



SCHOOL OF LAW  
CASE WESTERN RESERVE  
UNIVERSITY

**Health Matrix: The Journal of Law-  
Medicine**

---

Volume 6 | Issue 1

---

1996

## Direct Financial Incentives in Managed Care: Unanswered Questions

Henry T. Greely

Follow this and additional works at: <https://scholarlycommons.law.case.edu/healthmatrix>



Part of the [Health Law and Policy Commons](#)

---

### Recommended Citation

Henry T. Greely, *Direct Financial Incentives in Managed Care: Unanswered Questions*, 6 Health Matrix 53 (1996)

Available at: <https://scholarlycommons.law.case.edu/healthmatrix/vol6/iss1/5>

This Symposium is brought to you for free and open access by the Student Journals at Case Western Reserve University School of Law Scholarly Commons. It has been accepted for inclusion in Health Matrix: The Journal of Law-Medicine by an authorized administrator of Case Western Reserve University School of Law Scholarly Commons.

# DIRECT FINANCIAL INCENTIVES IN MANAGED CARE: UNANSWERED QUESTIONS

Henry T. Greely\*

**THE DIAGNOSIS WAS DEVASTATING.** Joyce — a health-conscious mother of a three-year-old son — had colon cancer. Twenty months and seven operations later, she was dead at age thirty-four.

Her husband contends that it was greed that killed Joyce Ching.

In a malpractice suit scheduled for trial this summer, he alleges that the financial incentives in their contracts with the HMO prompted his wife's doctors to place their interests ahead of hers.<sup>1</sup>

About the only phenomenon in American health care growing faster than managed care is concern about managed care.<sup>2</sup> The Ching case is only one of the most dramatic signs of this concern. Fear of managed care has been voiced loudly by two groups that rarely agree: organized medicine and the consumers

---

\* Professor of Law, Stanford Law School. I want to thank Professor Mehlman for the opportunity to participate in the workshop from which this article is drawn and all the participants for their thoughtful and stimulating presentations. This Article benefited particularly from the comments of Professor Frances Miller and the excellent work of my research assistant, Madeline Cohen. I also want to note that my wife is a physician with the Permanente Medical Group, and my family and I are members of the Kaiser Permanente system, one of the managed care organizations discussed in this Article.

1. David R. Olmos, *Cutting Medical Costs or Cutting Corners?*, L.A. TIMES, May 5, 1995, at A1. See *infra* notes 43 & 44 and accompanying text for more detail.

2. For a selection of concerned articles from the first part of 1995, see, e.g., Carolyn M. Clancy & Howard Brody, *Managed Care: Jekyll or Hyde?*, 273 JAMA 338 (1995) (addressing ethical issues of the physician-patient relationship in managed care); Council on Ethical & Judicial Affairs, American Med. Ass'n, *Ethical Issues in Managed Care*, 273 JAMA 330 (1995) (discussing the integrity of the physician-patient relationship in managed care); Ezekiel J. Emanuel & Nancy Neveloff Dubler, *Preserving the Physician-Patient Relationship in the Era of Managed Care*, 273 JAMA 323 (1995) (exploring the threat presented by managed care to the physician-patient relationship); Mark A. Rodwin, *Conflicts in Managed Care*, 332 NEW ENG. J. MED. 604 (1995) (addressing potential conflicts created by managed care); Adam Yarmolinsky, *Supporting the Patient*, 332 NEW ENG. J. MED. 602 (1995) (arguing that the physician-patient relationship may be harmed by business-owned HMOs).

movement. Managed care, they assert, threatens the health of patients, and the ethics and finances of doctors.

At the same time, managed care has almost entirely taken over health care financing in some parts of the country. In California, about thirty-eight percent of the population, and about sixty percent of those with private insurance, belong to health maintenance organizations (HMOs), the epitome of managed care, while another thirty-six percent of the population belongs to preferred provider organizations (PPOs), another form of managed care.<sup>3</sup> Even the Medicare population, which traditionally has resisted managed care, increasingly belongs to HMOs in California. More than thirty percent of Medicare recipients in California belong to “risk contract” HMOs,<sup>4</sup> compared to a national average of about seven percent.<sup>5</sup> An increasing percentage of Medicaid recipients also belong to “risk contract” HMOs. This strong movement to managed care has not sent health care in California tumbling into the Pacific—not yet, at least. Is managed care a threat to patients?

This Article begins to investigate that question with respect to one sort of managed care: managed care that uses direct financial incentives to affect physician behavior. It starts by setting out what we do know and, more importantly, what we do not know about the use of direct financial incentives in managed care. It then describes the very important, but often overlooked, fact that direct financial incentives provided by managed care usually are not direct, but are transformed into indirect incentives by compensation policies of physician groups. Finally, it considers what actions, both in the short run and in the long run, society should take to deal with the use of such incentives. I con-

---

3. Steven Findlay, *California: Edgy at the Cutting Edge*, BUS. & HEALTH, July 1995, at 36, 43. As long ago as 1991, in the San Francisco Bay Area, my home, about half of the entire population, and about 80% of those privately insured belonged to health maintenance organizations. Jane Birnbaum, *Health Care Plans of a New Generation*, N.Y. TIMES, Nov. 6, 1993, at A39.

4. Geraldine Dallek, Executive Director, Center for Health Rights, Testimony before Senate Special Committee on Aging, *Federal Oversight of Medicare HMOs: Assuring Beneficiary Protection* (Aug. 3, 1995). Both this statistic, and the following one, refer to HMOs that have accepted “risk contracts” with Medicare. They are paid on a capitated basis. Some HMOs accepted Medicare members as patients but have chosen to be reimbursed for them in Medicare’s traditional manner.

5. *The Future of Medicare, July 12, 1995: House Commerce Comm., Subcomm. on Health and Environment* (testimony of Jonathan Ratner, Associate Director, Health Financing and Policy Issues, U.S. Gen. Acct. Office).

clude that we need further research into the use and consequences of direct financial incentives for managed care, but that such incentive systems, *when delivered through fairly large physician groups* may, in fact, be an excellent way for society to pay for health care.

## I. WHAT WE (DO NOT) KNOW ABOUT DIRECT FINANCIAL INCENTIVES

Before probing the consequences for patients of direct financial incentives in managed care, we need to understand more about these incentives. This section first describes the direct financial incentives used in managed care. It then surveys what we know about the extent to which managed care uses different direct financial incentives. Finally, it looks at the actual incidence of direct financial incentives on the physicians who provide patient care.

### A. What Are Direct Financial Incentives?

Managed care has become a vague term for almost any system in which third parties pay for medical care, other than the "traditional" system of nearly unquestioning payment on a fee-for-service basis for anything ordered by a licensed physician.<sup>6</sup> In fact, there are three basic approaches that payors take toward managing care: micro-management, panel selection, and direct financial incentives.

Micro-management encompasses a variety of ways in which the payor "second guesses" a physician's recommendation and a patient's decision. The most common form of micro-management is through various types of utilization review. Prospective review requires approval by the payor, or its agent, of a physician's recommendation before the action is undertaken, whether it is an expensive procedure or a hospitalization. Concurrent review in hospitals or elsewhere most commonly is applied to inpatient care. It requires approval for continuing the patient's stay in the institution. Retrospective review involves deciding, after the fact,

---

6. It is worth noting that this "traditional" system did not cover a majority of Americans until sometime after World War II. See generally PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982) (tracing the history of the physician-patient relationship and the growth of the health insurance industry). The last two generations of doctors and patients are accustomed to it, but it scarcely has great depths of history behind it.

whether or not the provided services were “proper” and hence, whether they will be reimbursed.

The second approach that payors take towards managing care is through panel selection. In a panel selection (and “de-selection”) system, the payor “manages” care indirectly by encouraging or requiring its customers to use only particular physicians or facilities. It then selects the providers that are part of its plan based, among other things, on their costs to the payor. These costs encompass both the amount of the fees charged by the provider, often heavily discounted, and the cost of that provider’s style of practice. The providers are encouraged to be economical not by direct micro-management, but by knowing that they will no longer be on the panel should they fail to meet the plan’s standards for the cost of practice style. This creates an *indirect* financial incentive for physicians as such de-selection, presumably, would cut the number of the physicians’ patients and reduce their incomes. Panel selection and micro-management are often combined, but they need not be.

The third method of managing care is through direct financial incentives. These can take many forms, but the key is structuring the physician’s compensation in ways that create incentives to practice economically. Direct financial incentives in medicine are by no means new. The traditional fee-for-service system was a system of direct financial incentives; the more a physician did, the more the physician got paid. The financial incentives in a managed care system are aimed at discouraging the physician from doing everything possible, and instead aim at encouraging the physician to provide the “right” amount of care. Direct financial incentives also can be combined with panel selection and micro-management. If the incentives are strong enough, however, they should make the other systems unnecessary.

But what are these incentives? One federal statute defined a “physician incentive plan” for Medicare and Medicaid purposes so broadly as to be of questionable value, to wit: “any compensation arrangement between an eligible organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization.”<sup>7</sup> As that definition

---

7. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4204(a)(1)(B),

implies, financial incentives can take many forms, but four general approaches are commonly used: salary, capitation, profit sharing, and bonus.<sup>8</sup> Each can be combined with others in a variety of forms.

