

Patients' Attitudes Toward Cost Control Bonuses For Managed Care Physicians

Patients are worried about bonuses their doctors get for controlling costs, and they want them disclosed without having to ask.

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ABSTRACT: Physicians' cost containment incentives may create conflicts of interest. To understand how patients view these incentives, we interviewed 1,050 patients regarding a 10 percent cost control bonus and a combined cost control/quality bonus. Seventy-three percent said that the cost control bonus was a bad idea; 49 percent viewed the combined bonus more favorably

than the cost control bonus; and 91 percent favored disclosure of bonuses. We conclude that patients find bonuses worrisome and favor their disclosure. A quality component reassures some, but not all, patients. Initiating a dialogue with patients about practicing medicine in an era of limited resources may help health plans and physicians to address patients' concerns.

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THE PUBLIC WORRIES that managed care's focus on containing costs might compromise their health.¹ The media have paid particular attention to financial incentives such as bonuses given to physicians for limiting patients' health care use. Such bonuses are common; nearly 40 percent of California physicians reported in 1996 that their managed care contracts included bonuses.² These bonuses may benefit patients by reducing unnecessary and potentially harmful interventions and by restraining health care costs. However, they may create a conflict between the patient's interests in beneficial health care and the physician's financial self-interest.³ If bonuses lead physicians to withhold necessary care, patients' health could suffer.

Existing evidence is inconclusive on

whether specific financial incentives affect quality of care.⁴ Even without evidence that bonuses harm patients, the perception of a conflict of interest might lower patients' trust in their physicians.⁵ This loss of trust might lead to patient dissatisfaction, discontinuity in doctor/patient relationships, disenrollment from health plans, delays in seeking care, increased patient demands for diagnostic tests and specialty referrals, and calls for more government regulation of managed care.⁶

Patient protection laws often require disclosure of bonuses.⁷ Patients who are aware of bonuses might make better-informed health care choices. Disclosure also might deter health plans from using incentives that would be difficult to justify publicly. Allegations of failure to disclose financial incentives under-

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lie many recent class-action lawsuits against leading managed care plans. Some plans have responded to criticism of bonuses by creating combined bonuses that reward high-quality care, patient satisfaction, and low utilization.⁸

Understanding patients' perspectives on bonuses would help policymakers, health plans, and physician groups to better respond to patients' concerns. However, little is known about patients' attitudes regarding cost control bonuses.⁹ To understand these attitudes, we completed more than 1,000 random-digit-dialed telephone interviews in areas with heavy managed care penetration. We sought to answer the following questions: (1) What are patients' attitudes toward a 10 percent cost control bonus for physicians? (2) Do these attitudes change when a quality-of-care bonus is added? (3) Do patients want physician bonuses disclosed?

Methods

■ **Survey instrument.** We developed a ten-minute telephone interview consisting of thirty-nine closed-ended questions. Subjects rated both their regular doctor and their health plan on scales ranging from 0 ("worst possible") to 10 ("best possible"). Respondents' baseline trust in their regular doctor was assessed by asking subjects to respond to four statements (using a four-point scale ranging from "strongly agree" to "strongly disagree"): (1) My doctor would refer me to a specialist when needed; (2) I trust my doctor to do what is best for my health; (3) health plan rules make it difficult for my doctor to do what is best for me; and (4) I sometimes think my doctor gives me unnecessary tests.

Subjects were then read a brief description of a hypothetical case in which physicians could earn a cost control bonus of up to 10 percent. They were asked whether (1) they thought that this bonus was a good or a bad idea for patients (four-point response scale ranging from "very good idea" to "very bad idea"); (2) whether this bonus would change their trust in their doctor to do what was best for their health (four-point response scale ranging from trusting the doctor "a lot more"

to "a lot less"); and (3) whether they would choose a plan that used a cost control bonus or one that had no bonuses.¹⁰ Participants were then asked these same three questions regarding a combined cost/quality bonus.¹¹ We concentrated on bonuses after preliminary focus groups revealed that the concept of a bonus was more readily understood than were other incentives such as capitation.

■ **Sample and analysis.** The survey was conducted in the summer of 1998. A random sample of 3,784 phone numbers was generated for all eighty-seven metropolitan statistical areas (MSAs) with greater than 25 percent managed care penetration as of 1 July 1996. Eligible subjects were adults who had seen a doctor or been hospitalized in the past year or were able to identify a usual source of care. The data were weighted based on the probability of each subject's selection and the potential for nonresponse bias.

