Resolution Adopted by the House of Delegates
of the American Bar Association
August, 2001

RECOMMENDATION

RESOLVED, that the American Bar Association urges Congress to enact legislation to require group health plans, other health insurers and similarly situated entities that are employer-sponsored to: 1) disclose to their enrollees any financial incentive programs they provide to physicians with whom they contract to provide patient care; 2) display prominently information on these financial incentive programs, in large type, in a written document sent to all enrollees by group health plans and other health insurers.

REPORT

The area of financial incentives offered by health plans to providers of health care, i.e., physicians in private medical practice, has been the concern of America's consumer of health care ever since managed health care became mainstream in America's healthcare delivery system. It is not so much that aspect of the business of health care that has troubled many, but the lack of disclosure of such incentive programs to the consuming public that has caused concern. Without proper, timely and meaningful disclosure, the patient has no means to judge whether the physician treating her or him is doing so independent of any financial benefit that may accrue to such physician at year's end or at any other time, as may be provided by the business relationship between the health plan and the physician for the benefit of the patient.

The area of financial benefits to health care providers has covered the landscape of health care regulation over the last decade. During the past several years, some states have prohibited the non-disclosure by health plans of financial arrangements that may, at a minimum, create a perception that a particular financial arrangement has an adverse impact on delivery of health care according to sound and principled precepts within medicine and the medical specialties. In addition, in 1996 the Health Care Financing Administration (HCFA) promulgated regulations requiring HMOs and medical plans contracting with the Medicare program and certain HMOs and health insuring organizations contracting with the Medicaid program to disclose physician incentive plans to HCFA or to the state Medicaid agency in sufficient detail to allow HCFA to determine whether the arrangements comply with Departmental regulations and to provide a summary of the plan to enrollees, if requested.[1]

Furthermore, there has been a plethora of court decisions that disfavor not disclosing financial incentive programs between health plans and providers, so much so that many decisions have upheld a cause of action being stated under the federal ERISA statute or under state common law for offering a financial incentive that allegedly resulted in physical injury or death. Concomitantly, there have also been decisions that have held no such cause of action could be stated. It was not until the United States

Supreme Court entered this "fray" that finality for employer-sponsored plans, at least temporarily, has come about. In June 2000, the high court rendered its decision in Pegram et al v. Herdrich, 120 S.Ct. 2143 (2000). Writing for a unanimous court, Justice Souter wrote, in essence, that the realities of the HMO industry must be recognized and that the underpinnings of managed care, as an industry, include arrangements that could include financial incentive programs. Such programs, like year-end bonuses, do not rise to the level of a breach of fiduciary duty under ERISA. Of course, if such an arrangement is a proximate cause of deficient, or substandard, care that leads to injury or death, the doctor would be subject to a medical malpractice suit and in those states that allow it an HMO might be subject to that suit for vicarious liability. Such a suit would be brought in a state court --- for health care is traditionally a matter for state regulation. But a medical malpractice standard of care will not be fashioned for actions brought against an HMO for an alleged breach of fiduciary duty under ERISA in the area of failing to disclose financial incentives.

Notwithstanding the Court's edict here, it deferred to the Congress to decide whether or not to develop legislation that would provide for a breach of fiduciary duty under ERISA, premised upon failure to disclose financial incentives to a patient before treatment is undertaken.

What neither the Court nor the federal government addresses is whether consumers of employer-sponsored health care, through the health care plans by which they see physicians, should have the ability to be fully informed that their respective caregivers offer treatment through programs with health plans that allow for financial incentives, i.e., bonuses, to the caregiver under defined circumstances. If such a disclosure is given, the consumer of care becomes an informed consumer. The consumer can then either proceed with the care the caregiver provides, or go elsewhere if he or she is concerned that the care given by the provider may be influenced by financial considerations.