Under a salaried system, the physician's income is set by the plan, generally annually, through a salary. A salaried physician has no incentive to do "too much" for patients in order to make more money. Her incentive to do what the managed care plan considers "the right amount" comes from the fact that her salary could be raised or lowered, or she could be fired, depending on the cost of her practice patterns.

Under a capitated system, the physician is paid a certain amount, generally on a monthly basis, for each of the managed care plan's patients for whom she is responsible. In its purest form, if the doctor spends less than the capitated amount, she makes a profit on that patient; if she spends more, she takes a loss. Capitation comes in a dizzying number of forms, with the variations spreading over at least two dimensions.

One dimension is the range of services included in the capitation. Capitation to a primary care physician almost always will include primary care services. It may or may not include the costs of specialty or hospital services. It may include or exclude laboratory or radiological services. It could, but rarely does, include mental health services or pharmaceutical costs. If a service is excluded from the capitation agreement, its costs are not charged against the capitated physician, but are paid from some other pool of funds.

---

104 Stat. 1388-108 (1990) (amending 42 U.S.C. § 1395mm(i)).

8. For general discussions of the types of financial incentives used in managed care, see HEALTH, EDUC. & HUMAN SERV. DIV., U.S. GEN. ACCT. OFFICE, *MEDICAID MANAGED CARE: MORE COMPETITION AND OVERSIGHT WOULD IMPROVE CALIFORNIA'S EXPANSION PLAN* (1995) [hereinafter GAO REPORT] (reporting to the Subcommittee on Health and the Environment issues concerning expansion of the Medi-Cal program); Medicare and Medicaid Programs: Requirements for Physician Incentive Plans in Prepaid Health Care Organizations, 57 Fed. Reg. 59,024, 59,026 (1992) (to be codified at 42 C.F.R. pts. 417, 434, & 1003) (proposed Dec. 14, 1992) [hereinafter Physician Incentive Plans] (governing regulation of certain health care organizations dealing with Medicare and Medicaid) [Since this Article was written, the rule in question has become a final rule, with modifications. Medicare and Medicaid Programs: Requirements for Physician Incentive Plans in Prepaid Health Care Organizations, 61 Fed. Reg. 13,430 (1996). Its effective date, however, has been largely postponed to 1997. 61 Fed. Reg. 46,384 (Sept. 3, 1996).]; U.S. DEP'T HEALTH & HUMAN SERV., *REPORT TO CONGRESS: INCENTIVE ARRANGEMENTS OFFERED BY HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS TO PHYSICIANS* (1990) [hereinafter DHHS REPORT].

The second dimension is the degree to which the physician is at risk even for the capitated services. At the extreme, the risk could be total. A physician receiving ninety dollars per month as "global" capitation (physician services and hospital services) might be held financially responsible for the entire \$150,000 or higher costs if he prescribes high dose chemotherapy with autologous bone marrow transplantation, for example. More commonly, however, the risk is shared. The physician might be responsible for higher costs only up to a certain point, defined either in terms of dollars per patient or patient pool (through stop-loss insurance<sup>9</sup>) or in terms of a percentage of the capitated amount (through withheld funds). In the alternative, the physician, in turn, may spread the risk through capitated arrangements with other providers, such as hospitals or specialists.

A concrete example might make this more clear. Stanford University offers its employees a choice among three health maintenance organizations and the University's own "triple option" plan.<sup>10</sup> The three options in the triple option plan are:

- 1) to receive care on an HMO basis from physicians with whom the University has contracted;
- 2) to receive care on a "preferred provider" basis from certain other physicians, while paying a deductible and a twenty percent copayment; or,
- 3) to go entirely outside the network to any licensed provider, but pay a higher deductible and a forty percent copayment.<sup>11</sup>

The University contracts with three physician groups to provide the HMO-level care. These physician groups would receive approximately ninety dollars per month to cover all physician and hospital services for a middle-aged individual. The physicians then contract with a local hospital to cover all hospital ser-

---

9. Stop-loss insurance is commonly used to limit the physician's risk. The GAO reported that stop-loss "[c]overage usually begins at between \$1,000 and \$9,000 per patient per year for outpatient referral services and between \$10,000 and \$100,000 per patient per year for inpatient hospital services." GAO REPORT, *supra* note 8, at 35. As the GAO further noted, because that limitation is on a per-patient basis, a physician with an unusually expensive patient population might lose money under capitation even with this kind of stop-loss coverage. As a result, some physicians also like group "stop loss" coverage, where they are protected once the combined costs of a group of patients exceeds a certain level. *Id.*

10. Letter from James Franklin, Director of Total Compensation, Stanford University, to Henry T. Greely, Professor, Stanford Law School (Jan. 3, 1996) [hereinafter Franklin letter] (describing the Stanford triple option plan) (on file with *Health Matrix*).

11. *Id.*

vices for about forty dollars per month. The University's plan administrator withholds a percentage of the capitated payment to each physician group. This "withhold" pool is used to pay for services members receive under the second and third options, as well as for unanticipated expenses. At the end of the year, if money remains in the "withhold" pool, it is shared between the physician group, which receives eighty percent of the pool, and the University, which keeps the balance. If no money remains in that pool, the physician group is left with only the payments it has already received, but it is not responsible for any cost overrun.

A third strategy is the bonus. The physicians may be paid during a fixed period under any system: salary, capitation, or fee-for-service. At the end of that period, physicians receive a bonus based on the plan's financial results that year and the physicians' contribution to them. The manner of determining the bonus can vary widely.

One method sometimes used to determine the bonus makes up the last approach to direct financial incentives in managed care, that is, profit sharing. Under this method, the physicians receive a negotiated share of the plan's profits. They may receive that share as owners of the plan or otherwise. The details of the profit-sharing plan may vary widely.

In reality, all of these systems can be used and most of them can be combined. A salary system usually will have some kind of bonus, including possibly some profit sharing, to add to the incentives provided by the salary-setting mechanism. The bonus itself may be determined as a result of some comparison with expected capitation results. A capitation system also may have a bonus, determined in a myriad of ways. The number of possible systems of direct financial incentives is virtually unlimited. Our next problem is to determine how often each method is actually being used.

## B. How Does Managed Care Use Direct Financial Incentives?

About fifty million Americans belong to HMOs. How many of them belong to HMOs that use each specific type of direct financial incentive or that use direct financial incentives at all? We have almost no idea. We know neither how many plans are using each different system, nor, more importantly, how many patients are covered by plans that use each of the different compensation



forms. This section examines what little evidence exists and points out several complications in gathering such evidence.

We do know that financial incentives are used widely. In May 1995, in a report on expanding the use of managed care for California's Medicaid patients, the General Accounting Office discussed the different types of compensation schemes used by HMOs. The report started by noting that "[t]here are no reliable current data regarding the extent to which HMOs use financial incentive arrangements or the prevalence of the different types of arrangements."<sup>12</sup>

The GAO report cited three pieces of general evidence that financial incentives were commonly used by HMOs. This evidence included a 1987 survey finding that eighty-five percent used financial incentives, a 1988 study showing that ninety-five percent used them, and a 1990 journal article stating that "the great majority" of HMOs used such incentives.<sup>13</sup>

The use of financial incentives is great, may be growing, and seems to be broadening. The question remains, how often are the different incentive systems being used? Little evidence exists on this point.

The GAO report on managed care provided some evidence about the use of capitation, and one kind of capitation in particular in California. It concluded that "it has become increasingly common for HMOs to capitate physicians, or (more typically) physician groups, for all medical services — including inpatient hospital care."<sup>14</sup> It also reported that "[o]fficials at both HCFA and California's Department of Corporations told us they believe . . . that the capitation of medical groups for all medical services, including inpatient care, is becoming widespread."<sup>15</sup>

In a footnote, the report further explained that:

Under the arrangement, termed "full integration" by a Department of Corporations official, the medical groups enter into contracts with hospitals to provide inpatient care. The hospitals may be paid on a fee-for-service, capitation, or other basis. Even if it is capitated, however, the medical group has an incentive to hold down referrals to keep down the capitation fee

---

12. GAO REPORT, *supra* note 8, at 33.

13. *Id.*

14. *Id.*

15. *Id.* at 33-34.

it pays the hospital in the next period.<sup>16</sup>

Information at a national level is even less helpful. The following table shows the answers of managed care plans when asked how they paid physicians, broken down by the nature of the HMO. The survey was made in 1993.

PERCENTAGE OF HMO'S BY TYPES  
USING DIFFERENT FINANCIAL INCENTIVE SYSTEMS<sup>17</sup>

Group	Salary	Profit Share	Fee-for-Service	Bonus	Capitation	Totals
Group	44	20	29	27	63	183
IPA	7	9	74	16	65	171
Net-work	17	5	52	20	78	172
Staff	92	4	17	21	25	159

As the table indicates, some systems of compensation are more popular than others, particularly in certain HMO settings. Staff models, where the physicians are employed by the HMO, not surprisingly, prefer salary systems; IPA models, where the physicians practice independently, do not. Profit share models, in general, are not very popular; capitation systems are (except among staff model HMOs).

