SAS SENATE ANALYSIS SECTION

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Senate Bill 59 (Substitute S-5)
Sponsor: Senator William Sederburg
Committee: Health Policy

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RATIONALE

The Public Health Code authorizes the Department of Licensing and Regulation to investigate and take action against specified types of unprofessional conduct on the part of licensed health care professionals. Section 16221(e)(iii) specifically identifies as unprofessional conduct "directing or requiring an individual to purchase or secure a drug, device, treatment, procedure, or service from another person, place, facility, or business in which the licensee has a financial interest". ("Financial interest" is not defined.) The scope and effect of this provision have been the subject of controversy and challenge since the new code took effect in September 1978. In June 1979, the Attorney General issued an opinion (No. 5498) stating that the referral of patients or specimens to a health business in which the referring physician has an ownership interest ("self-referrals") is unprofessional conduct, whether or not the referral is medically necessary. This interpretation of the provision has been challenged in court. As a result of those challenges, it appears that, at present, doctors in Oakland County are constrained by a circuit court opinion essentially supporting the Attorney General's opinion, while a Genesse County circuit court injunction has prohibited the enforcement of the provision in that county.

Although the provision in question applies to all licensed health professionals with referral authority — including doctors, dentists, optometrists, podiatrists, psychologists, and veterinarians — and, arguably, to a wide range of referrals, attention has centered on the provision's impact on physician-owned clinical laboratories. A description of the conflict between physician-owned labs and independent labs illustrates the divergent positions over application of the provision.

Proponents of the broadest application of the provision view any financial interest on the part of a doctor in a lab to which he or she refers patients as an inherent conflict of interest. They claim that each referral that results in financial gain to the doctor is a form of kickback that encourages unnecessary referrals and against which independent labs cannot compete. Representatives of physician-owned clinics respond that physician ownership itself is not the problem: physicians may have many legitimate reasons in addition to financial gain for investing in a clinical lab, including convenience and the desire to obtain quality service or ensure continuity of services. They argue that a broad interpretation of the provision casts a legal cloud over valid investments and activities by health professionals. For example, they point out that the provision conceivably could prohibit doctors practicing together in a clinic from referring patients internally to one another. What's more, they say, many of the ways in which doctors may be involved financially in health care services, such as physician-owned health maintenance organizations (HMOs), can actually be innovative and cost-cutting. They believe that the focus of the law should be on the problem at which Section 16221(e)(iii) presumably is aimed — overutilization of medical services.

There have been a number of legislative proposals offered in the past eight years to clarify the provision in a way that would provide unambiguous direction to both those responsible for enforcement and the health care providers potentially affected by the provision, though the various parties have not been able to agree on a solution. As a result, the Legislature last year passed Senate Bill 56 (Public Act 319 of 1986) which removed Section 16221(e)(iii) from the law and provided that the provision would be reinstated on April 1, 1987. This in effect placed a moratorium on the issue and provided a period of time in which health professionals could operate without fear of being accused of unprofessional conduct while solutions to the problem were being considered. Some people argue that rather than returning to the current language in the code, once the moratorium expires, and face further legal challenges, a compromise must be reached that will permit patient referrals in certain cases while safeguarding against overutilization of medical services by licensed health professionals for the purpose of making financial gains off of these referrals.

CONTENT

Senate Bill 59 would amend the Public Health Code to do the following:

- **Prohibit overutilization of services and prohibit physicians and other licensed health care professionals from requiring or recommending to a patient or submitting a patient specimen to a health facility in which they had a financial interest except under certain circumstances. (The current prohibition against directing or requiring referrals, which the bill would replace with more specific language, is under a moratorium until April 1, 1987.)**
- **Define "financial interest", "overutilization", and "third party payer".**
- **Permit third party payers to conduct utilization audits of certain health facilities owned and operated by health professionals.**
- **Require third party payers to establish procedures for "managerial-level" conferences that would be held between the third party payers and a health care professional to resolve disputes regarding overutilization of services.**
- **Outline procedures for the Insurance Commissioner to follow in resolving disputes of payments to third party payers for amounts attributable to overutilization.**
- **Provide procedures under which third party payers could withhold payments to a health facility in the**

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event of a dispute or to protect against future overutilization.

