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MEDICARE: Physician Incentive Payments by Prepaid Health Plans Could Lower Quality of Care

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Subcommittee on Health
Committee on Ways and Means
House of Representatives

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SUMMARY

In 1986, the Congress prohibited health maintenance organizations (HMOs) with Medicare risk contracts from using payments to directly or indirectly influence physicians to reduce or limit medical services to Medicare HMO enrollees. The ban is effective April 1, 1990.

As requested by the Subcommittee on Health, GAO reviewed 19 HMO physician incentive plans and identified four characteristics that have the greatest potential to threaten quality of care for Medicare patients. These are

-- the amount of risk shifted from the HMO to physicians,

-- the number of physicians whose cost performance is used to decide the size of the incentive pool available for distribution,

-- whether incentive payments were based on a percentage of HMO savings or profits, and

-- the length of time over which cost performance is measured.

Essentially, the troubling nature of these characteristics revolves around two key issues: (1) the immediacy of the linkage between a physician's treatment decision and payment of an incentive and (2) the amount of risk transferred from the HMO to the physician.

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the report we prepared at your request concerning incentive arrangements between certain prepaid health plans and the physicians who provide health care services to plan members.[1]

Beginning April 1, 1990, current law prohibits physician incentive payments by prepaid health plans with Medicare risk contracts. When enacting this prohibition, the Congress directed the Department of Health and Human Services to study the incentive plans offered by prepaid health plans and recommend to the Congress exceptions to the prohibitions for incentive plans that do not have a substantial potential for adverse effects on quality. The Subcommittee asked us to review plans with a view toward identifying features that are most problematic from a quality-of-care standpoint.

Our report identified four incentive plan characteristics that singly or in combination may pose a threat to quality of care. Essentially, the troubling nature of these characteristics revolves around two key issues: (1) the closeness of the linkage between a physician's treatment decisions and payment of an incentive and (2) the amount of financial risk transferred from the health plan to the physician. We suggested that if the Subcommittee considers modifications to the prohibition of

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[1] Medicare: Physician Incentive Payments by Prepaid Health Plans Could Lower Quality of Care (GAO/HRD-89-29, Dec. 12, 1988).

incentive payments by prepaid plans, it also should consider retaining a ban on plans that closely link financial rewards to individual treatment decisions or expose primary care physicians to substantial financial risk for services furnished by other providers or both.

BACKGROUND

Medicare is the federal health insurance program for Americans age 65 and older and certain disabled persons. The program covers a broad range of health services for its 33 million beneficiaries. Medicare part A, hospital insurance, covers inpatient hospital, skilled nursing facility, hospice, and home health care. Part B, supplementary medical insurance, covers many types of noninstitutional services, such as physician, clinical laboratory, X-ray, and physical therapy services.

Medicare beneficiaries obtain physician services through two basic systems. Under one system, called fee-for-service, physicians charge for each service they perform and are reimbursed on a unit-of-service basis. Under this system, there is no financial incentive for physicians to control program costs because the more services a physician furnishes, the greater the physician's income.

The second way beneficiaries receive services is through enrollment in a prepaid health plan, specifically health

maintenance organizations (HMOs) and competitive medical plans.[2] HMOs receive a predetermined, fixed monthly fee paid in advance (that is, a capitation payment). In return, the HMO provides directly or arranges and pays for health care for a voluntarily enrolled population. Enrollees receive services from physicians who are employees of or contractors with HMOs. Because the HMO assumes responsibility for providing services within a fixed amount, it has a financial incentive to minimize the use of health services. All other things being equal, the fewer services the HMO provides, the more money from the fixed capitation fee it retains as profit.[3]

HMOs commonly use three basic compensation arrangements for their physicians:

-- Salary. Under this arrangement, the physician's income may be tied to factors such as training, experience, performance, or tenure; it is not related to utilization of services. Salaried physicians have minimal financial risk for utilization and have few financial incentives to control service utilization.

-- Fee-for-service. As in the traditional fee-for-service system, physicians affiliated with HMOs that use the fee-for-service approach are paid per unit of service, with modifications to encourage utilization control. The HMO may pay physicians' actual charges, prevailing charges in the area, or an amount based on a fee schedule.

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[2]HMO will be used to refer to both HMOs and competitive medical plans. While subject to essentially the same Medicare regulatory requirements as HMOs, competitive medical plans have greater flexibility than federally qualified HMOs in setting their commercial premium rates and types of service covered.

