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Reaction to Clark on Regulation

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REACTION TO CLARK ON REGULATION

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It is useful to restate Professor Clark's theme in two parts. Clark posits that society as a whole, and the legal system in particular, does not know how to respond to matters regarding physicians — that the legal system gives undue deference to the medical profession. Clark suggests that because of this deference, health care regulation fails. He then makes some suggestions for changing the way society treats the medical profession.

This essay, while considerably shorter, has three sections. In the first section, I support Clark's position regarding legal deference to the medical profession by reference to the regulatory experience that Maryland's hospital rate setting commission has had with physicians. The second section evaluates Clark's conclusion and posits an alternative reason why health care regulation fails. The third section makes some suggestions which, hopefully, follow from the first two sections.

I. COURT EXPERIENCES REGARDING "PHYSICIAN REGULATION"

Maryland's hospital rate setting agency, the Health Services Cost Review Commission (HSCRC) was created in 1971 and began reviewing rates in 1974. The first rates were set in February, 1975. Since then, there have been some 375 separate rate cases docketed before the Commission and hundreds of non-contested inflation adjustment orders issued by the Commission. During that time only four Commission rate orders have been subjected to judicial hearings. One of those cases, *Harford Memorial Hospital v. Health Services Cost Review Commission*,[1] related not to the total cost or total revenue approved by the Commission (the rate level), but to the Commission's determinations regarding how that revenue should be charged (the rate structure). This case is relevant to the subject of this paper only in demonstrating that the hospital did not challenge the Commission's findings regarding the most reasonable level for the hospital's aggregate rates or aggregate costs.

Thus, only three rate orders have produced judicial decisions regarding cases in which the hospital has challenged the Commission's

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1. 44 Md. App. 489, 410 A.2d 22 (1980).

findings as to the appropriate level of aggregate cost and aggregate revenue. All three of those cases involved physician expenditures and the associated rates. Moreover, while hospitals' annual filings with the Commission have reported that physician expenditures comprise only about six percent of all hospital costs in Maryland, these were the sole expenditures at issue in all three cases.

The first case involved Baltimore County General Hospital, an approximately 200 bed hospital in a Baltimore suburb.[2] The case was one of four initiated by the Commission on July 1, 1974 when its review authority became effective. Earlier in 1974, the Board of Medical Examiners[3] ruled that preceptors, foreign trained, unlicensed physicians, could not be employed as house staff by Maryland's hospitals. Baltimore County General Hospital, therefore, negotiated new coverage contracts with licensed physicians at an increased cost of about $500,000. The Commission held a hearing to determine the appropriateness of that increase.

Prior to the hearing, the Commission's staff had found three expert witnesses who were willing to testify. These witnesses included: a Maryland Department of Health and Mental Hygiene physician who was going to testify that Blue Shield already paid for the services to be provided by the hospital — and, thus, that Blue Cross would be paying twice for the same services; a nationally recognized expert on nursing service and nursing education who was going to testify that nurse practitioners were available and could perform the services called for in the physician contracts for much less money; and, the head of the manpower section of the State's Comprehensive Health Planning Agency who was going to testify that the physicians involved were needed much more in parts of the community having no physicians than in Baltimore County General where hospital rules already required each patient to have a private attending physician. In each case, the would-be witness had been instructed by his/her boss not to testify.

The Commission's staff was left with no expert witnesses other than the Commission's rate analyst. The hospital brought forward several physicians. The examination of these witnesses clearly demonstrated that the hospital did not know how much work was to be

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2. Baltimore County Gen. Hosp. v. Health Servs. Cost Review Comm'n, No. 5655 (Md. Cir. Ct., Balto. County, Oct. 8, 1975).

3. The Maryland Legislature created the Board of Medical Examiners and granted it monopoly power to act in those areas for which it was given statutory responsibility. *See* MD. ANN. CODE art. 43, §§ 120-21 (1980). Professor Clark also discussed grants of power to boards such as these. *See* Clark, *Why Does Health Care Regulation Fail?* 41 MD. L. REV. 1 (1981).

performed under the contract. The Commission found that the staff's recommended amount (approximately the old amount plus inflation) was appropriate. The court, however, found for the hospital, stating that the Commission's staff did not prove its case.[4] Perhaps the most interesting aspect of this case is that after the circuit court ruled and before the Commission determined whether to appeal, the hospital's board voted to renegotiate its physician contracts and to accept essentially the staff's recommendation. The Commission's staff had proven its case to the hospital board even though it had not convinced the court.