- Exempt from provisions of the bill the Department of Social Services and a health care corporation regulated under the Nonprofit Health Care Corporation Reform Act.
- Require health care professionals, who have a financial interest in another health facility or agency, to display a sign in their office disclosing that financial interest according to language specified in the bill.
- Require health care professionals, who recommend patients or submit patient specimens to a facility in which the licensee has a financial interest to recommend at least one other health facility in which the licensee does not have a financial interest.

Department Investigations

The Public Health Code authorizes the Department of Licensing and Regulation to investigate activities related to the practice of a health profession by a licensee, a registrant, or an applicant for licensure or registration. The Department can hold hearings, administer oaths, and order relevant testimony to be taken, and is required to report the findings to "the appropriate board or appropriate task force". The board is required to proceed with imposing sanctions for violations when it finds that any of the grounds listed in the code exist. In addition to the current grounds for investigation, the bill would include:

- Failure to report a financial interest.
- Requiring an individual to purchase or secure a drug, device, treatment, procedure, or service from another person, place, facility, or business in which the licensee had a financial interest. (This would replace the current prohibition against directing or requiring an individual to purchase or secure a drug, device, treatment, procedure, or service from another person, place, facility, or business in which the licensee has a financial interest. The effective date of that prohibition was delayed until April 1, 1987, by Public Act 319 of 1986.)

- Recommending to a patient or submitting a patient specimen to another person, place, facility, or business that was engaged in operating a health facility or agency for the purpose of obtaining a health service or test, if the licensee had a financial interest in the person, place, facility, or business, except as permitted under the bill.

- Overutilization.
- Acquiring a financial interest under an agreement that based the licensee's return on his or her investment on the number or value of patient referrals or patient specimens made by the licensee. A licensee would not be prohibited from receiving a return on the investment based on actual capital contributed or other proportional ownership interest.

Violation of the provisions on patient referral, overutilization or financial return on investment based on referrals could result in a reprimand, fine, probation, restitution, or license suspension, revocation, or limitation.

Under the code, a person or governmental entity that believes a violation has occurred or grounds for disciplinary action exist, may notify the Department in writing. If the appropriate board or its representative, upon reviewing the allegation, determines there is a reasonable basis to believe a ground exists, the Department must investigate. Under the bill, grounds for investigation would include requiring a person to purchase or secure a drug, device, treatment, procedure, or service from another person, place, facility, or business in which the licensee had a financial interest; acquiring a financial interest under an agreement that conditioned the return on the investment on the number of referrals; promoting for personal gain an unnecessary drug or treatment; recommending a patient or submitting a specimen to a facility where the licensee had a financial interest; and overutilization would be.

Permitted Referrals

A licensee could recommend to a patient or submit a patient specimen to another person, place, facility, or business entity, in which the licensee had a financial interest and which operated a health facility or agency for the purpose of obtaining a health service or test if the licensee complied, to the extent of the licensee's actual knowledge and authority, with the following:

- Disclosed the financial interest to all third party payers from which the health facility received reimbursement.

- Allowed all third party payers from which the health facility received reimbursement to perform periodic utilization audits to determine the frequency with which the licensee used the health facility.
- Agreed that the health facility would reimburse the third party payer, in accordance with the bill, if the third party payer had determined, based on a utilization audit or the Insurance Commissioner determined after a hearing held in accordance with the bill's provisions, that the licensee had engaged in overutilization of the health facility's services.

Patient Notification

A licensee who was the holder of a financial interest in a health facility or agency and who recommended to the licensee's patients or submitted patient specimens to a health facility or agency in which the licensee had a financial interest would have to display prominently in his or her office, in a place readily visible to patients, a sign that contained the following language:

Important Information

In connection with the treatment of our patients it may be necessary to recommend a health facility or agency outside of this office or submit patient specimens to a health facility or agency outside of this office. Where appropriate our office uses (insert name of health facility or agency in which licensee has financial interest). This health facility or agency is owned (insert 'wholly' or 'in part') by a member or members of this office.