The Special Committee on Professional Medical Liability has studied this area, and finds it problematic that there is no federal requirement that there be a disclosure of the type or description of incentive programs offered by employer-sponsored managed care plans to their providers. There have been increasing concerns of "money over medicine" and "profit over patient care," to coin but two phrases that have taken on meaning recently. Additionally, there is concern among the consumers of health care that money is an instrument of the managed care industry (indeed, the Supreme Court has even recognized that financial incentives or incentive-type programs are inherent in the business of managed care) that may well have had an impact on the rendering of timely and quality medical care in our country. If that be so, then all providers face increased risk and exposure to liability claims and consequent litigation.

The Special Committee considered the question of whether the provider, the health plan/HMO type entity or the employer should be the one required to make such a disclosure. The Special Committee believes that, on balance, such disclosures should be made by the employer-sponsored plan insurer. Neither the employer nor the physician should have this responsibility. Physicians who practice medicine often have many plans with which they contract to provide patient care and treatment, and not only would it be too onerous and cumbersome to make such disclosures for every plan with which a physician has such a contract, but the practice of medicine, in very pragmatic terms, should be left to the physician. Matters of business, terms and conditions of the plan, and the like should be left to each and every plan. Should a patient have a question of her or his physician or plan, after being advised that a financial incentive exists, then that patient would be free to receive whatever

information is supplied by the physician or plan as a response to the patient's further inquiry. Moreover, serious consideration should be given to also providing disclosure of financial incentive arrangements to employers, most appropriately before the employer selects a plan(s) for its employees. Again, however, the Committee has deliberately chosen not to include the employer base within the body of the recommendation. The focus of the recommendation, to reiterate, is disclosure itself, and, at a minimum, to the consumers/patients of health care and treatment provided them by providers they see through employer-sponsored health plans.

Many states have enacted strong and effective financial incentive laws. In addition, on the federal level, Medicare regulations prohibit managed care organizations from making specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to any particular Medicare enrollee. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.[2] Further, Medicare requires that HMOs disclose physician financial plans to any Medicare beneficiary who requests the information. (42 C.F.R. § 417.479(h)(3)(i)). The Special Committee believes that effective state financial incentive laws should not be pre-empted by federal law and it is not the intent of the Special Committee's recommendation to do this.

The Special Committee is cognizant that when it uses the words, "financial incentive programs" within its recommendation, it does so without going into specifics. This was done intentionally, after having surveyed various state statutes that use the term in a similar context as that contained in the Committee's recommendation. In reviewing relevant state statutes, the Committee found that from a definitional viewpoint, the range varied from the general and broad to the specific and detailed. While the following is neither exhaustive nor is it intended to be, it articulates a sampling of what states, which have chosen to address the issue, have done to address disclosure of financial incentives to medical providers by health plans.

Several states currently have statutes that simply permit the provider to disclose financial incentives offered by the insurer. For example, in Indiana, "an agreement between an insurer and provider…may not prohibit a provider from disclosing financial incentives to the provider" or "penalize a provider financially or in any other manner for making [such] a disclosure."[3] Similarly, Colorado legislation does not permit a carrier to "penalize a provider…because the participating provider discusses the financial incentives or financial arrangements between the provider and the managed care plan."[4]

A few states go one step further by specifying that the providers may disclose financial incentive information to enrollees of the health care plan. For example, Kentucky legislation states that "a health care provider shall not be penalized for discussing financial incentives and financial arrangements between the provider and the insurer with an enrollee."[5] Arkansas legislation also does not allow participating providers to be "prohibited, restricted, or penalized in any way from disclosing to any covered person any health care information that the provider deems appropriate regarding… information on financial incentives and structures used by the insurer."[6]