The second case regarding physician incomes involved Holy Cross Hospital — an approximately 300 bed hospital in the Maryland suburbs of Washington, D.C.[5] At the time this review began in 1976, the contracts between the hospital and its radiologists and pathologists called for the hospital to perform all billing. The patient's bills would show one consolidated amount for physician and hospital services. The separately negotiated "physician component" appeared in the hospital's books of account and audited financial records as a cost and as an expenditure. The contracts called for the hospital to provide the physicians with eighty-five percent of the gross billings for their services. The hospital kept the remaining fifteen percent for billing expenses, bad debts, etc.[6]

The Commission's staff presented testimony reflecting the cost per relative value unit for the "professional component" in a large number of Maryland hospitals. The hospital argued that its other costs were low because of the excellent work of its radiologists and pathologists. The radiologists also claimed the Commission had no jurisdiction because the contract had been changed so that they now billed directly. The circuit court found that the Commission had jurisdiction; however, the court remanded the case to the Commission to consider the incomes of physicians in all of metropolitan Washington, D.C. The reader is asked to ponder whether any judge would tell a Public Service Commission that, in deciding what rate to approve for a state or community's pay phones, it should consider how much was charged in an unregulated neighboring state or community. Presumably, if unregulated rates were thought to be reasonable, regulation would not have

4. Baltimore County Gen. Hosp. v. Health Servs. Cost Review Comm'n, No. 5655, slip op. at 6-7 (dictum) (Md. Cir. Ct., Balto. County, Oct. 8, 1975).

5. Holy Cross Hosp., Inc. v. Health Servs. Cost Review Comm'n, No. 46598 (Md. Cir. Ct., Montgomery County, Dec. 7, 1977).

6. This hospital, in one of the country's most wealthy communities, has a three to four percent bad debt experience, but much of that is generated by the emergency room.

been enacted. The Commission never heard the case on remand because the Court of Appeals eventually held that the Commission has no jurisidiction to review physician contracts unless the physicians are salaried hospital employees.[7] As the dissent in *Health Services Cost Review Commission v. Holy Cross Hospital, Inc.*[8] pointed out, this Act has a broad remedial purpose and should be liberally construed; however, the majority used a rigid and formalistic approach to impose a narrow construction that completely subverts the purpose of regulation.[9] Because the physician can make certain that his contract with the hospital does not characterize him as a salaried employee, he can effectively avoid any regulation.

The third case involved a request from Dorchester General Hospital to increase its anesthesia rate so that it could hire a second anesthesiologist.[10] About 50,000 minutes of anesthesia are administered per year at the hospital. At all but two or three Maryland hospitals, anesthesiologists bill on a fee-for-service basis. The Commission's staff showed that the cost per minute requested was far beyond the amount approved, and realized, at these other hospitals. Further, the staff showed that the amount of work was not sufficient to justify even one full-time anesthesiologist and that the hospital also had two nurse anesthetists. The hospital claimed that it was rural, that rural people are entitled to anesthesiologists' services and that one anesthesiologist would not work there and be on call without a second anesthesiologist.

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7. Health Servs. Cost Review Comm'n v. Holy Cross Hosp., Inc., No. 43 (Md. Apr. 23, 1981). Radiologists and pathologists have three principal means of contracting with hospitals. The least prevalent method is a standard employee relationship. The most prevalent method for pathologists is an agency relationship whereby the physicians are identified as independent contractors and the hospital pays according to a piece of work or according to a percentage arrangement. At the time the Commission's enabling act was passed, this agency relationship was also most prevalent for radiologists. All pathologists, and over 80% of radiology revenue, were governed by one of these two arrangements at the time the Commission was established. The third type, which has not become quantitatively significant for pathologists, but which has achieved almost 50% status for radiology, is a fee-for-service arrangement. At the time *Holy Cross* began, the Commission exercised jurisdiction over type one and type two, but not type three. During the case, the radiologists shifted from type two to type three. The circuit court originally held that the Commission regulates all three. After several years, two appearances before the Court of Appeals, an evidentiary proceeding before the circuit court, and various errors by the Clerk of the Court of Appeals, the final decision was that the Commission only has jurisdiction when the physician is a salaried employee of the hospital (type one). The Court of Appeals found that the Commission never had jurisdiction at Holy Cross Hospital despite the facts stated above regarding the situation at the time of the Commission's hearing.