Two points are particularly noteworthy. First, every box in the table is filled. Every kind of plan uses every kind of financial compensation. Some IPAs use salaries; some staff models use fee-for-service. Second, all of the rows total well over 100%, ranging from approximately 160% to over 180%. Thus, not only does each type of HMO use every type of compensation, many of them use more than one kind of compensation system.

The second point is particularly troubling to an effort to find out how many patients are covered by what kinds of direct financial incentive systems. Even when a plan uses the same general approach in compensating physicians, its arrangements with different groups may include different provisions, leading to different incentives. This means that we cannot just find out

16. *Id.* at 34 n.24.

17. Adapted from THE MARION MERRILL DOW MANAGED CARE DIGEST, HMO EDITION, 1994, at 12 (1994) [hereinafter MANAGED CARE DIGEST].

what methods different HMOs use and then add up the number of their members. To determine how many patients are covered by each type of direct financial incentive system, we would have to ask HMOs what systems they use to pay *which* physicians, and then ask how many of their members use *each set* of differently compensated physicians.

For an example, return to the Stanford University "triple option" plan.<sup>18</sup> The university contracts with three local physician groups and a statewide HMO to provide the HMO level of care for this plan. Each of the three physician groups is paid on a capitation basis to cover both the medical and hospital needs of the triple option members who come to them, but the contractual negotiations led to somewhat different outcomes.

First, the amount paid to the three groups by Stanford to cover its members differs from group to group, depending on the bargains the University struck with each. Presumably, the parties' bargaining positions and negotiating skills affected the variations in these overall rates.

Then, each of the physician groups in turn contracted with a local hospital, designated by the University, to subcapitate the hospital care of their triple option plan members. The amount the groups have to pay the hospital varies, in part because some of the physician groups provided services in their clinics that other groups obtained through the hospital.

Third, each of the groups' capitation payments are subject to a percentage withheld to cover member expenses for services obtained outside the HMO. These are mainly expenses of physician group patients who go outside the group under the second or third option of the plan. This "withhold pool" both limits the risk to the physician group and measures the amount of possible gain. The percentage withheld varies from group to group, depending on the outcome of their negotiations with the University.

Finally, the HMO level in the triple option plan includes not only the three local physician groups, but a statewide HMO run by Blue Shield. This plan pays its participating physicians on a capitated basis for their patients' medical expenses. The hospital expenses are not part of the physicians' capitation and, in fact, are not capitated at all. They are paid on a per diem basis.

---

18. For this discussion, see the Franklin letter, *supra* note 10.

The result is that each of the four sets of doctors participating in the HMO tier of Stanford's plan, although paid on a capitated basis, is paid differently. Because they are paid differently, the financial incentives they face in making decisions about a patient's care differ. They receive different amounts per patient. They will have different amounts at risk in the use their triple option members make of the second and third tier of services. Their relationship with the hospitals that their patients use is different both within the three local groups, which negotiate separately with the participating hospital, and between those groups and the statewide HMO, where the hospital costs and negotiations are handled entirely by Blue Shield.

Thus, not only do we have inadequate information about the extent to which different forms of compensation are being used, but we also have little information about how many patients are affected by particular sets of incentives. Such information will be extremely hard to obtain. As the next section points out, even if that information is obtainable, it might be largely irrelevant.

## II. HOW DIRECT ARE DIRECT FINANCIAL INCENTIVES?: THE ROLE OF PHYSICIAN GROUPS

Stanford's triple option plan contracted not with physicians, but with physician groups. In a group practice, each physician does not "eat what he kills," a phrase from other professional organizations that is particularly jarring when used with physicians. Instead, the group as a whole decides how to pay its physician members. Therefore, even if a group has an HMO contract that provides for strict capitation, the group might, in its own compensation scheme, pay the physicians on the basis of any system: salary, profit sharing, capitation, bonus, fee-for-service, or any combination of the above. To determine the effective incidence of the direct financial incentives, we would need to know two things beyond how the HMO pays physicians: i) how many HMO members receive care through doctors in group practices; and, ii) how those group practices compensate their physicians. We know neither.

### A. How Much HMO Care Is Provided in Physician Groups?

We can approach an answer to the first of those questions in two different ways. The 540 HMOs in the country often are divided according to their type: staff, group, network (a combina-

tion of groups), and IPA. In 1993, about ten percent of all HMOs were predominantly staff model, thirteen percent were group model, thirteen percent were network model, and sixty-five percent of HMOs were IPAs.<sup>19</sup> Patient membership was distributed somewhat differently: ten percent staff, twenty-nine percent group, thirteen percent network, and forty-nine percent IPA.<sup>20</sup> As staff, group, and network HMOs, by definition, involve group practices, we know that, at a minimum, fifty-one percent of all HMO members received care through doctors belonging to groups. This is only a floor, as IPAs can include sole and small practices *and* groups. The proportion of IPA-model HMO members who receive care in each physician setting is unknown, making "more than half" only a very rough floor for the percentage of HMO members seen by physicians in group practice.

The second route looks at the significance of physician groups in general and at the rate at which they contract with HMOs. We know, among other things, that physician groups are common, are growing, and are disproportionately likely to contract with HMOs.

The American Medical Association has long kept track of the number of physicians practicing in "groups." The AMA's survey data define a physician "group" as:

The provision of health care services by three or more physicians who are formally organized as a legal entity in which business and clinical facilities, records, and personnel are shared. Income from medical services provided by the group are [sic] treated as receipts of the group and distributed according to some prearranged plan.<sup>21</sup>

The percentage of active, non-federal physicians in group practice grew from 0.9% in 1932 to 10.2% by 1965 to 26.2% in 1980 and 30.0% in 1987.<sup>22</sup> By 1991, the figure had reached 32.6%.<sup>23</sup> This percentage conceals broad regional differences: the West North Central census division counted just under sixty percent of its physicians in group practice, while the Middle Atlan-

---

19. MANAGED CARE DIGEST, *supra* note 17, at 2.

20. *Id.*

21. PENNY L. HAVLICEK ET AL., AMERICAN MED. ASS'N, MEDICAL GROUPS IN THE U.S., A SURVEY OF PRACTICE CHARACTERISTICS (1993 ed. 1992).

22. MEDICAL CARE CHARTBOOK 177 (Leon Wyszewianski & Stephen S. Mick eds., 9th ed. 1991) (charting the percentage of active, non-federal physicians in group practice from 1932-1987).

23. HAVLICEK ET AL., *supra* note 21, tbl. 8.2 at 44.

tic division had just over twenty percent; North Dakota had 94.8% of its doctors in group practice, followed by Minnesota at 82.7%, while New York had the lowest percentage in the nation, at 15.2%.<sup>24</sup> Although most group practices are small, most group practice doctors are in medium to large groups. About forty-five percent of the group practices had three or four members, but practices with 100 physicians or more accounted for about one-third of all group practice physicians.<sup>25</sup>

Apart from HMO employees, in the relatively rare staff model HMOs, fifty percent of surveyed active physicians had at least one HMO contract in 1993. Of sole practitioners, who still make up about half or more of all practicing physicians, just under forty percent had at least one HMO contract in 1993. For practices of ten to twenty-four doctors, sixty-three percent had an HMO contract. And seventy-eight percent of practices with twenty-five or more doctors had HMO contracts.<sup>26</sup> Thus, physician groups are common, are growing, and are more likely than other forms of practice to have HMO contracts. But we still do not know how many members of HMOs are treated by physicians practicing in physician groups, let alone how many members are treated by physicians receiving direct financial incentives from the HMO.

## B. How Do Physician Groups Pay Their Doctors?

Our very rough idea of the importance of group practice physicians in HMOs is precision itself compared to our understanding of how group practices pay physicians. We know they pay in many different ways; we do not know which ways are more common, particularly in practices that have substantial income from HMOs, let alone from HMOs that use direct financial incentives. Again, let us look at some specific examples of physician group compensation methods, taken from my home region in Northern California.

---

24. *Id.*, *supra* note 21, tbl. 7.2 at 34.

25. *Id.* tbl. 3.1 at 7. These very large groups made up only 1.2% of all groups. Groups with more than 25 and less than 100 physicians made up 4.2% of all groups and 16.5% of all group physicians, so almost exactly half of group physicians practiced in groups with more than 25 doctors.

26. SOCIOECONOMIC CHARACTERISTICS OF MEDICAL PRACTICE, 28 (Martin L. Gonzalez ed., 1994) (discussing managed care participation rates by practice site).

The Permanente Medical Group (TPMG) is the physician group under exclusive contract to the Northern California Kaiser Permanente System, which, with about 2.4 million members, is the largest single HMO in the country.<sup>27</sup> TPMG has about 3000 "physician shareholders," with several thousand additional physicians in their probationary periods or working part time. TPMG pays its permanent physicians a salary, which is based largely on the compensation for similar specialties in the outside market. The physician's salary can be individually adjusted on an annual basis for above- or below-average performance.

