Financial Pressures Spur Physician Entrepreneurialism

Monetary pressures are motivating physicians to change their practice behavior in ways that could negatively affect some patients' access to basic care.

by Hoangmai H. Pham, Kelly J. Devers, Jessica H. May, and Robert Berenson

ABSTRACT: Using data from Round Four of the Community Tracking Study (CTS) site visits, we describe how recent revenue and cost pressures have led physicians to aggressively increase prices and service volume and provide fewer traditional services that are less lucrative. As a result, physicians' business practices are contributing to rising service use and hindering cost containment, which could impair access to critical services for certain populations. In response, policymakers may need to revisit regulation of physicians' conflicts of interest and consider how their financial incentives could be realigned. But the diversity of physicians' behavior requires that policy responses take account of differences between specialists and primary care physicians.

PHYSICIANS AND MEDICAL GROUPS have long sought revenue beyond that gained from providing traditional professional services.[1] For decades they have participated in pharmaceutical trials and invested in specialty care facilities as established means of generating extra income. But these activities have intensified as a result of recent financial pressures on physicians' practices.

During the period of managed care's greatest influence over cost control, and as other professional and technical workers' incomes rose, physicians' average income declined. Adjusted for cost of living and inflation, real-dollar income for physicians in clinical practice fell nationally by approximately 5 percent from 1995 to 1999, increasing only slightly in 2000.[2] Across the twelve markets we report on in this paper, the trend was similar, with stable or declining physician income in eleven markets from 1995 to 1999.[3]

Several factors contributed to declining physician incomes, primarily reimbursement pressures resulting from growth in managed care. Although not yet reflected in new income data, recent cuts in public program payments likely added

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more revenue pressure, with Medicare's 2002 rate reduction and Medicaid fees stagnating or falling because of states' fiscal crises.[4] At the same time, practice costs, including increases in liability insurance and labor costs, rose for physicians.[5] Anecdotes abound about specific responses by physicians, such as charging fees or concierge care.[6] But few data are available on the relative prominence of these activities, which physicians engage in them, the degree and causes of geographic variation, and how they affect the delivery of care.

Physicians' behavior has implications for efforts to control health care costs and for access to high-quality care. In this paper we use findings from Community Tracking Study (CTS) site-visit data to explore (1) how financial pressures have intensified physicians' entrepreneurial activity; (2) the range and relative prevalence of physicians' activities to increase the volume and prices of services; (3) how strategies varied across geographic areas and types of physicians; (4) how they contrasted with the relative lack of efforts to improve practice efficiency or quality; (5) physicians' strategies to limit the provision of less lucrative services; and (6) plans' and hospitals' responses. We cite examples of how different strategies have contributed to increased service use or hindered access.

Study Methods

Since 1996 the CTS has conducted four rounds of site visits involving more than 2,600 interviews in twelve U.S. metropolitan areas.[7] We focus on 270 Round Four interviews conducted between September 2002 and May 2003 with the three to four largest hospitals, health plans, and multi- and single-specialty physician groups in each market. We interviewed medical directors and medical staff presidents, chief executive and operating officers, executives responsible for contracting and physician networks, and medical association leaders. We also drew on interviews with seventy-five state legislators, safety-net providers, and health care advocates, particularly for information on physicians' caring for low-income populations.

We asked open-ended questions about what people perceived to be the major pressures physicians in their market faced in clinical practice and the strategies employed in response. We then probed specifically about physicians' participation in public programs, contracting relationships between physicians and plans, and physicians' quality improvement efforts. We chose this set of respondents as those likely to be in the best position to report on physicians' behavior in their market and how that behavior was affecting care elsewhere in the delivery system.

To further corroborate our findings from cross-sector interview data and to explore causes of market variation, we drew on complementary data on physicians' incomes, percentage of practice revenues derived from capitation, and Medicare participation from CTS Physician Surveys in the same twelve markets collected in 1997, 1999, and 2001; on metropolitan statistical area (MSA) physician supply in 1999 from the Area Resource File; and on 1999 MSA managed care penetration from InterStudy surveys.

Study Findings

The financial pressures physicians faced in clinical practice in site-visit markets mirrored well-documented national trends and motivated changes in physicians' practice decisions. Physician and nonphysician respondents in all of the markets reported heightened entrepreneurial activities among physicians and medical groups, to increase practice revenue. A common theme across markets was that harsh business realities had left physicians feeling financially beleaguered, forcing them to become more business-oriented.