[3]We use the term profit to refer to money the HMO may retain. Many HMOs are not-for-profit organizations, and for those HMOs, the term technically is "excess of revenues over expenses."

Physicians may share in the HMO's financial risk by having part of their payments withheld in a risk pool that is distributed to the physicians only if the HMO's total costs do not exceed specified levels.

-- Capitation. Under this approach, physicians are assigned specific HMO enrollees and accept a monthly amount as payment in full for each assigned member regardless of how many services the member receives during the month. Under capitation arrangements, an individual primary care physician can gain or lose depending on the frequency or extent of services provided to enrollees or both. Capitation arrangements can cover (1) primary care, (2) all physician services, or (3) all health services. Under the first arrangement, primary care physicians are responsible only for their own services. Under the second, physician service capitation, primary care physicians are responsible for both their services and for the cost of services provided by specialists to whom patients are referred. Under the third, health service capitation, primary care physicians are responsible for all covered health benefits for HMO members assigned to a physician's group.

MEDICARE RISK CONTRACTS

Because risk contracts offered the potential to constrain Medicare costs, the Congress modified Medicare's risk contract authority through the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Under TEFRA risk contracts, Medicare pays an HMO 95 percent of the amount the program estimates it would pay per beneficiary under the fee-for-service system in the HMO's service area. Under the TEFRA provisions, the HMO has a financial incentive to constrain costs because it may keep any profit from its Medicare risk contract that does not exceed its estimated profit rate on its private lines of business.

The first TEFRA risk contracts were signed in April 1985, and by April 1989, about 1.1 million Medicare enrollees were covered under 133 risk contracts.

PROHIBITIONS ON FINANCIAL INCENTIVES

Concerns about physician incentive plans surfaced in relation to plans offered by hospitals. In addressing the concerns, the Congress not only prohibited plans offered by hospitals but also by HMOs.

In July 1986, we reported that certain hospital plans offered financial incentives to physicians that could have a detrimental effect on the quality of care provided to Medicare patients.[4] One plan of particular concern included a combination of features that, taken together, could provide physicians too strong an incentive to undertreat patients. This plan distributed incentive funds monthly, based on each individual physician's performance in contributing to the hospital's revenues. Moreover, this plan did not contain control mechanisms, such as a quality review program, to prevent or identify abuses.

In the Omnibus Budget Reconciliation Act of 1986, the Congress prohibited, effective April 21, 1987, direct or indirect

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[4]Medicare: Physician Incentive Payments by Hospitals Could Lead to Abuse (GAO/HRD-86-103, July 22, 1986).

incentive payments by Medicare participating hospitals to physicians to reduce or limit services. The same provision also prohibited HMOs with Medicare (or Medicaid) risk contracts from making such incentive payments, effective April 1, 1989. The Omnibus Budget Reconciliation Act of 1987, extended the effective date for HMOs to April 1, 1990.

HMO FINANCIAL ARRANGEMENTS

Our December 1988 report presented the results of our review of the physician incentive arrangements used by 19 HMOs in the states of California, Florida, Minnesota, and Pennsylvania. These HMOs had about 44 percent of all Medicare HMO enrollees in May of 1988.

The 19 HMOs had a variety of physician compensation methods--4 used salaried physicians, 4 paid physicians on a fee-for-service basis, and 11 used capitation systems with coverage ranging from only primary care to all health services. The specifics of the 19 HMOs physician incentive plans also varied considerably. For example, two HMOs did not have incentive plans while one HMO used capitation to shift the financial risk for all health services to physicians. Between these extremes, virtually every conceivable combination of risk-shifting and cost-performance-evaluation period was represented by at least one of the HMOs.

Our review of the physician incentive plans identified four characteristics that we believe, singly or in combination, could tend to give physicians too strong an incentive to reduce services and, thus, could adversely affect quality of care for Medicare patients. Those characteristics are:

1. the amount of risk shifted from the HMO to physicians,
2. the number of physicians whose cost performance is used to decide the amount of the incentive funds available for distribution,
3. whether incentive payments were based on a percentage of HMO savings or profits, and
4. the length of time over which cost performance is measured.

Our rationale relates to two main factors that tend to increase the strength of financial incentives to reduce service provision:

-- the immediacy of the financial reward to individual treatment decisions made by physicians and

-- the extent of financial risk transferred to physicians.

