believe in the value of MRI as a diagnostic tool of significant medical value that has saved countless lives and can, when used appropriately, reduce health care costs. We hope that the Chairman and members of the Subcommittee recognize that while overutilization of MRI services must be eliminated through the banning of physician self-referrals and the implementation of appropriate practice guidelines, adequate reimbursement levels for medically necessary MRI scans must be protected.

Even before implementation of the Medicare RBRVS Fee Schedule, reimbursement rates for MRI had been significantly reduced through establishment of the radiology fee schedule and through mandated cuts by Congress on certain radiology services. Reductions over the years have been so great that in many regions of the country, Medicare payment fails to cover even the costs of providing the MRI scan.

QIA urges you not to condemn the use of a valuable diagnostic tool because of the way in which physicians have abused its use for their own financial gain. QIA believes it is vital to eliminate the perverse financial incentives inherent in physician joint ventures and wholeheartedly supports the Chairman's efforts to do so. At the same time, we would like policymakers to understand that it is critical to maintain fair reimbursement levels so that those patients who can benefit from diagnostic imaging, and there are many, will have access to this service.

Mr. Chairman, we hope that the abolishment of physician self-referral and the development of appropriate practice guidelines for MRI usage will restore confidence in the many valuable clinical applications of MRI. And we look to the Chairman to be as outspoken a leader on ensuring access to MRI services to all persons who could benefit from its appropriate use as he has been an outspoken crusader against the abuses that must be eliminated.

Thank you for the opportunity to present our views to the Subcommittee. QIA stands ready to work with the Chairman and other members of the Subcommittee for swift enactment of an all-payer, physician self-referral ban. I would be happy to answer any questions.

Chairman STARK. Thank you.
Dr. Wallace.

STATEMENT OF KARL K. WALLACE, JR., M.D., CHAIRMAN, BOARD OF CHANCELLORS, AMERICAN COLLEGE OF RADIOLOGY

Dr. WALLACE. Thank you, Mr. Chairman. My name is K.K. Wallace. I am chairman of the board of chancellors of the American College of Radiology. I practice in Charlottesville, Va. I am pleased to present the ACR's comments on the Comprehensive Physician Ownership and Referral Act of 1993. But before I do, I want to thank you for your untiring efforts to secure passage of the legislation to eliminate self-referral and joint ventures.

The ACR believes that physicians should not have a direct or indirect financial interest in diagnostic, radiology or radiation oncology to which they refer patients, and we support legislation which would eliminate this conflict of interest by prohibiting such ownership arrangements in health care. We are particularly pleased that your new legislation reflects our recommendation that radiation oncology facilities be included in this prohibition. We have long held that these financial arrangements lead to inappropriate utilization of medical services and that the justification for development of these arrangements is contrived.

Joint ventures which include referring physicians have not proliferated because of the need to increase access to care or to achieve economies of scale in providing health care services. These arrangements are intended to capture the market for a given set of health care services, and this control does not benefit the patient. We are also concerned with the resultant extortion of referral-dependent physicians as referring physicians band together to exercise market control, and by subterfuge demand a portion of the practice income of the consultant physicians in return for referrals.

The practice of physicians seeking compensation for this market control of patient referrals is pervasive, and we believe any anecdote as to the impropriety of these actions ethically, legally or morally should be eliminated. We have previously testified several times that this is a perverse incentive. Some have argued that the referring physician ownership need not be addressed in the legislation because the practice is not widespread. We know this not to be the case.

Studies such as the one conducted by the State of Florida show the extent of physician ownership in health facilities far exceeds our prediction. It can no longer be claimed that this is not a widespread problem. We oppose these financial arrangements even if only a few physicians were involved. Abusive activities by a few physicians should not be condoned any more than abusive activities of many. Those who support the continuation of financial arrangements among physicians have argued that these ventures are necessary to assure access to services in underserved areas.

We think the predominant reason for joint ventures is to provide access to services in rural or underserved areas. Certainly in the Florida experience this was not the case. A second point to be made in regard to access is specifically addressed to the argument that

health services would be unavailable without using referring physicians as a source of capital for these facilities. This is not the case.

Most often referring physicians' participation in these joint ventures involves only signing a note for debt, not in providing capital for the facility. If, in fact, an area in the country finds that lack of capital is restricting access to services, a clear exception could be made when there is concrete evidence that the referring physicians involved are actually providing needed capital for the facility. We do not believe that these joint ventures are created because there is no money in town.

While we support your legislative efforts to prohibit referring physicians' financial involvement in health facilities, we must urge your caution in developing this legislation. If facilities currently in operation may simply declare themselves as extensions of group practices or private physicians office, the intent of this legislation will have been circumvented because referring physicians will continue to self-refer. This has developed into a critical problem in radiation oncology, for example.

In this era of antitrust sensitivity and litigation, volunteer organizations such as the ACR can set standards and urge compliance, but we cannot mandate behavior of radiologists or others, nor can we mandate the behavior of others in the health care system. We believe the issue of referring physician ownership in medical facilities should be clarified in law by preventing such ownership.

Thank you, Mr. Chairman. I will be pleased to answer any questions.

[The prepared statement follows:]

Testimony of the American College of Radiology
to
The Subcommittee on Health
House Ways and Means Committee
by
Karl K. Wallace, Jr., M.D.
April 20, 1993

The American College of Radiology is pleased to present the following statement on the "Comprehensive Physician Ownership and Referral Act of 1993."

The ACR believes that physicians should not have a direct or indirect financial interest in diagnostic or radiation oncology facilities to which they refer patients and we support legislation which would eliminate this conflict of interest by prohibiting such ownership arrangements in health care.

We have long held that these financial arrangements lead to inappropriate utilization of medical services and that the justification for development of these arrangements is contrived. We do not believe that joint ventures which include referring physicians have proliferated because of a need to increase access to care or to achieve economies of scale in providing health care services.

We believe these arrangements are intended to capture the market for a given set of health care services and that this control does not benefit patients. The Florida study states that where referring physician joint ventures exist, the normal economic forces of competition do not apply. We believe that this market control has led to increased utilization, higher prices and lower quality which generate unmandated large profits.

We are also concerned about the resultant exploitation of referral-dependent physicians as referring physicians band together to exercise market control and by subterfuge, demand a portion of the practice income of the consulting physicians in return for referrals. The practice of physicians seeking compensation for this market control of patient referrals is pervasive and we believe any doubt as to the impropriety of these actions, ethically, legally or morally, should be eliminated.

ACR Policy

The current position of the American College of Radiology is based on our members' experience with such financial arrangements. As these joint ventures proliferated in the early 1980's, the ACR debated the merits and disadvantages of these arrangements. In 1984, our policy-making council initially adopted the position that radiologists could ethically participate in financial arrangements, such as joint ventures, in order to provide diagnostic and therapeutic care to patients. But our position also warned our members of the potential for abuse in financial arrangements that involved referring physicians. With that caution, we believed that financial arrangements to fund imaging centers and radiation oncology centers could be structured to avoid conflict of interest, fraud, and abuse of patient confidence.

We found we were wrong. In 1988, our council reconsidered this position. In those four years between 1984 and 1988, we found that the potential for, and actual abuse and exploitation of patients by unethical practices, and the flagrant disregard of physicians' ethical responsibilities to the patient to be so great and so pervasive that these arrangements could not be ignored. We adopted the following policy statement:

"The position of the American College of Radiology is that the practice of self-referral of patients for a diagnostic or therapeutic medical procedure may not be in the best interest of the patient. Accordingly, referring physicians should not have a direct or indirect financial interest in diagnostic or therapeutic facilities to which they refer patients, and that the American College of Radiology supports legislative efforts prohibiting reimbursement for any diagnostic or therapeutic procedure carried out in a facility in which the referring physician has a direct or indirect financial interest."

In 1992 we again strengthened our policy against these ventures:

"The practice of physicians referring patients to health care facilities in which they have a financial interest is not in the best interest of patients. This practice of self-referral may also serve as an improper economic incentive for the provision of unnecessary treatment of services. Even the appearance of such conflicts or incentives can compromise professional integrity. Disclosing referring physicians' investment interests to patients or implementing other affirmative procedures to reduce, but not completely eliminate, the potential for abuse created by self-referral is not sufficient. In accordance with these views, the American College of Radiology supports current and future federal and state legislation and regulatory action designed to prohibit self-referral or restrict its influence on patient care decisions. The American College of Radiology believes that radiologists and radiation oncologists should make efforts to restructure the ownership interests in existing imaging or radiation therapy facilities because self-referral may improperly influence the professional judgments of those physicians referring patients to such facilities."

Extent of the Problem

Some have argued that referring physician ownership need not be addressed in legislation because the practice is not widespread. We know this not to be the case. Studies, such as the one conducted by the State of Florida, show the extent of physician ownership in health facilities and it far exceeds our predictions. It can no longer be claimed that this is not a widespread problem.

We must oppose these financial arrangements even if only a few physicians were involved. Abusive activities by a few physicians should not be condoned any more than abusive activities of many.

Access to Care

Those who support the continuation of financial arrangements among physicians have argued that these ventures are necessary to assure access to services in underserved areas. We doubt that the predominate reason for joint ventures is to provide access to services in rural or underserved areas. A major conclusion in the Florida study was that "joint ventures do not increase access to rural or underserved indigent patients." We believe that further study will support this finding.

A second point to be made in regard to access is specifically addressed to the argument that health services would be unavailable without using referring physicians as a source of capital for these facilities. We do not believe this is the case. Most often, referring physicians' participation in these joint ventures involves only signing a note for debt, not in providing capital for the facility. If in fact, an area in the country finds that lack of capital is restricting access to services, a clear exception could be made when there is concrete evidence that the referring physicians involved are actually providing the needed capital for the facility. We do not believe that these joint ventures are created because "there's no money in town."

Self-referral of Patients

While we support legislative efforts to prohibit referring physicians' financial involvement in health facilities, we must urge your caution in developing the legislation. If facilities currently in operation may simply declare themselves as extensions of group practices or private physician offices, the intent of the legislation will have been circumvented because referring physicians will continue to self-refer. The problem with increased utilization in referring physician owned facilities will be simply changed to a problem of increased utilization of services within physicians' offices.

Allowing physicians to refer patients to themselves raises two issues. First, in many cases, these physicians may be performing examinations for which they have received little or no training to either perform or interpret. If this involves complex radiologic procedures, it is more egregious than the prevalent questionable practice of self-referral of standard radiologic and laboratory procedures.

The second issue in this practice of self-referral is the potential for increased utilization of radiologic procedures. The issue of self-referral of patients for health care services was the focus of a scientific paper published on December

6, 1990, in the New England Journal of Medicine. We have previously submitted this article for your review and consideration. Other studies are currently underway which will provide further data on the impact of self-referral, including an assessment of quality of care.

We do not believe that any legislation should create an incentive or circumstance where services are provided by untrained or unskilled physicians, who are either unconcerned with or unaware of proper practice standards. In the best interest of patients, we should assure access to medical care from physicians qualified to provide the service.

Conclusion

In this era of antitrust sensitivities and litigation, voluntary organizations such as the ACR can set standards and urge compliance, but we cannot mandate behavior of radiologists. Nor can we mandate the behavior of others in the health care system. We recognize that many of these practices arise from the pressure of the highly competitive health care marketplace, but under no circumstance should competition lead to the acceptance of exploitive and unethical practices.

We believe the issue of referring physician ownership in medical facilities should be clarified in law by preventing such ownership.

Chairman STARK. Thank you, Doctor.
Doctor Krause.

STATEMENT OF DAVID A. KRAUSE, M.D., CHANCELLOR AND MEMBER, GOVERNMENT RELATIONS COMMITTEE, AMERICAN COLLEGE OF RADIATION ONCOLOGY

Dr. KRAUSE. Yes, Mr. Chairman, good afternoon. My name is David Krause. I am a radiation oncologist. I practice in Lansing, Mich. Mr. Chairman, I am honored to have the opportunity to testify before you on behalf of the American College of Radiation Oncology. We are a professional association of physicians specializing in radiation oncology, physicians who provide direct sustained hands-on care to cancer patients.

Currently, the American College of Radiation Oncology has more than 1,000 members. ACRO is the only organization which specifically represents solely the interests of radiation oncologists. Radiation oncology is a unique hybrid specialty using technology to treat patients with cancer.

The radiation oncology physicians uses radiation treatment instead of surgery or chemotherapy to treat cancer patients. Depending on the patient's stage of disease, our goal is either to cure the cancer or prolong life or to relieve pain. Approximately 60 percent of all cancer patients will require the service of a radiation oncology physician and facility during the course of their disease.

We, as radiation oncologists, work strictly on referral basis, and approximately half of our members work in hospital-owned facilities, either as hospital employees or independent practitioners. The other half work in freestanding facilities. These are typically owned by radiation oncologists themselves.

Mr. Chairman, we salute you for your farsighted leadership in the fight against the unethical physician ownership and self-referral arrangements. Our specialty has not escaped the unethical practice of joint ventured self-referral. In the last several years several private corporations concluded there has been money to be made in building radiation therapy facilities, and often although these facilities are often located across the street or just down the road from an existing facility, they typically have a in full patient load from the day they open, regardless of the quality of their staff or the equipment that is available.

Their secret? It is simple. The corporate developers of these facilities offer ownership interest to the internists, the medical oncologists, the surgeons and other referring physicians generally at a price well below fair market value. As we have heard time and time again, when a referring physician has a financial interest in a facility, a physician has a strong incentive to refer patients there regardless of quality, location, or charges. The American College of Radiation Oncology believes that the conflicts of interest are inherent in such referrals and they pose a grave danger to patient care and cause the physician-patient relationship to be marred by suspicion and distrust and also, which is one of your main concerns, it increases the cost of both public and private payers.

Corporate sponsors of joint ventured radiation therapy facilities have worked aggressively to hide the ball, but there can be no serious doubts about the dangers of self-referral in radiation oncology.

Just briefly alluding to the Florida studies again, we note that the charges—and this was published in the New England Journal of Medicine, which, as you know, is a highly prestigious and independent journal of medicine. The charges for a radiation therapy facility using a joint-ventured situation were 40 to 60 percent higher than facilities without referring physician ownership and quality control activities were 18 percent less than in nonreferring physician-owned facilities. That is very important because quality is one of the things we talk about, but we often don't have a measure.

We actually have measures of it in radiation oncology. We have one technical concern, Mr. Chairman, and due to an unforeseen drafting problem, the bill you have introduced on this topic, H.R. 345, could inadvertently prohibit radiation oncologists from owning or having some other financial arrangement with a facility in which they work. It would even have the prohibition—it would even prohibit a physician from referring within his own hospital to a department within his own hospital because of the nature of the bill. I would be happy to address this afterwards in the question period.

We know, and we are confident because we have heard from staff that you didn't intend to prohibit a physician from owning his own facility or referring within his own hospital, and we urge this subcommittee to fix this technical problem. The Senate Judiciary Committee—I am sure the Senate Finance Committee has a companion bill, Senate 337, Senator Bingaman's bill, which already has language in it which is very acceptable to cure this problem. I have included this in our written testimony.

In closing, Mr. Chairman, and members of the committee, allow me to thank you for this opportunity and for your ongoing efforts to eliminate the unscrupulous joint-ventured, self-referral. We applaud your leadership and attention to this issue, and I again urge you just to include that one provision that would have the unintended consequence of outlawing what you didn't mean to outlaw. We would be happy to answer any questions.

[The prepared statement follows:]

Statement of the

AMERICAN COLLEGE OF RADIATION ONCOLOGY

The American College of Radiation Oncology (ACRO) is a professional association of physicians specializing in radiation oncology -- physicians who provide direct, sustained hands-on care to cancer patients. Founded in 1990, ACRO currently has more than 1,000 members. Although there are many radiology professional and scientific societies, ACRO is the only organization that specifically represents the socioeconomic interests of radiation oncologists. ACRO's membership includes physicians working in all care settings: community hospitals, freestanding centers, and academic and research institutions. It includes the directors of leading university departments, freestanding facilities, and both large and small community hospitals.