■ **Volume and types of services on the rise.** *Investments in ancillary services spread and diversify.* Despite earlier periods of increases in physician services, such as in the mid-1980s and early 1990s, respondents perceived that physicians' health care–related investments had recently accelerated.[8] Few quantitative data are available on the prevalence of such investments, but respondents noted that physicians in their markets began intensifying efforts to generate extra revenue several years ago. Based on hospital, plan, and medical group interviews, these investments appeared to grow in scope and prevalence within and across markets.[9]

Investment in ancillary services (such as imaging or laboratory testing) was mentioned by the most respondents as a major strategy among physicians in their market (Exhibit 1). In all markets, primary care physicians (PCPs) and specialists in single- and multispecialty groups and, less commonly, physicians in solo practice invested in equipment to provide ancillary services within existing practice space. Some physicians invested in freestanding ancillary facilities.

Physicians focused on a broadening array of diagnostic services, but respondents also cited screening tests such as bone densitometry, lithotripsy, and physical therapy. Some of these services had previously been too expensive for physicians to invest in but were now attractive because of new clinical applications covered by insurance (such as for bone densitometry). Others (such as positron emission tomography, or PET, scanners) required more capital that made outside partnerships necessary.

Usually individual physicians and medical groups preferred sole ownership of these facilities, to maximize autonomy and revenue. But they occasionally turned to local hospitals or for-profit companies for joint ventures requiring large capital investments or more managerial expertise. Respondents perceived that investments in ancillary services proved largely successful for physicians and medical groups, despite the large capital outlay sometimes required. Medical-group respondents claimed that they usually generated profits and operated at or near capacity and in some cases were critical to medical groups' financial standing. Although we could not obtain corroborating financial performance data, one multispecialty group practice executive captured the sentiment of many group respondents, stating that the group would "not be making money if it weren't for ancillaries." Another noted that ancillary revenue subsidized poorly reimbursed PCPs in the group, which would have to consider dropping primary care services

EXHIBIT 1
Practice Strategies Of Physicians In The Twelve Community Tracking Study (CTS) Communities, Round Four, 2002–03

	Number of markets where cited as practice strategy (N = 12)	Total respondents citing (N = 270)	Number of group or physician respondents citing (N = 90)
Strategies to increase volume of services			
Ancillary services	12	84	51
Specialty facilities[a]	11	106	37
Pharmaceutical/clinical trials	10	29	21
Increasing patient volume	10	29	18
Uncovered services[b]	9	27	13
Retailing products/supplements	6	8	7
Concierge care	4	16	6
Additional fees[c]	4	5	1
Strategies to increase prices			
Dropping/threatening to drop contracts	11	94	40
Refusing risk contracting	8	20	12
Group consolidation	7	57	25
Opting out of networks	4	11	4
Strategies to improve efficiency[d]	10	43	22
Organized quality improvement processes	7	17	12
		(N = 345)[e]	
Strategies to limit risk and low margins			
Not serving new Medicare patients	10	40	18
Not serving new Medicaid/low-income patients	10	76	26
Not taking, or demanding payment for, emergency department consultations and admissions	9	21	10
Decrease inpatient care	6	16	8
Avoid high-risk surgical procedures[f]	6	12	9

SOURCE: CTS site-visit data, 2002–03.

[a] Ambulatory surgery centers (ASCs); specialty hospitals; or cardiovascular, endoscopy, or rehabilitation centers.

[b] For example, cosmetic surgery, botox treatments, acupuncture, massage therapy.

[c] Fees/surcharges for filling out school forms, extended office hours, telephone calls, payments for hospital committee work.

[d] For example, consolidating practice sites, using physician extenders, eliminating visit wait periods with open-access scheduling, using productivity-based compensation.

[e] Total number is larger because an additional set of respondents was asked about physician participation in public insurance programs and charity care but not about other practice strategies.

[f] For example, obstetrics and some neurosurgery procedures.

without the extra revenue.