Our study has several limitations. Our results might have differed had we emphasized the positive or negative attributes of bonuses more heavily, or asked about other incentives, such as withholds, capitation, or positive bonuses for patient satisfaction. Our findings may not apply outside the urban markets with high managed care penetration.

Study Results

Of the 3,784 numbers called, we interviewed 1,050 eligible subjects. The overall response rate was 56.1 percent.¹² Exhibit 1 describes the characteristics of the respondents.

■ **Baseline physician/patient relationship.** Our subjects reported high levels of physician trust. Ninety-five percent of respondents agreed that "I trust my doctor to do what is best for my health," and 95 percent also agreed that "my doctor would refer me to a specialist when needed." Half agreed that "health plan rules make it difficult for my doctor to do what is best for me," and 13 percent agreed that "I sometimes think that my doctor gives me unnecessary tests." Respondents' median rating of their physician, with 10 as "best doctor possible," was 8.0.

■ **Attitudes toward cost control bonus.**

EXHIBIT 1
Characteristics Of Respondents To Survey On Physician Bonuses, 1998

Characteristic	Amount	Standard deviation
Mean age, years	43.8	0.7
Female	59.6%	1.7
White	76.8	1.8
College graduate	37.1	1.7
Total family income less than \$50,000	53.0	1.7
Self-reported health status		
Excellent	28.3	1.8
Very good	36.6	1.4
Good	23.1	1.7
Fair	9.7	1.0
Poor	2.3	0.4
Primary health insurance from employer or union ^a	61.0	1.9
Managed care plan ^a	76.0	1.5
Have a regular doctor ^a	84.3	1.2

SOURCE: Authors' analysis of survey data.

NOTE: N = 1,050.

^a Self-reported.

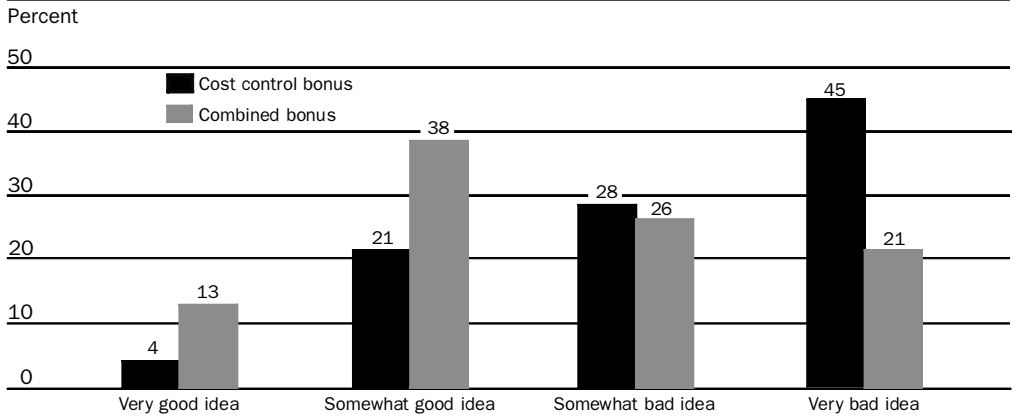
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Seventy-three percent of respondents believed that giving doctors a 10 percent cost control bonus was a bad idea for patients; 45 percent described this bonus as a “very bad idea” (Exhibit 2). Sixty-six percent of respondents said that such a bonus would lower their trust in their doctor (Exhibit 3). Ninety-five percent of those who thought that the cost control bonus was a bad idea also said that this bonus would lower their trust in their physician ($p < .00001$). Eighty-five per-

