

HEALTH POLICY

Physician Incentives and Disclosure of Payment Methods to Patients

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OBJECTIVE: There is increasing public discussion of the value of disclosing how physicians are paid. However, little is known about patients' awareness of and interest in physician payment information or its potential impact on patients' evaluation of their care.

DESIGN: Cross-sectional survey.

SETTING: Managed care and indemnity plans of a large, national health insurer.

PARTICIPANTS: Telephone interviews were conducted with 2,086 adult patients in Atlanta, Ga.; Baltimore, Md/Washington DC; and Orlando, Fla (response rate, 54%).

MEASUREMENTS AND MAIN RESULTS: Patients were interviewed to assess perceptions of their physicians' payment method, preference for disclosure, and perceived effect of different financial incentives on quality of care. Non-managed fee-for-service patients (44%) were more likely to correctly identify how their physicians were paid than those with salaried (32%) or capitated (16%) physicians. Just over half (54%) wanted to be informed about their physicians' payment method. Patients of capitated and salaried physicians were as likely to want disclosure as patients of fee-for-service physicians. College graduates were more likely to prefer disclosure than other patients. Many patients (76%) thought a bonus paid for ordering fewer than the average number of tests would adversely affect the quality of their care. About half of the patients (53%) thought a particular type of withhold would adversely affect the quality of their care. White patients, college graduates, and those who had higher incomes were more likely to think that these types of bonuses and withholds would have a negative impact on their care. Among patients who believed that these types of bonuses adversely affected care, those with non-managed fee-for-service insurance and college graduates were more willing to pay a higher deductible or co-payment in order to get tests that they thought were necessary.

CONCLUSIONS: Most patients were unaware of how their physicians are paid, and only about half wanted to know. Most believed that bonuses or withholds designed to reduce the use of services would adversely affect the quality of their care. Lack of knowledge combined with strong attitudes about various financial incentives suggest that improved patient education could clarify patient understanding of the nature and rationale for different types of incentives. More public discussion of this important topic is warranted.

KEY WORDS: trust; managed care; doctor-patient relationships; disclosure; quality of care.

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Contractual arrangements that place physicians at financial risk for services delivered are increasingly used.^{1,2} In part because of this fundamental shift in the way that physicians are paid, many have advocated for disclosure of financial incentives as a way of reducing potential conflicts of interest.³⁻⁸ Many patient advocates believe that disclosure of physician payment methods should be an integral part of a patients' "bill of rights".⁹⁻¹¹ Many states have already enacted legislation that prohibits contracts that restrict patient-physician communication including discussions about financial incentives.^{12,13} Some health plans already encourage such communications. The Federal government has issued rules mandating that Medicare health plans disclose physician payment methods to patients who request this information.¹⁴

Disclosure may not be as useful to patients as many advocates of such procedures hope without more patient education about financial payment methods. Physician contractual arrangements often include various combinations of primary payment methods (capitation, salary, fee-for-service) and secondary financial incentives (bonuses and withholds). Secondary financial incentives can be based on many factors including member satisfaction, performance of preventive services, group financial performance, and referral patterns. Information about complex financial arrangements may be difficult to convey in a concise and interpretable manner.¹⁵

Disclosure may also have unintended consequences. Many payor financial incentives are designed to encourage appropriate use and discourage inappropriate use of

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medical services¹⁶ but are viewed by some as having the potential of compromising the traditional role of the physician as primarily an agent of the patient.^{17,18} If physicians were required to discuss financial incentives in the context of clinical decisions, such discussions might undermine patients' trust in their physicians, especially in the absence of a long-term relationship.¹⁹ Furthermore, we do not know if patients would find such information useful when selecting a physician or health plan.²⁰⁻²³ The American Medical Association's *Principles of Managed Care*²⁴ contains provisions that advocate for disclosure of certain financial incentives but it is unknown how many physicians adhere to these provisions. Moreover, other factors might affect practice behavior, including expectations for a certain target income and fear of malpractice litigation that may drive overuse of diagnostic tests and procedures. These additional incentives are not addressed in this study.

In spite of the current debate about disclosure, there are few empirical studies about this issue. In a previous article that reported the results of a survey in a single market,²⁵ we found that almost two thirds of respondents did not know how their doctor was paid. In the study described herein, we previously reported that when patients were asked how their doctor was paid, about 68% of patients were incorrect or did not know.²⁶ These results may have important implications for efforts to disclose information to patients. In this article, we address 3 questions: 1) Which patients are more or less likely to be aware of how their physicians are paid? 2) If patients are unaware of how their physicians are paid, do they want to be informed? and 3) What is the perceived impact of financial incentives designed to reduce use of services on quality of patient care?