In a number of markets, plans contended and medical groups acknowledged that use of ancillary services had risen, although plans did not cite disaggregated data to differentiate whether the facility generating increased use was owned by physicians. In one representative example, a New Jersey medical director believed that "lab testing [was] off the wall," with physician-owned ambulatory diagnostic centers "creeping up out of nowhere" and accounting for one study per two plan members each year. National secondary data document similar trends.[10]

Specialty facilities continue to grow. Physicians' investment in freestanding specialty hospitals and ambulatory surgical centers (ASCs) continued to grow in CTS mar-

kets, as their numbers rose around the country.[11] Interest in specialty facilities had broadened to include endoscopy, cardiac care, rehabilitation, and chemotherapy infusion centers. Unlike ancillary services, however, investment in specialty facilities was concentrated among physicians in a few specialties (cardiology, orthopedics, gastroenterology), and, although present in most CTS markets, the facilities were much more prominent in some than others.[12] Physicians investing in specialty facilities had to contend not only with plans' occasional reluctance to contract but also with hospitals offering competing services. Also, unlike ancillary services, respondents did not report that specialty facilities had clearly demonstrated profitable performance, in part because it takes longer to generate returns on the larger capital investments.

Physicians market services directly to the consumer. Physicians also sought to increase the volume of services where prices were not constrained by insurers' fee schedules, by providing uncovered services, including concierge care, cosmetic surgeries, botox treatments, and complementary therapies such as acupuncture; medical products retailed in physicians' offices, from eyeglasses to orthopedic equipment, nutritional supplements, and pharmaceuticals; and previously uncompensated services, including surcharges for extended office hours, telephone calls, or filling out school forms.

Although we found no quantitative prevalence data on these strategies, respondents mentioned them far less often than investment in ancillary services and specialty facilities (Exhibit 1). Also, their impact on cost was obscured because patients paid for them out of pocket, leaving them less visible to plans and purchasers. Their effects on care delivery were similarly difficult to discern, although they were less well accepted within physician communities.[13] Several physician and nonphysician respondents expressed unease with the ethical implications of some new services, particularly therapies of questionable clinical value.

■ **Attempts to raise payment rates.** Physicians appeared to use a combination of strategies to increase prices for their services by altering contracting relationships with plans. Respondents described physicians' attempts to negotiate higher rates and increasing willingness to threaten dropping, or actually drop, plan contracts over specific issues, including payment rates and preauthorization requirements for ancillary services. Physicians in four CTS markets (northern New Jersey, Indianapolis, Greenville, and Seattle) were opting to leave plan networks altogether to receive higher charges outside the network.

Physicians also sought to change payment arrangements. With notable exceptions in Miami and Orange County, physicians limited risk contracting if it still existed at all in their market, whether in commercial or Medicare+Choice (M+C) insurance products. Respondents from different sectors reported that they often met little resistance from plans, who were also exiting M+C or realizing that physicians were unwilling to accept capitation, or both.

Although few plans reported major network disruptions as a result of these

strategies, respondents in many markets believed that physicians were confident of adequate patient volume even without participation in every plan.[14] Perceived physician shortages in some markets (such as Phoenix) increased physicians' leverage and helped guarantee sufficient volume.

■ **Distinct revenue advantages for specialists.** Responses across plans, medical groups, and hospitals suggested that specialists enjoyed clear advantages over PCPs. Higher income and continued consolidation of single-specialty groups, but not primary care or multispecialty groups, gave specialists greater access to investment capital.[15] Specialists had greater access to appropriate patients for pharmaceutical trials and for ancillary service referrals such as cardiac diagnostic testing.

Specialists also benefited from favorable relationships with hospitals and health plans. Hospitals' renewed strategic interest in specialty medicine favored joint ventures with specialists in specialty facilities.[16] And in plan negotiations, specialists had greater leverage because of their relative scarcity and plans' increasing reliance on products allowing patients to have direct access to specialty care. Specialists could thus be more confident of adequate patient volume should they opt out of a particular plan network than in the past.

Although we interviewed only a small number of primary care groups, respondents in different sectors concurred that PCPs could not implement many of these strategies as effectively as specialists could. We repeatedly heard that as a consequence PCPs were "left out in the cold," as one hospital respondent commented.

■ **Opportunities and strategies vary geographically.** Physicians' choice of strategies to increase the volume and price of services and their degree of success varied greatly across markets. Income pressures and market factors affecting physicians' leverage relative to that of plans and hospitals appeared most important in explaining the variation. In markets with the steepest declines in physician income from 1995 to 1999 (Indianapolis, Syracuse, and Phoenix)—the period immediately preceding new investments in ancillary services and specialty facilities detected in Round Three site visits—physicians were particularly active in such investments.[17] Markets where physicians had the greatest leverage relative to plans because of a previous history of single-specialty group consolidation (Indianapolis) or relative physician shortages (Phoenix) also saw more intense entrepreneurial activity than did markets with diffuse physician market structures (Miami) or relative physician oversupply (Boston). And where physicians were closely affiliated with particular hospital systems, as in Cleveland, few medical groups had the independence to seek income outside of traditional clinical care.