ACRO has three concerns that it would like to bring to the attention of the Subcommittee:

- First, ACRO believes that legislation is urgently needed to prohibit referring physicians from having a financial interest in providers of radiation oncology services. At the same time, it is essential to ensure that such legislation does not inadvertently preclude radiation oncologists from owning their own facilities.

- Second, ACRO staunchly opposes incorporating payment for radiation oncology services furnished to Medicare inpatients into the Medicare DRG payments.

- Third, ACRO opposes any reductions in the practice expense component of Medicare payments for radiation oncology services.

Before turning to these specific concerns, however, we would like to describe briefly for the Subcommittee the role of the radiation oncologist in caring for patients with cancer.

THE JOB OF THE RADIATION ONCOLOGIST

Radiation oncology is a unique, hybrid specialty that uses technology to treat patients who have or have had cancer. The radiation oncologist uses radiation as the treatment for cancer rather than surgery or chemotherapy drugs. Depending on the state the cancer is in when the patient is referred, the radiation oncologist's goal is either to cure the cancer or to relieve pain and prolong life. Approximately 60% of all cancer patients require a radiation oncologist's services at some time during the course of their disease.

There are only about 2,400 radiation oncologists in the United States. Roughly half of our members work in hospital-owned facilities, either as hospital employees or as independent practitioners. The other half work in freestanding facilities, which are typically owned by the radiation oncologists themselves.

Radiation oncologists work strictly on a referral basis. After a diagnosis of cancer is made, the patient is sent to a radiation oncologist for examination and the rendering of an opinion as to whether radiation is an appropriate treatment for the patient. If it is determined that radiation would be useful, the treatment of the patient is planned, supervised, and carried out under the immediate direction of the radiation oncologist. During the treatment period, the radiation oncologist generally assumes responsibility for the overall management of the patient's medical needs.

Because radiation oncology is entirely dependent on referrals, radiation oncologists cannot engage in self-referral. Moreover, the number of treatments that can be given to a particular area is narrowly limited by effectiveness of dose on the one hand and tolerance of normal surrounding tissues on the other.

PHYSICIAN SELF-REFERRAL IN RADIATION ONCOLOGY

In the last several years, it has become increasingly common for developers of radiation therapy facilities to offer ownership interests to internists, medical oncologists, and other referring physicians, often at prices well below fair market value. Developers have done so because they know that where a referring physician has a financial interest in a facility, the physician has a strong incentive to refer patients to that facility, regardless of the facility's quality, location, or charges.

ACRO believes that the conflicts of interest inherent in physician self-referral pose a grave danger to patient care and cause the physician-patient relationship to be marred by suspicion and distrust. While the corporate sponsors of joint-ventured radiation therapy facilities have worked aggressively to hide the ball, we believe there can be no serious doubt about the dangers that this phenomenon presents.

Indeed, research has concluded unequivocally that self-referral in radiation therapy results in substantially higher costs as well as lower quality. According to a study of Florida radiation therapy facilities that was published in the November 19, 1992 issue of the New England Journal of Medicine, the frequency and costs of treatment at radiation therapy facilities where referring physicians had an ownership interest were 40 to 60 percent higher than at facilities without referring physician ownership. Moreover, personnel of joint-ventured radiation therapy facilities spent 18 percent less time in quality control activities than their counterparts at facilities without referring physician ownership. The study also found that no joint-ventured radiation therapy facilities were located in inner-city neighborhoods or rural areas, showing that physician self-referral does not improve access to care in otherwise underserved areas.

The existing Medicare-Medicaid anti-kickback statute has proved inadequate to deter self-referral. Similarly, experience has shown that self-referral cannot be contained through voluntary ethical guidelines. Rather, federal legislation explicitly banning self-referral for radiation therapy services is needed to finally eliminate this serious threat to high-quality, cost-efficient cancer care. ACRO asks this Subcommittee and Congress to include in this year's budget reconciliation bill a provision that would prohibit physicians not trained in radiation oncology from referring patients to radiation therapy centers in which they have a financial interest.

Such legislation, however, must be carefully drafted to ensure that it does not inadvertently prohibit radiation oncologists from owning, or having some other financial relationship with, the facilities at which they practice. For example, Representative Stark's H.R. 345, as currently drafted, would likely have such an effect, even though Congressman Stark's staff bas assured us that this was not his intent.

H.R. 345 retains the definition of "referral" currently contained in Section 1877(h)(7) of the Social Security Act. This provision purposely defines "referral" very broadly, to include almost every case in which a physician requests an item or service -- even requests for services to be rendered within the physician's own practice or facility. It is expected that such on-site "referrals" will be protected through a special exception, known as the "in-office exception," contained in Section 1877(b)(2) of the Social Security Act.

Unfortunately, in the case of radiation therapy services, the current language of the "in-office exception" would not achieve its objective. To qualify for this exception, the service in question must be provided at a site at which the referring physician (or another member of his or her group) furnishes services that are "unrelated" to the referred service.

For clinical laboratory services and most of the other ancillary services that would be covered by H.R. 345, this language provides ample protection, since physicians who make "referrals" for such in-office ancillary services generally perform a variety of services which are clearly "unrelated" to the services for which the referral is made.

Radiation oncologists, however, do not provide any services that are "unrelated" to radiation therapy services. Thus, if H.R. 345 were enacted in its current form, not only would it prevent non-radiation oncologists from having an ownership interest in radiation therapy facilities, the bill would also prevent radiation oncologists themselves from owning, or having any financial relationship with, such facilities.

It may be possible to replace the current "unrelated" standard with other language more appropriate to the way in which radiation therapy services are actually delivered. However, we believe the best solution would be to adopt the approach taken by Senator Bingaman in his bill, S. 337, which is aimed at the self-referral issue as well. While that bill likewise has some technical drafting problems, it adopts the straightforward approach of providing an explicit exemption for referrals by a radiation oncologist for radiation therapy services. Specifically, Section 2703(4) of S. 337 provides a physician ownership or self-referral exemption for:

> a request by a physician specializing in the provision of radiation therapy services, if such services are furnished by (or under the direct or personal supervision of) such physician specializing in the provision of radiation therapy services pursuant to a consultation requested by another physician.

We believe this is the simplest, most effective solution, with the least potential for unintended, unforeseen consequences, and we urge the Subcommittee to adopt the same language.

OPPOSE INCORPORATION OF PAYMENT FOR RADIATION ONCOLOGY SERVICES INTO THE DRG AMOUNT

The President's budget proposal would fold payment for inpatient services furnished by radiologists, anesthesiologists, and pathologists into the Medicare DRG payments. As we understand it, the theory behind this approach is that few patients have a pre-existing relationship with their diagnostic radiologists, pathologists, or anesthesiologists. Rather, it is said, diagnostic radiologists, pathologists, and anesthesiologists simply "come with the hospital." Therefore, it is argued, such physicians should be paid like other hospital employees, rather than being permitted to bill patients directly.

We believe that there are serious flaws with this line of reasoning. But whatever its merits in general, it certainly does not apply to radiation oncologists. Unlike the situation with other RAP physicians, radiation oncologists provide direct, sustained, hands-on patient care, typically assuming primary responsibility for the patient during the entire treatment period, which may last for six to eight weeks or longer. Indeed, in marked contrast to the situation with, say, anesthesiologists and pathologists, patients often come to a particular radiation therapy program because of a particular radiation oncologist with whom they or their primary care physician are familiar.

Moreover, in many parts of the country radiation oncologists who work in the hospital setting have no formal relationship of any kind with their hospitals. Adoption of the Administration's RAPs proposal would force all radiation oncologists to enter into a formal contractual arrangement with each hospital at which they practice, in order to spell out the terms under which the basic DRG payment would be divided. We see no productive purpose that would be served by forcing radiation oncologists and hospitals to enter such a necessarily adversarial relationship.

We understand it has been suggested that, instead of incorporating inpatient RAP fees into the DRGs, the Subcommittee should reduce all radiology, pathology, and anesthesiology fees in order to achieve a comparable degree of savings. We believe that such a course would be entirely unfair to radiation oncologists.

Radiation oncologists serve very few inpatients. In fact, because patients treated on an inpatient basis tend to have multiple medical complications, making them

unusually difficult to treat, such patients tend to receive the shortest possible course of treatment. As such, the amount of savings that would be achieved from the incorporation of radiation oncology payments into the DRGs is minuscule. An across-the-board cut in all radiology, pathology, and anesthesiology payments would thus reduce radiation oncology payments by far more than would occur if the RAPs proposal, for all of its drawbacks, were adopted. We therefore urge the Subcommittee to seek other methods of achieving the necessary savings.

EXEMPT RADIATION ONCOLOGY SERVICES FROM ANY REDUCTIONS IN PRACTICE EXPENSE RVUs

The Administration's budget proposal asks for reductions in the practice expense components of certain services. The Administration has not yet revealed which services it believes should be subject to this reduction. ACRO believes that no radiation oncology services should be so reduced.

In 1991, HCFA increased the RVUs for the practice expense portion of radiation oncology services by over 14%. This adjustment was based on data submitted by ACRO and other radiation oncology groups showing that previous payment levels failed to cover the costs of delivering these expensive services. After scrutinizing this data, HCFA concluded that a 14% increase was necessary to bring radiation oncology practice expense RVUs in line with actual costs. Radiation oncology was the only specialty given such an across-the-board increase.

Given HCFA's conclusion that current payment levels for radiation oncology services reflect actual costs, there can be no basis for alleging that these services are overvalued. Indeed, any reductions in current practice expense RVUs would cause payments to fall below actual costs. We therefore urge the Subcommittee to exclude radiation oncology services from any legislative reductions in the practice expense component of physician payments.

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If the Subcommittee would like any additional information concerning these issues or if ACRO can assist the Subcommittee in any way, please contact our Washington counsel, Joel Suldan, at 202/778-8008.

Chairman STARK. You were so kind, you got a couple of digs in at our other bill. I thought you would bring those up. You guys were batting a thousand, but I noticed that you really don't like the idea of putting the RAPs on a salary or making them hospital-based.

Dr. KRAUSE. If I might address that specifically.

Chairman STARK. I will bring that up later. First of all, we didn't write that bill, but secondly, that is an old suggestion that has been around, I will bet you, since the days of Ronald Reagan. It keeps coming up in every budget like a new—we really don't have to go into that at this point, but I did want to note that there were one or two discordant notes in the testimony, and the practice expense ought to be used, which I do think we are going to encourage you all to look at as much as you initially did the resource-based relative value for the professional side. Dr. McDermott here understands all these Latin words, but the rest of us don't, and I think it is incumbent really on you to begin, because I am not sure that we are not unequally paying for practice overhead.

That means there will be winners and losers, but I would encourage you before we even think about it to get Dr. Hsiao or somebody else to begin to sort out who has what overhead expenses and who doesn't.

Dr. WALLACE. I don't think he would do that upon our request, Mr. Chairman.

Chairman STARK. I think that is something that is coming, and certainly if we don't use the information, the people in the managed competition cooperatives or buying groups will certainly want the information. It would be good for you to start to prepare that.

Dr. KRAUSE. There were two studies that the American College of Radiation Oncology brought to HCFA, both of which were studies. One was by PROMED and one was another study by AFROC, the Association of Freestanding Radiation Oncology Centers. This data showed, we believe, that practice expense ratios—radiation oncology is a fairly capital intensive business. We are actually underpaid by 40 percent. After much wrestling with HCFA, they gave us, and we were the only specialty, I might add, that was given a 14 percent rise in the technical component of our practice RVUs.

Chairman STARK. Don't let Dr. Wallace know that. He is going to want it for all the radiation oncologists.

Dr. KRAUSE. One of the issues being particularly directed against many office space specialty surgeons, etcetera, who seem to have a much higher technical RVU than is warranted by their office—by their expense ratios, radiation oncology machines are a million or a million and a half dollars apiece. The room costs are almost equal. These certainly have very high and very definable technical expenses.

Chairman STARK. As I say, I am encouraging you all to begin to find a formula to define that so we don't have to.

Dr. KRAUSE. We have already brought it to HCFA in studies. We brought two separate studies to HCFA. As you know, they are not terribly generous with some things, but they did give us a raise.

Chairman STARK. I am not sure HCFA should do it, either. I think maybe an independent study that includes all of the specialties and subspecialties. As I say, I think it would have to be as ex-

tensive as the original Hsiao study, maybe not done in the same way, but that appeared at least at the time to have broad support from the medical fraternity, and I would hope that we get into the practice-based reimbursement that, again, you all will cut up the pie, and all we will worry about is how big the pie is going to be.

I appreciate your testimony, all of you. I am concerned, and some of you have expressed this concern, that there is a cottage industry for people providing seminars to owners of ventures which provides services to patients and depend on their marketing primarily for new referrals from owners. I should think that they would applaud our bill, too, and hope it doesn't pass because it is—arguably it is an annuity, certainly a college scholarship for all their kids to keep running seminars on how to beat whatever law they think we are going to pass. But there will be, I am afraid, six loopholes for every line we try to draw, which is one of the things that makes me feel we should just err on the side of a very distinct bright line and just say no ownership. Then if it can be established later that we have somehow harmed someone. I am sure we could create those on a case-by-case exception. I would feel much more comfortable doing that than I would the other way, but you could provide us with any of the anecdotes, these anecdotes largely turn out to be prospective as nearly as I can tell. We have a roomful of them. We would appreciate seeing any of the creative accounting or creative formation vehicles that people put together to circumvent what I think we all understand is an attempt to stop making referrals a commodity much as pork bellies, and so, again, I appreciate you and your organizations saw the problem with this many years ago, and I appreciate your patience as we have tried to figure out how to legislate it.

Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman. Sometimes I have convinced the chairman that because I practiced medicine for 30 years I understand what goes on in the profession, and I have sat on disciplinary committees in hospitals and I have worked in PSROs and I have done claims examination for health and welfare trusts for labor unions and what not, so I have a lot of experience in looking at how things happen, but one question comes to mind and it is a technical question, I want to ask Dr. Krause.

I can understand the self-referral where you own an MRI and you can put somebody out there and get some benefit from the diagnostic experience of going through that machine, and you get some money back from it. Basically an unharmful test. What I have trouble figuring out is how an oncologist, who has an ionizing radiation machine, how he or she could refer somebody to that and not open themselves up to tremendous malpractice in this day and age of above all things do no harm, to put somebody in one of those machines needlessly.

The only thing I can think of, and maybe you will correct me, is that you might choose to do radiation rather than to do surgery or some other mechanism.

Dr. KRAUSE. Let me answer that in two ways. Number one is we are not saying that malpractice is being committed. What we are saying is that people—well, Atlanta is a very good example in which several units have been set up either down the street or

across the way from ongoing units and have devastated good hospital facilities because the referring physicians have had an interest in sending them where they are going to get a return.

Another thing, a perfect example, a patient came to me last Friday. It was a woman with endometrial cancer, cancer of the lining of the uterus. Current best practice says that that woman should go to surgery first. Now, 10 years ago we radiated all these people ahead of time. Still at some major universities, one or two, in this country radiation therapy is still done preoperatively, but they are really the exception. It is not malpractice to radiate the patient, but it is not best practice, so I sent the patient for surgery knowing that only 1 in 10 of those will have to have radiation therapy.

If there were economic pressure on a radiation oncologist because there were investors looking over his shoulder he might say, well, it is OK to do it, and it is good for the operation. You can always make the argument that every physician, including I, have an interest in treating that patient rather than sending him out, but I think when a physician, when the referring physician is looking in and they are saying you better do it because you are an employee of ours and if you don't do it, we will get somebody else who will, I think that is what happens.

Mr. MCDERMOTT. So you are saying that the problem really is that the willingness or the ability to look with a very clear eye at which is the best kind of treatment may be blinded by the financial interest one may have in this or that kind of facility.

Dr. KRAUSE. One may have or one's employer may have. Specifically most of the radiation oncologists who are employed—excuse me, who are working in these joint ventured facilities are employees of whatever corporation has been set up, and there is a lot of investor—it may not be open. OK, I am not vague. If you don't treat this patient, you are out the door, but you have been around long enough to know you don't have to say things to mean them.

