

To Tell the Truth: Disclosing the Incentives and Limits of Managed Care

E. Haavi Morreim, PhD

Abstract

As managed care becomes more prevalent in the United States, concerns have arisen over the business practices of managed care companies. A particular concern is whether patients should be made aware of the financial incentives and treatment limits of their healthcare plan. At present, managed care organizations are not legally required to make such disclosures. However, such disclosures would be advisable for reasons of ethical fidelity, contractual clarity, and practical prudence. Physicians themselves may also have a fiduciary responsibility to discuss incentives and limits with their patients. Once the decision to disclose has been made, the managed care organization must draft a document that explains, clearly and honestly, limits of care in the plan and physician incentives that might restrict the care a patient receives.

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*For editorial comment,
please see page 159.*

Ethical challenges sometimes arise not because we do not know what is the right thing to do, but because we do not know how to do the right thing without causing problems. In one classic example, a medical team agrees that resuscitation is not in the best interest of a very ill patient. An intern, however, believes that this fully competent person should be consulted. "If your heart stops, do you want us to start it again?" he asks earnestly. "Sure, why not?"

From the College of Medicine, Department of Human Values and Ethics, University of Tennessee, Memphis, Memphis, TN

Address correspondence to: E. Haavi Morreim, PhD, Professor, College of Medicine, 956 Court, Suite B-328, University of Tennessee, Memphis, Memphis, TN 38163.

the man replies. The team reluctantly designates "full-code" status for the patient but castigates the intern for the blunder that would probably cause the dying man needless pain. In this example, the real challenge is not *whether* to ask—a competent patient should ordinarily be involved in such an important decision—but *how* to do so in a way that highlights the important issues more clearly than the intern's simplistic question.

The same is true regarding disclosure of the financial incentives and treatment limits found in most managed care plans. It is easy to find reasons why members should be told. The more difficult task is determining who should tell them what, and how such a disclosure should be handled. This article addresses both the theoretical and practical dimensions of that challenge.

... IN THEORY: WHO SHOULD DISCLOSE WHAT? ...

Although managed care is not new,¹ recent forms have spawned aggressive, somewhat novel methods of cost control. These methods include gatekeeper systems in which approval of a primary care physician is required for tests, specialty care, and hospitalization; incentives such as withholds, capitation, and bonus pools that reward physicians financially for conserving resources; and utilization controls that sometimes lead to intrusive micromanagement of medical decisions.²⁻⁴ Many physicians are deeply concerned about the ethics of such measures, because they pit physicians' traditional obligations to patients against their own financial interests and against their contractual obligations to promote the interests of the managed care organization and all its members.⁵⁻¹¹

Conflicts of interest are not new, of course. Fee-for-service rewards excess, and the large sums of money flowing through the healthcare system in recent decades have markedly exacerbated the problem. Quite likely there should be disclosure in this system as well, although this conflict can at least be potentially de-

tected by the patient who notices that the more interventions the physician performs, the more he or his insurer must pay. In any event, this important issue goes beyond the scope of the current discussion.

In managed care, some limits are readily evident to patients, such as a rule requiring them to obtain approval from their primary care physician for specialist visits. Less obvious are incentives to limit care. Unless patients have substantial medical knowledge or are directly told, they do not know that their physicians earn more by doing less. Hence, if there are moral, medical, legal, or practical reasons why patients should understand their managed care organization's cost-containment program, disclosure must be explicit. Because this article focuses mainly on the practical challenge of *how* to make the needed disclosures, and because the theoretical arguments about *why* disclosures should be made are discussed elsewhere,¹²⁻¹⁴ the latter will be addressed only briefly here.