METHODS

Sample

Respondents were part of a study examining the relationship between physician payment methods and patients' trust in their physicians (for details regarding sample selection and methodology, see previous publication).²⁶ Briefly, eligible patients (18 years or older) had a primary care physician (family practice, internal medicine, or obstetrics/gynecology) office visit in 1995, and were enrolled in managed care or indemnity plans of a large, national health insurer in 3 health insurance markets (Atlanta, Ga; Baltimore, Md/Washington DC; and Orlando, Fla). A disproportionate stratified probability sample of patients was selected from physician practices with at least 8 eligible patients. We were particularly interested in comparisons between patients of physicians who were paid on a capitated basis and physicians who were paid on a managed fee-for-service basis. Thus, we drew a sample with a 1:2:2:1 ratio of patients whose physicians were paid on a salaried, capitated, managed fee-for-service, and non-managed fee-for-service basis, respectively, for those

patients. Payment method at the physician level was determined from health plan records, medical directors of multi-specialty group practices, or interviews with office managers of physician practices.

Questionnaire

To assess patients' awareness of how their physicians were paid, respondents were asked to identify their physician's method of payment: 1) doctor's pay is based on a straight salary; 2) doctor's pay is based on some fixed monthly amount which is dependent on the number of patients in the doctor's practice; and 3) doctor's pay is based on the number of office visits. Respondents were also asked about their desire for disclosure: "Do you think that you should be informed about what your doctor's pay is based on?"

Even though salary arrangements have no inherent financial incentives to provide more or less care, physicians paid a salary may be subject to bonuses and/or withholds. Therefore, any disclosure of payment methods will likely have to address these types of financial incentives. To assess the perceived impact of physician incentives on quality of care, we focused on a specific type of bonus and withhold that may discourage use of medical services.²⁷ We described to patients one type of withhold ("Some HMOs withhold a portion of the money paid to a doctor until the end of the year. The withheld portion is then paid to the doctor if there is a surplus in HMO medical funds.") and bonus ("Doctors were paid a bonus for ordering fewer than the average number of tests."). Respondents were asked whether they thought these types of bonuses or withholds would make care better, worse, or have no effect. Those who thought such bonuses would make their care worse were also asked if they would "pay a higher copay or deductible to get the tests that they thought they needed."

In the sites studied, some groups of salaried physicians received bonuses based on factors such as member satisfaction and financial performance. At the beginning of the study, withholds were used in salaried and capitated groups in one of the study sites; those were discontinued by the plan in mid-1996. The fee-for-service arrangements were not subject to plan bonuses or withholds in any of the study sites.

The questionnaire asked about patients' race, education, income, and health status. Patients' age and gender were obtained from administrative data. Information about physicians' age, gender, and international medical graduate status were abstracted from the AMA's 1997 Physician Masterfile and the insurer's administrative files.

Statistical Analysis

We used χ^2 tests to evaluate differences between groups of patients on their awareness of physician payment methods, desire for disclosure, and perceptions of the

Table 1. Patient Characteristics According to Physician Payment Method

	Salary, <i>n</i> = 359	Capitation, <i>n</i> = 691	Managed Fee-for-Service, <i>n</i> = 656	Non-Managed Fee-for-Service, <i>n</i> = 380	Total, <i>N</i> = 2,086	Weighted Total, <i>N</i> = 2,086
Mean age (SD), y*	44.0 (12)	42.8 (12)	43.1 (11)	54.4 (12)	45.2 (12)	45.0 (12)
Female, % (SE) [†]	65.5 (3)	67.0 (2)	73.0 (2)	71.1 (2)	69.4 (1)	71.0 (1)
White, % (SE)*	67.0 (3)	75.1 (2)	84.3 (1)	91.1 (1)	79.5 (1)	80.3 (1)
College graduate, % (SE)*	32.3 (2)	37.6 (2)	47.9 (2)	50.5 (3)	42.3 (1)	43.6 (1)
Income ≥\$45,000, % (SE)*	58.2 (3)	64.9 (2)	73.4 (2)	73.4 (2)	67.9 (1)	71.3 (1)
Self-reported health, % (SE)*						
Excellent	23.5 (2)	25.5 (2)	30.3 (2)	28.0 (2)	27.2 (1)	28.3 (1)
Very good	38.1 (3)	37.7 (2)	41.5 (2)	43.7 (3)	40.0 (1)	39.6 (1)
Good	27.2 (2)	27.3 (2)	21.6 (2)	22.5 (2)	24.6 (1)	24.3 (1)
Fair	8.7 (2)	7.8 (1)	5.9 (1)	4.2 (1)	6.7 (.5)	6.9 (.7)
Poor	2.5 (.8)	1.6 (.5)	0.6 (.3)	1.6 (.6)	1.4 (.3)	1.0 (.2)
Area						
Atlanta, Ga, %	13.1	0.0	14.3	27.1	11.7	11.7
Orlando, Fla, %	39.0	27.5	37.4	10.5	29.5	29.5
Baltimore, Md/ Washington, DC, %	47.9	72.5	48.3	62.4	58.8	58.8