In addition, in most years, TPMG physicians receive a bonus.<sup>28</sup> The bonus is derived from two different sources. TPMG has a capitation contract with the Kaiser Health Plan. If it provides the care it is contractually obligated to render to Kaiser members for less than the amount of the overall capitation, it keeps the difference. In addition, under the contract between the Kaiser Health Plan and TPMG, if the Kaiser Hospital Foundation (the third leg of the Kaiser system) has a surplus in its Northern California operations, some part of that surplus is given to TPMG for distribution.

In past years, the bonus pool has been divided up into separate allocations for each of Kaiser's Northern California medical centers. The TPMG physician-in-chief at each facility then would allocate the bonus pool to the physicians working there, generally through an allocation to each department, to be further allocated by the department chief.

In 1995, TPMG changed its bonus allocation process. Each medical center's bonus allocation was put at risk. Fifty percent of its allocation depended on whether the center met its budget; the other fifty percent depended on positive changes in both patient satisfaction and patient access, both determined by extensive consumer surveys. For 1996, the allocations are to include as a further factor the quality of care provided by the facility, as measured by objective outcome measures.

---

27. MANAGED CARE DIGEST, *supra* note 17, at 10. The information about TPMG that follows is derived from letter from Blair Beebe, M.D., The Permanente Medical Group, to Henry T. Greely, Professor, Stanford Law School (Jan. 15, 1996) [hereinafter TPMG letter] (on file with *Health Matrix*).

28. TPMG is organized as a professional corporation. The permanent physicians are shareholders of the corporation. They generally receive dividends on their stock each year, but those dividends are nominal, on the order of \$200 per physician.

Thus, TPMG is a medical group whose income is entirely capitated for physician services but has some potential financial "upside" as a result of its patients' hospital utilization. Yet the income of its more than 3000 doctors is affected mainly by specialty, by their standing with their department chair, by their facility's success on certain defined criteria, and by the Northern California Kaiser system's overall success. Each TPMG physician, facing a decision to order a costly intervention for a patient, does have an incentive to economize, but its extent in any given case is trivial.

Another local physician group, which I will call the Clinic, is a multi-specialty group of about 160 physicians, practicing near Stanford.<sup>29</sup> The Clinic has contracted with six major HMOs. It now receives about half of its revenue from capitation.

Compensation for Clinic physicians is on the basis of salary plus bonus. It uses the outside market compensation for particular specialties as a starting point for setting the salary. The salary and bonus also are affected both by the overall success of the Clinic and by the individual physician's "productivity." The Clinic has measured productivity largely on the basis of the number of patients the physician has seen and the amount of services she has billed. The Clinic now recognizes that measuring "productivity" by billings may be a counterproductive strategy with respect to its capitated patients. As a result, it is studying possible changes in its system. At this point, however, its compensation system seems to avoid any incentive for economizing on the care of its capitated patients.

The Stanford Medical School's clinical faculty are, in effect, another kind of physician group, one that practices in the Stanford Health System. These physicians practice, and provide associated clinical instruction, as part of their professional duties, largely at the Stanford University Hospital and Clinic or at the Lucile Salter Packard Children's Hospital at Stanford. In the past, the main part of their compensation has been a guaranteed "tenure base" academic salary, which is set as part of the university's academic salary process. This salary was largely independent of the faculty physician's actual practice revenues. In addition, clinical faculty received non-guaranteed bonuses based on

---

29. The information concerning the Clinic is derived from telephone conversations, reported in a memorandum by the author (on file with *Health Matrix*).



the success of the Faculty Practice Program. In 1995, the Medical School shifted to a three-part "X,Y,Z" system.<sup>30</sup> The first part, X, is the tenure base salary. The second part, Y, is set prospectively for one year at a time, based on the faculty member's "professional responsibilities, productivity, accomplishments, etc." The third part, Z, is a non-guaranteed bonus determined at the end of the year, based expressly on clinical productivity. Overall, the clinical faculty is expected to receive only about sixty percent of its income through the tenure base. The so-called Medical Center Line Faculty, whose focus is even more on clinical services, derives a much higher percentage of its income from clinical revenues. These changes attempted to build in some incentives to reward more extensive clinical efforts by faculty, but the connection between how Stanford Health Services is compensated for patients and how the clinical faculty are compensated remains unclear.

In all three of these examples, the description given applies only to the "regular" physician members of the group. Each of these groups will, from time to time, employ other physicians who are compensated in any number of ways — from hourly or shift wages, to salary, to a billings-based formula. Their incentives may well differ from the incentives of their "regular" colleagues.

HMOs may "pay" physicians in ways that create direct financial incentives for them to change their styles of practice. But, with respect to physicians in group practices, the effects of those incentives will depend heavily on how the group pays its doctors. In many cases, the group's compensation scheme may mitigate, or even reverse, the incentives created by the HMO.

That is not to say that the incentives may not make themselves felt. The HMOs' direct financial incentives should lead a physician group to encourage their physicians to practice in ways that maximize the group's net income from the HMO. The physician groups have many ways to encourage their physicians to adopt a particular practice style. They can educate physicians about efficient practice styles, select and retain physicians who are comfortable with those practice styles, apply peer (or man-

---

30. Stanford Medical School, Faculty Compensation in the School of Medicine: A Critical Assessment of Current Principles and a Recommendation for Change 7 (May 10, 1994) (unpublished report, on file with *Health Matrix*).

agement) pressure to adopt such styles, or give their doctors some financial incentives to practice in those ways. None of those forms of encouragement is exactly the same as the direct and sometimes harsh financial incentives provided by the HMO. Perhaps most importantly, these are forms of encouragement provided *to* doctors *by* doctors, through the mechanism of their group practice.

### III. IMPLICATIONS FOR PUBLIC POLICY: WHAT DOES IT MEAN?

What are the implications of direct financial incentives for patients and for public policy? This section of the Article explores those implications, suggests some possible steps that we might take in the short run concerning them, and discusses some longer run possibilities.

#### A. How Do Direct Financial Incentives Affect Patient Care?

To begin with, we need to remember what managed care is all about. Health care always has been managed by someone. In recent decades, it has been managed largely by physicians, occasionally with the patient's solicited consent, but rarely with actual decisions made by the patient. This method of managing care has led the United States to spend about fifteen percent of its gross domestic product on health care, far more than comparable nations. At that price, health care is widely seen as costing too much — at least by those who pay the bills, mainly employers and governments. Nor has there been great public outcry to increase taxes to finance these costs.

“Managed care” really means care managed by those who pay for it: the insurers, health plans, employers, and governments involved. Although managed care can be implemented in several ways — micro-management, panel selection, and direct financial incentives — all of these methods attempt to encourage less expensive health care. If direct financial incentives, or any of the other methods of managing care, do *not* lead to less costly care, they have failed and, presumably, will be abandoned.

Thus, direct financial incentives, like other managed care methods, are *intended* to lower the cost of caring for patients. Costs can be lowered in at least three different ways. First, patients can receive different and less expensive treatments at some risk to their medical goals. Second, patients can receive different

and less expensive treatments that are as good or better at meeting their medical goals as the traditional treatment. Third, existing treatments can be made less expensive by paying less for the goods and services that go into them.

As an example of the first method, a capitated plan that included diagnostic tests within the capitation might lead a physician not to order an expensive magnetic resonance imaging (MRI) scan for a patient even though there was a small, but non-zero, chance the test would reveal something useful. An example of the second method would be where direct financial incentives lead physicians to educate asthmatics better about controlling their disease, leading to fewer serious asthma attacks, better health, and fewer expensive emergency room visits and hospital admissions. Increasing the vaccination rates of a clinic's patients would be another example of financial incentives leading to both "better" and "cheaper" treatment. The third method could involve a clinic's driving a hard bargain in contracting for MRI services rather than buying, and underutilizing, its own machine. It also could involve shifting to less expensive generic drugs or could lead to paying less money for more work to technicians, nurses, or even doctors.

The public concern about, and organized opposition to, managed care has focused on the first method: the possibility that direct financial incentives will lead to different treatments, at some risk to patients' health. The argument is that when a physician knows that an additional expense will come out of her pocket, not that of the insurer, she is strongly tempted not to order it even though it is medically indicated.<sup>31</sup> Defenders of managed care have seized on the second method: arguing that its incentives for preventing disease both will cut cost and improve health. There has been little public discussion of the possibility that direct financial incentives will lead to tougher bargaining for the goods and services used in providing health care, with poorer financial results for suppliers, health care workers, and doctors. We can safely assume, however, that this point has not been lost on the groups most directly concerned.

---

31. Of course, accepting the argument that physicians will undertreat for financial reasons, in spite of the long-run economic arguments, the malpractice liability risks, and their professional ethos, strongly implies that physicians in a fee-for-service system, with few, if any, of those countervailing factors, will regularly give in to the temptation to *overtreat*.

