Cite this article as:
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*Health Affairs* 5, no.1 (1986):141-146
doi: 10.1377/hlthaff.5.1.141

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Capitation And Conflict Of Interest

by Robert A. Berenson

There is increasing government interest in using a capitation, or prepayment, method for Medicare reimbursement of medical services. Capitation provides much greater predictability of budget outlays and changes incentives at the provider level which, it is argued, should result in less costly care. The Reagan administration recently announced that capitation is its preferred way of holding down spending for physicians’ services.¹

The system of capitation payments to traditional health maintenance organizations (HMOs) has resulted in less expensive care, without measurable reductions in quality.² But as the capitation method of payment spreads rapidly beyond traditional, not-for-profit, closed panel HMOs, such as the Kaiser Health Plans, to new for-profit HMOs of various types, there is concern that the incentives inherent in capitation could result in underservice and reduced quality of care. Whether or not the potential for medical underservice outweighs the value of more comprehensive benefits, organizational accountability, and the demonstrated cost-effectiveness found in some HMOs is an important health policy issue deserving ongoing attention.

Of immediate concern is the very real and substantial conflict of interest that many physicians will face as a result of Medicare capitation. The administration is basing its new proposal on the Medicare risk contract program that began on a national basis in 1985. This program illustrates the conflict of interest between physicians’ incomes and the well-being of their patients under current approaches to Medicare capitation. The conflict of interest exists because a private physician can care for the same patient either under traditional Medicare fee for service or under the auspices of the HMO. Yet, the patient’s decision about whether or not to join the HMO, largely influenced by his physician advisor, can have major impact on physician income. Significantly, this new conflict of interest does not derive from a practitioner’s decision to become an entrepreneur, a practice that is being vigorously debated.³ Rather, it exists as an unavoidable matter of course in a physician’s practice of medicine.

In the Medicare risk contract program, Medicare pays a fixed, predetermined amount per capita to competitive health plans—usually HMOs—

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for each patient who signs up. The capitation payment is equal to 95 percent of the average adjusted per capita cost (AAPCC) that Medicare spends in the existing fee-for-service system, within defined geographic areas. To join a competitive health plan, a Medicare beneficiary agrees to forgo full freedom of choice of provider that he currently enjoys—the so-called lock-in provision. What makes the HMO option attractive to the beneficiary is the decision of the HMOs to offer broader benefits, with lower out-of-pocket expenses; the experience of Medicare capitation demonstrations since 1980 shows that participating HMOs were able to offer a benefit package far more attractive than the standard Medicare Part A and Part B benefits for the 95 percent of the AAPCC that the Health Care Financing Administration (HCFA) provides on behalf of each beneficiary who signs up.4

The Ethical Dilemma

This Medicare risk contract program leads to an ethical dilemma for the private physician. Simply put, the HMO package is a good deal for all Medicare beneficiaries, but especially for those patients with serious, chronic illnesses. In addition to reducing Medicare copayments and deductibles, the HMO option is likely also to include catastrophic coverage and prescription drugs in its benefit package. In comparison, Medicare supplemental insurance programs are poorly designed and/or very expensive.

In the existing system, it has not been unusual for me, for example, to have to negotiate with Medicare patients over my recommended drug regimens in order to accommodate patients’ very real budgetary constraints. Desirable care is often compromised. Now assume Kaiser or another HMO opens up down the street and receives authority from HCFA to offer a Medicare risk program. Do I suggest to my patient that he check out Kaiser or, alternatively, do I recommend that he stay with me even though standard Medicare cannot as adequately provide for his medical needs? Perhaps in the case of a competing closed panel HMO, I am able to convince myself that the imperative of continuity of care, combined with my own manifest skills outweigh the value of a better benefit package and, therefore, I can justify keeping the patient. The patient is always free to walk down the street on his own.