* $P < .01$.[†] $P < .05$.

impact of selected financial incentives on the quality of their care. We conducted multivariate analyses using logistic regression models in which desire for disclosure, perceived negative effect of financial incentives, and patients' willingness to accept a higher copay or deductible were dependent variables. Independent variables in the regression models included physician payment method, patients' perceptions of how their physicians were paid, patient characteristics (age, gender, race, education, income, and health status), and physician characteristics (age, gender, U.S. medical graduate). Variables also were included to control for site effects. Missing data in independent variables were imputed using regression models. Huber corrections adjusted for intracluster correlations among multiple patients of the same physician (STATA, Version 5.0, STATA Corp, College Station, Tex). For some analyses, weights were used that correct for the differential sampling probability for patients of physicians paid in different ways.

RESULTS

Of the 4,448 patients we attempted to reach for a telephone interview from January 1997 through June 1997, 2,733 patients were contacted and screened for eligibility. Of those screened, 602 patients (22%) were ineligible (i.e., no longer enrolled in the health plan, language problems or hearing difficulties, could not identify a "regular" doctor, or had no opinion about their physician). Among the eligible patients, 2,086 telephone interviews were completed for a response rate of 54.2% among those not known to be ineligible. Of those contacted and eligible, 97.9% completed an interview. Respondents were older on average than non-respondents (weighted data; 46 vs. 44 years old, $P <$

.01), and more likely to be female (weighted data; 71% vs 64%; $P < .01$).

Respondent characteristics are presented in Table 1. Non-managed fee-for-service patients were older on average ($P < .01$) and more likely to be white ($P < .01$) than other patients. Managed and non-managed fee-for-service patients were more likely to be female ($P < .05$) and more likely to have graduated from college ($P < .01$) than other patients. Patients with salaried physicians tended to report slightly poorer health status than other patients ($P < .01$).

Awareness of Payment Methods

Patients with salaried (32%, $P < .001$) or capitated physicians (16%, $P < .001$) were less likely to be correct about their physician's payment method than non-managed fee-for-service patients (44%). There was no difference in awareness of payment method between managed and non-managed fee-for-service patients (Table 2). Regardless of how their physicians were paid, very few patients identified capitation (11%) as a possible method of physician payment.

Preference for Disclosure

About half of the patients (54%) wanted to be informed about how their physicians were paid. Non-managed fee-for-service patients (62%) were more likely to want disclosure than those whose physicians were paid on a salaried (46%, $P < .001$), capitated (54%, $P < .05$), or managed fee-for-service basis (55%, $P < .05$).

Predictors of Preference for Disclosure

In logistic regression analysis that adjusted for other predictors, patients of non-managed fee-for-service physicians were more likely than patients of salaried (odds ratio

Table 2. Patient Perceptions of How Their Physicians Are Paid According to Payment Method

Perceived Physician Payment Method	Actual Physician Payment Method				Total (N = 2,066)
	Salary (n = 358)	Capitation (n = 685)	Managed Fee-for-Service (n = 652)	Non-Managed Fee-for-Service (n = 371)	
Salary, %	32*	14	10	6	14
Capitation, %	13	16*	9	5	11
Fee-for-service, %	24	34	42	44	37
Did not know how physician was paid, %	30	36	39	45	38
Total	99	100	100	100	100

Percentages may not total 100 due to rounding.