To what extent are physicians adopting these three methods of lowering costs as a result of direct financial incentives? More specifically, to what extent are they risking patients' health by cutting back on useful services? We do not know and we have little directly relevant evidence.<sup>32</sup>

A voluminous literature has built up over the past few decades seeking to find differences in the quality of care between fee-for-service and HMO systems. On balance, it seems to show that HMOs do not provide any worse care — or much better care. This verdict, however, is drawn largely from studies in the 1970s and 1980s, in an HMO world that featured more staff and group plans than the present. We cannot safely extrapolate from the responses of physicians in the systems studied in those eras to the responses of physicians in today's many different systems. And we have no credible evidence concerning the effects of today's mix of direct financial incentives. As the GAO reported in April 1995, "in the course of our work, we were unable to find any systematic analyses of the effects of specific types of incentives on the utilization of the services the incentives are intended to reduce, such as the effect of a bonus for controlling specialty referrals on such referrals."<sup>33</sup>

In the absence of data, we are left with logic and anecdotes, both often misleading when looking at human affairs. We will start with logic and examine the short-term incentives faced by a physician under a system of direct financial incentives.

In the short term, a physician confronting a patient does not have the options of inventing a new form of cost-effective preventive treatment, negotiating a lower price for drugs, or firing a nurse. In that setting, given a choice of several plausible diagnostic or treatment options, the physician facing direct financial incentives will have some incentive to choose the least expensive option. How strong that incentive will be depends on two main factors: the exact nature of the direct financial incentives used by the HMO and, if the physician is part of a group, the compensation policies of that group. Depending on those arrangements, the physician may face a direct choice between her own income and

---

32. From talking with physicians and others in the San Francisco Bay Area, the most competitive medical market in the country, my guess is that in this region the little-discussed third method is currently the most common, but I do not know of any good evidence to support that position.

33. GAO REPORT, *supra* note 8, at 38.

what she considers her patient's well-being. As we have seen, we know very little about either of those factors.

In theory, though, commentators have identified a number of more detailed factors that plausibly seem related to the degree of influence of direct financial incentives. The GAO report discussed nine such factors:

- 1) the extent of the physician's risk;
- 2) the existence and terms of stop-loss insurance;
- 3) the distribution of risk to individual doctors or groups;
- 4) the number of physicians sharing the risk;
- 5) the number of patients in a physician's patient panel;
- 6) the duration of the risk assessment period;
- 7) the generosity of the physicians' compensation for direct services;
- 8) the portion of the physician's income derived from the HMO; and,
- 9) the generosity of service utilization budgets<sup>34</sup>

Each of these factors relates quite plausibly to the force of direct financial incentives on an individual physician. On the other hand, neither the GAO, nor, in an earlier document, the Health Care Financing Administration, found any empirical research on the extent to which those factors actually influenced doctors.<sup>35</sup>

Two other plausible factors are worth mentioning. The first is drawn from work in cognitive psychology. Cognitive psychologists have carefully studied the way people react to risks. One of their strongest findings is that people are more concerned about losing something than about not gaining its equivalent. When people are given a choice between two strategies, one conservative and one speculative, they prefer the conservative strategy when a negative result would be to lose \$5, but the speculative strategy when a negative result would be a "fail to win" \$5.

---

34. *Id.* at 34-36. The "service utilization budget" applies to some managed care systems that allocate physicians a specific budget for various outside services — e.g., laboratory tests, radiology, and specialty referrals. In those cases, a service utilization budget that is large relative to the patient pool's needs will put less pressure on the physician with respect to any individual case. Of course, if the physician can keep some or all of a periodic surplus in the service utilization budget, she still may have a strong incentive to deny the service to any patient.

35. Physician Incentive Plans, *supra* note 8, at 59,024; GAO REPORT, *supra* note 8, at 37-38.

People protect what they already have much more strongly than what they hope to gain, even when the practical and probabilistic results would be the same.<sup>36</sup> Thus, a physician might feel a stronger pressure to avoid having to pay a penalty to the HMO than she would to gain a bonus.

The second factor is more mundane. At the end of the day, direct financial incentives may give the physician a choice between how she treats her patients and how much money she makes. The financial needs and desires of the individual physician are likely to be important in that decision. A physician with large debts — from education, a house, gambling, or for any other reason—may have a harder time accepting a reduction in her income. The willingness to accept such a decline will undoubtedly also vary with the physician's personality.

Thus far, we have discussed factors that might influence an individual physician facing particular direct financial incentives to provide too little care. On the other hand, at least three important factors will push against a physician's doing "too little." First, truly doing "too little" for a patient often will be more expensive, in the long run, than offering the proper mix of services. Screening for and treating hypertension can cost the physician much less than paying for the treatment and hospitalization of a patient whose undetected or untreated hypertension led to a serious stroke. Similarly, vaccinations can prevent later office visits. Not all good treatment saves the capitated physician money in the long run, but at least some, and possibly much, of it will.

Second, by doing too little, for whatever reason, physicians put themselves at risk for malpractice liability. Although the issue of reconciling managed care with malpractice liability has received extensive academic attention in recent years,<sup>37</sup> there is no

---

36. See Daniel Kahneman & Amos Tversky, *Conflict Resolution: A Cognitive Perspective*, in *BARRIERS TO CONFLICT RESOLUTION* 54-56 (Kenneth J. Arrow et al. eds., 1995) (discussing loss aversion and status quo bias).

37. See e.g., Mark A. Hall, *The Malpractice Standard Under Health Care Cost Containment*, 17 *L. MED. & HEALTH CARE* 347 (1989) (asserting that present legal standards can accommodate cost containment incentives); E. Haavi Morreim, *Cost Containment and the Standard of Medical Care*, 75 *CAL. L. REV.* 1719 (1987) (arguing that current law is inadequate where cost containment measures prevent physicians from delivering customary care); John A. Siliciano, *Wealth, Equity, and the Unitary Medical Malpractice Standard*, 77 *VA. L. REV.* 439 (1991) (arguing that a unitary malpractice standard inadequately protects indigent patients in an era of cost containment). See also Maxwell J. Mehlman, *Health Care Cost Containment and Medical Technology: A Critique of Waste Theory*, 36 *CASE W. RES. L. REV.* 778 (1986) (describing legal methods and remedies to reduce the risk of denying technology

precedent for a successful defense to a malpractice claim on the ground that the physician's direct financial incentives encouraged treatment that fell below the standard of care. In fact, *dicta* in one influential case, *Wickline v. State*, expressly stated the contrary:

[T]he physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care. He cannot point to the health care payor as the liability scapegoat when the consequences of his own determinative medical decisions go sour.<sup>38</sup>

Third, and most important, physicians want to do the right thing for their patients. Faced with a patient who the doctor believes *really* needs another test, the cost of which will come out of the doctor's income, I am confident that almost all doctors, almost all of the time, will order the test. The sense of professionalism may be particularly strong in the case of direct financial incentives where the decision to treat or not to treat is made by the patient's personal physician and not by a remote utilization review company that has neither treated nor seen the patient.

We have no data about how the factors discussed above affect physicians, individually or in combination. We can guess that the effects vary dramatically from physician to physician, and from compensation scheme to compensation scheme, and we may have some plausible intuitions about the direction of the effects. Without data, however, logic cannot take us any further.

Now consider two anecdotes, provided by litigation.<sup>39</sup> Individual lawsuits are, after all, just anecdotes, with greater or lesser degrees of proof of their facts.

Many patients have sued with concerns about managed care in the nine years since *Wickline*. Suits against managed care firms have not proceeded as far or as fast as commentators expected, probably in large part because of the barriers the Em-

---

in health care).

38. 239 Cal. Rptr. 810, 819 (Ct. App. 1986). The second sentence of this comment was explained by the same court in a later case, when it noted that the statement was *dictum* and that the continuing liability of the physicians did not imply that the managed care plan was itself exempt from liability. *Wilson v. Blue Cross*, 271 Cal. Rptr. 876, 879-80 (Ct. App. 1990).

39. Of course, if one accepts the view that I have sometimes heard expressed that, for lawyers, the plural of "anecdote" is "data," my earlier comment about the lack of data needs to be qualified.

ployee Retirement Income Security Act of 1974 (ERISA) raises against effective suits.<sup>40</sup> Most of the reported litigation has involved managing through micro-management. In *Wickline* itself, the issue was authorization for an extended hospital stay, as was the case in its successor, *Wilson v. Blue Cross*. A number of appellate cases have revolved around the effects of ERISA preemption on suits against health plans; those, also, generally have revolved around micro-management decisions. The *Corcoran* case from the Fifth Circuit, for example, concerned authorization for hospitalization in a difficult pregnancy.<sup>41</sup>

Sometimes these cases allege that the managed care arrangements created personal financial interests inimical to the patient's interests. The most noteworthy of those cases concerned denial by an HMO of an experimental treatment, high dose chemotherapy plus autologous bone marrow transplantation for metastatic breast cancer. It resulted in a \$89 million jury verdict against a California HMO. That case, *Fox v. Health Net*, included charges that personal financial interest affected the result, but the financial interest alleged was that of the HMO's medical director, the person who decided whether the procedure sought was experimental.<sup>42</sup>

More recently, the successful plaintiff's attorney in *Fox* represented the plaintiffs in another suit that based one cause of action on direct financial incentives to physicians in an HMO plan. This case concerns Joyce Ching who died in her early thirties of colon cancer.<sup>43</sup> Mrs. Ching was a member of an HMO. She re-

---

40. 29 U.S.C. §§ 1001-1461 (1994). The primary burden is found in ERISA's preemption provision, § 514 of the Act, 29 U.S.C. § 1144. ERISA's preemption provision generally means that with respect to health benefits provided through employers, suits cannot use state law causes of action, *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48 (1987), are limited to contractual damages, *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1331 (5th Cir. 1992), *cert. denied*, 506 U.S. 1033 (1992), and can be removed to federal court, where they are heard without a jury, *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 66 (1987).

