
Provider Disclosure of Financial Incentives In Managed Care: Pros and Cons

by Robert McCormack

Financial incentives in managed care organizations are under scrutiny. The organization, rather than the physician, has the responsibility to explain these incentives to plan holders in a clear and understandable manner.

Because of the escalating costs of medical care in the United States, managed care is rapidly becoming the health care delivery system for many Americans. Managed care has demonstrated the ability to help control costs of medical care, in part by changing the incentives of health care providers to make them more cost-conscious. This is an important part of the cost-control success of managed care.

It is impossible to have an efficient health care delivery system that does not have incentives. The *American Heritage Dictionary* defines incentive as: "Something inciting to action or effort, as the fear of punishment or the expectation of reward." Incentives can be intangible as in the sense of accomplishment of a job well done or tangible as in a financial reward. Financial reward is a strong motivator for most people, but it is important that financial incentives are not so great that behavior is distorted or driven to extremes. The challenge in managed care is to balance financial incentives to allow the most cost-effective and appropriate health care for all Americans.

Financial incentives in managed care organizations are receiving close scrutiny. The media is treating information about financial arrangements between managed care organizations and providers as a kind of "dirty secret" that needs exposure. Consumers have expressed concern about quality of care and access in managed care plans, in part because of these media revelations. The media also generalizes about managed care

organizations. For example, a recent article stated that "it takes five to seven days to get a referral approved by a managed care organization." All managed care organizations do not require physicians to get their approval for a referral; all managed care organizations are not the same. Because of misunderstandings and misinformation, I believe it is time for managed care organizations to assume a proactive role in addressing financial incentives and reimbursement.

This is an area in which all managed care organizations do not agree. Some plans and plan managers do not support the idea that it is their responsibility to inform members about provider financial incentives, perhaps contending that it is the members' responsibility to request this information. The information may also be considered proprietary in that releasing specific details of provider contracts and payment schedules could be used by competing managed care organizations. While releasing specific payment schedules or details of provider contracts is not necessary or appropriate, I believe that members should be given general information regarding provider compensation.

How should a managed care member be

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informed of the financial relationship between a managed care organization (MCO) and the member's primary care provider? More specifically, is it the physician's responsibility to discuss this with a patient, or should this information be the responsibility of the MCO? The issue of responsibility needs to be addressed to assure all MCO members receive this information. Before discussing the best way to inform MCO members about this financial relationship, I will examine the impact of provider financial incentives in general.

Fee-for-Service Incentives

In traditional fee-for-service medicine or indemnity insurance arrangements, most people are aware that the provider is paid something for everything the provider does for them. How much information the patient has about these matters depends on the provider and his or her business practices. In this arrangement, the incentives are for the physician to provide as many services as possible in order to maximize profit. Since many people believe that "more is better," this arrangement appears ideal. Fee-for-service medicine provides the easiest access for people who can afford to pay for it; however, there is no evidence the quality of care is better than in managed care. Moreover, the care is generally not as well coordinated. A recent study (N. Lurie et al. 1994) supports the conclusion that medical care provided in HMOs is as good or better than in fee-for-service medicine.

In fee-for-service medicine, if two treatments have about the same outcome, the incentive is for the provider to pick the more profitable one. This is one of the reasons fee-for-service medicine will never adequately control costs. The other reason has to do with patient pressure: If the provider has no financial responsibility for the services provided, he or she will be more likely to provide a service if the patient wants it, regardless of need.

How aware are people about issues in fee-for-service medicine? Do they consider that their physician's recommendation for a particular treatment or service might be motivated by how much

profit the provider will make on that treatment? If the patient chooses to raise financial issues with the provider, an appropriate discussion should clearly take place. However, most patients would be uncomfortable with the physician raising the issue of general financial incentives at a first visit. This could create suspicion between the physician and the patient that would be potentially destructive to the relationship. Still, most patients probably do have at least an intuitive understanding of these incentives in fee-for-service medicine.

Managed Care Incentives

In managed care, physicians are generally compensated through prepaid financial arrangements. This payment usually takes the form of either a salary or a capitation payment. In a salary compensation system the physician is paid a monthly salary to see and care for patients of the Managed Care Organization (MCO) as an employee of the MCO. In this instance the physician has no direct incentive to over or under utilize services and could be said to arguably have the most balanced incentives. Still, the MCO does pay the provider's salary, not the patient. In addition, the MCO will generally watch utilization carefully, and may give financial incentives to control utilization in the form of bonuses. The patient can still exert pressure on the physician to provide services the patient does not need, and there may not be any direct consequence to the physician for providing these services.