Managed Care Organizations' Obligations

The initial obligation to disclose rests with the managed care organization. First, the managed care organization has written its contracts with patients (or employers) and physicians. Since ambiguities in contract language are ordinarily construed against the drafter of the contract, the health plan that does not make its terms and limits clear can expect to lose when patients litigate benefits disputes.¹⁵⁻¹⁷ Additionally, health plans and other insurance-type contracts are commonly considered contracts of adhesion, in which a beneficiary who needs this service must simply take or leave the arrangements as given. Again, although courts are increasingly willing to enforce health plans' contractual limits,¹⁸ they are still fairly quick to side with patients when they perceive a substantial imbalance in the contracting process.¹⁵⁻¹⁷

Second, there is good reason to regard managed care organizations as fiduciaries of patients. Principles of law and ethics recognize a fiduciary relationship when a weaker party is dependent on a stronger party for some benefit or service for which the former has an important need. This inequality triggers duties for the fiduciary to promote the beneficiary's interests, to refrain from exploiting his or her vulnerability, and to avoid or at least disclose any conflicts of interest.^{13,19-22} The fiduciary's disclosure obligations are not discharged by remaining silent until the beneficiary asks questions. Rather, the fiduciary must be affirmatively forthcoming with the information.²³⁻²⁶

Although the matter is not yet definitively resolved, managed care organizations could be considered fiduciaries either through their role as an insurer

or as a provider of care.^{13,14,27-30} If so, managed care organizations would be bound by standard fiduciary obligations to treat members' interests with the utmost good faith and to disclose conflicts of interest. Plainly, this would require explaining to members the ways in which their contracts limit care and place physicians under conflicting loyalties.

Third, the federal government intends to require prepaid healthcare organizations that place physicians at "substantial financial risk" to have stop-loss protection and to conduct an annual beneficiary survey. It also expects managed care organizations to provide "to any Medicare beneficiary or Medicaid recipient...who requests it: whether the plan uses a physician incentive plan that affects the use of referral services; if so, the type of incentive arrangement [ie, withhold, bonus, or capitation]; whether stop-loss protection is provided; and, if a survey is required, a summary of the survey results" (p. 13445).³¹

Physicians' Obligations

Although managed care organizations have the initial obligation to disclose, physicians also have such a duty. First, in signing on with a managed care organization, physicians agree to abide by its medical and economic policies, whether they are incentive systems, guidelines for cost-effectiveness, or explicit restrictions on unproved or marginally useful tests and treatments. To the extent that managed care organizations have a moral obligation to disclose these policies, the physicians who implement them arguably have at least as strong a moral duty to ensure that their patients understand the nature and limits of the care provided.

Second, the principles establishing patients' rights of informed consent and self-determination generally hold that physicians should provide whatever information is "material" for patients to make informed decisions. Although the concept of "materiality" can be vague, an incentive system strong enough to prompt significant alterations in care can reasonably be considered material. In some cases, for instance, patients have argued that knowledge about incentives would have led them to request a second opinion or seek care outside the health plan much earlier.^{13,29,32} In addition to the risks and benefits of recommended treatments, material information can include medically reasonable alternatives—including those not financially covered by the health plan.

Third, physicians can be regarded as fiduciaries with the usual duties to promote patients' interests and disclose conflicts of interest. Although physicians might not be regarded as legal fiduciaries in every

technical sense,³³ in matters of informed consent, courts have been clear that physicians have standard fiduciary obligations.³⁴⁻³⁶ Physicians must identify medically reasonable treatment options and recommend specialists when the patient's problem exceeds their expertise,^{23,24,26} and they must disclose conflicts of interest. The California Supreme Court spoke with particular clarity in a case in which a physician repeatedly took samples of a patient's serum, bone marrow, and other tissues, not for the professed purpose of benefitting the patient, but for the ulterior purpose of cultivating a very lucrative cell line. The court found that "(1) a physician must disclose personal interests unrelated to the patient's health, whether research or economic, that may affect the physician's professional judgment; and (2) a physician's failure to disclose such interests may give rise to a cause of action for performing medical procedures without informed consent or breach of fiduciary duty" (p. 482).³⁷ Thus even if the managed care organization has not satisfied its duties of disclosure, a physician in a financial incentive system still has a clear obligation to do so.