Mr. MCDERMOTT. We in politics understand that. One of the things about our politics in this arena is that it is much more open than it is in medicine or medical schools or a lot of other arenas I have operated in. At least up here it is on the table. We know we are trying to influence one another to do one thing.

Dr. KRAUSE. If I could return to that one issue of the technical problem, because we do believe that what happens has happened in your proposed bill, Chairman Stark, is that it relies on a definition of referral, and the problem is that there is this exception in the rule for the office. It is called the in-office ancillary service exception. The problem is with radiation oncology, we don't offer other services within our either freestanding facilities or our departments, and therefore it has been made illegal.

There is a very simple sentence that the Senate bill says, Senate 337 provides an exemption for, quotation marks, "a request by a physician specializing in the provision of radiation and therapy services if such services are furnished by such physician specializing in a provisional radiation therapy services pursuant to consultation requested by another physician."

We would ask if you would put that in, then we absolutely, fully and wholeheartedly support it. It is just that I don't want you to make essentially all of my members in violation of the law, which

isn't just criminal law, which is a problem in and of itself, but, in fact, every provider can say you are in technical violation, and we are not paying you. We are not paying your department. We are not paying your facility, so we understand, nobody likes to write exceptions because you look like, quote, "a special interest", but since you didn't mean to outlaw it, we would hope you wouldn't outlaw it.

Mr. MCDERMOTT. I appreciate all of you coming and testifying. I have always thought the toughest part of any profession is policing yourself, and it is good to have professional organizations come and say straight out this has got to stop. Appreciate your coming.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Andrews.

Mr. ANDREWS. I don't have any questions, Mr. Chairman.

I do want to thank all of you for your testimony, though, today.

Chairman STARK. As I say, I worked with you all in your organizations for a number of years, and we do appreciate it. There are tougher times coming ahead as we try and ratchet down fees to try to save some money, so let's enjoy the glow of the day as we gird our loins for battle later on when we get the definition of managed competition, and we will see what that will do for you or—the single-payer system may come, too. I forgot that bill was out there. As between these two gentlemen they are going to write the reform bill, and I am just waiting with bated breath to see who is going to win here.

If you would like to join my pool, any of you, we will meet in the back later on. We have an office pool on this very topic. Thanks very much for your testimony.

We will continue with testimony from Mr. Thomas Mills, the counsel for Radiation Care Inc., and T^2 Medical, Inc.

Tom, welcome to the committee. Tom, we have your testimony in its entirety. Why don't you go ahead and enlighten us in any manner you are comfortable.

STATEMENT OF THOMAS L. MILLS, COUNSEL, RADIATION CARE, INC., T^2 MEDICAL, INC., AND AMERICAN LITHOTRIPSY SOCIETY

Mr. MILLS. Mr. Chairman, thank you. I am really delighted to be here. Thank you for the invitation. Mr. Chairman, I will limit my comments to Radiation Care and T^2 Medical's positions. I think that we have already handled the glitch for lithotripsy.

Mr. Chairman, the self-referral issue is one which you deserve a great deal of congratulations for highlighting and spending a lot of good and constructive time on over the years. What is in your bill, Mr. Chairman, is important. What is not in your bill in terms of the additional designated services is also important, and instructive, and it is from that aspect that I will talk.

Let me talk about two designated services, including home infusion therapy and radiation therapy, both of which I think ought to be taken out of the bill, and with those changes I will happily support the bill also. Bet you didn't think you would hear me say that.

Let's talk first about infusion therapy. Mr. Chairman, let me say that dialysis, lithotripsy, and surgery are not in this bill and they are not in the bill for an important reason which you have recog-

nized before, and that where the physician is performing a service and there is no intervening physician, that there is generally not considered to be a referral. If that is the rule and the logic here, I think that infusion therapy likewise ought to be eliminated because there is no physician which intervenes between the physician and his patient who is infused.

You know, Mr. Chairman, infusion therapy and, of course, Congressman McDermott being a physician also understands the intricacies of infusion therapy. It is clear that the abuse of self-referral is primarily one of overutilization. It is secondarily in some cases one of overpricing. You have said many times before, Mr. Chairman, you are not interested in legislating ethics. That is a slippery slope, and none of us would quite know what, I think, to do, even through so erudite a panel as this.

In infusion therapy there is absolutely not one study, not one piece of empirical evidence which ever suggests, and it is intuitively obvious, that no one is being infused who does not need it in terms of pricing and the cost to society, cost to the fisc of which you are in charge, and that is a daunting task. Indeed, it is very clear that infusion therapy is one of a few technological advances that have occurred over the last decade which has, in fact, led to a decrease in costs to the system and, indeed, directly to the public fisc and with respect to physician ownership of infusion therapy facilities.

It is in large part an extension of the physician's practice. In point of fact, T^2, which has pioneered much of infusion therapy, particularly the ambulatory infusion therapy centers which provide a very convenient and less costly alternative to very complex therapies being done in hospitals, is consistently, and we have the only pricing data that we know of, and it is consistently priced at the bottom of the market. So there would seem to me to be no reason at all and no public benefit, indeed a disbenefit, for including infusion therapy on the ban.

Let me quickly switch to radiation therapy to keep within the 5 minutes and leave time for answering questions. Radiation therapy is, of course, a therapy like, for example, dialysis, in which it is extraordinarily difficult to comprehend that anybody would be radiated who did not have an exact need.

Let me respond. I thought, Mr. McDermott, your question was extremely accurate and helpful to the debate. Let me fill out another aspect of the answer from the previous panel. You are correct, of course, that nobody is being radiated who does not need it. The natural and practical medical bars and the harm would inure to the patient would be more than enough in addition to the ethics to prohibit that.

The answer you got was, in fact, not a patent answer, but an economic answer that perhaps a radiation oncologist who were on salary would feel in this case subtle pressures from his employer to radiate when maybe that is not the best choice. And I ask you, sir, I think that is answered by the simple syllogism that why is it that a radiation oncologist—who owns 100 percent of the facility and who is being paid a professional fee and additionally a technical fee—what is it in his makeup or training that makes him empirically ethical and unlikely to treat when it is a marginal question,

when he gets 100 percent of the return, but would make a medical oncologist, a more highly trained cancer specialist and who would own a very small part of the facility, what would make him so unethical as to impose his will indirectly on the radiation oncologist to get him or her to treat where it wasn't appropriate.

It is illogical, and there is no empirical evidence of any credibility to suggest it. So Radiation Care's position on this bill is we don't think that radiation therapy ought to be included at all, but if it were, we would be quite satisfied for the bar to stay as it now exists, and that is across the board, as the Chairman has suggested. Again, the better answer, I think, is to take them out.

With that, that ends my time, and I am delighted to answer questions, sir.

[The prepared statements follow:]

TESTIMONY OF THOMAS L. MILLS

ON BEHALF OF RADIATION CARE, INC.

My name is Thomas Mills. I am a principal in the Washington D.C. law firm of Dyer, Ellis, Joseph & Mills. In the course of my practice I represent various health care providers on a number of health issues, including the issue that has come to be known as "physician self-referral." Some of these providers own, operate, or manage facilities nationwide and have significant physician involvement.

I am here today on behalf of Radiation Care, Inc., a provider of outpatient radiation therapy services utilized in the treatment of cancer. Radiation Care has been in operation since 1991 and now operates 19 facilities in 10 states. The Company is publicly-held and its stock is listed for trading in the NASDAQ National Market System.

As I will make clear in this testimony, Radiation Care believes that there is no basis for including radiation therapy as a "designated health service" in legislation that would ban physician-owner referrals for such services. That notwithstanding, if Congress believes, as a broad policy matter, that physician-owner referrals for radiation therapy services should be prohibited, such a ban should be applied to all physicians, including radiation oncologists. Physician self-referral legislation sponsored by Rep. Stark, while including radiation therapy services, correctly and fairly applies the ban to all physician-owners of such services, including radiation oncologists. Radiation Care agrees that radiation oncologists should not be exempt from the legislation. While Radiation Care does not believe that abuse occurs with respect to radiation therapy services, if it were to occur, the radiation oncologist is the only physician involved in the treatment process who is in a position to conduct such abuse.

RADIATION THERAPY

Radiation therapy, which treats cancer with high-energy radiation, is used alone and in conjunction with surgery, chemotherapy and, to a lesser extent, hormone therapy and immunotherapy. Radiation therapy is used both to cure cancer by destroying and eliminating cancer cells, and, where curing the cancer is not possible, as palliative treatment, which is the shrinking of tumors in order to reduce pain and other symptoms.

While we are all aware of the unfortunate prevalence of cancer, the statistics are nonetheless startling. According to the American Cancer Society, about seven million Americans have a history of cancer and about 76 million will eventually contract the disease. In 1991 alone, approximately 1.1 million Americans will be diagnosed as having cancer, excluding relatively minor forms of skin cancer. Indeed, the December 7, 1992 issue of Modern Healthcare declares cancer as the "disease of the future." With an estimated one half of all cancer patients receiving radiation therapy according to the National Institutes of Health, it is clear that high-quality radiation therapy must be readily accessible to all Americans at a reasonable cost. Since 90 percent of all patients being radiated are being treated on an outpatient basis, outpatient radiation therapy, such as that provided by Radiation Care, will play an increasingly important role in treating cancer patients.

RADIATION CARE, INC.

Radiation Care opened its first radiation therapy center in June 1991 and, as I have indicated, currently has 15 radiation therapy centers in operation in 9 states, including Georgia, South Carolina, North Carolina,, Virginia, Maryland, Tennessee,

California, Alabama and Florida. Radiation Care provides treatment to private pay, Medicare and indigent patients. Unlike many other radiation therapy providers, Radiation Care accepts Medicare assignment. Radiation Care's stockholders include some practicing medical oncologists and other physicians who may refer cancer patients for treatment to the Company's centers.

Radiation Care has been designed by some of the preeminent cancer treatment specialists in the country with a sensitivity to the criticisms that are directed toward healthcare providers. A key element of Radiation Care's commitment to providing quality cancer treatment is to employ radiation oncologists with superior academic training and experience in their specialty. The choice of radiation oncologist is important, because it is he or she who, following a referral from a medical oncologist or other physician, ultimately decides whether radiation therapy is an appropriate treatment, prescribes the type and amount of therapy and supervises its administration. This responsibility makes the radiation oncologist the "gatekeeper" of radiation therapy.

Radiation Care encourages its radiation oncologists to participate actively not only in the local medical community served by the center under their supervision but also in the nationwide medical community. Many of the Company's radiation oncologists have experience in teaching hospitals and the Company requires them and supports their ability to keep abreast of and participate in developments in cancer research. In this respect Radiation Care is one of the pioneer users of "IMPAC" -- a cost-effective computer software system linking each of the Radiation Care centers. The primary function of the IMPAC system is quality assurance -- radiation treatments of each patient are recorded in great detail and are verified on a daily basis. There is also a nationwide data base containing a patient and tumor registry. The IMPAC system allows each Radiation Care center to be linked instantaneously to sophisticated, state-of-the-art radiation treatment planning. The IMPAC data base will provide cancer researchers with a wealth of data with which they can analyze how new medical technologies work in both university settings and in communities nationwide.

DEVELOPMENT OF THE PHYSICIAN SELF-REFERRAL ISSUE

The focus of today's hearing is to examine the physician self-referral issue. This Subcommittee began looking extensively at this issue in 1989 in response to legislation introduced by Chairman Stark. That bill, as introduced, applied to physicians generally and would have banned them from making Medicare-reimbursable referrals to a health care provider in which they had any financial interest. Before its passage, however, many exemptions were carved out of the bill and ultimately, as you know, the legislation prohibited referrals to physician-owned clinical laboratories only.

The legislation, as enacted, required that not later than October 1, 1991, each entity providing Medicare-covered services provide HHS with information about the entity's ownership arrangements, including the Medicare-reimbursable items and services provided by the entity, and the names and identification numbers of all physician-investors in the entity. The reporting providers were to include clinical laboratories, enteral and parenteral suppliers, end stage renal disease facilities, suppliers of ambulance services, hospitals, and providers of physical therapy and diagnostic imaging services. This information has been gathered and after it is analyzed by HHS a report will be released.

Since passage of the physician self-referral legislation in 1989, similar bills have been introduced and considered in both Chambers of Congress. At least thirty states also have considered

the issue and will continue such consideration this year. Moreover, similar bills have been introduced and are now under consideration in both Chambers of Congress. Most significantly, Chairman Stark has introduced two bills concerning physician self-referral. H.R. 345, the "Comprehensive Physician Ownership and Referral Act of 1993," proposes to expand current law beyond referrals reimbursable under Medicare to those reimbursed by all payors and to ban physician financial arrangements with providers of certain "designated health services." These include clinical laboratory, physical therapy, radiology -- including magnetic resonance imaging, computerized axial tomography scans, and ultrasound -- home infusion therapy, occupational therapy and inpatient and outpatient hospital services, including services furnished at psychiatric or rehabilitation hospitals, and the furnishing of durable medical equipment, parenteral and enteral nutrition equipment and supplies and outpatient prescription drugs. The bill has various exemptions, including, among others, in-office providers and group practices, public companies, rural providers and hospitals. H.R. 200, the "Health Care Cost Containment and Reform Act of 1993," focuses upon overall health care reform and includes the same physician self-referral provisions contained in H.R. 345.

The President has also proposed to prohibit physicians from making referrals for certain services to facilities in which the physician has a financial interest. The proposal, as contained in the President's Economic Recovery Plan, includes such services as physical and occupational therapy, durable medical equipment and enteral and parenteral nutrition equipment and supplies. The Department of Health and Human Services' fact sheet summary of the President's Plan expanded the list to include radiology and radiation therapy services.

Various studies of the physician self-referral issue also have been undertaken over the last several years. The earlier studies focused on providers of diagnostic services. These included a study conducted by the U.S. Department of Health and Human Services' Office of Inspector General. It focused upon clinical laboratories, diagnostic imaging centers, and durable medical equipment suppliers. It concluded only that there is possible abuse in connection with physician ownership of clinical laboratories. It found that patients of referring physicians who own clinical laboratories received up to 45% more laboratory services than Medicare patients in general. The OIG admits, however, that there is no evidence to indicate that these services were unnecessary. In fact, these additional services may, at least in part, be the result of increased availability of certain laboratory services.

Additionally, a study of physician ownership by the University of Arizona was published in December 1990 in The New England Journal of Medicine. It compared the frequency and costs of diagnostic imaging between referring physicians who use imaging equipment in their own offices and physicians who refer patients to a radiologist for imaging services. It found that the self-referring physicians obtained imaging examinations 4 to 4 1/2 times more often than the others. Moreover, patients of the self-referring physicians were charged more for imaging services than those of the radiologist-referring physicians.[1]

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[1] While the study was conducted by the University of Arizona, it was supported by the American College of Radiology. This fact alone casts suspicion upon the study's findings because ACR's membership consists of physicians who are vehemently opposed to ownership of radiology and radiation therapy facilities, unless such ownership is by physicians who are members of ACR, i.e., radiologists or radiation therapists.

THE FLORIDA STUDY

The Florida Health Care Cost Containment Board (HCCCB) requested two economists from Florida State University, Drs. Mitchell and Scott, to evaluate the effect of joint ventures on healthcare in Florida. Their study, released in September 1991, focused on nine types of physician joint ventures and found "clear" evidence of higher utilization in three so-called "problem areas": diagnostic imaging, physical therapy and clinical laboratory joint ventures. The study's results were inconclusive with respect to radiation therapy, ambulatory surgery, home health care and durable medical equipment joint ventures. The study found no evidence of higher utilization with respect to acute care hospital and nursing home joint ventures.

In October 1991, the Florida HCCCB reviewed the Mitchell/Scott study. It recommended restrictions on joint ventures in the three so-called "problem areas" along the lines of the federal Medicare Stark legislation restricting clinical laboratory joint ventures. In its most controversial decision, the HCCCB added radiation therapy as a fourth "problem area" even though the study's results were inconclusive with respect to radiation therapy. In fact, the one clear conclusion on radiation therapy is that non-joint ventures had higher utilization than joint ventures. The HCCCB provided no explanation in its recommendations for its decision to add radiation therapy as a "problem area." The HCCCB had apparently been persuaded by heavy lobbying from Florida radiation oncologists.