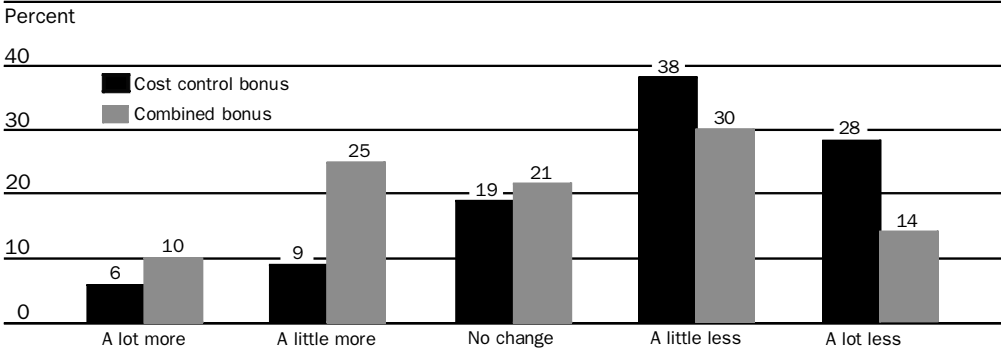
cent of respondents said that they would choose a health plan that had no bonuses over one that used a cost control bonus. Thirty-two percent had heard about bonuses for doctors, but only 5 percent said that they knew whether their regular doctor got a bonus.

What factors were associated with patients' attitudes toward the cost control bonus?¹³ On multivariate analysis, the independent predictors of describing the cost control bonus as a bad idea included having a

EXHIBIT 2
Views On Whether Bonuses To Physicians Are A Good Or A Bad Idea, 1998



SOURCE: Authors' analysis of survey data.

EXHIBIT 3**Views On Whether A Bonus Would Affect Respondents' Trust In Their Physicians, 1998**

SOURCE: Authors' analysis of survey data.

college education, a lower health plan rating, and increasing age. For example, 83 percent of college graduates thought that the cost control bonus was a bad idea, compared with 69 percent of non-college graduates. The independent predictors of the cost control bonus lowering one's trust in one's doctor included female gender, having a college education, and lower physician ratings. Self-reported health status and enrollment in managed care were not associated with attitudes toward a cost control bonus.

■ **Attitudes toward combined bonus.**

Subjects rated the combined bonus somewhat more favorably than the cost control bonus. Whereas 26 percent of respondents thought that a cost control bonus was a good idea for patients, 51 percent thought that a combined bonus was a good idea ($p < .0001$) (Exhibit 2). Forty-nine percent held a more positive attitude toward the combined bonus than the cost control bonus, while 41 percent rated the two bonuses identically. Independent predictors of thinking that a combined bonus was better than a cost control bonus included lower physician ratings, having a college education, and white race. Forty-four percent said that the combined bonus would lower their trust in their physician, compared with 66 percent who reported that a cost control bonus would lower their trust (Exhibit 3). Sixty-eight percent would choose a plan with

no bonuses over one that used a combined bonus; 85 percent would avoid a plan with only a cost control bonus.

■ **Attitudes toward disclosure.** Ninety-one percent of respondents favored disclosure of their physicians' bonuses. Among those respondents who initially opposed disclosure, 59 percent desired disclosure if their "doctor did not order a test or referral that you think you need." Eighty-two percent of all respondents were likely to ask their health plan whether it gives doctors a bonus, and 60 percent were likely to ask their regular doctor whether he or she receives a bonus. Eighty-two percent agreed that "I should be told whether my doctor receives a bonus without having to ask." Some respondents expressed misgivings about discussing bonuses with their physicians. Thirty-eight percent of all respondents agreed that "asking my doctor about his or her bonuses will make my doctor mad at me," and 62 percent felt that "talking with my doctor about bonuses would be awkward."

Discussion And Policy Options

Our nationwide survey revealed that the public considers a 10 percent cost control bonus for physicians a worrisome conflict of interest. Compared with some managed care incentives, a 10 percent bonus is relatively small.¹⁴ It is possible that stronger incentives for cost control would evoke even greater con-

cern among patients. What policy options exist to address these concerns?

■ **Disclosure of incentives.** Disclosure has been endorsed by ethicists and professional organizations and is a core component of many patient protection efforts. Our respondents were largely unaware of cost control bonuses, and they strongly endorsed disclosing these incentives to patients. However, despite its theoretical benefits, it is unclear whether disclosure would promote informed patient choice. Nobody is certain about how to inform patients about incentives and who should be responsible for disclosure. Plans may not know how individual physicians are reimbursed by physician groups. Furthermore, while existing federal regulations require plans to disclose their incentives to patients only on request, our respondents strongly preferred to be told about incentives without having to ask.

■ **Product diversification.** Health plans and employers might offer more choices of plans with different incentives for physicians to restrain costs. However, some patients might be unable financially to avoid health plans whose incentives they find troubling. These disgruntled patients may report lower satisfaction or be more likely to use resources inappropriately. Yet even if such choices are unaffordable to many consumers, offering them may be helpful by forcing patients to place a dollar value on their concern about managed care financial incentives.