8. No. 43 (Md. Apr. 23, 1981).

9. *Id.*, slip op. at 9-10 (Davidson, J., dissenting).

10. Dorchester Gen. Hosp. v. Health Servs. Cost Review Comm'n, No. 4348 (Md. Cir. Ct., Dorchester County, Dec 11, 1980).

Further, the hospital showed that it took over $100,000 to entice an anesthesiologist to live in the rural Eastern Shore of Maryland. The Commission determined a reasonable rate for the professional service based upon the costs and charges at the other hospitals. More was approved to allow for one full-time anesthesiologist. The court accepted the hospital's argument in toto. The Commission was directed to issue an order including over $200,000 for two anesthesiologists even though the fee-for-service market would not have supported even one.

The courts have implied in all the above cases, but especially in *Holy Cross*, that physicians can choose when they want to be subject to Commission jurisdiction. They can opt out whenever they can get more in the market place and opt in whenever the market place will not provide them what they can get out of the hospital's board. Indeed, a contract entered into the record in a current administrative hearing before the Commission states that the physician can terminate the contract if he does not accept the Commission's decision.

The Commission has concluded, as has Clark, that regulation of physician incomes simply does not work. On July 1, 1981 the Commission's Chairman issued a statement that says in part:

> The Commission has had a great deal of experience in attempting to regulate physician services. All of them have proven unsuccessful. That is not to say that all of the rates we have approved for physician services are unreasonable. Several are reasonable, but they are reasonable entirely because of the leadership of the hospital board at the particular hospital which secured the cooperation or acquiescence of the physicians involved. The Commission has found that any attempt to exercise its authority without board leadership has failed. But regulation which only works when it ratifies others [*sic*] decisions is a wasteful exercise. We have been uniformly denied the ability to apply our judgment of reasonableness. The recent Holy Cross III decision makes it even clearer that we can not possibly successfully regulate physician costs in the public interest. Any time the Commission approves a physician's ability to earn income at a level below that set in the market place, the physician is totally free to avoid that decision. At the same time, physicians — or hospitals on their behalf — can come to the Commission seeking to get more income than is available in the market place — a market place very heavily weighted toward high physician incomes already. The decision in the Commission's recent Dorchester case shows how physicians are likely to be successful in such attempts.
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> Holy Cross III only spoke to radiologists, pathologists and cardiologists. It did not directly address other physician costs or services. The Commission, however, has consistently stated its be-

> lief that the relationship of hospitals to radiologists and pathologists is much closer than the relationship of hospitals to other physicians. Indeed, in most other specialties we would not even suggest that the hospital, as opposed to the physicians, are offering the services or that the costs are hospital and not physician costs. We, therefore, believe it is inappropriate to deregulate physician services in radiology, pathlogy and cardiology without deregulating all physician patient services. We have repeatedly identified Medical Staff administration as a cost of hospital administrative service and residents and interns as a cost of a hospital educational service. We do not believe Holy Cross III calls for deregulation of these costs which we continue to believe are hospital costs.
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> The Commission has concluded that if it continues to futilely spend its scarce resources in this area, it will not be able to respond successfully to the Medicaid challenge. While the Commission can not assure the public that charges are reasonable, we urge insurers to not simply pay these uncontrolled charges, but to act so as to assure that they are paying reasonable amounts on their subscribers [*sic*] behalf. We call upon the Insurance Commissioner to insist upon such behavior and the Attorney General's office to attack monopolistic practices.[11]

Clark's contention that we do not know how to limit physician's market power through the legal system is correct. But why doesn't the market itself sufficiently limit their ability to increase the amount of resources devoted to health care?