Capitation

Capitation is prepayment that takes the form of a monthly amount paid to each provider for each member in his or her MCO panel. For this payment the physician agrees to provide, at a minimum, certain basic services such as all office visits and hospital professional fees. Depending upon the physician's specialty, other services may be included as well. Sometimes there is also a "withhold" from this capitation payment that may be kept by the MCO if the provider does not meet certain utilization goals, i.e., does not keep use of resources down to an agreed level. Withholds are not as commonly used now as they have been in

the past. This capitation arrangement needs to provide enough money for the physician to take care of the patients in his or her panel and to make a reasonable profit. In some HMOs this capitation amount includes tests, treatments, and referrals ordered by the physician. It is in this situation that the provider may be "at risk" and a negative financial incentive may exist.

The purpose of a capitation financial arrangement is to create a system in which the physician will no longer have the incentive to provide unnecessary services or services that are unnecessarily expensive. This system addresses some of the flaws in the fee-for-service payment method. Physicians are not given incentives to provide unnecessary high-cost services. This arrangement also creates a situation in which providers who care for a group of members more efficiently will make a higher profit. A physician can be capitated in different ways: for only the services provided in ordinary primary care, or for these services plus additional tests, treatments, and referrals. It is in the latter situation that capitation agreements may have potential for misuse.

Informing Patients

Informing members about physician financial incentives is an extension of the principle of informed consent. Because physician incentives can affect the manner in which a member is treated, however appropriate that treatment may be, the member's understanding and acceptance of these incentives is important. Members have a right to know what to expect from their managed care plan and their health care provider. What, then, is the best way to educate patients about these various reimbursement systems within a managed care organization?

It adds perspective to this issue to remember that physicians caring for patients in traditional fee-for-service medicine have not routinely informed patients about the pros and cons of the fee-for-service compensation system. It is only because we have had fee-for-service medicine in the United States for a long time that people understand it as well as they do. Managed care is a

relatively new way of providing medical care. It is more organized than fee-for-service medicine in that there is an administrative structure to hold accountable. Consequently, the managed care organization itself should explain financial reimbursement issues with members when they join the MCO. This should be done in clear, easily understood language. This could be done with a written statement included in member orientation materials and in discussions during member orientation meetings. The managed care industry as a whole should also address these issues at a national level to educate the American people about

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the way managed care works.

The discussion of financial incentives should not be the responsibility of physicians. In a 1995 task force studying ethical issues in managed care, consumer focus groups (members of managed care plans) indicated that they "suspected treatment decisions were being made solely to save money."¹ Should a managed care physician indicate to a new patient that the physician's income may be affected by the amount of care provided, the patient might understandably be uneasy and distrustful. This, in turn, would affect the patient-physician relationship negatively. Such a discussion at the onset of care may prevent physicians from ever successfully convincing patients that they are not withholding services in order to make more money at the patient's expense.

Patients need to get acquainted with a new physician before they will be comfortable discussing health concerns with him or her. Discussing financial issues in this setting could create unfair and unnecessary doubts in patients' minds about the physician's judgment. Having the MCO plan managers disclose these financial arrangements

frees the physician to focus on addressing the patient's health concerns. However, if the patient asks about financial compensation issues, the physician should respond.

Ethical Disclosure

Most physicians, in managed care and in fee-for-service medicine, do what they think is best for their patients. It is unethical for a physician to withhold needed medical care that is a covered benefit of the managed care plan. Likewise, it is unethical for a physician to order or provide unnecessary medical care.

Issues of financial incentive become more problematic in subtle areas. Research has shown that physicians in managed care are generally less likely to provide extra services than physicians in fee-for-service medicine. As long as the care withheld is unnecessary for the patient, this is not an ethical issue and, in fact, would be expected protocol in a well-managed plan. Unfortunately, medical necessity determinations involve an element of judgment as well as fact.

Conclusion

All regulatory and accrediting agencies that review managed care organizations expect the MCO to monitor their participating physicians to identify any who may be withholding needed medical care. The National Committee for Quality Assurance (NCQA) standards state "The managed care organization has mechanisms to detect underutilization as well as overutilization" (NCQA 1995). This can be accomplished through review of member encounters, referral rates, and medical record reviews. NCQA also requires MCOs to provide members with clear statements of their rights and responsibilities and information on how to appeal a decision they feel adversely affects their health.

The managed care organization is responsible for assuring that provider incentives are not unethical and do not encourage withholding necessary care by physicians. It is also the MCO's responsibility to monitor physician utilization to assure that underutilization (withholding of

necessary medical care) is not occurring. Asking the physician to initiate the discussion of financial issues with the patient is an unnecessary burden on the physician and the physician-patient relationship. The preferred solution is to encourage managed care organizations to do a better job of informing prospective and new members about physician financial incentives.

It is important for patients to understand managed care physician financial incentives and the need to take a more active role in their health care as managed care organization members. The responsibility for educating patients about this issue should rest with the managed care organization.

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