Other market factors affecting physicians' choice of strategies included certificate-of-need (CON) laws limiting new specialty hospitals and ASCs (for example, lack of CON requirements in Indianapolis, Phoenix, and Little Rock enabled specialty facility formation) and the prominence of capitation, which presented disincentives to providing additional, costly services (such as in Orange County).[18]

■ **Little physician competition on efficiency or quality.** In the face of dimin-

ishing incomes, physicians could respond by increasing revenue or otherwise attempt to gain market share by competing on price or quality. But physicians tried to raise prices and considered investing in organized quality improvement processes to be of lower priority than increasing service volume.

A few respondents reported on medical groups' efforts to improve efficiency by consolidating practice sites, using physician "extenders" (such as nurse practitioners), or instituting open-access scheduling (queuing patients on a walk-in basis without appointments) to minimize waiting times. Even fewer respondents mentioned efforts to improve clinical quality. Few were using patient satisfaction surveys, implementing quality improvement projects, or establishing quality performance incentives. A few groups were investing in electronic medical records to improve efficiency, quality, and accounting and to help meet regulatory requirements (such as those of the Health Insurance Portability and Accountability Act, or HIPAA). Many physicians cited the lack of financial incentives from plans or purchasers as a deterrent to groups' committing sizable resources to quality improvement, and they perceived little consumer pressure to compete on quality.

■ **Traditional obligations falling by the wayside?** Interview responses suggested that although they were focused on generating and protecting revenue, physicians withdrew from less profitable traditional services or those associated with higher perceived malpractice risk.

Leaving public programs—more talk than action. Despite disgruntlement with Medicare's 2002 fee reduction and threatened additional cuts, and in contrast to their assertive engagement with private payers, physicians took tentative steps to change their public payer mix. In most markets, CTS Physician Survey data show only slight decreases in Medicare participation between 1997 and 2001.[19] Respondents believed that subtler access barriers such as long waits for appointments for Medicare patients were more common than outright refusals.

Respondents across markets reported that PCPs were better positioned than specialists to limit Medicare participation. Medical and surgical specialists treating chronically ill populations, such as oncology and orthopedic surgery, derive up to 60 percent of practice revenues from Medicare. Reliant on consultations to generate most patient volume, specialists also cannot selectively refuse referrals, because PCPs might avoid referring to specialists who they expect will turn patients away. Medicaid participation, although lower than Medicare participation, appeared similarly stable according to respondents and in survey data.

Physicians avoid low-income patients and liability risk. Physicians reduced other less lucrative or higher-risk services. Most commonly, physicians in site-visit markets refused to take call in emergency departments (ED) or demanded extra pay from hospitals for doing so. Some physicians refused new patients admitted through EDs. In Miami, Seattle, Cleveland, and New Jersey this was partly a response to malpractice insurance costs because of increased risk of lawsuits associated with ED care.[20] In most affected markets, though, physicians wanted to avoid uninsured

or low-income patients evaluated in EDs. Low reimbursement for caring for such patients compounded malpractice concerns because of physicians' belief that they are more litigious, despite evidence to the contrary.[21] One theme heard in several markets was summarized by a Seattle hospital executive, who said that staff surgeons resented having to cancel scheduled operations or office visits to care for uninsured ED patients who they expected to be sicker and not follow up with recommended care, then turn around and sue them.

Similarly, some PCPs in a majority of markets avoided inpatient care when possible because they could bill for more office visits than in equivalent time spent on inpatient care. Some respondents believed that PCPs also hoped to avoid liability risk in hospitals, given consumers' increased awareness of patient safety issues. They used hospitalists where possible or refused new patients admitted through EDs, or both. Less commonly, specialists in markets with escalating malpractice coverage costs refused to perform obstetrical, neurosurgical, or other high-risk procedures. In these markets both specialists and PCPs avoided acute office care, by sending patients with acute problems to the ED.[22] In combination, physicians' decisions to withdraw these traditional services contributed to hospital ED crowding in the majority of site-visit markets.[23]

■ **Responses to physicians' behavior.** Interview data suggest that health plans, hospitals, and purchasers did little to check physicians' entrepreneurial activity. In some markets, plans attempted to exclude ancillary services from physician contracts because of anticipated utilization increases. But for the most part, plans were not pursuing aggressive cost control. Physicians generally were able to negotiate contracts. Only a few plans (for example, in Seattle) were contemplating profiling physicians or group practices on referral volumes for ancillary services.