Several states have more specific statutes that require insurers to provide printed documents at specified times and/or upon request to enrollees, which describe financial incentives. For example, Maryland's legislation requires each carrier to "identify and disclose in layman's terms in its enrollment sales materials the

reimbursement methodology or methodologies the carrier uses to reimburse physicians for health care services rendered to enrollees, including capitation, case rates, discounted fee-for-service, and fee-for-service reimbursement methodologies."[7] New Jersey legislation also requires carriers of a managed care plan to "disclose to a subscriber, in writing…at the time of enrollment and annually thereafter, general information about the financial incentives between participating physicians under contract with the carrier and other participating health care providers and facilities to which the participating physicians refer their managed care patients."[8] Similarly, Kentucky legislation states that "upon request, a managed care plan shall inform its enrollees in writing of the type of financial arrangements between the plan and participating providers if those arrangements include an incentive or bonus."[9] Kentucky legislation also specifically states that "an insurer…shall notify an enrollee, in writing, of the availability of a printed document…containing…general information about the type of financial incentives between participating providers under contract with the insurer and other participating health care providers and facilities to which the participating providers refer their managed care patients."[10]

Minnesota has similar, but more specific, written disclosure requirements. The Minnesota statute requires "a health plan company,…health care network cooperative, …and a health care provider,…during open enrollment, upon enrollment, and annually thereafter, [to] provide enrollees with a description of the general nature of the reimbursement methodologies used by the health plan company, health insurer, or health coverage plan to pay providers. The description in the written disclosure must explain clearly any aspect of the reimbursement methodology that creates a financial incentive for the health care provider to limit or restrict the health care provided to enrollees. An entity required to disclose shall also disclose if no reimbursement methodology is used that creates a financial incentive for the health care provider to limit or restrict the health care provided to enrollees. This description may be incorporated into the member handbook, subscriber contract, certificate of coverage, or other written enrollee communication. The general reimbursement methodology shall be made available to employers at the time of open enrollment. Health plan companies, health care network cooperatives, and providers must, upon request, provide an enrollee with specific information regarding the reimbursement methodology." The information must include, but is not limited to, "a concise written description of the provider payment plan, including any incentive plan applicable to the enrollee" and "a written description of any incentive to the provider relating to the provision of health care services to enrollees, including any compensation arrangement that is dependent on the amount of health coverage or health care services provided to the enrollee, or the number of referrals to or utilization of specialists."[11]

Missouri legislation provides an example of a state statute that requires disclosure to a specific state agency, rather than enrollees, so that the department can make a determination as to whether "such arrangements offer an inducement to a provider to provide less than medically necessary services to an enrollee." Specifically, the statute requires health maintenance organizations to "disclose to the department of insurance all financial arrangements, financial interest in, or contractual provisions with utilization review companies or any other health care provider that would encourage or limit the type, amount, duration and scope of services offered, restrict or limit referral or treatment to patients, including but not limited to financial incentives to limit, restrict or deny access to or delivery of medical or other services prior to the delivery of such services." The statute also states that "capitation arrangements between health maintenance organizations and health care providers shall not be considered an inducement to limit, restrict or deny access to medical services."[12]

In addition, there were several state statutes that do not allow certain financial incentives between insurers and health care providers. For example, Pennsylvania legislation states that "no managed care plan shall use any financial incentive that compensates a health care provider for providing less than medically necessary and appropriate care to an enrollee." However, the legislation goes on to clarify that "nothing in [that section of the legislation] shall be deemed to prohibit a managed care plan from using a capitated payment arrangement or other risk-sharing agreement."[13] Similarly, Nevada legislation states that "a managed care organization shall not offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay specific medically necessary health care services to an insured," and goes on to clarify that "nothing [in that section of the legislation] prohibits an arrangement for payment between a managed care organization and a provider of health care that uses capitation or other financial incentives, if the arrangement is designed to provide an incentive to the provider of health care to use health care services effectively and consistently in the best interest of the health care of the insured."[14] Maine legislation also prohibits "a carrier offering a managed care plan…[to] offer or pay any type of material inducement, bonus or other financial incentive to a participating provider to deny, reduce, withhold, limit or delay specific medically necessary and appropriate health care services covered under the plan to an enrollee." It also clarifies that "this subsection may not be construed to prohibit contracts that contain incentive plans that involve general payments such as capitation payments or risk-sharing agreements that are made with respect to providers or groups of providers or that are made with respect to groups of enrollees."[15]