* $P < .001$ for the differences between the non-managed fee-for-service group and each of the other groups in the percent of respondents who correctly identified their physician's payment method.

[OR], 0.64; 95% confidence interval [CI], 0.43 to 0.94) or capitated (OR, 0.67; 95% CI, 0.47 to 0.95) physicians to want disclosure (Table 3). Those who stated they did not know how their physicians were paid were no more likely to prefer disclosure than other patients. College graduates (OR, 1.43; 95% CI, 1.18 to 1.73), and patients who had poorer health status (OR, 1.12; 95% CI, 1.01 to 1.25) were more likely to want disclosure. When the same model was run with weighted data, the coefficients were comparable, but the confidence intervals changed slightly and physician payment type and reported health status were no longer significant.

Perceived Impact of Incentives on Care

Many patients believed that the use of certain types of bonuses (76%) or withholds (53%) would adversely affect their care (Table 4). Non-managed fee-for-service patients were more likely to believe that the bonuses would negatively affect their care than were capitated patients (77 vs 72 %, $P < .05$). More non-managed fee-for-service patients (58%) believed that using the specified type of

withhold would adversely affect their care than capitated patients (52%, $P < .01$) or those with salaried physicians (50%, $P < .001$). Few patients (3% to 10%) believed that use of such bonuses or withholds would have a positive effect on the quality of their care.

Predictors of Perceived Impact of Incentives

In logistic regression analysis, white patients (OR, 3.91; 95% CI, 2.55 to 6.01), women (OR, 1.77; 95% CI, 1.17 to 2.69), college graduates (OR, 2.03; 95% CI: 1.29 to 3.18), and those with higher annual incomes (OR, 1.87; 95% CI, 1.25 to 2.79) were more likely to believe that the specified type of bonus would adversely affect the quality of their care (Table 5). Compared to younger patients, those between the ages of 35 and 54 inclusive were more likely (OR, 1.82; 95% CI, 1.14 to 2.93) to believe that those bonuses would have a negative impact on their care.

Those who believed that the use of those withholds would adversely affect the quality of their care were more likely to be white (OR, 2.42; 95% CI, 1.63 to 3.61), female (OR, 1.90; 95% CI, 1.26 to 2.86), and college graduates

Table 3. Multivariate Predictors of Desire for Disclosure (N = 2,006)*

Predictors	Odds Ratio (95% CI)
Physician was paid on a salary basis [†]	0.64 (0.43 to 0.94) [‡]
Physician was paid on a capitated basis [†]	0.67 (0.47 to 0.95) [‡]
Physician was paid on a managed fee-for-service basis [†]	0.74 (0.54 to 1.01)
Thought physician was paid on salary basis [¶]	0.88 (0.63 to 1.24)
Thought physician was paid on a capitated basis [¶]	1.03 (0.70 to 1.53)
Thought physician was paid on a fee-for-service basis [¶]	1.29 (0.95 to 1.77)
Correctly identified that physician was paid on a salary basis	0.60 (0.34 to 1.03)
Correctly identified that physician was paid on a capitated basis	1.51 (0.85 to 2.71)
Correctly identified that physician was paid on a fee-for-service basis	0.94 (0.63 to 1.41)
College graduate	1.43 (1.18 to 1.73) [§]
Poorer health status	1.12 (1.01 to 1.25) [‡]

* Controlling for age, gender, race, income, physician age, physician gender, foreign medical graduate physician, and site.

[†] Reference group was comprised of non-managed fee-for-service patients.

[‡] $P < .05$.

[§] $P < .001$.

[¶] Reference group was comprised of patients who did not know how physicians were paid.

Table 4. Perceived Impact of Bonuses (N = 1,987) or Withholds (N = 1,872) on Care According to Payment Method

	Salary	Capitation*	Managed Fee-for-Service	Non-Managed Fee-for-Service	Total
Bonus					
Positive effect, %	7	8	5	3	6
No effect, %	18	20	16	20	18
Negative effect, %	75	72	80	77	76
	Salary†	Capitation‡	Managed Fee-for-Service	Non-Managed Fee-for-Service	Total
Withhold					
Positive effect, %	10	9	7	3	7
No effect, %	40	39	39	38	39
Negative effect, %	50	52	54	58	53

* P < .05.

† P < .001 for the differences between non-managed fee-for-service group and each of the other groups.

‡ P < .01.