In addition to this health facility or agency, others are qualified. We are required by law to recommend at least one other health facility or agency which is not owned wholly or in part by a member of members of the office, and which we consider qualified.

The sign would have to be in at least 36-point type in the English language, and could contain only the text authorized in the bill. At the option of the licensee, the sign also could appear in one or more other languages.

Each licensee who recommended to patients, or submitted patient specimens to a health facility or agency in which the licensee had a financial interest, would be required, at the time the recommendation was made or the specimen was taken, to recommend to the patient at least one other health facility or agency in which the licensee did not have a financial interest and which the licensee considered qualified.

A licensee would not be prevented from providing professional advice to his or her patients regarding the selection of a health facility or agency.

Utilization Audits

An individual or group that operated a laboratory as

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permitted in the health code, and an individual licensed to practice medicine, osteopathic medicine and surgery, dentistry, podiatry, or chiropractic who used an x-ray machine for examination of patients in his or her office, would be required to allow third party payers who pay reimbursement for the laboratory or x-ray services to perform periodic utilization audits to determine the frequency that the laboratory or x-ray machine was used. A third party payer from which the individual or group received reimbursement for the laboratory or x-ray services would have to have reasonable cause to believe that the individual or group had engaged in overutilization of the laboratory or x-ray services.

Overutilization of Services

If a third party payer determined by a utilization audit that a licensee who held a financial interest in a health facility had engaged in overutilization of services, the third party payer would be required to notify the licensee and health facility in writing by registered mail, return receipt requested, within 14 days after the determination was made. The notice would have to contain:

- A list of the services rendered by the health facility that were ordered by the licensee which the third party payer claimed constituted overutilization, and the third party payer's claim for a refund of the reimbursement paid for those services.
- A statement that if the licensee or the health facility disputed the overutilization finding, the licensee or health facility would be entitled to a private, informal "managerial-level" conference with the third party payer within 14 days after the notice was received.
- A statement that unless the licensee or health facility demonstrated at the managerial-level conference that the disputed services did not constitute overutilization, the third party payer could pursue a refund of the reimbursement for those services.
- A statement that if the dispute were not resolved at the informal conference, the licensee or health facility would be entitled to a determination by the Insurance Commissioner.

Managerial-Level Conference

Each third party payer would be required to establish "reasonable" internal procedures to provide a licensee or health facility with an informal, managerial-level conference to resolve a dispute regarding a finding of overutilization. The procedures for the informal conference would have to be approved by the Insurance Commissioner.

If a licensee or health facility failed to attend an informal conference, the third party payer could request a hearing, as provided in the bill.

If a third party payer failed to provide an informal conference and proposed resolution within 14 days after the notice was sent, or if the licensee or health facility disagreed with the proposed resolution of the third party payer after the conference, the licensee or health facility would be entitled to a determination of the matter by the Commissioner.

If the licensee or health facility did not request a determination by the Commissioner within 30 days after the date of the informal conference, the third party payer would be entitled to reimbursement of the amount determined by the third party payer to be attributable to overutilization and could request a hearing by the Insurance Commissioner.

Requirements of the Insurance Commissioner

Upon the request of a licensee or health facility, the Insurance Commissioner would be required to do one or more of the following:

- Schedule a hearing that conformed with Chapters 4 and 6 of the Administrative Procedures Act (APA) and hold an informal meeting with the licensee, health facility, or both, and the third party payer in order to reach agreement on holding an amount pending the outcome of the hearing. If both parties agreed on a disposition of the third party payer's claim, the Commissioner would have to cancel the administrative hearing. (Chapters 4 and 6 of the APA provide for contested case hearings and judicial review of contested case determinations, respectively.)
- Accept an assurance of repayment by the licensee, health facility, or both of amounts alleged to have been attributed to overutilization and due the third party payer. If the licensee, health facility, or both gave an assurance of repayment, the Commissioner would be required to cancel the scheduled administrative hearing.
- Hold or institute a hearing. The presiding officer at a hearing would determine if an amount attributable to overutilization were due the third party payer and would include the determination in the proposal for a decision.

