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Fine-Tuning Physician Compensation

by John S. Hoff

Lawyers sue; surgeons cut; and politicians pass laws to win re-election. Health care presents a tempting assortment of targets of opportunity for politicians wanting to make things "fair." Compensation of physicians is a particularly juicy target—particularly when it involves incentives for inappropriate care decisions.

Legislators have passed numerous laws to regulate physician incentives. They have chased the changes in the health care system. When it was thought that physicians in a fee-for-service environment were benefitting by referring patients inappropriately, the federal government and some state governments passed laws to ensure that physicians were not improperly influenced by financial considerations. The laws first prohibited a physician from receiving anything of value in exchange for the referral, and then they prohibited referral to entities in which the referring physician had an ownership interest or from which he or she received compensation.

After these laws were passed, managed care became increasingly prevalent. Managed care is a market response to overutilization, by the physician himself and through excessive referrals. The growth in managed care focused attention on the possibility that plans may not provide enough care. There is a counterweight to scrimping on care—the plans' need to provide quality care in a competitive market and the professionalism of their participating physicians. Plans, however, may seek to neutralize that countervailing influence by implementing physician incentive plans (PIPs) that align physician incentives with their own. This may be done through capitating the physician; withholding some compensation and paying it only if certain financial targets are met; or, conversely, by paying lower compensation, with a bonus for those who meet the financial targets.

Governments now are regulating these PIPs. The most comprehensive regulation is the federal government's rules concerning PIPs that affect referrals by physicians in plans that serve Medicare or Medicaid beneficiaries.

Federal law prohibits such a plan from giving a financial incentive to a physician to limit any individual patient's access to medically necessary services. PIPs are lawful only if the financial incentives are applied more broadly. Even then, a PIP is permitted only if certain conditions are met. Most generally, the plan must describe the PIP to HCFA and the state Medicaid agencies.

The rules are more complicated when the physician is put at "substantial financial risk." This term is defined in regulations issued by HCFA on March 27, 1996. The regulations were supposed to become effective on May 28, 1996. On that day, however, HCFA announced that it recognized that it was unrealistic to expect compliance by then. (Plans would have had to renegotiate many of their contracts.) HCFA deferred the effective date of the regulations to January 1, 1997, and said that in the interim it would re-examine them.

Under the promulgated (but deferred) rules, a PIP would put the physician at substantial financial risk for referrals if his or her compensation could be increased 33 percent or more by bonuses; decreased 25 percent or more by withholds; or changed 25 percent or more by a combination of withholds and bonuses. If the physician is capitated, substantial financial risk would occur if the capitation risk for the cost of referral services was 25 percent or more of the compensation or if the capitation arrangement was not clearly explained in the contract.

The plan must also provide adequate stop-loss protection for physicians who are at substantial financial risk. The regulations define the amount of coverage that must be provided. The plan must pay for the stop-loss coverage, but may require physicians to bear some of the risk (up to 10 percent of the cost of referral services that exceed 25 percent of potential payments.)

If the PIP puts the physician at substantial financial risk, the plan must conduct annual surveys of its enrollees—and former enrollees—to determine the extent of their satisfaction with the plan. The plan also must provide information about its PIPs to Medicare or Medicaid beneficiaries requesting it, including the results of the satisfaction surveys.

Discussion of what compensation arrangements should be permitted will continue for a long time. By its PIP rules, the government is trying to strike just the right balance between letting plans impose incentives on their physicians that will help the plans meet their goals and preventing plans from making their physicians inappropriately reluctant to make referrals. It is always good to have the government struggle to resolve the unresolvable.

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