(OR, 2.07; 95% CI, 1.35 to 3.18). Actual physician payment method and patient health status were not associated with perceived impact of the bonuses or withholds on quality of care. When the same model was run with weighted data, the coefficients were comparable, but the confidence intervals changed slightly and gender was not significantly related to perceived effects of either bonuses or withholds, the effect of college education was no longer significant for perceived effects of withholds, and income no longer had a significant effect on perceived effects of bonuses.

Predictors of Willingness to Pay

Among 1,443 patients who thought the use of bonuses that reward physicians for ordering fewer than the average number of tests were problematic, 64% were willing to accept a higher copay or deductible to get medical tests they perceived as being necessary. Non-managed fee-for-service patients were more willing to pay a higher copayment or deductible than patients with salaried (OR, 0.52; 95% CI, 0.31 to 0.88) or capitated (OR, 0.46; 95% CI, 0.29 to 0.73) physicians. College graduates were also more

willing to pay more to get medical tests that they thought were necessary (OR, 1.50; 95% CI, 1.19 to 1.89). Other patient characteristics including age, gender, race, income, and health status were not associated with reported willingness to pay. The results were comparable when the models were run with weighted data.

DISCUSSION

In spite of extensive debate concerning disclosure of financial incentives, little is known about patients' awareness of how their physicians are paid.²⁵ This may be due in part to the difficulty of compiling such information. When intermediaries such as medical groups modify financial incentives from payors,²⁸ data about how practicing physicians are paid when providing care to individual patients are not readily available. For example, a salaried physician may have been part of group that was paid on a capitated basis. Further, at the practice level, physicians may be paid through a variety of financial arrangements for different groups of patients (e.g., capitation, managed fee-for-service, and non-managed fee-for-service). We

Table 5. Multivariate Model of Perceived Negative Effect of Bonuses or Withholds on Care

Patient Characteristics	Bonus (n = 1,969)	Withhold (n = 1,856)
	Odds Ratio (95% CI)	Odds Ratio (95% CI)
Patient age*		
35 – 54	1.82 (1.14 to 2.93) [†]	1.76 (1.13 to 2.75) [†]
55 – 64	1.69 (0.86 to 3.32)	2.10 (1.11 to 3.97) [†]
> 64	0.84 (0.34 to 2.09)	3.25 (0.92 to 11.4)
White patient	3.91 (2.55 to 6.01) [‡]	2.42 (1.63 to 3.61) [‡]
Female patient	1.77 (1.17 to 2.69) [§]	1.90 (1.26 to 2.86) [§]
College graduate	2.03 (1.29 to 3.18) [§]	2.07 (1.35 to 3.18) [§]
Income ≥ \$45,000	1.87 (1.25 to 2.79) [§]	1.19 (0.78 to 1.82)

* Reference group comprised of 18- to 34-year-olds. Models control for age, gender, race, income, physician age, physician gender, foreign medical graduate physician, physician payment method, and site.

† P < .05.

‡ P < .001.

§ P < .01.

evaluated financial incentives at the individual physician level for each patient in the study.

Patients of salaried physicians were least likely to say they did not know how their doctor was paid and twice as likely as patients of capitated physicians to correctly identify their physician's payment method. Capitated patients were least likely to correctly identify their physician's payment method. Fee-for-service patients were most likely to correctly identify the payment method of their physician. This could be because fee-for-service patients are better educated and/or more aware of payment methods. Alternatively, it could be that fee-for-service patients were more likely to be right simply because all types of patients were most likely to guess fee-for-service and patients of physicians paid fee-for-service for their care were more likely to be correct.

Despite this significant knowledge gap, only about half of the patients wanted to be informed about their physician's payment method. Patients who stated they did not know how their physician was paid were no more likely to prefer disclosure than other patients. College graduates were most likely to want to know how their physician was paid.

In light of growing public concern about changes in the health care system,²⁹⁻³¹ we had expected that the overall interest in disclosure would be higher, especially among patients who regularly use health care services. The low interest may be partly explained by the finding that most patients trust their physicians to act in their best interest regardless of patient perceptions of their physician's payment method.²⁶ In addition, the implications of financial incentives on care may not be of concern to patients until serious illness strikes or until expensive procedures and interventions are under consideration. Very few patients think that fee-for-service payment, a traditionally common form of payment that may encourage overuse of medical services,³² has an adverse impact on the quality of care.²⁵ Patients may be more concerned about premium costs and covered benefits²¹ than information about physician payment methods.