Indeed, physicians encountered little resistance to increasing ancillary services. If purchasers were aware of rising ancillary service volume as an important component of rising costs, they did not check it by pressuring plans for more selective contracting. And there were few local regulatory barriers. CON laws applied to limited ancillary services or could be skirted by using old or leased equipment to remain below CON capital thresholds. We return to this point later.

In most site-visit markets where physician investment in specialty facilities was growing, local hospitals did not hinder it. Despite competitive start-ups by some, hospitals largely conceded that physicians had advantages in niche specialty services. Some hospitals also worried that too competitive a response could alienate critical specialty groups on their staffs. In these cases, hospitals tried to retain a portion of potential revenue from specialty facilities through joint ventures with physicians in an "if you can't beat 'em, join 'em" approach.[24]

Hospitals also were largely reactive to physicians' withdrawal from acute care, ED care, and care of low-income populations. Pressured by nursing staff shortages and ED overcrowding, hospitals in some affected markets accommodated physicians who shirked these traditional obligations instead of confronting them.

Discussion

Despite cross-market differences, there were several general trends in physicians' responses to pressures in clinical practice. They favored increasing volume of services over competing on efficiency or quality, attempted to increase prices for services, and retreated from less lucrative services.

■ **Payment, insurer, and regulatory policies create favorable climate.** In selecting strategies, physicians seized opportunities created by a confluence of existing payment and regulatory policies as well as health insurance market trends.

Physicians responded to financial incentives created by coverage and payment policies. Respondents in some markets believed that both commercial and Medicare payments continue to favor procedure-based services over evaluation and management services, despite Medicare's attempt to redistribute payments using the resource-based relative value scale (RBRVS). Several medical group respondents cited new Medicare coverage for colon cancer screening in 1998 as motivation for creating endoscopy centers. And Medicare paid higher facility fees to ASCs than hospital outpatient departments for eight of the ten most frequently performed procedures in 2001.[25]

At the same time physicians began exploring these opportunities, in the late 1990s, health plans loosened cost control—retreating from capitation and aggressive utilization management and eliminating gatekeeping requirements in favor of direct patient access to specialists. In combination, these trends compounded the effect of physicians' practice strategies on service volume and prices.

Established regulations against physicians' financial conflicts of interest had become less meaningful. When initially proposed in the early 1990s, exemptions to federal self-referral and antikickback laws seemed reasonable compromises that respected the sanctity of physicians' autonomy in their practices.[26] They gave physicians latitude in investment options but only when those investments would not have undue influence on care delivery. For example, a cardiologist could refer patients for cardiac care at a general hospital where he or she had an ownership stake but would be unlikely to generate a large enough referral volume to greatly affect return on his or her investment. Similarly, before the advent of expensive imaging techniques or widespread use of diagnostic procedures such as colonoscopy, self-referral for ancillary services would likely have been limited to laboratory testing or other low-cost services.

By the turn of the millennium, however, these self-referral and "safe harbor" exemptions were not effective in restraining physicians' financial interests from influencing care. Advances in medical technology and practice transformed the self-referral exemptions into potentially lucrative opportunities for physicians. Broadened clinical applications of modalities such as magnetic resonance imaging (MRI) increased potential patient volume and made investment in such equipment feasible for physician practices. While specialty hospitals in the past were limited largely to eye or psychiatric care, advances in medical practice now gave

physicians an arsenal of services to provide in new types of specialty facilities to larger patient populations. And as financial pressures mounted, physicians' investment in specialty facilities grew, to capture facility fees for services.

Physicians' strategies threaten to raise costs for public and private payers through increased use. Respondents across site-visit markets noted signs that supplier-induced demand was returning. Even the potential offset of outpatient specialty facilities generating net efficiencies compared with inpatient facilities at general hospitals remains debatable.[27] Also, to the extent that they increase prices, physicians' contracting strategies also drive up costs for purchasers and patients.