■ **Combined incentives.** Increasingly, health plans are adopting mixed bonuses that also reward patient satisfaction and health care quality. One large managed care plan highlights its “quality care compensation system” in membership advertisements.¹⁵ However, these quality-of-care bonuses have important shortcomings. The proportion of a bonus devoted to quality is often relatively small.¹⁶ Also, these bonuses typically measure quality through administrative data, which

provide limited information about the quality of care. Bonuses for quality may cause physicians to subconsciously devote less energy to aspects of good patient care that are not directly rewarded.¹⁷ Our study raises another criticism: Nearly half of our respondents were not reassured by a combined bonus.

■ **Greater regulation of incentives.** Some have advocated more stringent regulation of physician incentive plans. However, regulations may have unintended detrimental

“Some patients might be unable financially to avoid health plans whose incentives they find troubling.”

effects and entail administrative burdens. In addition, identifying the financial incentives that consistently endanger patients and therefore need stricter regulation may prove difficult. Underuse is difficult to detect, except in the few clinical situations where the standard of care is unambiguous and decisions are clearly documented, such as the use of beta-blockers after a myocardial infarction. Furthermore, the relationship between a given incentive and physician behavior is confounded by a variety of factors, such as panel size, reinsurance, and subcontracts. Finally, regulations frequently take years to promulgate, by which time the relevant incentives will likely have changed.

■ **Tort reform.** Others are seeking redress in court for alleged harms caused by financial incentives. The recent U.S. Supreme Court decision in *Pegram v. Herdrich* protects the managed care industry from liability under the Employee Retirement Income Security Act (ERISA) for using financial incentives.¹⁸ This decision may accelerate efforts in state courts to hold managed care companies accountable for the purported adverse effects of their financial incentives.¹⁹ Such lawsuits are costly, are time-consuming, take place only after patients have already been harmed, and may lead to higher premiums.²⁰

■ **Moving beyond disclosure.** Health plans and physician groups should move beyond mere disclosure of financial incentives and begin a dialogue with patients about the

broader issue of cost-effective medicine. Patients might be less critical of incentives once they understand the dilemmas of rising costs, evidence of widespread overuse, and the challenges of changing physician behavior using nonfinancial incentives. Patients need to consider whether they find more acceptable alternative cost control strategies such as utilization review, physician profiling, guidelines, and restricted formularies.

ENGAGING MEMBERS in a frank dialogue about cost containment may require that health plans and physician groups answer difficult questions about the details of how physicians are reimbursed. For-profit health plans will face questions about how much of the savings from cost control efforts are returned to patients versus shareholders. Some awkward moments are inevitable as health plans, physicians, and patients start talking together about the challenges of practicing medicine in the context of resource constraints. Nonetheless, undertaking such a dialogue would show patients that their fears about managed care are being taken seriously; it might also help to develop innovative cost control strategies that generate less patient concern about potential conflicts of interest.

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NOTES

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10. Cost control bonus description: "As you may know, the cost of medical care is very high. Health plans try to lower the cost of health care in many ways. One way is to give doctors a bonus for sending patients to specialists less often. On the one hand, these bonuses might lower the cost of health care and make health care more affordable. On the other hand, patients might not get referrals they need.
"We do not know whether your regular doctor gets a bonus. However, suppose your regular doctor receives a bonus where they could get up to 10 percent extra income if they keep health care costs under control."
11. Combined bonus description: "So far we have only been talking about bonuses for doctors to keep costs under control. Some doctors also get a bonus for providing high quality care, such as making sure patients get cancer screening tests. Now imagine your regular doctor receives a combined bonus—both a 10 percent bonus for keeping costs under control, and a 10 percent bonus for providing high quality care."
12. The response rate was calculated as the product of (1) residential status determination rate, 91.9 percent; (2) household eligibility determination rate, 94.4 percent; (3) rostering rate, 67.5 percent; (4) person eligibility determination rate, 97.8 percent; and (5) interview completion rate, 98.0 percent.
13. Independent predictors of attitudes toward the cost control and combined bonuses were determined using logistic regression. The associations are significant at $p < .05$. Odds ratios and values are available from the authors; e-mail Tom Gallagher, <tgallagh@im.wustl.edu>.
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