While the Florida study is often cited as proof for the proposition that diagnostic imaging, physical therapy and clinical laboratory joint ventures routinely "overutilize" and "overcharge," even the study's authors, as well as the HCCCB which commissioned the study, have admitted its limitations.[2] Testifying before the U.S. House of Representatives Ways and Means Health Subcommittee in October 1991, Dr. Mitchell stated "We do not make any claims about inappropriate utilization." In a June 1992 report to the Florida legislature, the HCCCB stated that the study "did not address the issue of 'price'... the price or charge for the service was often lower in joint venture facilities." The HCCCB added, "It would be an over-simplification to conclude that banning self-referral will correct the over-utilization problem and, therefore, reduce costs."

Indeed, Radiation Care, as it has previously testified before the Subcommittee, agrees with the study's authors that it has serious problems. Most significantly, it did not identify the positive impacts that new health care joint ventures have had in three key areas -- cost, access and quality -- as was required by the legislature. For further discussion of these deficiencies, we refer the Subcommittee to Radiation Care's written testimony presented to the Ways and Means Health and Oversight Subcommittees at their October 1991 joint hearing concerning the Florida joint venture study.

Particularly with respect to the study's analysis of radiation therapy joint ventures, despite the fact that it found no evidence of over-utilization or abuse, the study is nevertheless seriously flawed. The study notes that physicians own about 80 percent of

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[2] In April 1992, after the Florida legislature had approved its joint venture legislation, at the request of the Florida Medical Association, Lewin-ICF released a comprehensive critique of the Florida study. Lewin-ICF stated, among other criticisms, that the utilization, profitability and access data used by Mitchell and Scott were inaccurate and misconstrued. In particular, Lewin-ICF found that the Florida study failed to make any direct, head-to-head utilization and cost comparisons between joint ventures and other providers.

Florida's freestanding radiation therapy facilities with radiation oncologists owning most of the facilities. The study, however, does not differentiate between facilities owned by radiation oncologists and those owned by other referring physicians.

Moreover, the study is clearly mistaken in its conclusions concerning the purported pricing differential between physician-owned and nonphysician-owned radiation therapy facilities. The study states that joint venture gross revenues are about $5,000 per patient while non-joint venture gross revenues are about $4,650. In its discussion of expenses and profit, however, the study admits that the data are unclear whether the reported expenses and profits derive from "facility services" (i.e., "technical fees" only) or "facility services" plus "professional services" (i.e., "global fees"). Accordingly, the study's conclusion about the purported pricing differential is flatly wrong. It is impossible to reach any conclusion about comparative cost per patient without knowing whether the costs reported are complete or incomplete.[3] Ironically, the only defensible finding, which the authors do not comment upon, is that nonphysician-owned facilities have a statistically significant greater number of procedures per patient than physician-owned facilities.

THE ACR/SUNSHINE STUDY

The record of this committee's October 1991 hearing on self-referral includes a study by Dr. Sunshine of the American College of Radiology purporting to analyze physician ownership of radiation therapy facilities in Florida. Subsequent versions of the ACR/Sunshine study were released in December 1991 by the so-called "Special Committee for Health Care Reform," a coalition of Florida radiation oncologists lobbying for self-referral legislation,[4] and again in January 1992 by the Florida radiation oncologists, this time signed by Drs. Sunshine and Mitchell. Yet another version of the study subsequently appeared in the New England Journal of Medicine in November 1992.

While the ACR/Sunshine study on its face would appear to provide a basis of support for a ban on physician ownership of radiation therapy facilities (except for ownership by radiation oncologists), it is so methodologically flawed that its findings should not be given any credence whatsoever. When analyzed in the context of the data available to the authors, but not presented, the study is nothing more than a shameless propaganda piece, masquerading as an academic analysis.

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[3] It is Radiation Care's experience that in nonphysician-owned facilities, the professional fee is billed separately by the radiation oncologist, leading to the conclusion that, in Florida, the total cost per patient, like the number of procedures, is actually higher in nonphysician-owned facilities than in physician-owned facilities.

[4] The "Special Committee for Health Care Reform" is funded by the American College of Radiology. As further discussed later in this testimony, the ACR opposes in particular physician ownership of radiation therapy facilities. Ironically, however, it supports an exemption from any proposed ban on physician ownership of these types of facilities for its own members, i.e., the radiation oncologists. As discussed below, these physicians are as much in a position, if not more, to self-refer as any other physician who refers patients to a radiation therapy facility.

First, the study hides the potential abuses and over-utilization by the ACR's members by excluding radiation oncologists from its definition of physician owned "joint ventures." It does so by pre-emptively concluding what the study should be analyzing, i.e., that radiation oncologists aren't "referring" physicians. With respect to their professional services, they may or may not be, as later discussed. But as to the only issue studied -- the financial return to a physician from the facility that treats the physician's patient, they clearly are. The study concludes that (1) physician-owned radiation therapy joint ventures result in increased utilization and higher costs and (2) excess costs attributable to joint venture radiation therapy facilities in Florida were about $12 million in 1991." The alleged basis of these conclusions are the study's findings that --

o joint ventures operate almost 50 percent of the freestanding centers in Florida compared to seven percent nationally;

o Florida's freestanding radiation therapy centers -- whether owned by hospitals, radiation oncologists or joint ventures -- rendered approximately 52 percent more procedures per Medicare enrollee than the national average; and

o Florida's freestanding centers -- again whether owned by hospitals, radiation oncologists or joint ventures -- charged 32 percent more than the national average.

The study states these findings "*suggest* that joint ventures are responsible for the substantially higher utilization rates which characterize freestanding radiation therapy facilities in Florida" and "*imply* the excess costs attributable to joint venture radiation therapy facilities were at least $12 million in 1991."

CRITICISMS OF THE ACR/SUNSHINE STUDY

Numerous factors render the ACR/Sunshine study insupportable and devoid of any credibility. Although most studies are paid for by interested parties, independent researchers provide some level of presumed integrity. This study, however, was both conducted and funded by the ACR. It represents radiologists and radiation oncologists and one of its major legislative efforts is to eliminate competition from diagnostic imaging and radiation therapy joint ventures. Thus, its self-interest in finding that radiation therapy facilities owned by physicians, other than radiation oncologists, over-utilize and over-charge, while hiding its own interests, invalidates the study from the start. [5]

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[5] Dr. Sunshine, is the Director of Research of the American College of Radiology (ACR). Co-signing the later version of the ACR/Sunshine study is Dr. Mitchell who, at the time the original ACR/Sunshine study was being conducted, was a Florida State University (FSU) economist. Dr. Mitchell is also one of the two authors of the Florida study. As Radiation Care has previously testified, the Florida study found "clear" evidence of higher utilization and higher charges in only three "problem areas" which did not include radiation therapy. The only clear conclusion in the Florida study with respect to radiation therapy is that hospital-owned radiation therapy providers have higher utilization than radiation oncologist-owned and joint venture-owned providers.

At an October 1991 hearing before the House Ways and Means Committee, Dr. Sunshine submitted on behalf of the ACR a study stating that the HCCCB/FSU study incorrectly grouped radiation oncologist-owned centers with joint venture-owned centers and that joint ventures had higher utilization and charges. At the hearing, Dr. Mitchell stood by her Florida study, including her finding that radiation therapy was not a "problem area." This testimony clearly

The ACR/Sunshine study was again released in December 1991 by a coalition of radiation oncologists lobbying for Florida self-referral legislation, under the rubric of the "Special Committee for Health Care Reform." This study, while unsigned, rehashed the October 1991 study released to the House Ways and Means Health Subcommittee and conducted only by Dr. Sunshine. In January 1992, the "Special Committee" released basically the same study, this time signed by Drs. Sunshine and Mitchell. Dr. Mitchell has emerged as a kind of unofficial national spokesperson for the ACR and the radiation oncologist lobby.

Aside from the obvious questions raised by Dr. Mitchell's signing on to a study that has already been finished which contradicts her own previous study, and never reconciling the patently obvious opposite conclusions, thereby casting doubt upon its findings, the study itself has egregious and fatal methodological flaws.

Although the HCCCB collected data from most of Florida's radiation therapy providers and that data was available to Drs. Sunshine and Mitchell, they chose not to use that data in their utilization and cost analysis.[6] Instead, they relied on state-by-state comparisons of Medicare data. Nowhere in the study are direct "head-to-head" comparisons of utilization and charges by joint venture-owned, radiation oncologist-owned and hospital-owned facilities in Florida.[7] Instead, the study intimates that Florida's higher utilization and charges result only from Florida's

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does not comport with Dr. Mitchell's negative "findings" concerning radiation therapy in the ACR/Sunshine study.

[6] Drs. Mitchell and Sunshine could have requested their clients, the radiation oncologists, to provide any supplementary data necessary to complete the comparisons. Had they informed the various joint venture radiation therapy providers of their study, they likely would have cooperated.

[7] Interestingly, with respect to "economic access" the Sunshine/Mitchell study analyzed the same raw data submitted to the Florida HCCCB for the joint venture study that it ignored with respect to utilization and charges. The use of the HCCCB's raw data to determine "economic access" raises the obvious question why Drs. Sunshine and Mitchell did not use that same data to make utilization and cost comparisons. One answer may be found in a study rebutting the Sunshine/Mitchell study, which found that based on the raw HCCCB data, joint ventures have lower utilization and charges.

As to economic access, Drs. Sunshine and Mitchell grouped radiation oncologist-owned freestanding centers with hospital-owned centers, which because of government mandates typically have high rates of Medicare, Medicaid and indigent care, to find that "nonjoint venture" facilities better serve poorer patients. Obviously, a fair evaluation would make direct comparisons among hospital-owned, radiation oncologist-owned and joint venture-owned centers.

higher percentage of joint ventures.[8] The rooster crows and the sun rises, therefore, the rooster controls the sun.

Radiation Care requested that Dr. O'Grady of the Center for Consumer Healthcare Information review the Sunshine/Mitchell study and the raw data provided to the Florida HCCCB by Florida's radiation therapy providers. The first O'Grady study, released in January 1992, criticized the logic of the various radiation oncologist-commissioned studies and suggested that further studies use direct comparisons among radiation therapy providers to determine whether joint ventures in fact over-utilize and over-charge.

The second O'Grady study, released in February 1992, analyzed the raw data provided to the Florida HCCCB. Noting the limitations of the raw data, Dr. O'Grady stated that radiation therapy joint ventures had "somewhat lower fees, lower per patient utilization, lower revenues per patient." Dr. O'Grady stated that the differences were not statistically significant and concluded that the HCCCB raw data did not support restrictions on radiation therapy joint ventures. Neither of these studies have been challenged by Drs. Sunshine or Mitchell.

Another study, conducted by Charles River Associates and a professor at the Massachusetts Institute of Technology, comprehensively analyzed radiation therapy joint ventures. The study's authors were asked to determine whether the available evidence is sufficient to support firm conclusions that radiation therapy joint ventures have either positive or negative effects on the cost, quality and availability of radiation therapy services and, if not, to recommend what types of studies are needed to resolve the issue.

Charles River Associates states that the ACR/Sunshine study commits numerous errors in logic and interpretation that make it impossible to conclude that the prevalence of joint-venture radiotherapy facilities leads to greater utilization. The study suggests that focusing on the behavior of medical oncologists and other referring physicians might better determine whether a financial interest in the radiation therapy provider affects their behavior. It also recommends comparing the behavior of radiation oncologists employed on a salary basis by joint ventures with those who own their own facilities and receive both a professional and technical fee on a per patient basis.

PHYSICIAN JOINT VENTURES AND RADIATION THERAPY

The crux of the argument against radiation therapy joint ventures is that (1) medical oncologists and other referring physicians will unnecessarily refer patients to radiation therapy facilities in which they have a financial interest and (2) radiation oncologists employed at those facilities will lack the independence to advise referring physicians when treatment is inappropriate and will always choose the most expensive treatment. A necessary corollary is that radiation oncologists, whose

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[8] In the same vein as the Sunshine/Mitchell radiation therapy study is a highly-publicized January 1992 study by Dr. Dyckman of the Center for Health Care Policy Studies, which was paid for by Health Images, Inc. The Dyckman study purportedly found that diagnostic imaging, physical therapy and clinical laboratory joint ventures increased health care costs in Florida by an estimated $500 million annually. Like the Sunshine/Mitchell study, the Dyckman study did not make any direct cost comparisons between joint ventures and non-joint ventures and inferred from Medicare data that Florida's higher percentage of joint ventures was the reason for Florida's higher health care costs.

financial return for treating a patient at his or her own facility, is many times greater than a co-owning medical oncologist, will act ethically when a medical oncologist will not.

In the context of physician ownership of medical services generally, it is important to distinguish between providers of diagnostic and therapeutic services, or more acutely, between referrals that may because of a physician's financial interest, be subject to abuse, and those that are not. This distinction is important because referring physicians typically have considerably more latitude in ordering diagnostic tests than they do in prescribing therapies such as radiation therapy, surgery, lithotripsy, dialysis and infusion therapy. Most therapies must be medically necessary, and it is not surprising that there is no empirical evidence that financial considerations motivate physicians to prescribe improper treatment of serious illnesses. It is unthinkable that a person would undergo dialysis without end stage renal disease, lithotripsy without a visible kidney stone, surgery without a medically documented basis, infusion without documented proof of cancer, nutritional deficiency or infectious disease, or radiation therapy without a malignancy.[9]

The Florida study's findings of over-utilization with respect to clinical laboratories, diagnostic imaging, and physical therapy generally are not, despite the methodological flaws, inconsistent with this distinction between diagnostic services and "hard" therapies.

Certain factors must be considered when determining whether radiation therapy, in particular, poses a potential for abuse and over-utilization. The process leading to a decision to utilize radiation therapy, surgery or chemotherapy or some combination of the three to treat cancer involves many participants and is subject to many restraints. Because the discretion of each participant is limited by the nature of the disease and treatment, the potential for abuse and over-utilization is virtually negligible.

As discussed above, the "gatekeeper" of radiation therapy is the radiation oncologist who ultimately decides whether radiation therapy is an appropriate treatment and, if so, prescribes the type and amount of therapy and supervises its administration. This is not the "referring" physician who initially sees the patient. Although the radiation oncologist is the gatekeeper, his or her own discretion is generally limited by medical constraints that do not vary because of that physician's financial relationship with the referring physician.

Typically a patient's primary care physician first will evaluate whether the patient has indications of a malignancy from symptoms and preliminary diagnostic tests. While occasionally the primary care physician will perform a biopsy, more often that physician refers the patient to a surgical or medical subspecialist who will perform the biopsy. The biopsy will determine the existence and type of cancer. Further diagnostic tests determine

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[9] As indicated by the Florida study, one exception to this general diagnostic-therapeutic distinction may be physical therapy. While the study states that patients treated at physician-owned physical therapy facilities averaged 43 percent more visits per patient than patients treated at non-physician-owned facilities, the study does not determine the cause of the increased visits to physician-owned facilities nor does it consider whether the increased visits resulted from better quality care. Even assuming evidence of over-utilization and abuse exist with respect to physical therapy, it does not extend to the "hard" therapies (e.g. radiation, ambulatory surgery, lithotripsy, dialysis and infusion). In contrast with the hard therapies, additional physical therapy generally is not harmful to the patient and the patient often requests additional treatment.

whether it is widespread or localized. A team comprised of the patient's primary care physician, medical oncologist, surgical oncologist and radiation oncologist determines whether surgical removal, radiation or chemotherapy, or some combination of these, is most appropriate for the patient. Many factors are considered, including the patient's age and physical condition. Notwithstanding the consultative nature of the determination, the subspecialist who will provide therapy ultimately is responsible for the decision to proceed with that therapy. This consultative process ensures that a patient will not undergo surgery or receive chemotherapy or radiation therapy unless there is a medically documented need for such treatment.