Some physician strategies threaten access to care, particularly for patients seeking less profitable services or services with high malpractice risk. Although limited availability of specialized surgeries would affect few patients, limited outpatient acute care and physician call coverage for EDs have ripple effects throughout care delivery systems that endanger timely care for larger populations. Uninsured and low-income patients face even greater access hurdles.

Physicians' practice strategies have uncertain effects on quality. Increases in use of ancillary services may be inappropriate or may reflect advances in medical knowledge and correction for previous underuse. In-office ancillary services may be more convenient for patients. Conversely, some new services marketed directly to consumers are of questionable clinical value. And specialty facilities' potential to improve care as "focused factories" requires more evidence for evaluation.

■ **Implications.** Traditionally, physicians have acted as agents advocating for patients' best interests, conforming to familiar professional ethics and societal expectations. With commercial managed care's growth and emphasis on cost control, health plans began imposing restrictions on physicians' clinical autonomy. Physicians often found themselves playing the role of "double agents," with potentially conflicting responsibilities to patients and insurers.[28] Now in the post–managed care era, physicians have responded to mounting financial pressures with a range and intensity of activities that evoke images of "free agents" defending their own financial interests and challenge established professional norms.

To address cost and access concerns in this context of physicians' transformation from patients' agents to double agents to free agents, policymakers might revisit two major policy areas while considering how policy decisions affect specialists and primary care physicians differently. First, physician self-referral and antikickback laws regulating potential conflicts of interest include exemptions that may deserve reexamination.

Second, physicians respond to financial incentives, particularly when pressed by cost and revenue concerns. Policymakers might consider restructuring incentives to protect access to care and contain use, while acknowledging the real revenue and cost pressures that physicians face. For more than a decade, policymakers have been focused on relative values of professional services but now may need to reconsider facility fees. If they are excessive for some services relative to costs, they

present physicians with incentives for investment in specialty hospitals and ASCs.

More generally, escalating use could be a sign that payments are relatively too high for some services and inadvertently creating financial incentives that skew care delivery. Policymakers might consider directly linking payments to cost and quality outcomes. Such pay-for-performance models may need to be leveraged with meaningful incentives, to change physicians' behavior. Some health plans (such as in Seattle and Boston) were contemplating such arrangements. Shifting purchasing decisions to consumers, through "tiering" physicians into different copayment categories based on their cost and quality performance, could be another alternative. Policymakers might also consider restricting high-volume services such as imaging to specific providers paid on a capitated basis.

In an era of physician free agency, professionalism may no longer check self-interest. Policymakers might need to take a more active, compensatory role.

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NOTES

1. R.A. Nylen, "Research Provides Golden Opportunity for Physicians: An Overview of Clinical Trials and How to Conduct Them," *Physician Executive* 28, no. 1 (2002): 32–37; and U.S. General Accounting Office, *Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served*, Pub. no. GAO/HEHS-03-683R (Washington: GAO, 2003).
2. M. Reed and P.B. Ginsburg, *Behind the Times: Physician Income, 1995–99*, Data Bulletin no. 24 (Washington: Center for Studying Health System Change, 2003); and Lewin Group, *TrendWatch* (June 2003). More recent physician income data were not available, so we cannot determine whether some of the business responses described were associated with subsequent increases in physician income.
3. Income data are from Rounds 1–3 of the Community Tracking Study (CTS) Physician Survey. Total reported net income after expenses and before taxes for the year prior to the survey year was weighted by site and specialty to account for the study's sampling design; adjusted for inflation using the Bureau of Labor Statistics' Consumer Price Index (CPI) with 1995 as the reference year; and adjusted for local cost of living. Among the twelve communities, average physician income rose only in Lansing.
4. V. Smith et al., *Medicaid Spending Growth: A Fifty-State Update for Fiscal Year 2003* (Washington: Henry J. Kaiser Family Foundation, 2003).
5. Medicare Payment Advisory Commission, *Assessing Payment Adequacy and Updating Payments for Physician Services, Report to Congress* (Washington: MedPAC, March 2003), sec. 2B. Cost data are from the BLS. Payroll Index was calculated for production workers in physicians' offices and adjusted for inflation using the CPI with 1995 as the base year.
6. S.G. Boodman, "That's Going to Cost You," *Washington Post*, 27 May 2003; and E. Niedowski, "Concierge Care, but at a Cost," *Baltimore Sun*, 16 December 2002.
7. For details on the CTS site-visit methodology, see C.S. Lesser, P.B. Ginsburg, and K.J. Devers, "The End of an Era: What Became of the 'Managed Care Revolution' in 2001?" *Health Services Research* 38, no. 1, Pt. 2 (2003): 337–355.
8. J. Holahan et al., "Understanding the Recent Growth in Medicare Physician Expenditures," *Journal of the American Medical Association* 263, no. 12 (1990): 1658–1661; and GAO, *Referrals to Physician-Owned Imaging Facilities Warrant HCFA's Scrutiny*, Pub. no. GAO/HEHS-95-2 (Washington: GAO, 1994).
9. Federal law places limits on physicians' "self-referring" Medicare and Medicaid patients to facilities in which they have a financial interest. When physicians have an ownership interest in a specialty facility, they capture a portion of the facility fee along with their professional fee. "Medicare and Medicaid Programs; Physicians' Referrals to Health Care Entities with Which They Have Financial Relationships," Final Rule, 42 CFR Parts 411 and 424, *Federal Register* 66, no. 3 (2001). The law was intended to limit poten-