Fourth, failure to disclose could carry sobering, and largely unrecognized, legal peril if a denial of care leads to an untoward outcome and then to litigation. Although a malpractice plaintiff (patient) ordinarily bears the burden of proving that the defendant (physician) breached his or her duty of care, that burden is reversed if the defendant is a fiduciary who did not disclose a conflict of interest. In this situation, the court presumes that the fiduciary concealed his conflict in order to use his superior position to exploit the beneficiary. In other words, the court could presume that the physician tried to protect his income by covertly denying beneficial care to a vulnerable patient. The court would then require the physician to prove that he did not.¹⁹⁻²¹ Physicians under managed care incentives may have a difficult time proving that a denial of care was not tainted when they work under this obvious conflict and have not been candid with their patients about it.³⁸

The general burden-shifting feature of fiduciary law is clear. Because no cases directly on point have yet arisen, it is not certain whether courts will apply it to physicians. However, the issue has come perilously close to the surface in at least one case,³⁸ and with current concerns about whether patients are being treated fairly by health plans and physicians, it is reasonable to expect that sooner or later courts may invoke it.

Unfortunately, disclosure by physicians is impeded by the nondisparagement agreements, or "gag" clauses, found in some managed care organization

contracts (*American Medical News*. Letter. March 19, 1995:25. May 9, 1995:5-6).³⁹⁻⁴³ As one contract states: "Physician shall agree not to take any action or make any communication which undermines or could undermine the confidence of enrollees, potential enrollees, their employers, their unions, or the public... Physician shall keep the Proprietary Information [payment rates, utilization review procedures, etc.] and this Agreement strictly confidential" (p. 1706).³⁹

Because gag clauses could in essence require physicians to violate fiduciary duties to patients, it is unlikely they would be upheld if challenged in court. However, because many physicians sign "at-will" contracts with managed care organizations, in which either party can leave without offering a reason, managed care companies would be unlikely to cite violation of the gag clause as a reason for terminating the contract. Thus a direct court challenge of the gag clause may be slow to materialize.

Several states have enacted legislation prohibiting gag clauses (*The New York Times*. September 9, 1996: A9. *American Medical News*. September 9, 1996:3, 10-12). However, these laws may have a limited effect because health plans can find other ways to sever ties with physicians. Therefore, we need to consider other, largely empirical reasons why managed care organizations should disclose treatment limits and incentive systems.

Additional Reasons for Disclosure

Once physicians discharge their duty to disclose, the managed care organization gains nothing by being secretive about what the physician has already discussed. Furthermore, the press has already begun the disclosures with a flurry of recent stories describing patients who claim they were denied beneficial care because of incentives to cut costs. The media have trumpeted the high-profile cases of Nellene Fox and Christine deMeurers, two women whose health maintenance organizations denied a bone marrow transplant to treat their breast cancer, and Joyce Ching, whose health maintenance organization allegedly denied access to specialists and delayed her diagnosis of colon cancer (*American Broadcasting Corporation*. *20/20*. April 15, 1994. *Newsweek*. January 19, 1994:36-38. *Wall Street Journal*. December 28, 1993:B4. *Time*. January 22, 1996:44-52. *USA Today*. January 22, 1996:1D-2D. Columbia Broadcasting System. *60 Minutes*. October 1, 1995. *Newsweek*. October 23, 1995:54-56).

A recent article in the *New England Journal of Medicine*³⁹ describing incentive systems and gag clauses received considerable coverage from the national

press. Other articles have informed readers that managed care physicians “often make more money by denying you care,” “may be asked to treat conditions they’re not trained for,” and “can’t speak freely about the HMO [health maintenance organization]” (*Newsweek*. October 23, 1995:54-55). Readers are told to “find out how your doctor gets paid,” (*Money*. December 1995:21) “confront your doctor,” and “hire a lawyer” (*Newsweek*. October 23, 1995:55-56).