What happens when I become a participating physician in an IPA-model (independent practice association) HMO, one in which the patient joins an HMO on a prepaid, fully covered basis and picks me as his gatekeeper physician? The Medicare beneficiary then can have the better benefit package offered by the HMO and, at the same time, keep me as his personal physician. This is the best of both worlds for the patient, especially if the IPA also includes the specialists that he has seen in the past. However, for me as primary care physician, the patient’s decision to
stay with traditional, fee-for-service Medicare or join the prepaid HMO may have substantial financial impact.

**Problems with HCFA’s payment structure.** The primary reason is that HCFA’s payment calculated on 95 percent of the AAPCC in the area does not take into account the actual burden of patient illness. In 1981, the estimated 5 percent of Medicare beneficiaries who received physicians’ services whose submitted charges totaled $2,500 or more accounted for about 48 percent of total submitted charges. By contrast, 30 percent of beneficiaries with less than $250 of total submitted charges accounted for about 6 percent of the total; and some 35 percent of beneficiaries did not even use enough physicians’ services to exceed the Part B deductible. Yet, the average HCFA capitation payment does not reflect this startlingly wide variation in actual spending per beneficiary, but rather is adjusted only for basic demographic factors of age, sex, welfare status, and institutional status.

In this situation, the HMO’s interest is to attract relatively healthy patients so that actual costs will be much less than the 95 percent payment, permitting it to offer a better benefit package, to attract more enrollees, and, ultimately, to generate greater profits. Because the IPA physician’s financial fate is directly tied to the HMO’s financial position, the physician’s financial interest, similarly, is based on seeing relatively healthy patients. In many IPAs, primary care physicians themselves are compensated on a capitation basis—perhaps $20–$25 per member per month for a Medicare beneficiary—regardless of the actual utilization of services. These HMOs may offer additional bonuses if actual expenditures for specialist and hospital services are less than budgeted amounts. Given these financial incentives, the best way to assure a satisfactory bottom line is to avoid seeing the sickest patients—the 5 percent who generate nearly half the costs. Thus, the physician’s financial interest clearly requires him to encourage only his relatively healthy patients to sign up for the HMO. Yet, the physician’s trustee responsibility to this patient’s well-being may require him to actively encourage his sickest patients to join the HMO. The ethical dilemma is not theoretical but real, largely because the potential effect on physician income of who joins the HMO is not trivial.

Certainly, the potential for conflict of interest exists in the fee-for-service, indemnity insurance-based system. By virtue of his authority and knowledge and the trusting consent of his patient, the fee-for-service physician generally makes the decisions to use the medical services that he himself provides and is paid for. Potential for abuse is apparent. Yet as Arnold Relman points out, one of the most important protections against conflict of interest in the fee-for-service environment is disclosure. The physician’s financial interest in the transaction is implicit and clear. The patient understands that physicians benefit from performing tests or procedures and can question any specific recommendation, much
as he can question other vendors in the marketplace. Importantly, the patient is free to go elsewhere if physician judgment is of concern. From the physician’s perspective, fee-for-service payment is different also. An ethical physician can function quite well in this setting, guarding against the possible tendency to do too much, for economic gain. A conflict of interest is not inherent. In the fee-for-service setting, a physician can provide the amount of uncompensated care with which he is financially comfortable because his losses are his own.

Under a Medicare risk contract, a participating physician theoretically could encourage his chronically ill, high-utilizing patients to enroll and, in effect, provide uncompensated care. However, his HMO is at risk for the patient’s hospital and other nonprimary care costs since the capitation payment includes all covered benefits, not just physician care. In addition, the physician with consistently poor performance, as measured by criteria such as hospital days generated, number of specialist referrals, and utilization of ancillary services, would be seen as responsible for disproportionately using up pools intended for distribution to fellow IPA physicians. Possibly, although less likely, the physician would be dropped by the IPA for being a high-cost provider, contributing negatively to the group’s bottom line.