tially adverse effects on patients of physicians' financial conflicts of interest. But it included exemptions physicians could capitalize on, including the whole hospital and office-based ancillary services exemptions. The whole hospital exemption allows physicians to refer patients to hospitals where they practice if their ownership stake in the hospital is not limited to a specific department. The office-based ancillary services exemption allows self-referral for services performed in the physician's office or by supervised employees, in a facility used solely by the physician's practice. While not covered under self-referral laws, physicians' investment in ASCs is allowed as a "safe harbor" under the federal criminal antikickback statute. Physicians could invest in ASCs if the facility functioned as an extension of their office practice. "Medicare and State Health Programs: Fraud and Abuse; Clarification of the Initial OIG Safe Harbor Provisions and Establishment of Additional Safe Harbor Provisions under the Anti-Kickback Statute," Final Rule, 42 CFR, Part 1001, *Federal Register* 64, no. 223 (1999).

10. MedPAC, *Assessing Payment Adequacy.*
11. L.P. Casalino et al., "Focused Factories? Physician-Owned Specialty Hospitals and Ambulatory Surgical Centers," *Health Affairs* (Nov/Dec 2003): 56–67; and GAO, *Specialty Hospitals.* We consider ASCs to be specialty facilities because although they were used by combinations of proceduralists in the past, more recently they have become specialty-focused.
12. Casalino et al., "Focused Factories?"
13. American Medical Association, "Report of the Council on Ethical and Judicial Affairs," Report 3 A-03, 2003, www.ama-assn.org/ama1/pub/upload/mm/369/ceja_report_3a03.doc (18 August 2003).
14. There were exceptions such as in Seattle, where a large surgical group left the local Blue Shield plan's network for six months, reentering only after the plan agreed to drop its intent to adopt Medicare's RBRVS, which would have lowered payments for surgical services.
15. L.P. Casalino et al., "Growth of Single-Specialty Medical Groups," *Health Affairs* (Mar/Apr 2004): 82–90.
16. T. Lake et al., "Something Old, Something New: Recent Developments in Hospital-Physician Relationships," *Health Services Research* 38, no. 1, Part 2 (2003): 471–488; and Casalino et al., "Focused Factories?"
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22. Physicians in Miami took more extreme approaches to discourage lawsuits. Most obstetricians and neurosurgeons there minimized vulnerable assets and practiced without any malpractice insurance because of escalating coverage costs. See Berenson et al., "Malpractice Liability."
23. For a detailed discussion of hospital capacity constraints, see G.J. Bazzoli et al., "Does U.S. Hospital Capacity Need to Be Expanded?" *Health Affairs* (Nov/Dec 2003): 40–54.
24. Casalino et al., "Focused Factories?"
25. A. Winter, "Comparing the Mix of Patients in Various Outpatient Surgery Settings," *Health Affairs* (Nov/Dec 2003): 68–75.
26. See Note 9, especially "Medicare and State Health Programs."
27. The two most comprehensive studies of specialty facilities show that on average, patients at freestanding specialty facilities are less sick than those treated at general hospitals, raising concerns about cream skimming. Winter, "Comparing the Mix of Patients"; and GAO, *Specialty Hospitals.*
28. H. Waitzkin and J. Fishman, "Inside the System: The Patient-Physician Relationship in the Era of Managed Care," in *Competitive Managed Care: The Emerging Health Care System,* ed. J.D. Wilkerson et al. (San Francisco: Jossey-Bass, 1997).