The gulf between these stories and managed care organizations’ secretive gag clauses paints a cartoon: an elephant is standing in the examination room with the physician and patient, while the managed care organization executive whispers to the physician, “Don’t you *dare* tell the patient about the elephant!” In this setting, managed care organizations that discuss incentives and treatment limits will only be telling patients what so many have come to know

Table 1. Sample Disclosure Form

STRAIGHT TALK ABOUT KEEPING COSTS DOWN AND QUALITY HIGH

Many people who choose managed care plans, or who are enrolled by their employers, are concerned about the cost of healthcare. They want to receive all the care they need, but they don’t want to see premiums and out-of-pocket costs rise through the ceiling. We share this concern and would like to explain the ways we try to keep costs down.

Healthcare Costs Are Skyrocketing

In the United States, the money we spend on healthcare has increased steadily for decades—much faster than the rate of inflation. Today, about 15¢ out of every dollar is spent on healthcare. The quality of American healthcare is the envy of the world, but we must keep the cost under control, or fewer and fewer of us will be able to afford it.

It’s Your Money

If you receive health coverage as an employment benefit, it’s easy to assume that your employer, rather than yourself, pays for your healthcare. Wrong. You are paying, whether or not you realize it. The bottom line is, your employer pays a certain amount to keep you working. Some of it goes into one of your pockets as wages, and some of it goes into another pocket as benefits. In either pocket, it’s still your money. The more your employer has to spend for healthcare, the less is left to increase your wages or other benefits.

Besides that, you may pay part of the monthly premium for your health plan. Your contribution goes up when premiums go up. And if you pay copayments—when you see the doctor, are hospitalized, or buy medications—those costs rise, too.

Fairness to You Requires Honoring the Limits for Everyone

When you buy your health plan, it’s with the understanding that you will receive certain benefits in exchange for your premium. In a health maintenance organization (HMO), we must provide all the care that

everyone in the plan needs, within a fixed budget every year. There’s plenty of money in that budget to cover all the care that members need. But if a health plan doesn’t draw limits on what it covers, either it will run out of money or premiums will rise out of sight.

Once those limits are drawn, they must be honored. It would be unfair to everyone if we let some people have more benefits than they actually bought. For instance, if one of your fellow members wanted us to pay for a face lift, it would be unfair to *you* if we said yes. You bought the plan with the understanding that it has some limits. If we play favorites and ignore those limits for some members, it violates everyone’s trust. It’s our obligation to be careful with your money, so that your healthcare is there when you need it.

All Health Plans Enforce Limits, But Not All Plans Tell Their Members

As you can understand, insurers and HMOs must make sure that resources are used wisely. Virtually all of them have utilization controls to ensure that patients receive necessary services, but not all sorts of tests and treatments they don’t need. And most HMOs have incentives that encourage doctors to be prudent about what they order. In fact, the federal law that regulates HMOs actually permits, even expects, them to have some incentives. But not all health plans are willing to be honest with their members. Many plans say nothing about incentives, and some actually forbid their doctors from telling patients anything that might make them think poorly of the plan—including information about limits on care.

At Healthplan, we believe that the more you know about your health plan, the more you can be a full partner with us, and the better we can serve you. You know what it’s like to work within a budget, because you do the same thing every day as you care for your family within the income you earn. We have to do the same, and we know you understand what that means.

anyway—except, it is to be hoped, with less sensation and greater accuracy. In the atmosphere of conspiracy created by such media stories, managed care organizations find it difficult to convey the salutary features of carefully managing care, such as decreasing iatrogenic injuries and wasteful interventions.

Although being honest with patients may increase their trust in their healthcare providers and health plans, managed care organizations may still be reluc-

tant to part with financial incentive information. They may fear that disclosure of proprietary information may affect their competitiveness with other healthcare companies.³¹ They also may fear that members will misjudge the information and leave for another plan. Such concerns are not unusual. By analogy from the informed consent setting, physicians are sometimes reluctant to explain the risks of a proposed medical intervention, lest patients refuse it. Years

It's Not Just Costs, It's Quality

It's easy to focus on costs, but there's a flip side to that—quality. The more careful we are not to waste your money, the more funds are left to do more for you. Last year, we added several services, like extra home health visits for some of our elderly patients and for women with high-risk pregnancies. As we carefully track which services are provided for which patients, and pay attention to what works and what doesn't, we are learning more and more about what is best care. Needless medical tests and treatments don't just waste money, they can sometimes do a lot of damage. And on the other side, not providing enough care can cost more money in the long run, if someone becomes sicker because he or she wasn't treated right the first time.