From an economic perspective, the participation of a variety of physicians guards against the overuse of any one kind of treatment. Primary care physicians and surgical oncologists derive the most income from performing surgery; medical oncologists derive the most income from prescribing and overseeing chemotherapy; and radiation oncologists derive the most income from prescribing and overseeing radiation therapy. Of course, these physicians typically work together over the long-term and a physician who always recommends the most personally remunerative treatment soon would be excluded from the consultative process. Moreover, even assuming that remuneration were the determining factor, a primary care physician, surgical oncologist or medical oncologist with a tiny percentage ownership interest in a company owning a radiation therapy facility would never recommend radiation because it would be massively more lucrative to provide personally the surgical service or chemotherapy, respectively.

Assuming radiation therapy is chosen as appropriate, the radiation oncologist designs the plan of treatment. Key factors of the plan are the overall amount of radiation, intensity of each daily treatment and extent of the targeted area. It is important to recognize that the radiation oncologist's discretion here is not unfettered. The radiation oncologist must balance the negative side-effects resulting from radiation's toxicity with the gains in the destruction of the tumor. In finding this balance, the radiation oncologist will rely on medically accepted guidelines for treatment contained in published literature and derived from his own clinical experience. The result is that if 10 different radiation oncologists reviewed the measurements and characteristics of 100 different patients and recommended a treatment plan for each one, the treatment plans for each patient would be remarkably similar, particularly in those cases where the goal is to cure the patient rather than merely relieve pain.

If there is any opportunity for abuse with radiation therapy, it exists with respect to the number of treatment sessions that each patient undergoes. As I have already discussed, the only clear result with respect to radiation therapy in the Florida study (not commented upon by the authors) is that hospital-based radiation oncologists perform 25 percent more procedures than outpatient facility-based radiation oncologists.

Another area of abuse, not explored in either the Florida study or the ACR/Sunshine study, is that a radiation oncologist who owns his or her own center profits in two ways -- from both the professional fee and the technical fee. If anyone has an incentive to manipulate professional and technical fees to maximize income, it is a radiation oncologist who has built an outpatient center. In contrast, a radiation oncologist, on salary, has no such incentive.

I thank you for the opportunity to offer comments to the Subcommittee and appreciate the Subcommittee's commitment to study in-depth the full range of issues involved with respect to physician-owned providers. I will be happy to answer any questions that you may have.

TESTIMONY OF THOMAS L. MILLS

ON BEHALF OF T² MEDICAL, INC.

My name is Thomas Mills. I am a principal in the Washington D.C. law firm of Dyer, Ellis, Joseph & Mills. In the course of my practice I represent various health care providers on a number of health care issues, including the issue that has come to be known as "physician self-referral." Some of these providers own, operate, or manage facilities nationwide and have significant physician involvement. I thank the Chairman and the Subcommittee for the opportunity to speak today and to present the views of T² Medical, Inc. concerning physician ownership.

T² MEDICAL, INC.

I am here today on behalf of T² Medical, Inc., a provider of home infusion therapy. T² has been in operation since 1984 and is the second largest provider of home and outpatient infusion therapy services in the country. The Company owns and manages 245 companies in 37 states. T² is a publicly-held company and its stock is traded on the New York Stock Exchange.

T² is committed to providing its patients with the highest quality of care at the most competitive prices and believes that its presence in the industry has assisted in compelling these results industry-wide. T² physician-stockholders and owners of its managed facilities typically are prominent and respected physicians within their community who also believe in and carry out T²'s commitment. The Company is proud of its physician-driven innovations that have increased the quality of care and quality of life for all of its patients.

INFUSION THERAPY SERVICES

Infusion therapy is simply intravenous treatment, and is administered only for serious illnesses -- chemotherapy for cancer patients, nutritional therapy for patients who have lost or damaged gastrointestinal function, antibiotic therapy for serious infections that do not respond to oral antibiotics, and pain management for terminal diseases. The patient almost always begins intravenous therapy while in the hospital for a documented illness. Home infusion therapy involves, therefore, a site transfer of the patient from the higher cost environment of the hospital to the lower cost environment of the home. Similarly, outpatient infusion therapy centers, specialized infusion clinics with a personalized home-like atmosphere, which T² has pioneered, also are significantly cheaper than the hospital.

Infusion therapy represents one of the few technological advances in recent medicine which have effected a dramatic savings in cost while achieving significant improvements in quality of life.

QUALITY OF CARE

Infusion therapy traditionally was furnished at a local hospital where it was extremely inconvenient (and expensive) for the patient. With rapid technological improvements, it has become possible to provide these therapies at home or in an outpatient clinic.

Home or outpatient infusion therapy has significantly improved the quality of life for patients, who genuinely prefer the comfort

and convenience of care and treatment at home among family and friends. In its clinics, T schedules treatment at the patient's convenience, including evenings and weekends, to facilitate work and children.

A multitude of other quality of care and quality of life concerns also are addressed by treating infusion therapy patients at home. For example, home infusion therapy particularly presents advantages unique to HIV patients. First, they are removed from the hospital setting where there is a high risk of infection. Since these patients do not have to go to the hospital for treatment, patients' confidentiality and privacy concerns are alleviated.

The United States Office of Technology Assessment, in its comprehensive report on home infusion therapy, released in May 1992 and entitled "Home Drug Infusion Therapy Under Medicare," concluded that "legal, financial and professional concerns can impede physician involvement in home care. Physicians cite fear of malpractice, lack of compensation and lack of faith in the quality and supervision of home care personnel as deterrents to referring their patients to home care." After all, physicians remain medically responsible for treatment furnished to their patients regardless of the site of service.

Since so many disincentives deter physicians from discharging patients to be treated at home or an outpatient basis, a physician-owner relationship with the infusion therapy facility, allows physicians to maintain the necessary control over their practice to treat patients at home or as an outpatient confidently. The physician is in a position to make any needed improvements or adjustments and has a voice in the quality of care provided to patients since the physician participates in the provider's management.[1] Indeed, the OTA study cited above emphasized the substantial risks inherent in home infusion therapy and that rigorous quality standards are critical to ensure patient safety. The study then concludes that active physician involvement is key to safe and effective delivery of home infusion therapy services and that the quality of care increases as the physician's participation in a patient's treatment plan increases. Thus, it seems imperative that physicians be permitted to maintain their ownership of infusion therapy facilities to ensure that patients receive the highest quality of care possible.

It has been the Company's experience that physician ownership is the best way to ensure active physician involvement so essential to quality infusion therapy. T's facilities meet or exceed all of the quality standards established by the Joint Commission on Accreditation of Healthcare Organizations and the National Alliance for Infusion Therapy. Each of T's facilities surveyed by JCAHO has been accredited after the first visit. T hires the most highly skilled personnel with extensive training and experience in oncology and intravenous care. It also encourages and rewards its nurses who become certified through professional organizations such as the Intravenous or Oncology Nursing Society. At T facilities, physicians meet regularly to review medical matters, including, among other things, quality assessment and improvements, utilization review, outcome analysis, incident reports and patient surveys. T is very proud of its record on quality of care provided to its more than 4000 patients treated per day. This is reflected by the fact that T consistently receives very high marks in patient satisfaction surveys (averaging over a 98 percent favorable rating,) and regularly receives letters of appreciation from patients and their families. T believes its quality of care is unsurpassed anywhere.

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[1] The physician also makes employment decisions concerning the medical professionals that will assist in providing care to their patients.

Physician ownership also has been instrumental in T's forging the way in providing complex therapies that have never before been furnished to patients at home or on an outpatient basis. For example, T is not aware of any infusion therapy company, other than itself, that administers the new cancer drug, Taxol, on an outpatient basis. Again, since physicians are involved in the management of the provider, they are comfortable with providing Taxol and other complex therapies to patients outside of the hospital setting.

HISTORY OF PHYSICIAN SELF-REFERRAL LEGISLATION

The focus of today's hearing is to examine the physician self-referral issue. This Subcommittee began looking extensively at the physician self-referral issue in 1989 in response to legislation introduced by Chairman Stark. That bill, as introduced, applied to physicians generally and would have banned them from making Medicare-reimbursable referrals to a health care provider in which they had any financial interest. Before its passage, however, many exemptions were carved out of the bill and ultimately, as you know, the legislation prohibited referrals to physician-owned clinical laboratories only.

The legislation, as enacted, required that not later than October 1, 1991, each entity providing Medicare-covered services provide HHS with information about the entity's ownership arrangements, including the Medicare-reimbursable items and services provided by the entity, and the names and identification numbers of all physician-investors in the entity. The reporting providers were to include clinical laboratories, enteral and parenteral suppliers, end stage renal disease facilities, suppliers of ambulance services, hospitals, and providers of physical therapy and diagnostic imaging services. This information has been gathered and after it is analyzed by HHS a report will be released.

Since passage of the physician self-referral legislation in 1989, at least thirty states have considered the issue and will continue such consideration this year. Moreover, similar bills have been introduced and are now under consideration in both Chambers of Congress. Most significantly, Chairman Stark has introduced two bills concerning physician self-referral. H.R. 345, the "Comprehensive Physician Ownership and Referral Act of 1993," proposes to expand current law beyond referrals reimbursable under Medicare to those reimbursed by all payors and to ban physician financial arrangements with providers of certain "designated health services." These include clinical laboratory, physical therapy, radiology -- including magnetic resonance imaging, computerized axial tomography scans, and ultrasound -- home infusion therapy, occupational therapy and inpatient and outpatient hospital services, including services furnished at a psychiatric or rehabilitation hospitals, and the furnishing of durable medical equipment, parenteral and enteral nutrition equipment and supplies and outpatient prescription drugs. The bill has various exemptions, including, among others, in-office providers and group practices, public companies, rural providers and hospitals. H.R. 200, the "Health Care Cost Containment and Reform Act of 1993," focuses upon health care reform and includes the same physician self-referral provisions contained in H.R. 345.

The President has also proposed to prohibit physicians from making referrals for certain services to facilities in which the physician has a financial interest. The proposal, as contained in the President's Economic Recovery Plan, includes such services as physical and occupational therapy, durable medical equipment and enteral and parenteral nutrition equipment and supplies. The Department of Health and Human Services' fact sheet summary of the President's Plan expanded the list to include radiology and radiation therapy services.

Various studies of the physician self-referral issue have been undertaken over the last several years. The earlier studies focused on providers of diagnostic services. These included a study conducted by the U.S. Department of Health and Human Services' Office of Inspector General. It focused upon clinical laboratories, diagnostic imaging centers, and durable medical equipment suppliers. It concluded only that there is possible abuse in connection with physician ownership of clinical laboratories. It found that patients of referring physicians who own clinical laboratories received up to 45% more laboratory services than Medicare patients in general. The OIG admits, however, that there is no evidence to indicate that these services were unnecessary. In fact, these additional services may, at least in part, be the result of increased availability of certain laboratory services.

Additionally, a study of physician ownership by the University of Arizona was published in December 1990 in The New England Journal of Medicine. It compared the frequency and costs of diagnostic imaging between referring physicians who use imaging equipment in their own offices and physicians who refer patients to a radiologist for imaging services. It found that the self-referring physicians obtained imaging examinations 4 to 4 1/2 times more often than the others. Moreover, patients of the self-referring physicians were charged more for imaging services than those of the radiologist-referring physicians.[2]

THE FLORIDA STUDY AND LEGISLATION

The Florida Health Care Cost Containment Board (HCCCB) requested two economists from Florida State University, Drs. Mitchell and Scott, to evaluate the effect of joint ventures on healthcare in Florida. Their study was released in September 1991 and is probably the most comprehensive study of physician joint ventures yet published. It focused on nine types of physician joint ventures and found "clear" evidence of higher utilization in three so-called "problem areas": diagnostic imaging, physical therapy and clinical laboratory joint ventures. The study's results were inconclusive with respect to radiation therapy, ambulatory surgery, home health care and durable medical equipment joint ventures. The study found no evidence of higher utilization with respect to acute care hospital and nursing home joint ventures.

In October 1991, the Florida HCCCB reviewed the Mitchell/Scott study. It recommended restrictions on joint ventures in the three so-called "problem areas" along the lines of the federal Medicare Stark legislation restricting clinical laboratory joint ventures. In its most controversial decision, the HCCCB added radiation therapy as a fourth "problem area" even though the study's results were inconclusive with respect to radiation therapy. In fact, the one clear conclusion on radiation therapy is that non-joint ventures had higher utilization than joint ventures. The HCCCB provided no explanation in its recommendations for its decision to add radiation therapy as a "problem area." The HCCCB had apparently been persuaded by heavy lobbying from Florida radiation oncologists.

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While the Florida study is often cited as proof for the proposition that diagnostic imaging, physical therapy and clinical laboratory joint ventures routinely "overutilize" and "overcharge," even the study's authors, as well as the HCCCB which commissioned the study, have frankly admitted its limitations.[3] Testifying before the U.S. House of Representatives Ways and Means Committee in October 1991, Dr. Mitchell stated "We do not make any claims about inappropriate utilization." In a June 1992 report to the Florida legislature, the HCCCB stated that the study "did not address the issue of 'price' ... the price or charge for the service was often lower in joint venture facilities." The HCCCB added, "It would be an over-simplification to conclude that banning self-referral will correct the over-utilization problem and, therefore, reduce costs."

Following the release of the Florida study, the Florida legislature enacted the nation's most far-reaching joint venture legislation. It banned new and phased out existing joint ventures in the three "problem areas" of diagnostic imaging, physical therapy and clinical laboratories. The legislation banned new radiation therapy joint ventures while grandfathering existing ones. The legislation does not apply to and specifically exempts infusion therapy, ambulatory surgery, lithotripsy and dialysis joint ventures. It also permitted radiologists and radiation oncologists to continue to "self-refer" patients they see at hospitals to centers they own.

Florida legislators did not apply the comprehensive ban to infusion therapy services because after extensive hearings and a widely publicized and thorough examination of the issue they agreed that physician ownership of such facilities does not result in over-utilization or over-pricing. That is, it does not add unnecessary cost to the health care system. Additionally, the Florida legislation acknowledges that a referral does not occur when a physician prescribes infusion therapy services for a patient, reflecting that since the physician is merely treating his or her own patient without the involvement of any other physician, no referral could possibly occur.

PROPOSED BAN ON PHYSICIAN OWNERSHIP OF INFUSION THERAPY FACILITIES

As recognized by the Florida legislation, T believes that infusion therapy services provided to patients by physician-owners of infusion therapy facilities do not constitute "referrals" and, therefore, these services should not be covered under any legislation proposing to ban such ownership. Physician-owners of infusion therapy facilities treat their own patients. They establish the patient's plan of care, continually monitor each patients' progress, modify the plan of care, if necessary, and regularly communicate with the nurses and pharmacists who assist in administering infusion therapy to patients. Physicians remain actively involved in and legally and medically responsible for their patients throughout each stage of care from diagnosis to termination of treatment. Physicians-owners, at no time, refer their patients to any other physician for infusion therapy services.

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[3] In April 1992, after the Florida legislature had approved its joint venture legislation, at the request of the Florida Medical Association, Lewin-ICF released a comprehensive critique of the Florida study. Lewin-ICF stated, among other criticisms, that the utilization, profitability and access data used by Mitchell and Scott were inaccurate and misconstrued. In particular, Lewin-ICF found that the Florida study failed to make any direct, head-to-head utilization and cost comparisons between joint ventures and other providers.

In any event, legislation proposing to ban physician self-referrals generally should include only those services that have been empirically shown to lead to over-utilization or over-pricing. As discussed below, any physician self-referral legislation that includes infusion therapy services goes too far and could produce unintended consequences such as decreased quality of care, reduced competition and increased costs.