Legislation from Alaska is the most expansive in prohibiting certain types of financial incentives. In one of its statutes, it states that "a health maintenance organization, including a health maintenance organization operating a managed care plan, or a representative of a health maintenance organization may not cause, request, or knowingly permit financial incentives to be given or offered to a provider for denying or delaying health care services."[16] An additional Alaskan state statute however, goes on to clarify that "a contract between a participating health care provider and a managed care entity that offers a group managed care plan may not contain a provision that has as its predominant purpose the creation of direct financial incentives to the health care provider for withholding covered health care services that are medically necessary," but also states that nothing in the paragraph "shall be construed to prohibit a contract between a participating health care provider and a managed care entity from containing incentives for efficient management of the utilization and cost of covered health care services."[17]

At the federal level, The Bipartisan Patient Protection Act of 2001, S. 283 (McCain (R-AZ) and Kennedy (D-MA)) and H.R. 526 (Ganske (R-IA) and Dingell (D-MI)), also contains provisions to require disclosure of physician incentive plan compensation methods (Sec. 121(c)(2)). Later in the legislation (Sec. 133), there is additional language precluding improper physician plan incentive arrangements.[18]

Thus, given the variations in defining financial incentives that we have described in this report, the Special Committee decided not to request the House of Delegates to endorse specific language but instead to endorse the principle that if financial incentives are provided, information regarding them needs to be disclosed to consumers of health care. It is most suitable to leave it to Congressional draftpersons to craft definitional language. The message that the Special Committee believes the

ABA should send to Congress is that, given the pronouncement by the U.S. Supreme Court in Herdrich, federal legislation is needed to require disclosure of financial incentives to patients in employer-sponsored plans. Consumers of health care must be adequately informed so they can be assured that their medical care and treatment is unaffected, and not tied to, financial arrangements, including incentives/disincentives, between their providers and payers of that medical care and treatment. Concomitantly, a consumer of health care should not be "disenfranchised" from receiving required, appropriate and proper health care that is dictated solely by medical condition or disease rather than by what the health care provider receives financially, or what that provider has the ability to receive, financially, based upon certain yardsticks or measurements tabulated at the end of a fiscal time period.

Respectfully submitted,

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Medical Professional Liability

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1. 42 CFR §§ 417.479(h) and 434.70(a) (1996).
2. 42 CFR § 422.208
3. Ind. Code Ann. § 27-8-11-4.5 (Michie 1999).
4. Colo. Rev. Stat. Ann. § 10-16-705 (2000).
5. Ky. Rev. Stat. Ann. § 304.17A-530 (Michie Supp. 2000).
6. Ark. Code Ann. § 23-99-407 (Michie 1999).
7. Md. Code Ann., Ins. § 15-121 (Michie 1997 & Supp. 2000). This might be the most preferential definition of any the Committee reviewed.
8. N.J. Stat. Ann. § 26:2S-5 (West Supp. 2000).
9. Ky. Rev. Stat. Ann. § 304.17A-530 (Michie Supp. 2000).
10. Ky. Rev. Stat. Ann. § 304.17A-510 (Michie Supp. 2000).
11. Minn. Stat. Ann. § 62J.72 (West Supp. 2001).
12. Mo. Ann. Stat. § 354.443 (West Supp. 2001).
13. Pa. Stat. Ann. tit. 40, § 991.2112 (West 1999).
14. Nev. Rev. Stat. Ann. 695G.260 (Michie 1998).
15. Me. Rev. Stat. Ann. tit. 24-A, § 4303 (West Supp. 2000).
16. Alaska Stat. § 21.86.150 (Michie 2000).
17. Alaska Stat. § 21.07.010 (Michie 2000).
18. See Sec. 1876(i)(8)(B) of the Social Security Act ("physician incentive plan" means any compensation arrangement between an eligible organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization.)