41. 965 F.2d 1321, (5th Cir. 1992), *cert. denied*, 506 U.S. 1033 (1992).

42. The *Fox* case was settled before the appeal was heard, so it did not result in a reported appellate opinion. The case is well-described in Christine Woolsey, *Jury Hits HMO for Coverage Denial*, *Bus. Ins.*, Jan. 3, 1994, at 1, 23 (describing the complaint and the decision of California's Riverside County Superior Court). In that case, the plaintiff's claims were not preempted by ERISA because the patient had received her health coverage through her husband's employer, a public school district. Governmental employers had been exempted from ERISA to save them from the burden of complying with its requirements. Ironically, this has left governments as the only employers whose health plans are subject to tort damages, including punitive damages, in those kinds of suits.

43. Olmos, *supra* note 1, at A1. The description of the case that follows is taken largely from that article and from a copy of the complaint (on file with *Health Matrix*).



ceived her care through a physician group, Simi Valley Family Practice, that received \$27.94 per month for her care. The complaint alleged that the physician group had to pay for any diagnostic tests or referrals to specialists. When Mrs. Ching came to the clinic in mid-August 1982 with abdominal and pelvic pain and rectal bleeding, she was referred for an ultrasound examination, at a cost of over \$200 to the clinic. The ultrasound had indeterminate findings. It was not until her third visit, in October, after her pain had greatly increased, that the physicians ordered another diagnostic test, a barium enema x-ray, at a cost to the clinic of \$261. That x-ray showed a colon cancer which, after seven operations and twenty months, proved fatal.

The complaint alleged that the cancer should have been diagnosed at an earlier and more treatable stage, but that the capitation agreement made Ms. Ching's physicians too reluctant to spend the money needed for the relevant tests. Anything they spent on her diagnosis would come out of the group's income, and the ultrasound already had devoured about eight months of her capitation payments. The defense argued that colon cancer is so rare in young adults without a family history of the disease that the physicians properly did not test for it in the first visits. The defense also pointed to the ordering of the ultrasound examination as evidence that the physicians were not ignoring their patient's medical needs because of capitation.

Mrs. Ching's husband and young son did not sue the health plan, probably because of the barriers ERISA imposes. Instead, to the usual malpractice allegations against the treating physicians, they added a cause of action for breach of fiduciary duty, arguing that the managed care contract created an impermissible conflict between the physicians' interests and those of their patients. The plaintiff's attorney may have had three hopes for the allegation: it might avoid the restrictions on damages for medical malpractice cases; it might make it easier to win punitive damages; and it might allow into evidence otherwise irrelevant testimony about the financial arrangements, which could sway the jury's verdict.

Several times during the course of the trial, the trial judge rejected efforts by the defense to eliminate the cause of action for breach of fiduciary duty. Just before the case went to the jury, the judge granted a directed verdict on that cause of action, removing it from the jury, but not erasing from their minds the testimony that had been admitted during the trial, as they consid-

ered the remaining, traditional, malpractice claims. The jury returned a verdict on November 15, 1995, finding for the plaintiffs in the amount of \$3 million, which was then reduced to \$700,000 as a result of California's \$250,000 cap on non-economic damages in medical malpractice cases.<sup>44</sup>

The second anecdote also comes from southern California; it concerns a dental malpractice claim. I learned of this case in May 1995, when the plaintiff's attorney telephoned me, seeking some (free) advice about suits concerning managed care. He told me that his client, through the client's employer, had been a member of an IPA-type HMO for dental care. The lawyer said the HMO had only a small number of dentists in its panel in his client's area, and that the HMO paid those dentists on a fully capitated basis. His client had some serious dental problems, but, the attorney said, none of the five HMO dentists the client visited would treat him. The first four, after determining the problem, told him that their schedules were full and kept him waiting interminably. The fifth, after some discussion, told him that he needed major root canal work. The attorney recounted that this dentist said the HMO did not pay him enough to do that kind of work. The dentist would be willing to pull the offending teeth for the HMO's payment, but he would require an additional \$8,000 from the patient to fix the teeth. The patient had already sued the individual doctors for malpractice and patient abandonment, but was trying to find a successful theory for pursuing the HMO.

These are just a few of the many anecdotes told, in court and otherwise, about mistakes or abuses in managed care. Assuming the allegations in these two cases are true, compare them to the factors noted above.

The GAO report listed nine factors as potentially affecting how a doctor responds to direct financial incentives: 1) the extent of the doctor's risk; 2) stop-loss insurance; 3) the distribution of the risk to individual doctors; 4) the number of doctors sharing the risk; 5) the number of patients in the physician's (or group's) panel; 6) the duration of the risk assessment period; 7) the level of compensation by the HMO; 8) the percentage of in-

---

44. *California Jury Awards \$3 Million to Family of Deceased Cancer Patient*, HEALTH CARE DAILY (BNA), at D5 (Nov. 27, 1995); Paul Elias, *Doctors Negligent in Woman's Cancer Death, Jury Finds*, L.A. TIMES, Nov. 16, 1995, at A3; Paul Elias, *Focus of Malpractice Case Is Restricted to Negligence Issue*, L.A. TIMES, Nov. 10, 1995, at B1.

come the physician or group gained from the HMO; and, 9) the generosity of the service utilization budget.<sup>45</sup> We identified two other factors: the general reluctance to lose rather than not to gain, and the physicians' individual financial situation and character. Then we noted three countervailing factors: the lower long-term cost of effective care, the possibility of malpractice suits, and the doctors' professional ethic.

In the Ching case, the physician group appears to have been entirely at risk for her medical care, at least outside the hospital, although we know nothing about the way the group compensated individual doctors. Nor do we know anything about most of the other factors, except the countervailing factors. In the case of a possible missed colon cancer diagnosis, the patient's outcome might be much worse; the group may have to provide more expensive services than if it caught the cancer earlier; and the risk of malpractice liability is very real. Compared with the relatively small cost of a barium enema x-ray or other diagnostic procedures, such as colonoscopy, those countervailing factors seem quite powerful.

The dental case looks quite different. There, all the dentists involved were sole practitioners who were capitated for all services to plan members. These dentists, therefore, would feel the full brunt of any higher expenditure, with no sharing among their colleagues. That expenditure, in this instance, apparently would have been several thousand dollars. Here, the countervailing factors were not strong. Failing to act quickly apparently would not increase the dentists' costs, and it might even lower them by making removal of the teeth essential. The medical outcome for the patient, though not at all pleasant, would not be life-threatening. Because the patient's problem did not threaten death or disability, his damages in any malpractice suit likely would be fairly small, which would also decrease the chances that such a suit would be brought.

## B. What Should We Do in the Short Run?

We cannot dismiss the possibility that, in some circumstances, direct financial incentives could harm patients. It seems plausible that we could identify some factors or situations that

---

45. GAO REPORT, *supra* note 8, at 34-36.

might increase the odds of such bad outcomes. At the same time, the health care world is in the midst of a complicated and rapidly changing revolution in how society buys care. At this point in that revolution, what should be done about direct financial incentives?

One set of at least partial answers has been advanced by the federal government. In the Omnibus Budget Reconciliation Act of 1986, Congress had forbidden hospitals and prepaid health care organizations with Medicare or Medicaid risk contracts from knowingly making incentive payments to physicians to induce them to reduce or limit services.<sup>46</sup> The Act further required the Secretary of Health and Human Services to report to Congress about those incentive arrangements.

The ban on offending incentive provisions was to begin on April 1, 1989. The implementation date was extended twice by Congress, but before the second extended date, the HHS report to Congress arrived.<sup>47</sup> That report failed to find a link between such incentive provisions and poor quality care. Perhaps as a result, Congress repealed the prohibition. In its place, Congress substituted three rules governing organizations using such incentives. First, the organizations could not have a physician incentive plan that made specific payments to doctors to induce them to limit or reduce medically necessary services to a specific individual. Second, they had to tell HCFA about their physician incentive plans in detail. Finally, if their plans put physicians or physician groups at "substantial risk," as defined by regulation, they had to provide stop-loss insurance to the physicians and survey their present and past members about the members' access to and satisfaction with the services they received.<sup>48</sup>

In December 1992, HCFA issued its Notice of Proposed Rulemaking to implement the 1990 legislation. The proposed regulations spelled out the requirements that the organizations disclose their physician incentive plans to HCFA, for Medicare, and to state Medicaid agencies. They defined "substantial financial risk" as situations where a physician, or group, would have either more than twenty-five percent (for physicians or groups

---

46. Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9313(c), 100 Stat. 2003 (1986).