The Insurance Commissioner would be required to comply with both of the following:

- The licensee, health facility, and third party payer would have to be notified of the dates of the informal meeting and administrative hearing by registered mail, receipted by the addressee, or by proof of service to the licensee, health facility, and third party payer.
- An informal hearing would have to be concluded no later than 35 calendar days after the date of notification. The administrative hearing would have to be scheduled the 45th calendar day after the notification date. Except as otherwise provided in the bill, the Commissioner would be required to convene the administrative hearing on the 45th day, regardless of a party's cause for delay in concluding the informal meeting within the time limit set in the bill.

A hearing would have to be held on the merits of the claim of the licensee, the health facility, or both, or the third party payer, or on the merits of the claim of all parties.

Withholding Payments

Any time after the hearing began, the third party payer could seek from the Insurance Commissioner a withholding of not more than 25% of present and future payments of billings submitted by the health facility. If granted by the presiding officer, the withholding would be in effect pending the hearing and until a decision was reached. The licensee, health facility, or both would be able to respond to the third party payer's withholding request. The third party payer's showing and the decision of the presiding officer would have to be based on the following criteria:

- A showing based on specific facts that probable cause existed that overutilization of the health facility's services, upon the order of the licensee, had occurred.
- A showing that alleged overutilization amounted to a specific percentage of payments made, as characterized by a statistically valid audit.
- A showing that the funds cited in the overutilization showing were in "significant" jeopardy of not being recovered.

Any finding for withholding by the presiding officer would be in effect until a final decision on the case was reached, unless modified by the presiding officer. If the presiding officer ruled that an amount should be withheld from present and future payments to the health facility, the third party payer would transmit the funds to the Insurance Commissioner for deposit in an interest-bearing account. If the final ruling by the presiding officer determined that an amount was due to the third party payer, and that

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amount was less than the amount withheld, the Commissioner would be required to pay the health facility the difference and proportionate interest of the funds held in escrow. If the final ruling by the presiding officer determined that an amount was not due the third party payer, then the Insurance Commissioner would have to pay the health facility all of the funds held in escrow, including any earned interest.

Hearing Decision

The presiding officer would be required to render a proposal for decision on the merits of the claim not later than 90 days after the hearing began and to advise all parties that exceptions could be filed with the presiding officer no later than 15 days after the date the proposal was mailed.

The Insurance Commissioner would be required to make a final decision no later than 15 days after the closing date for filing exceptions and would not be able to delegate authority to make a final decision in a contested case. The final decision in a contested case could contain an order directing payment of an amount that was found to be attributable to overutilization and due the third party payer.

If a withholding of present and future payment for billings submitted by the health facility had not been allowed, or if a withholding had been allowed but was in an amount insufficient to pay the amount due, the final decision could allow the health facility a period of time that was "reasonable under the circumstances" to pay the third party payer. If the health facility were allowed a reasonable period of time to pay, the order would specify the period of time allowed and an interest rate equal to the current rate being earned by the State Treasurer to be paid by the health facility. If the health facility failed to "timely comply" with the order, the third party payer could petition a court of competent jurisdiction to enforce the order. Failure to appeal the final order within 30 days after receipt of a copy of the order would foreclose the health facility from collateral attack against the order or any underlying determination.

Within 10 days after the Commissioner made a final decision that included an order directing payment for overutilization and due the third party payer, the Commissioner would be required to prepare and "immediately forward" to the Department, a report that gave the name of the licensee and health facility to which the order applied and other information the Department considered necessary.

Withholding Future Payments

If a decision in favor of a third party payer had been made, the third party payer in order to protect against future overutilization could seek an additional order from the Insurance Commissioner allowing the third party payer to withhold from future payments to the health facility, for not more than 18 months, a percentage determined to be a statistically valid ratio of the following:

- Payments by the third party for overutilization of health services or tests ordered by licensees who were holders of financial interests in the health facility.
- All payments made by the third party to the health facility during the period covered by the utilization audit that led to the determination of overutilization.