So How Do We Keep the Lid on Healthcare Costs?

Here at Healthplan, we arrange for your care by entering into contracts with physician group practices. Some of these groups have only primary care physicians, such as family doctors and pediatricians. Other groups include specialists, such as cardiologists (heart doctors) and pulmonologists (lung doctors). Because each group is free to pay its doctors and deliver care in whatever way it wants, no one system applies to all of them. But most of them use two basic approaches: utilization management and incentives.

Utilization Management

To ensure that all the people who subscribe to Healthplan receive the same high quality of care, we developed guidelines for our physician groups. These guidelines help identify what sort of care is actually needed in which situations. Sometimes the guidelines say you shouldn't receive some things you might expect. For example, we don't prescribe antibiotics for the common cold because they're ineffective and can actually do some harm.

Guidelines aren't just written to avoid wasting time and money. They also incorporate the latest advance-

ments in medical knowledge. If a new drug or procedure proves to be a real improvement over older treatments, our guidelines are updated to include it. Or if an older approach really is the best after all, the guidelines reflect that too. Healthplan is constantly reviewing the latest medical literature and studying our own medical experience to deliver high-quality care at a price you can afford.

Our guidelines are not hard-and-fast rules. People are not all alike, and even the best guidelines sometimes won't fit a particular patient's needs. At Healthplan, your doctor has the discretion to ensure that you receive the care you need. Sometimes, in complicated situations, we also use a case manager. When a patient is very sick and needs lots of care, the case manager's job is to help cut through any red tape and coordinate the various healthcare services needed. If you have any questions about your care, talk things over with your doctor. And if you still have questions, call our toll-free HelpLine.

Incentives

The second way we contain costs is to encourage the cooperation of our doctors. After all, guidelines don't do much good if no one follows them. As we said, each doctor group is free to pay its doctors in whatever way it likes, so no single incentive system applies to all of them. For details on the incentives that apply to your doctors, you'll need to talk to the people at your own medical group.

To understand how our physician incentives work, you first need to understand that economic incentives are everywhere. Suppose you hire someone to paint your house. If you pay him by the hour, he has an incentive to take his time. If you pay him a fixed fee to paint the whole house, he has an incentive to hurry so he can go to the next job. But—and this is important—just because he has an incentive doesn't mean he'll do a bad job. It only means that, no matter how you pay someone for a service, there are incentives in one direction or another.

(continued on following page)

ago, many physicians did not share a grim diagnosis at all, fearing patients would commit suicide.⁴⁴ More recently, physicians and hospitals in New York expressed concern about the mandatory release of morbidity and mortality data for heart surgery, lest low-scoring providers suffer unfair practice losses.^{45,46}

Realities can run surprisingly contrary. In the early 1980s, studies from the President's Commission on Bioethics showed that in most cases too little discussion, not too much, prompts refusals of care.^{47,48} Similarly, after the release of morbidity and mortality data in New York, researchers found that "no movement of patients away from hospitals with high mortality rates has occurred" (p. 395).⁴⁹ Similarly, malpractice lawsuits often spring not from poor care but from poor relationships and patients' feeling that their physician has not fully informed them about treatment choices and outcomes.^{50,51}

In this light, once patients realize that all health plans must contain costs and that virtually all use incentives to do so, a managed care organization that discloses its resource policies candidly may win a large

measure of trust from people otherwise cynical about the healthcare industry. Table 1 offers one possible form for disclosure by a managed care organization. This could be included in members' handbooks and in the information sent to prospective subscribers. It is not intended as a legal document, but rather, like the handbook, as a lay-language summary of important information.

... IN PRACTICE: HOW SHOULD INCENTIVES BE DISCLOSED? ...