Given varied patient interest in physician payment information, current Health Care Financing Administration (HCFA) regulations concerning disclosure¹⁴ could lead to more vulnerable populations being less informed about such issues because they might be less likely to request such information. Some have argued that the doctrine of informed consent should encompass information about financial incentives that might affect clinical decision making.^{33,34} Advocates of this broader conceptualization argue that information about financial incentives is as relevant to informed consent as information concerning the risks and benefits of medical tests and procedures. Some would argue that fairness may be undermined if primarily well-educated, commercially insured patients get information about how physicians are paid, which is possible if the information is disclosed only to patients who request it.

We found that a majority of patients believed that using a bonus or withhold designed to limit use of services would have a negative impact on the quality of their care. Patients who were 35 to 54 years old were significantly more likely to view these types of bonuses and withholds negatively, compared to younger patients. White, college-educated, and more affluent patients tended to have a negative evaluation of these bonuses and withholds. They may view such incentives as restricting their access to needed but expensive medical services. Among patients who believed that these bonuses might adversely reduce use of medical services, many stated a willingness to pay a higher co-payment or deductible in order to get the tests that they considered necessary. This study did not address bonuses and withholds designed to increase utilization of appropriate services and decrease utilization of inappropriate services.

Given such strong attitudes towards certain incentives, effective use of physician payment information requires that patients have an educated basis for interpreting such information. Better-informed patients may conclude that incentive arrangements based on factors such as patient satisfaction or appropriate utilization of preventive services can control costs while improving quality of care. Patients who have choice of health plans may prefer to enroll in plans that use such incentives. At the same time, patients could avoid plans that use incentive arrangements that place physicians at high financial risk.³⁵ Patients with employment-based insurance coverage often have few health plan choices.^{36,37} Nevertheless, disclosure may discourage the overall use of financial incentives that patients view as being incompatible with quality care, and thereby even patients who have no choice of plans may indirectly benefit from disclosure.

Despite the knowledge gap regarding how physicians are paid, little is known about how to inform patients about these complex financial issues. For example, patients may be more concerned about incentives that limit access to care, but may not appreciate that financial incentives that encourage overuse of medical services might negatively affect quality of care. Therefore, prior to widespread adoption and implementation of disclosure regulations, research is needed to evaluate ways of educating patients about different physician payment methods.²⁰

Our study had several limitations. Results may not generalize to other health insurance plans or other cities. However, the study sites represented diverse medical care markets: Baltimore has high HMO market penetration, while Atlanta has relatively low penetration. Some patients who correctly identified how their physicians were paid may have simply guessed correctly. Therefore, the fraction of patients that actually knew how their physicians were paid is probably lower than our data suggest. The questions asking patients how their physician is paid necessarily simplified the many complexities of physician payment. For example, fee-for-service payments are usually based on the type of visit as well as particular

procedures performed or services provided. To make the question understandable to most patients, we simply characterized fee-for-service payments as the doctor being paid based on the number of office visits. Similar simplifications were made when describing capitation and salary payment methods. Financial incentives such as bonuses and withholds can be based on a variety of factors, such as member satisfaction, provision of preventive services, group financial performance, compliance with nationally recognized clinical practice guidelines, and referral patterns. Because our study did not address these, our findings should not be generalized to them. In this study, we addressed only the type of bonus many people would consider to be the most negative, one that does not distinguish between appropriate and inappropriate uses of medical services. It is unknown to what extent this type of bonus has actually been used by insurers. Furthermore, we did not include any questions to assess patients' awareness of the risks of traditional indemnity arrangements.³⁸ In addition, the wording of some of the questions (e.g., "Would you pay more for tests you thought you needed?") may have influenced patients' responses. Finally, observed differences among patient groups may partly reflect selection bias. We statistically adjusted for measured differences in the patient groups, but there may be unmeasured differences as well.

Demand for disclosure is likely to increase as public concern about changes in the health care system grows. It also seems inevitable that patients increasingly will expect physicians to discuss issues of financial incentives, especially when such matters become relevant to care.³⁹ Given current attitudes and lack of knowledge about physician payment methods, increased patient education about the appropriate role of financial incentives in medicine appears warranted. Only about half of the patients in this study wanted to be informed about how their physician was paid, but interest in payment method might increase as patients become more aware of the variations in physician payment strategies and the potential implications of those strategies.

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