OVER-UTILIZATION

In the context of possible over-utilization of health care services, it is important to distinguish between providers of diagnostic and therapeutic services. This is because physicians have considerably more latitude in ordering diagnostic tests than they do in prescribing most therapies. Physicians may, for example, order diagnostic services, such as clinical laboratory tests or MRIs, without harming the patient and thus have no practical medical disincentive to order only those tests that are necessary for the patient. In most cases, of course, ethical considerations provide sufficient disincentive. With the exception of physical therapy, physicians do not, however, have this same discretion with regard to therapeutic services, such as infusion therapy. Physicians cannot prescribe unnecessary therapeutic services without harming the patient. Since, as I have previously mentioned, infusion therapy services are utilized only for serious illnesses -- chemotherapy for cancer patients, antibiotic therapy for serious infections that do not respond to oral antibiotics, and parenteral and enteral nutrition therapy for patients who have lost or damaged gastrointestinal function -- there is little likelihood of over-utilization. It is inconceivable that a physician would, for example, prescribe chemotherapy for a patient who does not have cancer. As a further safeguard against over-utilization, the majority of patients initiate treatment in the hospital and come under the hospital peer review system. Thus, the decision to treat and type of treatment, are generally made at a time when no financial incentive is present. Moreover, all discharges to home care are also pre-certified by the third party payor.

The Florida study's findings of over-utilization with respect to clinical laboratories, diagnostic imaging, and physical therapy, although flawed, are not inconsistent with this distinction between diagnostic services and "hard" therapies (e.g., infusion therapy, lithotripsy, ambulatory surgery and kidney dialysis). No study has ever documented evidence of over-utilization with respect to infusion therapy services.

OVER-PRICING

While physician ownership legislation may, in some instances, result in over-pricing of medical services, it is undeniable that physician ownership of certain health care providers can, and have, resulted in lower health care costs.[4] Care must be taken to assure that curative legislation not result in the carve out of market share for the benefit of those who want to monopolize ownership of certain health care facilities. Indeed, the main proponents of physician ownership legislation are interests who traditionally have owned certain types of medical facilities and who would personally benefit if physicians are prohibited from the ownership of such facilities. If physician-providers are eliminated from a particular service market, only hospitals, exempt physicians and

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[4] Achieving lower health care costs is precisely the reason that the Health Care Financing Administration historically has encouraged physician-ownership and development of ambulatory surgery centers.

large corporate providers ultimately survive. Hospitals, in particular, have generally had an economic incentive in forestalling the growth of home and outpatient care and have often lagged behind in providing the latest in technology until pushed by competition.

Physician ownership of home and outpatient infusion therapy providers allows the physician, who participates in managing the provider and thus has a voice in the quality of care provided to patients, to have confidence in the provider's treatment of the physician's patients. This allows the physician to feel comfortable removing the patient from the more costly hospital setting where the patient would otherwise receive the same therapy the patient can receive at home or in an outpatient facility at a substantially lower cost. This ability and confidence is becoming increasingly more important as more effective treatment for patients, particularly HIV patients, becomes available, thereby enabling patients to live longer with a concomitant increase in the cost of care. In this day of burgeoning health care costs, it is crucial to foster and maintain the ability to provide cost-effective care. Indeed, the New York Times reported that the cost of infusion therapy furnished at home is 30% less than in a hospital.

Moreover, no study has ever shown that physician-owned infusion therapy facilities charge higher prices than non-physician-owned facilities. T² has commissioned two independent pricing studies comparing prices of major competitors in the infusion therapy market. These studies were conducted in September 1991 and more recently in March of this year. These studies show that T² prices are consistently at the bottom of the market. Copies of the both studies are submitted for the record.

T²'s payment record experience with third party payors confirms the reasonableness of its prices in that days of sales outstanding and bad debt experience is the lowest in the industry. For example, a July 1992 report by Cowen and Company of Boston, Massachusetts indicated that its bad debt is 32 percent less and its days of sales outstanding is 23 percent less than the industry average. T² also is a preferred provider with over 75 insurers, HMOs and other payors. In addition, physician ownership provides physicians with greater flexibility in treating those who have difficulty paying their bills. T² has a policy of always continuing service after insurance benefits have been exhausted, which is reassuring to its physicians, particularly its many HIV patients. In fact, to cite just two examples, T² provided over $1,000,000 worth of free care in Atlanta and also in Northern New Jersey in 1992.

T² has advocated that, free market forces, free of unnecessary government intervention, are the most efficient way to lower prices. In fact, that is precisely what has occurred in the infusion therapy market. As the Subcommittee is aware and as numerous press reports have indicated, while the home infusion therapy industry has represented enormous cost savings to the health care system by removing patients from the more costly hospital setting, the industry has been profitable since it began in the mid 1980's. Many providers, therefore, have entered the market, creating extreme competition in the industry. This has driven prices down (while the high quality of care because of physician involvement has remained).

Analysis of the profitability over the last several years of the major providers that offer the full range of infusion therapy services confirms this fact. From 1990 to 1992, the net income of major infusion therapy providers has substantially decreased. Moreover, as recently as last year, all of the major providers of infusion therapy services that reported financial results were profitable. As a direct result of the intense competition and

resulting price compression, none, except T, is profitable as of the last financial reporting period.

These results are further substantiated by T's pricing studies. From September 1991 to March 1993, the average weighted discounted price per patient per day of full service infusion therapy companies dropped by 15 percent.[5] This difference and overall downward shift in pricing is even more significant since infusion therapy companies are now furnishing more complex and costly therapies to sicker patients than ever before.

I thank the Chairman and the Subcommittee again for the opportunity to offer the views of T concerning this important issue and am happy to answer any questions.

[ATTACHMENTS TO THIS STATEMENT ARE BEING RETAINED IN THE COMMITTEE FILES.]

[5] These infusion therapy providers include T Medical, Inc., Caremark International, Inc., Critical Care America, Inc. (now merged into Medical Care America, Inc.), HMSS Management, Inc. and Home Nutritional Services, Inc.

Chairman STARK. Mr. McDermott.

Mr. MCDERMOTT. I guess I really have no questions because I think you have really emphasized what went on on the previous panel. Although I can wonder about setting up something and referring people to your own unit for infusion therapy. There have been times in medical history where things have been thought to be useful that, in fact, later turned out to be not useful, and we often get into these marginal arguments about whether or not the giving of this or that vitamin or this or that treatment is useful.

The problem, I suppose, with infusion therapy is that you have the needle, the implanted needle which makes it less likely somebody is going to go to that much trouble to use some kind of schema to fill their pockets, but I wouldn't say that there is no infusion therapy given—that is a categorical none. That is a little hard for me to accept that there is no infusion therapy given that should not be given.

Mr. MILLS. Understand that the—and you take issue with the absolute answer that I give, and let me say that I am sure that there is some unethical person somewhere who has done an unnecessary surgery, and who probably has done an unnecessary infusion.

I think that, first of all, it is absolutely clear that there is not one empirical study of any kind anywhere, anyplace that shows it. Overwhelmingly, infusion therapy, done either in the home or in ambulatory infusion centers is basically two treatments, for cancer and antibiotic therapy. Overwhelmingly AIDS, and chemotherapy, the natural bars, I think, are even more profound than in radiation therapy, and for AIDS and for other serious infections which respond to antibiotic therapy, again the protocols and the natural medical bars are increasingly important.

Second, and this is an important point that you will particularly appreciate, and that is we are talking about conflicts of interest and things that could infect the physician's therapeutic judgment, something which intervenes.

Let's remember the system in which we operate, and that is that there are already financial incentives on a physician, and the safest thing to do is leave the patient in the hospital where it is somebody else's worry for that part of it, and before a patient is going to be moved to the home and it is unquestionably better for the patient and unquestionably dramatically cheaper for the system, that negative financial disincentive, the disincentive has to be overcome, and it can only be overcome, according to the Federal Government, the Office of Technology Assessment says that physician involvement in infusion therapy is absolutely critical to an effective program.

Indeed, there is a problem that I will mention because the chairman is chairman of Medicare, as it were, and that is that overwhelmingly infusion therapy is not paid for in the home or in an outpatient basis by Medicare because there is not a direct benefit, so the public fisc is already wasting an awful lot of money paying for unnecessary hospitalization, and that is not helpful.

Mr. MCDERMOTT. I guess I just reacted, having once learned that one should never say never, you should say seldom, if ever.

I accept the premise because I can give the anecdote of my own experience in my district of a young man who had AIDS, didn't need to be in a $900-a-day bed in the hospital, but needed some assistance in the community, and the CHAMPUS program would not pay for that, so I got into an argument all the way up to the top of BUMED when I was finally told by somebody up there that, well, we are going to make an exception in this case. And it seemed to me it ought to be the policy to find the least costly way and the most humane way to deliver the care; $900 in a big hospital in Seattle or $128 in assisted living, that seemed to be a pretty clear advantage to the patient and everybody else to put him in the other setting, so I basically don't have any real questions about the therapies, so thank you very much.

Mr. MILLS. Thank you. Just one additional thought, and that is just to add to the problem, not only did the fisc and the public system pay too much, but, of course, the AIDS patient is much better off at home where the risk of opportunistic infection is far less, and indeed as technology improves, and it is improving daily and dramatically, we are happily keeping AIDS patients healthier longer. And as we have learned, and as the Federal Government has learned in dialysis, that is going to involve an increase over the long term of cost of caring because they are going to live longer and live better, that puts all the more importance on the pressure of keeping the cost the most efficient.

Chairman STARK. Tom, I appreciate your testimony. We are familiar with Radiation Care and T^2, and we will take your testimony under advisement. Thank you very much.

Mr. MILLS. Mr. Chairman, thank you very much.

[Whereupon, at 1:30 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

American Association of Clinical Endocrinologists

STATEMENT OF THE
AMERICAN ASSOCIATION OF CLINICAL ENDOCRINOLOGISTS
TO THE
WAYS AND MEANS COMMITTEE
SUBCOMMITTEE ON HEALTH
FOR THE RECORD OF THE APRIL 20, 1993 HEARING

RE: BUDGET ISSUES RELATING TO CLINICAL LABORATORY SERVICES AND PHYSICIAN OWNERSHIP AND REFERRAL

The American Association of Clinical Endocrinologists (AACE) is pleased to provide this statement for the record of the Ways and Means Subcommittee on Health hearing on budget issues relating to clinical laboratory services and physician ownership and referral arrangements. AACE was founded in the Spring of 1991 to create a unified voice for clinical endocrinologists nationwide on issues affecting health care and the practice of endocrinology. We represent the majority of clinical endocrinologists practicing in this country.

Reduction in the Clinical Laboratory Fee Schedule

The proposed cuts in the Medicare laboratory fee schedule are of concern to endocrinologists, many of whom are struggling to keep their office laboratories open at a time when their costs are increasing due to the OSHA law and the requirements of the Clinical Laboratory Improvements Amendments of 1988 (CLIA). We believe that the Clinton Administration and Congress should reassess the impact of those CLIA costs and reductions in clinical lab testing payments on the ability of endocrinologists and other primary care physicians to provide their patients with quality laboratory testing. If it turns out that many physicians are in fact being forced to close their laboratories due to the high costs of complying with CLIA and lower Medicare clinical lab test payments, Congress should consider modifying the administration's proposal to allow for payments that are sufficient to cover the actual costs that physicians incur in providing their Medicare patients with quality clinical laboratory testing.

To allow for Congress to make an informed judgement, AACE recommends that Congress require HHS to study and report annually to Congress on changes in the number of labs operated by physicians and the impact on beneficiary access to those services, including an assessment of the impact of costs of complying with CLIA, OSHA, and reduced laboratory reimbursement on availability of in-office laboratory testing.

Exemption Needed for "Shared" Clinical Office Laboratories Under the Current Self-Referral Ban

The Clinton Administration as well as Chairman Stark also propose to extend the current ban on physician "self-referrals" which apply to outside (i.e., not in-office) clinical laboratories to other facilities such as imaging centers. AACE supports further restrictions on potentially abusive self-referrals. However, there is also still a missing piece in the current self-referral law which needs amendment -- namely that relating to "shared" clinical office laboratories.

An exemption for "shared" clinical office laboratories was contained last year in H.R. 11, which was vetoed by President Bush, and has been re-introduced as part of H.R. 21, by Rep. Dan Rostenkowski (D-IL). It is essential that Congress promptly enact the shared clinical office laboratory provision in H.R. 21 so that physicians who are in these arrangements can continue to deliver the same convenient, cost-effective high-quality clinical laboratory testing services to their Medicare patients. Otherwise more of these patients will have testing at more expensive facilities (hospitals) where the physician has no direct input into the testing or control over the quality of the results.

Shared clinical laboratories are office laboratories that are shared by several physicians (who are not members of a group practice) to provide clinical lab testing for their own respective patients, usually located in space contiguous to their offices. These are common arrangements,

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particularly in endocrinology and other primary care settings, and are often the only way many physicians who are not in group practices can afford to maintain a lab for their patients.

If a shared laboratory exemption is not provided for under current law, physicians will be forced to either form group practices or shut down these shared in-office laboratories. The latter will result in sending Medicare patients to outside facilities -- often delaying treatment because of the lag time in receiving test results; and burdening the patient with additional hassles, lost time and added cost. An individual physician trusts the quality of the results from his or her own in-office or shared clinical laboratory much more so than results from an outside commercial laboratory.

In-office clinical laboratories owned by solo physicians and group practices are exempt from the current ban on physician self-referral. Yet, a conflict of interest is no more inherent in a limited shared clinical laboratory arrangement than in a group or solo practice that provides clinical laboratory services to patients. Shared clinical laboratory arrangements are a convenient and cost-effective way to provide quality patient testing in an office. In this time of rising health care costs, it makes no sense to prohibit this practical and economical way of providing laboratory services to Medicare patients.

Physicians have been waiting for over three years for guidance from the Department HHS or Congress regarding shared clinical laboratory arrangements, and none has been provided. Even now, physicians have no way of knowing whether they must restructure their arrangements or whether they will be required to refund Medicare clinical lab payments received since January 1, 1992, the effective date of the law. As a result, many physicians are being forced to form group practices solely for the purpose of providing patient testing, so as to avoid any potential risk associated with the prohibition. This is a completely unnecessary added cost to provide quality patient care. For many endocrinologists, however, the formation of a group practice for the sole purpose of providing patients with laboratory services is simply not feasible. Therefore, many more have closed--or may soon be forced to close--their laboratories. The uncertainty and frustration experienced by physicians about this issue has been compounded by the Department's decision to require shared facilities to pay for separate CLIA certificates (as well as fees, inspections and proficiency testing) for each physician in a shared arrangement.

Recently, a coalition of physician organizations sent the attached joint letter supporting the shared laboratory exemption in H.R. 21 and urging Congress to resolve the shared laboratory problem at the earliest opportunity this year. This coalition includes our organization -- the American Association of Clinical Endocrinologists -- as well as the American Medical Association, American Academy of Family Physicians, American Society of Internal Medicine, American College of Physicians, American College of Rheumatology, American Society of Hematology, American Society of Clinical Oncology, American Academy of Dermatology, American College of Obstetricians and Gynecologists, and the Joint Council of Allergy and Immunology.

The absence of a shared laboratory exemption to the self-referral ban presents an enormous problem that is already having a negative impact on physicians' ability to provide medically necessary laboratory tests for their patients. AACE urges Congress to enact the shared clinical laboratory provision in H.R. 21, modified to eliminate the grandfather clause that limits the exemption only to those laboratories in existence prior to June 26, 1992.

The American Association of Clinical Endocrinologists (AACE) appreciates this opportunity to present our views.

Attachment

aacelab.test/bjn

Letter sent to Senate Fin. Comm, House Ways and Means, and House Energy and Comm, encouraging the enactment of shared laboratory prov. in HR 21.

April 22, 1993

The Hon. John D. Dingell
2328 Rayburn House Office Building
U.S. House of Representatives
Washington, D.C. 20515

Dear Representative Dingell:

We urge you to seek enactment of the shared clinical laboratory exemption to the Stark prohibition on physician self-referral (Pub. L 101-508), contained in H.R. 21, at the earliest possible opportunity this year. The absence of a shared laboratory exemption to the Stark ban presents an enormous problem that may have a negative impact on physicians' ability to provide medically necessary laboratory tests for their patients. This problem needs to be resolved immediately.