II. THE UNDERLYING PROBLEM IN THE HEALTH CARE INDUSTRY

The peculiar role of physicians is not the underlying problem in the health care industry; the basic problem is a market structure that masks opportunity cost. Society's deference to physicians certainly is important. Clark notes that society does not know how to relate to any professional group. Yet being a Ph.D. in economics does not assure one affluence; being a Ph.D. in history does not even assure comfort. Most lawyers do not make what any physician can make. But the underlying problem goes beyond professionalism. In the health care market, individuals can act as if they do not forego anything else when they consume more hospital or physician services. By socializing the payment for care, as opposed to the provision of care, the health care providers meet relatively little opposition from the insured, tax-supported payor. Because physicians are paid separately from hospitals, they

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11. Statement by David P. Scheffenacker, Chairman of Health Services Cost Review Commission, 3-5 (July 1, 1981).

earn no less money — but earn more or earn it more easily — by making hospitals more costly. The Baltimore County General Hospital case exemplifies this phenomenon. Thus, regulation of hospitals can neither stop consumers from demanding what they do not pay for as individuals nor can it stop physicians from practicing medicine in ways which make separately funded hospitals more costly.

III. SOME SUGGESTIONS

The reader might be surprised that someone who is "a regulator" is not supportive of regulation as a long run solution. I believe we have probably caused net harm to society by licensing physicians. Physicians are lobbying very strongly against the removal of "freedom-of-choice" from Medicaid programs. But "freedom-of-choice" is the freedom to choose any physician or hospital. Why not extend freedom-of-choice beyond physicians? If we continue to give physicians monopoly power, must we give it to them free? Why not at least require them to provide care for the patients for whom the state has assumed fiscal responsibility? Instead we give physicians monopoly power and extract nothing in return. The state must still obtain medical care for those it supports, often from physicians who are unwilling to participate in Medicaid programs. In our present system, physicians have the right to treat only those willing to pay their fees; but, if this is to be the case, we should revoke their monopoly power and allow non-physicians to provide medical care.

We should change the structure of physician fees so that physicians earn more by not hospitalizing patients, and by relying more upon professional judgment and time rather than performing ever more procedures.[12] We should also move toward systems that make physicians financially responsible for the decisions they make in their role as the major resource managers in hospitals.[13]

Perhaps the most complete solution would be to make consumers, or their elected representatives, choose between health expenditures and other expenditures as if the opportunity costs were real. We might attain this goal by changing the tax laws to create a competitive market

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12. *See* M. Blumberg, Physician Fees as Incentives, presented at Twenty-First Annual Symposium on Hospital Affairs, *Changing the Behavior of the Physician; A Management Perspective*, Chicago, Ill. (June 1-2, 1979). Mr. Blumberg suggests that buyers and providers should negotiate prices for medical services. This would assist in equalizing rates charged by internists, whose office fees are too low, and surgeons, whose operating fees are too high when compared with their fees for important non-surgical care.

13. *See* M. Redisch, Hospital Inflationary Mechanisms, presented at Western Economic Association Meetings, Las Vegas, Nev. (June 10-12, 1974).

and by using block grants in which medical needs would have to compete with non-medical needs. These suggestions may be seen as very threatening to our current system in which we seem to fund most perceived "wants" in medical care, although we do not fund them in any other sector.[14] Who knows, the poor may rather have decent living conditions while they are healthy and do with a little less when they are sick (and perhaps they would be sick less often). Maybe the middle class would rather have smaller classes in their children's schools than have all private rooms in their hospitals. Maybe the wealthy would support more modern heavy industry rather than more modern (tax free) hospital plants.

It would be interesting to find out what decisions Americans would make if our tax and licensing laws did not come between them and their own personal judgment. Courts would not have opportunities to second guess our individual (as opposed to our bureaucratic) decisions involving personal balancing of benefits and costs. Therefore, we would not be overly burdened by the deference the courts give physicians.

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14. *See* Lewis, *California May Deregulate Physicians*, Am. Med. News, July 10, 1981, at 1, col. 3; *Mr. Gephardt's Bill*, Am. Med. News, Apr. 24, 1981, at 4, col. 1.