Plans that base their incentive payments on cost performance over relatively long periods of time for large numbers of enrollees served by a number of physicians would probably not provide strong financial incentives to underserve individual patients. On the other hand, the closer financial incentives are tied to individual treatment decisions and the more risk placed

on the physician, the higher the potential for adverse effects on quality of care.

Under arrangements where HMO risk is shifted to the physicians, they are liable for providing or paying for needed services, either directly from the physician's payment from the HMO or from funds withheld from the physician's compensation. Shifting risk to physicians can place them in a compromising position when treating potentially expensive cases. If the HMO physician must pay for specialty or institutional services out of his or her own or group's account, the physician has an incentive not to order such services.

HMOs that base incentive payments on performance of individual physicians have a relatively higher potential to adversely affect quality of care than do plans where the size of the incentive payment is based on the performance of a group. Furthermore, the larger the group whose performance determines the amount of the incentive payment, the less likely adverse effects on quality will result. The main concern here is the immediacy of the linkage between treatment decisions and an incentive payment.

An individual physician is normally responsible for a limited number of patients. If a physician's incentive payment is based only on his or her own performance, the physician may be

tempted to postpone or withhold treatment when faced with a potentially expensive case. If, on the other hand, a physician's incentive payment is based on the performance of a group of physicians, with a larger pool of patients over which to spread treatment costs, the more remote individual treatment decisions become from the amount of payment received. This also makes it less likely that the incentive plan will cause a reduction in quality of care.

The third characteristic that may threaten quality of care is whether the HMO pays its physicians a percentage of plan savings. Under this arrangement, the fewer treatments provided, the higher the potential incentive payment to physicians. The pull of this incentive would be greater if the plan linked incentive payments to savings on an individual physician's patients versus savings on a group of physicians' patients, or if the payments were computed on savings or profits over a short period of time rather than a relatively long period of time.

Fourth on our list is the length of time over which performance is measured. Basing incentive payments on physician cost performance over a short period of time, such as a month, may increase the temptation to underprovide services. With brief performance periods, the effect of treatment decisions on the amount of incentive payment is always short term. Thus, if physicians know that every month or so they will be rewarded for

holding down treatment costs, they may be more concerned about the effect that each patient's treatment cost has on incentive payments than if rewards are based on longer periods of performance measurement.

In addition to increasing the incentive for physicians to underserve beneficiaries, short performance periods may encourage physicians to delay care for beneficiaries needing costly treatment. Delays in obtaining care may encourage beneficiaries to disenroll from the HMO. If a beneficiary were to disenroll before receiving needed expensive services, the physician could be eligible for a larger incentive payment than if the beneficiary remained in the HMO.

CONCLUSIONS

The primary purpose of HMO physician incentive plans is to get physicians to consider the cost implications of diagnosis and treatment alternatives. The goal of such plans should be to encourage physicians to select the least expensive course of care that meets the patient's needs and results in adequate care. However, singly or in combination, certain HMO incentive plan features have a higher potential than others to encourage physicians to inappropriately limit services. HMOs that place physicians directly at risk, or that withhold physicians' compensation and place it at risk, for specialty or hospital expenses or both without limiting their financial liability could

result in the diminution of patient care. Also, arrangements in which incentive funds are distributed based on individual physician performance, cost performance over a short period of time, or a portion of the HMO's profits or savings cause concern.

The stronger the financial incentive given to physicians to reduce the costs of care, the stronger the mechanisms that should be in place to prevent and identify inappropriate reductions in services. Medicare law already requires HMOs to have quality assurance and utilization review programs, systems to check on physician credentials, and grievance procedures to help assure that beneficiaries receive quality care. Thus, the question becomes: How effective are those systems in counterbalancing the incentives given physicians by financial incentive plans? This is difficult to answer. Our review of the literature and discussions with federal and private health care experts did not identify any studies directly assessing the effect of HMO physician financial incentive plans on quality of care that would help to answer it.

In conclusion, we believe that if the Subcommittee considers modifications to Medicare to permit certain HMO physician incentive payments, it also should consider retaining a ban on arrangements that closely link financial rewards with individual treatment decisions or expose the primary care physician to substantial financial risk for services provided by physicians or

institutions to whom he or she refers patients for diagnosis or treatment or both.

Mr. Chairman, this concludes my prepared remarks. I will be happy to answer any questions you may have.