Shared laboratories are office laboratories that are shared by several physicians to provide testing for their own respective patients, usually located in space contiguous to their offices, but which do not otherwise meet the definition of a group practice. These are common business arrangements, particularly in primary care settings, and are often the only way many physicians can afford to deliver in-office testing services. If a shared laboratory exemption is not enacted, a large number of physicians will be forced to shut down their in-office laboratories and to send their Medicare patients to outside facilities--causing the patient added time, effort and expense--to obtain the same services.

Congress passed such a shared laboratory exemption last year as part of H.R. 11. Except for President Bush's veto, this exemption would have been enacted into law. This exemption has been re-introduced as part of H.R. 21, introduced by Rep. Dan Rostenkowski (D-IL). We urge you to seek enactment of the exemption in H.R. 21, modified to eliminate the grandfather clause that limits the exemption only to those laboratories in existence prior to June 26, 1992. Clinical laboratories owned by solo physicians and group practices are exempt from the Stark ban. We firmly believe that a conflict of interest is no more inherent in a shared laboratory arrangement than in a group or solo practice that provides laboratory services to patients. Shared laboratories are a convenient and cost-effective way to provide quality patient testing in an office. In this time of rising health care costs, it makes no sense to prohibit this practical and economical way of providing laboratory services to Medicare patients.

Physicians who participate in laboratory-sharing arrangements have been waiting in limbo for more than a year to find out whether or not they can continue to provide in-office testing services for their patients. Many are being forced to form group practices solely for the purpose of providing patient testing, so as to avoid any potential risk associated with the Stark prohibition. Many more have closed their laboratories. The Clinical Laboratory Improvement Amendments (CLIA) regulations have complicated this issue even more because HCFA is requiring shared facilities to pay for individual CLIA certificates (as well as fees and inspections) for each physician in a shared arrangement. The reason given for this unfair policy is that shared laboratories are prohibited under the *proposed* Stark rule.

HCFA officials indicate that the agency will not release a final rule implementing the Stark law until they receive clarification from Congress regarding the shared laboratory issue. The agency is well aware that the failure of the Stark regulations to protect certain types of shared laboratories is a significant problem--over 50 percent of the comments received on the proposed rule addressed the need for a shared laboratory exemption--but says the matter needs to be corrected legislatively. Since the Department of Health and Human Services (HHS) does not believe that it has the authority to grant a regulatory exemption for shared labs, it essential that Congress promptly enact the shared laboratory provision in H.R. 21. Quick action would ensure that physicians who are in shared laboratory arrangements would be able to continue to deliver the same high-quality clinical laboratory testing services to their Medicare patients that they have in the past.

Thank you for your consideration of our concerns. We look forward to working with the Committee on this issue.

Sincerely,

American Academy of Family Physicians
American Association of Clinical Endocrinologists
American College of Physicians
American College of Rheumatology
American Medical Association
American Society of Hematology
American Society of Internal Medicine
American Society of Clinical Oncology
American Academy of Dermatology
American College of Obstetricians and Gynecologists
The Joint Council of Allergy and Immunology

STATEMENT OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION

The American Physical Therapy Association (APTA) is the national professional membership organization representing over 57,000 physical therapists, physical therapist assistants and students of physical therapy across the country. On behalf of our 52 chapters, our Private Practice Section, our 18 other Sections and our two Assemblies, we appreciate this opportunity to share with the Subcommittee on Health our staunch opposition to those situations in which physicians invest in services and then trade upon their power of referral by directing their patients to these very services in which they have an ownership interest. Creation of an effective remedy to this intolerable and costly situation has long been a priority of the APTA and we are heartened by the fact that several bills are now pending in the House, a bill is pending in the Senate and the President has called for action. We are also tremendously encouraged by the bipartisan interest that has emerged and by the broadened scope of the pending legislation. Early attempts at curbing this abuse were limited to the Medicare and Medicaid programs. Without exception, the bills which are currently pending would apply their remedies to all payor settings both public and private. This is a significant step toward eliminating self-referral situations.

The APTA is opposed to these situations for a number of reasons. First and foremost among these is the fundamental issue involving equity, fair play and patient freedom of choice. There is something intrinsically and undeniably wrong with a system in which the gatekeepers to the services of other providers can position themselves to profit from the very services to which they control access. So far as Medicare and many third party payors are concerned, physical therapy services are only covered pursuant to a physician's referral. Consequently, only if a physician refers a patient to physical therapy is the demand for physical therapy services recognized by our current health care system. Under this system, there is little to dissuade referring physicians from investing in these services to which they control access and, thereby, profiting not simply from their own services but from the services of others as well.

Nor is this simply an academic observation. From a survey of 700 APTA members conducted in late 1992 we learned that it was the experience of 86% of the respondents that referral for profit situations increased during the period 1988-1992. The practices of 81% of the respondents had been adversely affected by referral for profit, and 58% of the respondents had been approached by referral sources with proposals to enter into financial arrangements. Clearly, a considerable number of physicians who refer to physical therapy are interested in profiting from these services to which they control access.

This raises several concerns. First are the implications for patients' ability to be certain that physicians' decisions as to their need for additional services are not simply a function of the referring physician's desire to enhance his or her income.

These situations also compromise the patient's freedom of choice. If a physician has an investment interest in physical therapy services, that physician is far more likely to refer to physical therapy than if there were no such financial incentive to do so. Nowhere is this better documented than in the study done of California's Workers' Compensation program in 1992.

That study conducted by William M. Mercer, Inc. found that, if an injured worker received initial treatment from a provider with an ownership interest in physical therapy services, that patient received a referral to physical therapy 66% of the time. If, on the other hand, the injured worker received initial treatment from a provider with no ownership interest in physical therapy services, the patient was referred to physical therapy only 32% of the time.

In the face of such findings, patients are left with much cause for concern. Was it solely their need for services that led to their referral? Or might a consideration have been the physician's opportunity to profit from these additional services? Were the patients given the freedom to choose their physical therapist? Or were they simply referred to the physical therapy services in which their physician invested? The Mercer study concluded that financial incentives played a major role in these decisions. According to the study, the added incentive for investing physicians to refer to physical therapy generated approximately $233 million per year in services delivered for economic rather than clinical reasons.

Along with these fundamental reasons for eliminating referral for profit from our system, there is the anti-competitive effect that such situations impose on physical therapists. Unless these practitioners are willing to enter into financial arrangements with their referral sources, those sources will simply redirect their referrals to others who do agree to enter into such financial arrangements.

The APTA believes that these fundamental problems are sufficient reasons in and of themselves to end this abuse which Chairman Stark has characterized as a "scourge in the practice of medicine." However, there are additional compelling reasons to eliminate referral for profit. As indicated in another context earlier, the Mercer study in California found that referral for profit is a costly

proposition. This is the conclusion of other studies as well. Investment encourages higher utilization and the cost of care is inflated accordingly.

In 1989, the Florida legislature mandated that State's Health Care Cost Containment Board to examine the impact of joint ventures in health care on the cost of services, quality of services and access to services in Florida. Physical therapy services were surveyed in two settings: free-standing physical therapy facilities and comprehensive rehabilitation centers that provide physical therapy services. The findings were dramatic.

Physician-owned physical therapy facilities provided 43% more visits per patient than did non-joint-venture physical therapy facilities, generating approximately 31% more revenue per patient in joint-venture facilities than in non-joint-venture facilities. At comprehensive rehabilitation facilities, 35% more physical therapy visits were provided per patient in joint-venture facilities, generating approximately 10% more revenue per patient than in non-joint-venture facilities.

Equally important, the Florida study found that quality of care in joint-venture facilities was lower than in non-joint-venture facilities, and that joint-venture facilities did not increase access to services. In fact, the non-joint-venture facilities offered increased access to a wider range of clients. (Higher quality of care and increased access to services are often cited as rationales to defend joint ventures.)

Subsequent to the study conducted in the State of Florida, the Center for Health Policy Studies estimated the impact of physician joint ventures on medical care costs in Florida. This was done for three categories of services: imaging services (MRI and CAT Scan tests), clinical laboratory services and physical therapy services. Estimates for 1991 were developed based on findings from an analysis of Medicare claims data, results from the report by the Florida Health Care Cost Containment Board, "Joint Ventures Among Health Care providers in Florida" and from other sources. The estimated 1991 cost impact of physical joint ventures for these services in Florida are:

•	Imaging Services (MRI tests and CAT Scans) (74% of MRI costs, 16% of CAT Scan Costs)	$322.9 million
•	Clinical Laboratory Tests (16.3% of clinical lab costs)	$167.0 million
•	Physical Therapy Services (2.4% of physical therapy costs)	$10.9 million
	TOTAL	$500.8 million

The cost estimates for clinical laboratory and physical therapy services likely understate the true figures as only additional costs for users of these services were estimated. The incentives for physicians to refer to joint venture facilities likely also resulted in an increase in the number of users, the cost impact of which is not included in the estimates.

Nor is the incentive simply for physicians to refer to outside facilities in which they have an investment interest. In fact, they stand to profit even more directly by expanding their individual or group practices to offer physical therapy or one or more of the various other services to which they control access through their power of referral.

"A Study of Physician Self-Referral" was presented to Virginia's Joint Commission on Health Care on January 12, 1993. The study was presented by Virginia's Deputy Secretary of Health and Human Services. One of the findings was that Blue Cross/Blue Shield claims-paid-data indicate 60% of physical therapy claims dollars were paid to physician provider numbers. That amounted to $8.3 million out of $14 million.

A similar although even more dramatic result is found in Medicare Part B data for 1989. An analysis of Medicare 1989 total allowed frequencies for physical therapy services billed under the CPT-4 coding system reveals that approximately 72% of those services were provided by physician's offices.

This is especially significant in light of the approach taken by all of the anti-self-referral bills pending in Congress at this time. That approach is to clamp down on physician's self-referrals to outside entities in which they invest while leaving untouched their ability to simply continue profiting from referrals to those same services when provided within the structure of their individual or group

practices.

As the data indicate, many physicians have already found this to be a lucrative practice. Many more are likely to reach the same conclusion when their outside investment options are restricted.

While the various proposals which are pending in Congress to restrict referral for profit are welcome steps in the right direction, the American Physical Therapy Association urges that the approach be tightened to eliminate financial interest from the referral process. The fact that referral sources are profiting from their referrals to the services of others is what is objectionable. It makes little difference whether those services are offered in outside facilities or within the referring physician's office.

The APTA recommends that legislation be enacted to ban this practice of physician self referral to services to which they control access either as a matter of law or third party reimbursement policy. As the law is currently written, physicians are encouraged to offer through their employees the very services which other nonphysician practitioners are licensed by the States to provide but for which a physician's referral is required.

Consequently, if physicians are prohibited from investing in these services, such as physical therapy, but encouraged to offer them through their employees, a significant part of the problem will still remain. Those physical therapists who are unwilling to become employees of referring physicians will simply not receive physician referrals and will, therefore, be precluded from providing the services they are licensed to provide.

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April 19, 1993

The Honorable Pete Stark
Chairman
Subcommittee on Health
House Ways and Means Committee
1114 Longworth House Office Building
Washington, D.C. 20510

Dear Chairman Stark:

On behalf of the membership of the American Society for Medical Technology (ASMT) I am writing to express support for H.R. 345, the "Comprehensive Physician Ownership and Referral Act of 1993."

The American Society for Medical Technology (ASMT) is an organization representing more than 20,000 clinical laboratory personnel across the country. The society's primary missions are to improve the public's health and safety through the promotion of efficient and effective use of laboratory testing, effective standards of practice, and provisions of continuing education to improve competency of practitioners in laboratory science.

Physician investment in ancillary health care facilities to which they refer patients continues to demonstrate increasing utilization and costs for our health care system. A 1989 study conducted by the Office of the Inspector General (OIG) from the Department of Health and Human Services (HHS) found that 25 percent of all independent clinical laboratories in the U.S. were owned in whole or in part by referring physicians. Richard P. Kusserow, Inspector General at HHS, testified on April 28, 1989 before both the Subcommittee on Health and the Subcommittee on Oversight of the House Ways and Means Committee, that patients of referring physicians, who owned or invested in clinical laboratories, "...received 45 percent more clinical laboratory services than Medicare patients in general, regardless of where the laboratory services were performed."

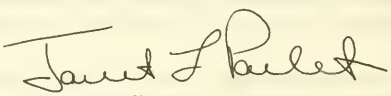
More recently, a 1991 study by the Florida Health Care Cost Containment Board found that nearly 50 percent of Florida's independent clinical laboratories were owned in whole or in part by referring physicians. Clearly, these studies demonstrate a prevailing problem that must be addressed on a national level with a comprehensive ban on self-referral to include not only the Medicare program, but Medicaid, Blue Cross/Blue Shield, commercial insurers, and managed care organizations.

The incentive to refer patients to health service facilities where one has a financial interest is an extreme burden which practicing physicians should not have to carry. H.R. 345 can help take the carrot away from physicians and allow them to focus on offering quality, cost effective medical care to all Americans.

Although the Society is supportive of H.R. 345, ASMT believes that a direct billing component must be included to get to the heart of excessive utilization and costs in the laboratory. The current laboratory reimbursement system contains a structural flaw which has unnecessarily increased costs to the system. Currently, physicians demand and obtain large volume discounts from laboratories performing non-Medicare tests. Since there is no direct billing requirement for non-Medicare services, physicians mark-up these discounted prices by a significant amount when they bill patients and third-party payers. Removing this financial incentive from physicians will reduce utilization and lower overall health care costs.

ASMT stands ready to assist you in passage of such legislation.

Sincerely yours,



Janet L. Pailet,
Director, Government & Education

STATEMENT OF THE AMERICAN SOCIETY OF INTERNAL MEDICINE

The American Society of Internal Medicine (ASIM) appreciates the opportunity to present the following testimony for the record of the Ways and Means Subcommittee on Health regarding the "Comprehensive Physician Ownership and Referral Act of 1993" (H.R. 345). ASIM represents over 25,000 practicing internists in all 50 states, the District of Columbia and Puerto Rico. Our members provide primary and subspecialty care to more Medicare beneficiaries than any other specialty.

H.R. 345 would expand the Medicare ban now applicable to physician self-referral to clinical lab facilities and apply it to all services and payers. ASIM fully endorses the AMA's Council of Ethical and Judicial Affairs most recent opinion on the issue of self-referral that states that in general "physicians should not refer patients to a health care facility outside their office practice, at which they do not directly provide care or services, when they have an investment interest in the facility". Likewise, ASIM would support further restrictions on potentially abusive self-referrals, provided that "shared" office laboratories and certain in-office ancillary services that are an intrinsic part of physicians' practices are exempted.

Exemption for "Shared" Office Labs

We are concerned that while the current Medicare ban provides exemptions for clinical laboratories owned by solo physicians and group practices, it does not provide a similar exemption for in-office laboratories shared by several independent physicians. Such a shared laboratory exemption was contained last year in H.R. 11, which was vetoed by President Bush, and has been re-introduced as part of H.R. 21, introduced by Rep. Dan Rostenkowski (D-IL).

Shared laboratories are office laboratories that are shared by several physicians to provide testing for their own respective patients, usually located in space contiguous to their offices, but which do not otherwise meet the definition of a group practice. This business arrangement is very common. An ASIM survey of its membership from last year showed that 89 percent of respondents participated in some type of shared laboratory. Another ASIM survey of 2000 physicians showed that 95 percent of respondents were in a shared laboratory arrangement. For many of these physicians, shared arrangements are the only way they can afford to maintain a lab for their patients. If shared laboratories are not exempted from the current and any future self-referral bans, a large number of physicians will be forced to shut down their in-office laboratories and to send their patients to outside facilities--costing the patient added time, effort and expense--to obtain the same services.

ASIM firmly believes that a conflict of interest is no more inherent in a limited shared laboratory arrangement than in a group or solo practice that provides laboratory services to patients. Shared clinical laboratory arrangements are a convenient and cost-effective way to provide quality patient testing in an office. In this time of rising health care costs, it makes no sense to prohibit this practical and economical way of providing laboratory services to patients. In the interest of maintaining patient access to convenient, high-quality in-office testing services, Congress should grant shared laboratories the same protection provided to clinical laboratories owned by solo and group practices.