47. DHHS Report, *supra* note 8.

48. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4204(a), 104 Stat. 1388-108 (1990).

evaluated annually) or fifteen percent (if evaluated more frequently than annually) of its total compensation from the organization at risk, based at least in part on services the physicians did not provide directly. These "at risk" percentages count withholds, bonuses, capitation for referrals, and other systems. The proposed regulation also would have implemented the stop-loss and survey requirements. Finally, it clarified that, although physicians could not be compensated for limiting medically necessary services to an individual, they could be compensated for low aggregate utilization.

Although this proposed regulation would have applied directly only to HMOs that had risk contracts with Medicare or Medicaid, it could well have influenced HMO physician payment plans more generally. As of early 1996, however, the regulation remains in limbo. It has neither been adopted nor withdrawn.

I believe that what we know about direct financial incentives justifies only a small part of the proposed regulation, and no other substantive actions. We do not know enough to impose any meaningful substantive action. In its Notice of Proposed Rulemaking, HCFA itself disclaims any knowledge of information connecting direct financial incentives to health problems.<sup>49</sup> It proposes the fifteen percent and twenty-five percent definitions for "substantial financial risk" solely because those seem to be near the limit of the risk amounts currently used by plans. As the current plans have no proven problems, HCFA suggests, those percentages should be safe. This, of course, entirely avoids the questions of whether those percentages, or any percentages, are necessary. Similarly, the ban on payments to induce limits on services to particular individuals, which merely implements congressional language, also lacks any attempt at justification. The Notice gives, as an example of prohibited conduct, a \$100 bonus for each maternity patient discharged after two days in the hospital rather than three. Without more evidence, including medical evidence about what is reasonable in the case of each such bonus plan, there is no reason to assume that those plans should be banned.<sup>50</sup>

---

49. Physician Incentive Plans, *supra* note 8, at 59,026.

50. *Id.* at 59,032-33 (stating that federal regulations should prohibit the operation of physician incentive plans which make specific payments as a direct, or indirect, inducement to reduce or limit medically necessary services provided to a specific enrollee). The statute speaks of limiting "medically necessary" services. Of course, neither an HMO nor a doctor

There seems little reason for substantive regulation when all the regulators can say is that what they propose is consistent with what the industry already does. And, when an industry is evolving as rapidly as this one, such regulation may prove burdensome. The better public policy combines continued watchfulness with three steps to gather, and disclose, more information about direct financial incentives to HMO members, to physicians and physician groups, and to researchers.

The first step would be to require health plans to disclose to their members, in some detail, the ways in which they manage care: whether by micro-management, panel selection, or direct financial incentives. Legislation mandating such disclosures has been proposed in several states<sup>51</sup> and has been supported by the American Medical Association.<sup>52</sup>

Such legislation seems to have some real, but limited, costs and benefits. The costs stem mainly from the complexity of the required disclosures. Consider again the Stanford triple option

---

would admit that, in the circumstances where the earlier discharge occurred, an additional day in the hospital was "medically necessary."

51. See, e.g., S.B. 1562, 89th Gen. Assembly, 1995-96 Reg. Sess. (Ill. 1996); S.B. 718, 1996 Leg. Sess. (Md. 1996); H.B. 2391, 180th Gen. Assembly, 1995-96 Reg. Sess. (Pa. 1996); H.B. 1015, 1996 Sess. (Va. 1996). In New York, a "Health Care Bill of Rights," including a broad array of disclosure provisions for managed care plans, won the support of a majority of the state's Assembly in 1995. The legislative session ended before the bill reached the state Senate. Julie Johnson, *State Laws on Managed Care Spur New Battles*, AM. MED. NEWS, July 24, 1995, at 3. As of March 1996, only Maine has enacted an incentive disclosure requirement into law. ME. REV. STAT. ANN. tit. 24, § 2337 (West 1995).

It is unclear whether such state legislation could be applied to employee plans. Not only does ERISA generally preempt state laws that "affect" employee benefit plans, 29 U.S.C. § 1144, but ERISA itself contains specific requirements concerning information that employers must provide about such plans, 29 U.S.C. §§ 1021-1031. On the other hand, this might be upheld as a requirement that had general applicability to health plans, rather than to benefit plans. See *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 115 S. Ct. 1671 (1995) (finding that a state statute requiring hospitals to collect surcharges from patients and HMOs did not "relate to" an employee benefit plan within the meaning of ERISA's preemption provision). Finally, the legality might vary depending on whether the employer merely contracted with the HMO or whether, in some way, it actually "created" the HMO, as in the Stanford triple option plan. In any event, there would be no legal barrier to federal legislation requiring such disclosures.

52. In 1990, the AMA's Council on Ethical and Judicial Affairs issued a report stressing the ethical duty that managed-care physicians have to disclose relevant financial incentives and contractual restrictions relating to the delivery of health care under the plan. Council on Ethical and Judicial Affairs, American Med. Ass'n, *Financial Incentives to Limit Care: Financial Implications for HMOs and IPAs*, in AMERICAN MED. ASS'N, CODE OF MEDICAL ETHICS: REPORTS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS OF THE AMERICAN MEDICAL ASSOCIATION 130 (1990). The Council issued a related report in 1995, reiterating the importance of disclosure about managed care incentives. Council on Ethical and Judicial Affairs, American Med. Ass'n, *Ethical Issues in Managed Care*, 273 JAMA 330 (1995).

plan. If the legislation were serious, a Stanford employee would have to be told, first, that her physicians would be compensated in different manners, and in different amounts, depending on whether she used the HMO tier, the PPO tier, or the outside tier. Then, within the HMO tier, she would be told that although the basic system of compensation would be capitation with a withhold, the amount being paid to the physician or physician group would be different for each of the three physician groups and for the Blue Shield HMO. The extent to which particular services, such as clinical laboratory services, were the financial responsibility of the physicians would vary from group to group. Finally, the actual incentives faced by the physicians in at least the three groups with which Stanford directly contracted would depend on the compensation policies of their physician groups. A complete accounting then would have to describe those compensation policies and the ways that they differed for different physicians—primary care, specialists, new physicians, part-time physicians, and so forth.

Such a full description seems difficult to create. It also seems likely that description of their group compensation plans would be resisted by physicians, whose political clout has been used to encourage such legislation. The result most likely would be a long and burdensome disclosure form that would fail to tell employees how their personal physicians actually were paid for seeing them.

Would even that limited information be useful to consumers? In some cases, such as where employees have no choice of health plans, the information would be of little value. Even employees who have choices would have to read and understand the disclosure and then put a value on the differences from plan to plan. It is questionable that several pages of fine print disclosures, in fact, would change many prospective members' minds.

Of course, it might. If some consumers, in fact, are willing to pay more for a plan that avoids direct financial incentives, then there seems to be no reason not to give them that opportunity.<sup>53</sup> On the other hand, one should not expect much change as a result.

---

53. Of course, such highly motivated consumers might determine this information themselves, through, for example, asking doctors how they were paid. For those consumers, a mandated disclosure could be unnecessary.

A second solution would be more general disclosure of management arrangements to those involved. It is possible that physicians and physician groups contracting with managed care organizations have inadequate information about the range of management options that exist. Knowledge of the different options might allow them to bargain more effectively, in their own interests, and, if the physicians think their patients would be importantly affected, in their patients' interests.

A state medical society, for example, might create a repository of contract terms offered by various managed care organizations. Some state medical groups already maintain such repositories. Those repositories could be created or expanded to include the contractual provisions concerning micro-management, panel selection, or direct financial incentives. They could then be open to physicians—and the press and public—to allow a better understanding of the terms that are available. The repositories could be required by legislation<sup>54</sup> or, unless barred by non-disclosure clauses in the contracts, by the voluntary action of the contracting physician groups themselves.

Of course, in seeking managed care contracts, physicians compete with each other. The sharing of information among competitors can have serious anti-competitive consequences, and can lead to liability under the antitrust laws. It is unclear to what extent the kinds of terms under consideration here would raise antitrust concerns. In any event, the Department of Justice has issued guidelines allowing health care providers to share even financial information about contracts with a three-month delay.<sup>55</sup> Such a delay should not destroy the value of the proposed contract repository.

My final proposed solution builds on the first two: we need more information for researchers and more researchers interested in using it. Currently, information about how particular plans are managing care is limited. If that situation were remedied, it might be possible for a researcher to try to correlate methods of

---

54. Whether a state could enforce such legislation against ERISA plans remains uncertain, for the same reasons discussed above.