Once the managed care organization decides to disclose, the challenge is to craft a document that is honest but not unduly alarming or needlessly negative. The sample disclosure document aims first to satisfy fiduciary obligations by informing patients that providers and health plans have diverse, sometimes competing, obligations and interests. It also seeks balance, explaining why some of these conflicts are unavoidable and why careful cost control is in the patient's interests. To avoid obscuring the basic mes-

Table 1. (continued from previous pages)

<p>That's true of physicians, just like everyone else. Before HMOs came along, doctors usually were paid a separate fee for each service they performed. This fee-for-service system rewarded doctors for performing many services. Gradually, the medical profession began to deliver care that sometimes went beyond what patients really needed. As a result, there is a fair amount of "fat" in the system, and doctors must now figure out where they've been doing too much. Doing too much doesn't just waste money. It can hurt patients. But deciding what's "too much" and what's "just right" takes time and effort. Incentive systems can reward doctors for drawing this line carefully.</p> <p>When Healthplan arranges for members' care with various physician groups, these groups agree to provide all the doctors' services, laboratory tests, and other healthcare services their patients need. Hospital care is under a separate budget. The physician groups as a whole are paid a fixed amount of money for each patient, each month. This payment is called "capitation," and all care must be delivered within the capitated funds. If patients' care costs less than the capitated amount, the group can keep the remaining funds. If it costs more, the group will earn less.</p> <p>Probably the best feature of this broad, group-level capitation is its flexibility. Once the group receives the payment, it can use the money to do whatever makes</p>	<p>the most sense for its patients. One of our doctor groups uses part of their funds to set up support groups for patients with asthma, diabetes, or arthritis. This win-win idea helps patients enjoy better health and, in the process, avoids some of the high costs of illness.</p> <p>Paying the whole medical group by capitation doesn't determine how individual doctors are paid. To pay their doctors, the groups use one of two basic approaches: a salary or a smaller-scale, doctor-level capitation, or fee-for-service with incentives.</p> <p><i>Salary or Capitation.</i> Some groups pay each doctor a fixed salary. Other groups pay each doctor a capitated amount for each patient on the doctor list, so that no matter how often or how rarely the patient visits, the doctor's payment is set. Some of those groups then add incentives of the sort described just below.</p> <p><i>Fee-for-Service with Incentives.</i> In this approach, doctors are paid a specific fee for each service they provide, but with incentives to avoid overdoing things. The idea is to balance the fee-for-service incentive to "do more" with a counterincentive to "be prudent."</p> <p>One type of incentive is the bonus. Bonuses may be awarded to doctors who keep the overall costs of care within the appropriate limits. In most Healthplan groups, bonuses are also given for providing a high quality of care and achieving high levels of patient satisfaction.</p>
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sage, the disclosure document is not excessively detailed. Members wanting additional information are invited to inquire further.

Because there is a bewildering array of managed care arrangements,⁵² the sample disclosure describes a single hypothetical managed care company, one fashioned as an umbrella organization that contracts with a number of group practices, which in turn use a variety of structures. Note also that because this sample form covers a variety of structures, it is considerably more complex and lengthy than that, say, for a staff model HMO, whose disclosure might describe just one set of arrangements for all their physician employees. The use of upbeat language is intentional. Managed care organizations in a highly competitive market cannot be expected to describe themselves in negative terms, even if they must be honest and direct.

The sample disclosure covers three areas. First, the document discusses utilization controls and treatment limits, explaining why a fair but firm enforcement is in the interest of both the patients and the healthcare plan. Second, the document discusses two of the more

common types of incentive arrangements—fee-for-service and capitation. Even these basic forms can vary widely, so the descriptions below are only suggestive. Finally, because this author believes that incentives should also be extended to patients in ways that do not create barriers to care,¹⁴ an additional section describes patient incentives.

... DISCUSSION AND CONCLUSION ...

Admittedly, not all patients will understand even this rather simple disclosure. And there is no guarantee that managed care organizations will be forthcoming at this limited level. Adequate protections for patients may require further measures, perhaps "information ombudsmen" or maybe the legislation some states are enacting or contemplating. However, even if not every member of the public understands the information, the sunshine itself can have a salutary effect. Something like this seems to have happened regarding New York state's mandatory disclosure of data pertaining to heart surgeries. Evidence suggests

Another type of incentive is a "withhold." Under this system, part of a doctor's pay, about 15%, is withheld. If the health plan delivers care within its annual budget, the withheld amount is returned to the doctor. If not, the doctor may not receive all of it back.