The absence of a shared laboratory exemption to self-referral ban is already having a negative impact on physicians' ability to continue to provide medically necessary laboratory tests for their patients. Physicians have been waiting for over three years for guidance from the HHS or Congress regarding shared facilities, and none has been provided. Even now, physicians have no way of knowing whether they must restructure their arrangements or whether they will be required to refund payments received since January 1, 1992, the effective date of the law. As a result, many physicians are being forced to form group practices solely for the purpose of providing patient testing, so as to avoid any potential risk associated with the Medicare prohibition. For many internists, however, the formation of a group practice for the sole purpose of providing patients with laboratory services is simply not feasible. ASIM has heard from many physicians who have closed--or may soon be forced to close--their office laboratories. This problem has been made worse by the Department's decision to require shared facilities to pay for separate CLIA certificates (as well as fees, inspections and proficiency testing) for each physician in a shared arrangement.

Recently, a coalition of physician organizations sent a joint letter supporting the shared laboratory exemption in H.R. 21 and urging Congress to resolve the shared laboratory problem at the earliest opportunity this year. This coalition includes the American Medical Association, American Academy of Family Physicians, American Society of Internal Medicine, American College of Physicians, American Association of Clinical Endocrinologists, American College of Rheumatology, American Society of Hematology, American Society of Clinical Oncology, American Academy of Dermatology, American College of Obstetricians and Gynecologists, and the Joint Council of Allergy and Immunology.

The shared laboratory problem needs to be resolved immediately. We urge Congress to seek enactment of the exemption in H.R. 21, modified to eliminate the grandfather clause that limits the exemption only to those laboratories in existence prior to June 26, 1992. Quick action is required to make sure that physicians who are in shared laboratory arrangements will be able to continue to deliver the same high-quality clinical laboratory testing services to their patients that they have in the past. We also urge the Subcommittee to amend H.R. 345 to include the exemption for shared lab that is contained in H.R. 21, modified by eliminating the grandfather clause.

Exemptions for In-office Ancillary Services

ASIM is pleased that H.R. 345 would continue most of the current exceptions to the general ban on referrals in the current law for in-office ancillary services. ASIM believes that these ancillary services are integral and critical to the practice of internal medicine. In particular, ASIM believes it is essential that exemptions are maintained for the following services: laboratory, x-ray, EKG, ambulatory surgery centers, renal dialysis facilities, holter monitor studies, flexible fiberoptic sigmoidoscopy, stress tests, sonography, ENDO-thyroid scans, Doppler Vascular studies, oxygen saturation studies, chemotherapy, pulmonary function, and IV infusions.

ASIM is particularly concerned about maintaining the exception for in-office diagnostic radiology. The Society is aware that the American College of Radiology is urging Congress to expand the self-referral ban to x-ray and other radiology services provided by nonradiologists, arguing that this could be a possible source of Medicare savings. ASIM strongly believes that restrictive limitations on in-office diagnostic radiology are not in the best interest of patients. Such a policy would neither save funds nor improve patient care. Instead, it would seriously inconvenience patients, delay diagnosis and treatment, and increase the cost of care. To illustrate, if an elderly patient goes to an internist's office complaining of a cough and fever, the internist will perform a history and physical examination on the patient. The physician may order a chest x-ray if he or she determines one is necessary to diagnose whether the patient has pneumonia. If the physician has the x-ray done in-office, he or she is able to diagnose and treat the patient immediately. However, if the physician is unable to perform in-office diagnostic radiology, the patient would have to go to another office or hospital to have the x-ray taken and return for treatment. Not only does this inconvenience the patient, but the cost of the care received may be higher as a result.

ASIM strongly believes that no one specialty has the exclusive "right" to perform imaging services. These diagnostic procedures are an integral part of patient care in many specialties. In the interest of timely and quality patient care, we believe that all physicians should be allowed to perform in-office diagnostic radiology as long as they have the appropriate training, experience and demonstrated competence. We urge the subcommittee to continue to protect patients' access to convenient and cost-effective in-office radiology procedures when considering H.R. 345.

Finally, ASIM urges the subcommittee to continue to protect physician ownership in and referral to renal dialysis facilities in H.R. 345. There are special circumstances that require that "referrals" to renal dialysis facilities be protected from legislation prohibiting the practice of self-referrals. Unlike most other "referral" facilities, dialysis provides a medically necessary therapeutic service. Because of this, such services are often an extension of the physician's practice. For this reason, ASIM strongly believes that referrals to dialysis centers by a physician, even if the physician has an ownership interest in the center, should not be prohibited.

To recap, ASIM supports the expanded restrictions on potentially abusive self-referrals included in H.R. 345, provided that "shared" office laboratories and the in-office ancillary services outlined above are exempted. ASIM urges the subcommittee to support the enactment of the shared laboratory provision in H.R. 21--modified to eliminate the grandfather clause--and to amend H.R. 345 to include the same exemption. It is essential to exempt shared office laboratory arrangements so physicians who are in these arrangements can continue to provide in-office ancillary services for their patients. Further, ASIM urges the subcommittee to maintain the exemption in H.R. 345 protecting in-office ancillary services, including x-rays, and to oppose any amendment that would broaden the scope of current law to prohibit such services when performed in physicans' office facilities.

Thank you for the opportunity to submit comments on H.R. 345 and physician ownership and referral arrangements. ASIM looks forward to working with Congress on these and other health care issues in the future.

Statement of the College of American Pathologists Before the Subcommittee on Health Committee on Ways and Means, U.S. House of Representatives on Physician Ownership and Referral Arrangements and H.R. 345: "The Comprehensive Physician Ownership and Referral Act of 1993"

The College of American Pathologists appreciates the opportunity to share with the Subcommittee on Health pathologists' perspective on physician ownership and referral arrangements. The College represents more than 13,000 physicians who practice laboratory medicine in community hospitals, academic medical centers, independent medical laboratories, and other settings in which Medicare patients are provided necessary medical services.

The College of American Pathologists supports efforts to limit physician self-referral arrangements. The College believes, however, that prohibitions on physician ownership and referral arrangements must, in order to be equitable and effective, create a level playing field. That is, there should not be exemptions for certain types of services that will produce distortions in the market and adversely affect the quality of those exempt services. Some of the exceptions in current proposals to limit self-referral arrangements are too broad and need to be eliminated or revised.

The current Medicare prohibition on self-referrals went into effect on January 1, 1992, and applies to all clinical laboratory services, including tissue pathology and Pap smears. We are concerned about proposed exemptions to the prohibitions on self-referral in H.R. 345 for interpretation of tissue pathology, Pap smear slides, and the provision of other cytology services. Prohibitions on self-referral should include tissue pathology and cytology services as well, to assure that there is a level playing field in arrangements for these services. The College urges that the current Medicare prohibition on self-referrals for clinical laboratory services, including tissue pathology and Pap smears, be retained and included in proposals to expand self-referral prohibitions to all payers.

In addition, the College firmly believes that a direct billing requirement goes hand-in-hand with prohibitions on self referral. Since 1984 there has been a direct billing requirement for services under the Medicare clinical laboratory fee schedule (clinical diagnostic laboratory testing). Payment can be made only to the entity that provided the service, with an exception for referrals between laboratories that are independent of a physician's office. Physician pathology services subject to the Medicare relative value fee schedule are not subject to this requirement. For those services, an ordering/referring physician can purchase the service from pathologists and bill the Medicare program themselves, although they have not provided the service.

The College urges the Congress to expand the direct billing requirement for Medicare to pathology services subject to the Medicare relative value scale, and in any legislation that expands self referral prohibitions beyond Medicare to include a direct billing requirement for anatomic and clinical laboratory services.

In summary, the College supports limitations on physician self-referral arrangements for all clinical laboratory services including tissue pathology, Pap smears and other cytology services. The College also supports the expansion of the Medicare direct billing requirement for clinical diagnostic laboratory tests to all payers and to all clinical laboratory services, including tissue pathology, Pap smears and other cytology services.

We appreciate the opportunity to present our views and will be pleased to work with the Committee on this issue.

TESTIMONY OF MEDICON
to
THE SUBCOMMITTEE ON HEALTH
HOUSE WAYS AND MEANS COMMITTEE
by
ALAN P. MINTZ, MD

April 20, 1993

As the President and CEO of Medicon, a medical resource management company, I am pleased to offer the following statement in support of H.R. 345, the Comprehensive Physician Ownership and Referral Act of 1993. Because Medicon has been so successful in managing diagnostic imaging services, we wish to share our views as you consider H.R. 345, as well as offer our experience as an example that can be used by the federal government in its efforts to control runaway health care costs while maintaining quality of care.

Medicon has developed proven solutions to the problems of excessive costs and inappropriate utilization in diagnostic imaging. Since 1985 Medicon has successfully implemented these solutions through establishment and administration of diagnostic imaging networks and utilization management services for health care purchasers throughout the country. Our goal is to improve the quality of medicine by eliminating inappropriate diagnostic imaging studies thereby reducing health care costs.

Based in suburban Chicago, Medicon is an innovative team of radiologists, health care administrators, advisors, and support personnel that serves managed care organizations (HMOs, PPOs, IPAs, etc.), insurance companies and hospitals across the country. The diagnostic imaging providers in Medicon's networks serve over 650,000 individuals under capitation.

There is absolutely no question that overutilization of diagnostic imaging procedures is a significant contributor to skyrocketing health care costs. Our experience has shown that typically between 40% and 50% of all imaging studies performed are not appropriate. While we maintain that most physicians are good people who do good work, it is apparent that self-referral has been a contributing factor to those high utilization rates. From a fiscal standpoint as well as a medical one, that kind of wasteful behavior simply must change.

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Medicon supports the approach taken in H.R. 345 and agrees with the American College of Radiology that physicians should not refer to diagnostic imaging facilities in which they have direct or indirect financial interest. Medicon would go one step further, however and take the position that self-referral for diagnostic imaging which occurs in the doctor's own office must come under strict regulation. While self-referral to facilities in which the referring physician has a financial interest has received the most attention recently, more self-referral goes on within a doctor's own office. According to the article in the December 6, 1990 New England Journal of Medicine by Dr. Bruce J. Hillman, et.al., entitled, "Frequency and Costs of Diagnostic Imaging in Office Practice: A Comparison of Self-Referring and Radiologist Referring Physicians," self-referring physicians ordered diagnostic imaging procedures four to four and one-half times more often than physicians who referred patients to radiologists. It has been my observation that not only does the performance of diagnostic imaging procedures in primary care physicians' offices lead to overutilization and higher charges but it is frequently an unsafe practice in which untrained equipment is handled by untrained personnel. I should respectfully suggest that this is an area for future examination and legislative remedy by the subcommittee.

Medicon also maintains that the effort to reduce utilization rates must go beyond bans on self-referral; wasteful ordering practices caused by lack of information about appropriate utilization of diagnostic imaging procedures must be identified and then changed. That is where Medicon is unique and has realized success bringing about behavior modification. Medicon's resource management system is built on a unique data base from which a series of reports are generated. The purpose of that data is to identify patterns of wasteful ordering of tests. Used effectively, Medicon's resource management reports can lead to greater efficiencies in managing costly imaging resources. Through the establishment and management of diagnostic imaging networks, we are able to effectively identify those imaging studies that are wasteful.

Medicon converts the data we collect from the imaging providers into information for the education of the physician, the radiologist, and the payor. Behavior modification occurs through physician-to-physician interaction and by aligning incentives to encourage the practice of total quality medicine.

Medicon tailors its program to the needs of each individual client. At the initiation of service, we achieve immediate and substantial savings, typically between 20% and 30% of previous costs. As overutilization patterns are identified and improved, savings in the range of 10%-50% of volume are achieved, dependent upon the pre-existent utilization rate. Continuous monitoring and education ensures the achievement of maximal savings on an ongoing basis. On a national level, the current rate increases for diagnostic imaging have been at the level of the Radiology/Medical Care Price Index, generally three times higher than the Consumer Price Index. When Medicon's programs are in place, increases do not exceed the CPI.

Mr. Chairman, in conclusion I commend your many efforts over the years to reign in health care costs, especially your focus on radiology services, which are a significant component of rising health care costs. I truly believe that Medicon has accomplished a significant feat and would welcome the opportunity to show you how the Medicon model can be applied to all medical disciplines. Thank you for the opportunity to express my support of H.R. 345 and share with the Congress the Medicon model of medical resource management.

rpa
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Statement of the
Renal Physicians Association
to the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

For the Record of the April 20, 1993 Hearing

Re: Health Care Reform: Physician Ownership and Referral Arrangements and HR 345 -- "The Comprehensive Physician Ownership and Referral Act of 1993"

The Renal Physicians Association (RPA) is pleased to provide a statement to the Ways and Means Subcommittee on Health for the record to the April 20, 1993 on physician ownership and referral arrangements and the Comprehensive Physician Ownership and Referral Act of 1993 (HR 345).

RPA is the professional organization of nephrologists whose goals are to insure optimal care under the highest standards of medical practice for patients with renal disease and related disorders. RPA acts as the national representative for physicians engaged in the study and management of patients with renal disease.

We will focus our statement on the nephrologist ownership of and referral to dialysis facilities.

Extending the Physician Ownership and Referral Ban

HR 345, the Comprehensive Physician Ownership and Referral Act of 1993, introduced by Chairman Stark, as you know, would prohibit physician ownership and referral in both public and private health programs for the following services:

> "(1) clinical laboratory services; (2) physical therapy services; (3) radiology services, including magnetic resonance imaging, computerized axial tomography scans and ultrasound services; (4) radiation therapy services; (5) the furnishing of durable medical equipment; (6) the furnishing of parenteral and enteral nutrition equipment and supplies; (7) the furnishing of outpatient prescription drugs; (8) ambulance services; (9) home infusion therapy services; (10) occupational therapy services; and (11) inpatient and outpatient hospital services."

President Clinton's economic package would similarly extend the current ban on Medicare physician ownership and referral to outside clinical laboratories to other services including: physical and occupational therapy; radiology and other diagnostics; radiation therapy; durable medical equipment, and parenteral/enteral nutrition equipment and supplies.

RPA is fully supportive of efforts to eliminate unethical referral arrangements by physicians. Although the HR 345 and the President's provision in this area does not include renal dialysis facilities, RPA would like to ensure that any bill passed by the Congress in this area specifically exclude nephrologist owned renal dialysis facilities because **dialysis centers are an extension of the nephrologist's medical practice and because there is no potential for abuse**. This is

clearly recognized within the medical community. Unlike most referral facilities, dialysis is a therapeutic and not diagnostic service. Dialysis facilities do not create a potential for abuse because:

1. there is no opportunity to artificially inflate prices as reimbursement is capped under the composite rate within the ESRD program -- it is a set prospective charge per treatment similar to DRGs; and

2. because overutilization is precluded -- nephrologists cannot create unnecessary utilization of services. Outpatient dialysis facilities serve only patients with irreversible kidney failure who must receive regular dialysis to maintain their lives. Dialysis is not an elective procedure for ESRD patients, and its medical necessity cannot be questioned. Most ESRD patients require dialysis three times per week in a facility (subject to hospital stays), and Medicare will rarely cover treatments provided with any greater frequency.

Quality of care is also maintained through the HCFA run ESRD Networks and we are not aware of any problems with regard to patient free choice in pursuing dialysis services at other facilities or other modalities of treatment if medically indicated.

Legislation which would blanketly or selectively ban self referral arrangements by physicians should explicitly exclude renal dialysis facilities. The following legislative language is suggested by the RPA:

> Nonreferrals. The following shall not constitute a referral by a referring physician: a referral by a physician, or by a member of his or her group, to a renal dialysis provider in conjunction with a renal dialysis procedure performed under the supervision of the physician or by a member of his or her group.

We are pleased to note that in previous draft legislation, Chairman Stark specifically included exceptions for dialysis referrals. We hope that current legislation in this area makes this clear as well. The Renal Physicians Association is pleased to submit our views to the committee and looks forward to working with the Congress on this issue.

rpaer/bjn

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