The Insurance Commissioner could not issue an order for withholding future payments if the health facility either:

- Could demonstrate to the satisfaction of the Commissioner that the health facility had adopted and implemented policies and procedures designed to prevent overutilization.
- Posted a bond with the Commissioner with sureties approved by the Commissioner in an amount equal to the amount determined to be attributable to overutilization and due the third party payer. The bond would insure the Insurance Commissioner for the benefit of the third party payer, would be in force for not less than 18 months, and would be on condition that the health facility not bill the third party payer for health services attributable to overutilization.

At any time beginning 12 months but not later than 18 months after an order issued under the preceding circumstances, the third party payer would have to conduct a follow-up utilization audit for the health facility.

Definitions

Under the bill, "financial interest" would mean a direct or indirect ownership or beneficial interest in a health facility which was held by an individual, or if the individual had actual knowledge of such ownership, by the individual's spouse, parent, sibling, or child. An ownership or beneficial interest in a health facility or agency would be indirect if it were in an entity or trust that had an ownership or beneficial interest in a health facility of agency. Financial interest would not include any of the following:

- The ownership of securities issued by a publicly-held corporation, the shares of which were traded on a national exchange or the over-the-counter market.
- A licensee's ownership of his or her own practice, or a licensee's employment within a practice, whether the licensee were a sole practitioner or part of a group, when a health care service, drug, device, treatment, or procedure was prescribed or otherwise provided solely for the licensee's own patients and was provided or performed by the licensee or by an individual who was employed by or under contract to the licensee under the licensee's supervision.
- An interest in real property resulting in a landlord-tenant relationship between a licensee and the health facility from which the licensee ordered a service or procedure, unless the rent were determined, in whole or in part, by the business volume or profitability of the tenant, or were otherwise unrelated to fair market value of the real property.
- An interest, if it were a licensee's sole financial interest in a hospital, resulting from the licensee's employment or other contractual relationship, or professional affiliation with a hospital, if the service or procedure were provided or to be provided in the hospital or other licensed health facility or agency in which the hospital had not less than a 25% ownership interest. Hospital would mean a single hospital, or group of hospitals, or a corporation owned by a single hospital or group of hospitals.
- An interest in a health maintenance organization, an organization that had entered into a prudent purchaser agreement, or other health facility or agency that delivered health services that were medically indicated to enrollees under the terms of a contract, directly or through contracts with affiliated providers, in exchange for a fixed prepaid sum or per capita prepayment, without regard to the frequency, extent, or kind of health services. "Health maintenance organization" and "prudent purchaser agreement" would be defined with reference to the definitions in the health code and the Prudent Purchaser Act, respectively.
- An interest in an independent practice association, which would mean a partnership, corporation, association, or other legal entity comprised of licensees that entered into a service agreement with a health maintenance organization, and organization that had entered into a prudent purchaser agreement, or another health facility or agency which delivered health services, as previously described in the bill.

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A service agreement would provide, at a minimum, for both of the following:

- That the licensees would provide their professional services in accordance with a compensation agreement established by the partnership, corporation, association, or other legal entity.
- To the extent feasible, for the sharing by the licensees of medical and other records, equipment, and professional, technical, and administrative staff.

"Overutilization" would mean the rendering, ordering, or prescribing of health services by a licensee, which services were unrelated to medical necessity as determined by the applicable professional standard of care. This would apply to licensees who were authorized under the code to render and order, or to render and prescribe, health services independently.

Third party payer would mean an insurer that was regulated under the Insurance Code; a dental care corporation regulated under Public Act 125 of 1963, which deals with nonprofit dental care corporations; and the sponsor of a medical, surgical, dental, vision, or health care benefit plan. This provision would not include a health care corporation, regulated under the Nonprofit Health Care Corporation Reform Act (Blue Cross and Blue Shield), and the Department of Social Services, as administrator of the program for medical assistance under the Social Welfare Act.