55. U.S. DEP'T OF JUST. & FED. TRADE COMM'N, STATEMENTS OF ENFORCEMENT POLICY AND ANALYTICAL PRINCIPLES RELATING TO HEALTH CARE AND ANTITRUST (Sept. 27, 1994). In addition, to the extent the repositories were required by state law and carefully supervised by the state, they might be immune from antitrust liability under the "state action" doctrine. See *Patrick v. Burget*, 486 U.S. 94, 105-06 (1988) (finding immunity from antitrust laws only where the state has made peer review state action).



managing care with other variables. Quality of care obviously would be a very important one, but quality is notoriously hard to measure. Member satisfaction might be an easier variable to measure. In some systems, member satisfaction is managed regularly. The California Public Employees Retirement System, for example, provides health plans for more than one million people through more than twenty different health plans. This system surveys its members' satisfaction with their plans on a regular basis. If the management methods of the different plans were known, it might be possible to tease out connections between those methods and member satisfaction.

In the short run, then, what we need, is to know more about direct financial incentives and their effects. Currently, we do not know what methods are being used, how frequently, or with what effects on patients. Nor do we know whether those methods have effects in the markets; consumer reactions might be driving plans toward one, or a few, methods. At this stage, we just do not know enough to propose substantive regulation of direct financial incentives.

### C. What *Might* We Do in the Long Run?

I want to end by speculating about two kinds of longer run responses to direct financial incentives in managed care. One would limit managed care's use of some direct financial incentives; the other would try to adapt medical practice to those incentives.

The first, and nearer term, response would be to control what kinds of direct financial incentives could be used by managed care organizations. If evidence from research made it clear that some combinations of managed care incentives hurt patients, those methods could be banned or discouraged. Even if the evidence were clear, there are some good reasons to focus on the second verb.

Banning managed care arrangements is likely to be quite difficult and intrusive. First, it is unlikely that any one arrangement will be a bad thing for patients in all circumstances. As the GAO report pointed out, a number of factors have been put forward as causing concern about direct financial incentives. An incentive, such as global capitation, could be very worrisome when dealing with a sole practitioner whose entire income came from that capitation. It could cause less concern if the practitioner got

less than five percent of his income from that source. It would cause almost no concern if the practitioner were part of a medical group of several hundred, or several thousand, physicians, among whom that risk was spread widely.

Applying such restrictions in an appropriately narrow manner is likely to prove difficult in several ways. It will be hard, politically, to treat one sector of medicine more restrictively than another, even if the restrictions are "for their own good." It will be hard to determine exactly where the boundaries are between practices that are "large enough" and "too small."

Second, if taken seriously, those kinds of restrictions would have to apply not only to how the managed care plan paid the physicians, but also to how physicians in groups pay each other. Logically, there is no difference between the incentives that can be created by either method, a point that the managed care industry would undoubtedly trumpet. Such a direct legislative intrusion into medical groups seems both unhappy and unlikely.

Finally, whatever regulations are created would be probed immediately for loopholes. Both managed care organizations and physicians will make a myriad of subtle or formal changes in order to reach some perceived advantage under the rules. The result is likely to be an extended regulatory dance, of regulation, evasive reaction, amended regulation, and new evasive response. This kind of behavior exemplified the petroleum price and allocation controls of the 1970s, which remain in litigation fifteen years after they were abolished. They have long characterized some areas of tax practice. In such regulatory dances, only the lawyers, accountants, and regulators ultimately benefit.

The disadvantages of banning some forms of direct financial incentives largely are avoided if, instead, we discourage dangerous forms. This could be done by publicity and market pressures. Research into determining the dangers of various methods could be commissioned, and then publicized. If coupled with a requirement that patients be told how their doctors are paid, this might have a substantial effect in pushing managed care organizations to focus on the safer incentive schemes.

Although, as Louis Brandeis stated, sunlight is the best disinfectant,<sup>56</sup> it is rarely a panacea. Using publicity to discourage dangerous systems of managed care would still be subject to

---

56. LOUIS D. BRANDEIS, *OTHER PEOPLE'S MONEY* 92 (1914).

problems of context and of line drawing, as well as the further problem of consumer understanding and reaction. Without a regulatory solution, however, both the ability and the incentive of managed care organizations and physician groups to find and use loopholes, would be much more limited.

The second form of solution would not so much adjust managed care's incentives as adjust the context into which they fit. The main drawback to direct financial incentives is their ability to overpower a physician's professional judgment and convince her to treat her patient in a way that she does not believe is best. Some would go further and argue that the more insidious danger is that it would, subconsciously, change the physician's idea of what good practice is, to the detriment of the patient.

The benefit of managed care's use of direct financial incentives, at least compared with either micro-management or panel selection, is that it lets the physician exercise her professional judgment, without fear of being overruled by a utilization review, or of being mysteriously "de-selected" from a closed PPO or HMO panel. That fear is replaced by a fear of losing income, which, in turn, is most pressing when the risks involved in the financial incentives are not being shared.

In the long run, direct financial incentives may provide a useful solution to the problem of managing care, but only in a context where their risks are shared, and, hence, softened. The obvious context is a large group practice with a compensation system that does not just mirror the managed care incentives. By setting their own compensation systems, physicians organized into groups can spread the risk that one doctor will have particularly expensive patients. At the same time, they have both the opportunity and the incentive to see how each of them practices medicine, and thus have a better chance to determine whether the higher costs are from more expensive patients or unnecessarily expensive physician practices. Finally, they have the opportunity, mainly through peer interactions, to counsel and educate physicians whose practice patterns seem inappropriate.

Through direct financial incentives, a physician group takes on all the financial risk of a patient's treatments, but also takes all the responsibility for it. Those incentives might be capitation, a salary and bonus scheme, or even a global annual budget in a single payor health care system. The key point is that the medical group, and not the utilization review nurses, the health plan medical directors, or anyone else, can decide what care it thinks

is optimal and how best it can be delivered. The group, unlike outside parties, has the best chance to observe and change poor physician care.

Thus, one way to adjust to direct financial incentives is to reconstruct medicine into a world of fairly large group practices that will be subject to those incentives. In light of the increase in group practice in the last decades, that may be inevitable, with or without direct financial incentives or even managed care. The increasing group nature of practice may make direct financial incentives an opportunity, and not a threat.

The deeper issue of the ways in which direct financial incentives could change physicians' perceptions of proper medical practice also requires some attention. I know many physicians who practice under one form of managed care with direct financial incentives: the Kaiser Permanente system. They tell me that they never feel pressure to make a treatment decision for financial reasons, but they also say that they practice differently at Kaiser than they did elsewhere and that their views of what is good medical practice have changed. Many of those differences probably reflect simple changes with no ramifications for patient care. Physicians may use less expensive but equally effective drugs, or not keep patients in the hospitals longer than studies show is appropriate. All agree that much unnecessary, or unnecessarily expensive, care can be wrung out of the medical system.

At some point, though, when the unnecessary care has been eliminated, society still may be unwilling to pay the bill for all the appropriate care that is technically available. Under a system of care delivered by physician groups, operating under financial incentives, these rationing decisions would be made largely by the physician groups. This may be a good description of the current British National Health Service, since the reforms of the early 1990s.<sup>57</sup> By burying the decisions in physician groups, one avoids the kinds of express allocation rules that prompt litiga-

---

57. For some general background and interesting observations on the changes in the British system, see Robert G. Lee & Frances H. Miller, *The Doctor's Changing Role in Allocating U.S. and British Medical Services*, 18 L. MED. & HEALTH CARE 69 (1990) (observing the similarities between American and British physicians' roles in allocating health care); Frances H. Miller, *Competition Law and Anticompetitive Professional Behavior Affecting Health Care*, 55 MOD. L. REV. 453, 455 (1992) (discussing how competition laws might impact market-distorting activity due to changes in the National Health Service); Frances H. Miller, *Doctors' Conflicts of Interest (& Altruism) in the United States and Great Britain*, 27 IND. L. REV. 687, 694-95 (1994) (book review).

tion—and accountability.<sup>58</sup> Are physician groups the right bodies to make these rationing decisions? Compared to having them made by managed care groups? Congress? The courts? The “market?” These questions may lurk below the surface of the speculative future outlined above.

#### IV. CONCLUSION

Not all physician groups will respond to direct financial incentives in the same manner. In the best of all worlds, consumers would have a choice of what groups they would use. This choice might come through managed care plans that contract with several groups, or through a world in which each patient was able to choose among several managed care plans, each of which contracted with one or more groups. In some parts of the country, the population will be too sparse to support more than one, or even one, such physician group; in most of the country, the groups might exist, but patients may not have access to them, at least not through their health coverage.

The late, and, I believe, insufficiently lamented Clinton Health Plan would have solved the second problem. Under that plan, families would have been able to choose among several managed care, and non-managed care health plans through a health alliance, which would have been responsible for collecting, analyzing, and providing information to families about consumer satisfaction and quality in each plan. In a world that is, at least for the time being, “post” health reform, that kind of choice between responsible physician groups remains rare.

With direct financial incentives in managed care, as with almost every other important question about the American health care system, we ultimately arrive at the importance of thorough reform of the health care financing system. As we struggle through these ancillary issues, we must never forget that the fundamental issue remains unresolved.

---

58. The two other forms of managing care, through micro-management or de-selection, necessarily generate some kinds of express rules or standards about practicing medicine. Their existence, even if internal to the organization, means that it is possible for them to be discovered (both literally and litigatively) and challenged. Physician groups might allocate by similarly express standards, but they also might not.