The described concern about potential physician conflict of interest under Medicare capitation also exists in capitation arrangements in existing, employer-based HMO options, but compared to Medicare, this is of relatively minor importance. For the most part, the indemnity options for employed people provide benefits comparable to HMOs. Thus, there is generally no clinically based imperative for the patient to be encouraged to join the HMO, as with Medicare. Furthermore, employees who are faced with the choice of health insurance options can go to people other than their physician to seek advice about which plan to join, such as the employee benefits officer and fellow workers. The employed patient may ask the physician’s opinion, but for the most part, does not depend upon the physician to guide him through the maze of options. For the elderly, retired population, however, the doctor or other health professional is much more often the primary or, in cases of millions of elderly living on their own, the sole, advisor about how to negotiate the health care system. The free market ideal of informed consumer decisions regarding choice of alternative health insurance programs may not be applicable for many seniors, particularly for those who are infirm or socially isolated. Yet, the physician advisor under Medicare capitation has become, in a sense, a marketer for an insurance plan, with an interest in achieving favorable patient selection for the plan and for himself.

**Possible Solutions**

There are potential solutions to this very real ethical dilemma. The
best solution consistent with promotion of capitation as a desirable Medicare policy initiative would base the AAPCC on health-related factors that would attempt to predict actual burden of illness, rather than the inadequate demographic factors, as under current law. Research suggests that an adjustment that takes into account available information on prior use of health care services may be a better predictor of subsequent Medicare reimbursement than demographic data. For now, much more work on severity of illness measures to modify prepayment is necessary. Until necessary payment adjustments are developed, HCFA might consider assuming the liability for extraordinary expenses that the capitated Medicare beneficiaries may incur, thus keeping with President Reagan's interest in providing the elderly with catastrophic health insurance protection. The percent of AAPCC provided as prepayment would then be correspondingly less than 95 percent since the HMO's risk would be less. If HCFA retained the responsibility for paying catastrophic expenses, HMOs could care for sicker patients without suffering as severe financial consequences as when they were fully at risk themselves. The financial pressures on the primary care gatekeeper to be concerned about patient selection would be somewhat less. And HCFA, appropriately, would become more involved with case management for beneficiaries with catastrophic expenses.

In addition, physicians and managers in IPA-model HMOs should seriously reconsider the growing commitment to paying primary care physicians on a per capita basis. From a purely managerial perspective, giving individual physicians the same incentive as the plan as a whole, by passing through a percentage of the overall capitation payment directly to the primary care physician, seems to make good sense. The same managerial rationale is the basis for attempts by hospitals to share profits with physicians who reduce expenditures under Medicare's prospective pricing system for hospital payments. Yet, the American Medical Association has properly challenged hospital attempts to provide direct financial incentives to physicians for cost-reducing behavior as a form of a kickback in which physicians' allegiance to patients could be compromised. A similar criticism could be made of paying physicians on capitation, certainly in situations in which the physicians themselves can largely determine which patients enroll in the plan.

The general issue raised is whether physicians and the institution that also receives prepayment for care of patients—whether hospital or insurance plan—should have similar or different financial incentives. It may well be that the best solution is to proceed with prepayment and capitation, because of the inherent incentive for decreasing unnecessary service, but at the same time accept an "inefficient" tension between the plans and their contracted physicians by continuing a modified fee-for-service payment system for physician care. What is needed is the development of a fee schedule that attempts to be incentive neutral, unlike
the current payment system based on physician charges, that has been justly criticized as inflationary and inequitable. In a new payment system, physicians would neither gain nor lose financially for providing additional services at the margin. Remuneration would roughly equal the cost of production. Under such a physician payment system, physicians would neither gain nor lose financially to any major extent based on whether their patients did or did not choose to join an IPA. General incentives for cost-conscious behavior would be maintained because the plan’s total reimbursement would be limited by the fixed capitation payment it receives. But specific incentives to win or lose financially on individual patients would be greatly reduced. The kind of modified, relative-value-based fee schedule that many have recommended and the administration now opposes would help reform Medicare fee-for-service payments. A similar schedule, combined with active utilization review, could be used by HMOs for internal physician compensation. Whether or not HCFA is willing and able to develop such a fee schedule, individual IPAs should do so to protect themselves and their patients.

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