MCL 333.16104, et al.

BACKGROUND

The Division of Laboratory Improvement within the Bureau of Labs in the Department of Public Health conducted a study in March 1985 of the number of privately-owned, nonhospital labs in the State. The study showed a total of 173 labs in the State made up of the following:

- Labs owned by physicians (not pathologists): 45 for 26% of the total.
- Labs owned by physicians (pathologists): 19 for 11% of the total.
- Laymen-owned, nonphysician owned labs: 52 for 30% of the total.
- Mixed ownership of physicians and laymen in limited partnerships: 28 for 16% of the total.
- Other, such as health maintenance organizations, university-owned labs, and public stock ownership listed on the national stock exchange: 29 for 17% of the total.

In addition, there are 44 group-practice-owned labs not included in the 1985 figures. This involves six or more physicians who set up a lab solely for their own patients.

FISCAL IMPACT

The bill would result in an indeterminate increase in administrative and enforcement costs for the Insurance Bureau. The magnitude of the cost increase would depend on the number of overutilization cases brought before the Commissioner of Insurance.

ARGUMENTS

Supporting Argument

The health care industry has been subjected to intense competitive pressures recently. In response, hospitals, doctors, and various health care professionals have responded with cooperative joint ventures (in which a patient may be referred from one health care provider to another, or from an emergency room to a specialist, a clinical lab, or an outpatient surgical center) that they may partially own or in which they may have a financial interest. The evolution of developments surrounding the vague language in Section 16221(e)(iii), however, has led to uncertainty as to whether health professionals are engaging in unprofessional conduct by referring patients to health facilities in which they have a financial interest. While there are those who claim that there is an inherent conflict of interest in a health care professional's referring patients to a facility that he or she may have an interest in, entirely prohibiting such activity is unfair regulation and casts a cloud of illegality over what actually may be a legitimate investment on the part of health practitioners.

Supporting Argument

The bill focuses more specifically on the problem that the original language in the health code proposed to address — that of overutilization of medical services. The bill would define and prohibit overutilization by making it unprofessional conduct whether or not there were an ownership interest, and would provide potential penalties in the form of license impairment, fines, and restitution. The bill also would provide for controls designed to discourage overutilization of medical services by requiring that health care entities that have health care providers as owners inform third party payers of the financial interest; allowing third party payers to conduct utilization audits; and imposing special reimbursement methods on providers who overutilize. Further, the bill would require physicians who bill for ancillary services performed in their offices to allow third party payers to conduct utilization audits of those services.

Response: The solution to controlling overutilization by physicians with ownership interests who self-refer requires more than empowering third party payers specifically to audit those physicians and recover funds. Such authority has been available for a number of years yet the problem persists. Legislation should be targeted at the issue of ownership rather than its effects.

Supporting Argument

Since the passage of the health code in 1978, there reportedly are some areas of the State where the practicing physicians have built the only clinical laboratories in the area. A strict enforcement of the health code could leave these rural areas without the service of a clinical laboratory. The best interest of the public is not served by prohibiting physicians in these areas from utilizing the clinical labs that they have built.

Response: There reportedly are a number of major labs in the State that offer a pick and delivery service for physicians' offices. Thus, if physicians — including those in rural areas — were restricted from referring tests to their own labs, they could make use of such delivery services and patients living in the rural parts of the State would not be limited in their access to total medical care.

Supporting Argument

The absolute restriction on referrals to a facility in which the licensee has any financial interest is contrary to the established and evolving professional practice arrangements. The bill is a moderate approach that would accommodate current practice settings while retaining some protection against overutilization. The bill would establish a balance between the interest of protecting against overutilization and the interest of accommodating the real world of health care practice settings.