A third type of incentive is the "risk pool." Managed health plans such as HMOs need to set aside enough money to cover all healthcare services, such as laboratory tests and specialist consults. During the year, the money remains in this designated account to cover whatever services patients need. At the end of the year, if patients did not use all of this fund, some of what's left may be shared among doctors. Some groups share this money equally among all doctors in the plan, while other groups try to recognize those who did the best job of staying within the budget. At Healthplan, many of our physician groups also use part of the surplus to reward doctors who have provided the highest-quality care and who have earned the patients' highest satisfaction scores.

No matter what payment or incentive system a group uses, Healthplan limits the total economic risk to our doctors. No doctor can lose, or gain, more than 15% of his or her salary or capitation fees. We want our doctors to be careful, not stingy. And we don't want them to be penalized financially because they have a few patients who need more than the usual level of care.

Incentives for Patients

Most HMOs have incentives only for doctors, but at Healthplan, we believe the patient is the most important member of the team. Your health, your healthcare, and your money are all at stake. So it makes sense to reward you for thinking prudently about your care. You'll start each year with a fund of 1000 points known as PlanDollars. When you visit your doctor for routine medical problems, such as colds or scrapes, you'll spend some PlanDollars. When you come in for recommended screenings and immunizations, you'll earn some. If you have a chronic illness, such as diabetes or asthma, you can earn points by keeping follow-up appointments and taking classes to learn about your disease. If you do not keep a scheduled appointment and don't phone at least 8 hours in advance, you'll lose points. But if your doctor is more than 30 minutes late in seeing you, you'll be awarded extra points. Details on this patient incentive plan are included in the special brochure that came with your membership packet. At the end of the year, you can spend the PlanDollars remaining in your account for items in our catalogue, such as health club memberships, massages, athletic shoes, bicycles, and jogging suits. Or you can save them for next year. ■

that the bare fact of disclosure spurred improvements in quality of care. Some of the lower-ranking hospitals, for instance, improved their protocols for stabilizing patients before surgery, while others restricted the privileges of low-volume surgeons.⁴⁹

Perhaps as another sunshine effect, disclosures can create an important brake on the arrangements themselves. An incentive scheme that is ethically acceptable—one that conserves resources prudently without posing too great a conflict between patient interests, plan interests, and self-interest—can surely be described in a way that communicates both the nature of the constraints and their justification. If, on the other hand, an incentive scheme or treatment limit cannot be honestly described to show a clear justification, then probably the arrangement itself is not acceptable. Thus the effort to describe the system in plain English becomes a compass for the very structure of the plan. Morally odiferous incentives that tie physicians' pay too directly to patients' care would be as difficult to vindicate in writing as they are to justify in principle. Incentives that reward physicians for quality and patient satisfaction, and that broadly reward efficiency, are obviously easier to explain.

In the end, even if disclosures are provided, work remains for both physicians and managed care organizations. Physicians must ensure that patients have reviewed the disclosure statement, perhaps by reminding them in their own information packet for new patients. If any incentive hinders a physician's ability to make a specific patient-care decision (eg, by restricting the availability of specific, medically reasonable treatment options), the physician should discuss this with the patient. Physicians and their legal advisors also should carefully scrutinize the managed care organization's incentives, disclosures, and other arrangements before they sign a contract with the company.

Managed care organizations, for their part, must ensure that their systems for making the best use of available resources are medically and morally credible. Their incentive structures must encourage prudent resource use without forcing physicians to forego care a patient needs. Practice guidelines must be based on good science, with a flexibility that permits the individualized care so indispensable to good medicine. Whenever possible, managed care organizations should actively discuss resource priorities with physicians, and even with patients. A good bit of preventive ethics can go a long way toward alleviating some of the challenges inherent in the business aspects of medical practice.

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