Supporting Argument

The major third party payers in the State are Medicaid, Medicare, and Blue Cross/Blue Shield, which account for 75% of the health care insurance dollar. The Department of Social Services is the agency responsible to the Federal

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government for administration of the Medicaid program, which includes determination of overbilling due to overutilization, misutilization, and/or abuse of medical services and the litigation of disputed claims. Blue Cross/ Blue Shield also has statutory authority through Public Act 350 of 1980 to conduct overutilization audits and recover money. As fiscal intermediary in Michigan for the Medicaid program, Blue Cross/Blue Shield also is responsible for protecting that program and pursuing overutilization through Federal regulations. By defining third party payer and exempting the Social Services Department and Blue Cross/Blue Shield, the bill would resolve a potential statutory conflict while establishing a legal base and process to conduct and lititgate overutilization audits for other third party payers in the State that now are without such legal bases.

Opposing Argument

The bill would not resolve the inherent conflict between the patient's medical interests and the physician's financial interests. If a physician knows that the more patients or patient specimens referred to a health facility in which that physician has a financial interest, the greater the profits for the lab and consequently the physician, there is a natural tendency to order such tests, regardless of the necessity or benefit to the patient. While the current law admittedly needs some refinement to clear up ambiguities and to accommodate certain group practices, such as health maintenance organizations, any revision should embrace the philosophy that physicians should not own their own labs.

Opposing Argument

In 1984, Blue Cross and Blue Shield of Michigan reviewed claims from the third quarter of 1983 for all independent labs in the State. Of those 148 labs, 40 were selected as a sample: 20 were known to have physicians (other than pathologists) involved in the ownership and 20 were known not to have physicians (other than pathologists) involved in the ownership. These 40 labs represented approximately two-thirds of the total payout and services of the 148 labs in the state. The average payment per patient in the physician-owned lab group was $8.26 (22.59%) higher than the average for all labs and $19.34 (43.15%) higher than the average for the nonphysician-owned labs. The average number of services per patient in the physician-owned lab group was 1.08 (20.97%) higher than the average for all labs and 2.47 (39.65%) higher than the average for the nonphysician-owned labs. The data suggest that the overall utilization in a physician-owned laboratory was significantly higher (40%) than that found in nonphysician-owned labs. Clearly, overutilization of medical services occurs and must be controlled.

Opposing Argument

Permitting doctors to have ownership in clinical labs is anti-comptetitive. It is naive to believe that physicians who are partners in a lab have an "arm's length involvement" in the business. Rather, some people contend that these physicians are entreprenuers who solicit other doctors to participate in the partnership as equity owners to avoid the appearance of these labs' providing illegal kickbacks. Further, it has been claimed, that only doctors who can provide a market of referrals are asked to join these partnerships. Independent, nonphysician-owned labs cannot compete in this climate. Even if such independent labs can provide fast, low-cost service to doctors, they cannot offer the financial benefits that physicians receive from their own labs. While some argue that doctors have a "right" to make investments, doctors don't have a "right" to invest in a business where only doctors are solicited to participate and other investors (who aren't physicians) are restricted.

Opposing Argument

The problem with allowing physicians to make self-referrals to labs in which they have a financial interest is that overutilization of medical services occurs. Yet, to deal only with overutilization does not get at the root of the problem: ownership. The major third party payers in the State have activities to deal with overutilization and they have achieved some success. Nevertheless, overutilization still occurs. The only real answer is to have control over ownership interests. As a whole, ownership ought to be prohibited.

Opposing Argument

The bill would require that health care professionals who have a financial interest in another health facility or agency to display a sign in their office to disclose the financial interest. Health professionals who recommend patients or submit patient specimens to a facility in which the licensee has a financial interest would be required to recommend at least one other health facility in which the licensee does not have a financial interest. The physician-patient relationship, however, is built on trust: most patients don't question their physician about the type of lab test that has been ordered or who will conduct the test as long as that test will help the doctor diagnose the ailment. Even if a physician discloses his or her financial interest or recommends another lab, most patients won't risk questioning the physician's judgment and risk instilling an element of skepticism in their relationship. Consequently, the bill's requirements to disclose financial interest or recommend another facility would have little effect since patients, in reality, won't want to jeopardize their relationship with their doctor.

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This analysis was prepared by nonpartisan Senate staff for use by the Senate in its deliberations and does not constitute an official statement of legislative intent.