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Module 6

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Case 6.2: Financial Incentives—The 50-Milligram Difference

Case Presentation

Dr. Dan Troy has been practicing internal medicine for more than 20 years in a multispecialty group practice and enjoys his work.

He was put in charge of monitoring the group's expenditures for prescription drugs. After some research, he discovered that in the case of many formularies, it was actually more cost-effective to prescribe a higher dose of the medication and have the patient split each pill rather than prescribing the actual dose the patient needed. For example, the cost of a single 50-mg tablet of Zoloft was $2.40 while the cost of a 100-mg tablet of Zoloft was $2.43.

Dr. Troy noted that his group has consistently exceeded the financial limit that many insurance companies place on expenditures for prescription medication. Adopting a policy to prescribe more cost-effective medication when possible would improve the group practice's insurance profile and, at the same time, reduce the insurer's overall spending on prescription drugs.

Two weeks later, one of Dr. Troy's well-established patients, Ajaz Ria, came in for a routine check-up and a refill on his medication. Mr. Ria is a middle-aged man who comes in regularly and usually gets a prescription for Zoloft for treatment of his depression. Dr. Troy prescribes 50-mg tablets, with instructions to take one tablet a day.

Dr. Troy examines Mr. Ria and is about to write out his prescription, when he realizes that if he writes the prescription for 100-mg tablets, it would represent a savings of more than $400 over the course of a year. Dr. Troy suggests this to Mr. Ria. He explains that it is more cost-effective to purchase the medication in that dosage and split the tablets than to fill twice as many prescriptions for the 50-mg pills. Mr. Ria thanks Dr. Troy for his concern but explains that he would rather have the prescription for the 50-mg pills because he is used to taking the whole pill each day and he's afraid he'd forget to split it in half. "Besides," he remarks, "I pay the same co-pay in either case, so why does it matter?"

What should Dr. Troy do about Mr. Ria's prescription? (select an option)

A. Inform Mr. Ria that he will write the prescription for 100-mg.
B. Respect Mr. Ria's preference by writing the prescription for 50-mg.
C. Inform Mr. Ria of Dr. Troy's incentive to write the larger prescription and ask if he would be willing to get the 100-mg prescription.

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Option Assessment

A. Informing Mr. Ria that he will write the prescription for 100-mg should be **avoided**. It violates Opinion 8.054, "Financial Incentives and the Practice of Medicine," which states that physicians' "first duty must be to the individual patient. This obligation must override considerations of the reimbursement mechanism or specific financial incentives applied to a physician's clinical practice."

B. Writing the prescription for 50-mg is **acceptable**. It is supported by *Code* Opinion 8.054, "Financial Incentives and the Practice of Medicine": physicians "first duty must be to the individual patient. This obligation must override considerations of the reimbursement mechanism or specific financial incentives applied to a physician's clinical practice."

C. Informing Mr. Ria of Dr. Troy's financial incentive to write the larger prescription and asking if he would be willing to get the 100-mg prescription is **preferable**; it is the most reasonable option and is supported by the *Code* in Opinion 8.054, "Financial Incentives and the Practice of Medicine": "patients must be informed of financial incentives that could impact the level or type of care they receive."

Compare these options

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Option Comparison

Because option C fulfills Dr. Troy's primary obligation to Mr. Ria and also informs him of the financial incentives in the background of their patient-physician relationship, it is preferable. Even though option B, continuing to write a prescription for 50-mg tablets, does not inform Mr. Ria of the financial incentive, one could argue that it is an acceptable alternative because it respects Mr. Ria's preference. Dr. Troy does not gain direct benefit from Mr. Ria's prescription at 50- or 100-mg doses; he only benefits if improving the practice's profile lowers costs down the road. It is preferable to inform Mr. Ria of the financial incentive. This will allow Dr. Troy to inform Mr. Ria that health care costs rise whether or not Mr. Ria pays for them out of his own pocket.

Because option A undermines Dr. Troy's obligations to Mr. Ria and fails to inform him of the financial incentive that motivates Dr. Troy's insistence, it should be avoided.

Preferable: Option C

Acceptable: Option B

Avoid: Option A

Additional discussion and information

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Additional Information

The most fundamental goal of the medical profession is to provide for the health of patients. In the context of clinical care, this requires physicians to place the health interests of their individual patients before other concerns and to facilitate access to all necessary treatments.

Opinion 8.03, "Conflict of Interests: Guidelines"

> Under no circumstances may physicians place their own financial interests above the welfare of their patients. The primary objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration...If a conflict develops between the physician's financial interest and the physician's responsibilities to the patient, the conflict must be resolved to the patient's benefit.

Accordingly, financial incentives as well as potential financial conflicts of interests should be judged according to their success or failure at fostering improvements in patient care. The following Opinion excerpts explain guidelines for these situations:

Opinion 8.051, "Conflicts of Interest under Capitation"

> ...(1) Physicians have an obligation to evaluate a health plan's capitation payments prior to contracting with that plan to ensure that the quality of patient care is not threatened by inadequate rates of capitation...Physicians should seek agreements with plans that provide sufficient financial resources for all necessary care and should refuse to sign agreements that fail in this regard.
>
> (2) Physicians must not assume inordinate levels of financial risk...
>
> (3) Stop-loss plans should be in effect to prevent the potential of catastrophic expenses from influencing physician behavior...
>
> (4) Physicians must be prepared to discuss with patients any financial arrangements which could impact patient care.

One potential benefit of financial incentives is a reduction of waste in the use of medical resources, including

payments by insurers for unnecessary services and prescriptions, thereby effectively increasing the pool of resources for care. Financial incentives, however, accomplish this social benefit by involving the personal financial interests of the physician in the therapeutic relationship.

As the above Opinions make clear, incentives should be judged according to the extent to which they allow physicians to maintain their role as advocates for the health of individual patients. Specifically, incentives should never discourage physicians from fulfilling their obligations to disclose all treatment options, to appeal denials of coverage for necessary care, to make referrals on the basis of individual patient needs, or to provide each patient with the treatments they believe will be of material benefit. (For normative standards on limitations to prescription coverage see Opinion 8.135, "Cost Containment Involving Prescription Drugs in Health Care Plans.")

The effect of financial incentives is felt most acutely when there is not a clear clinical course and the physician is called upon to render an objective analysis of several complex considerations. Because it is difficult to maintain true objectivity when a monetary reward or penalty is associated with one of the possible courses of action, placing limits on financial incentives helps protect clinical objectivity. There are several means of limiting the negative effects of these incentives including applying the incentives across groups of physicians and correlating incentives to large pools of patients over a substantial length of time.

The potential to affect the objectivity of physicians is not the only cause for concern about financial incentives. Inducements that are based on the use of resources across physicians' practices compound the conflict between the interests of the physician and those of the patient by introducing conflicts between patients. For instance, bonuses attached to patterns of reduced use encourage physicians to consider which patients need certain services most rather than what an individual patient needs.

Finally, patients have a right to be informed of all factors that could impact their care, including the payment system under which their physician practices. In this case, Mr. Ria should be told that his insurer's extra costs will likely come back as increases in coverage costs or decreases in covered care. A much more difficult question to answer than whether or not to disclose incentives is where the responsibility for providing such information lies. Disclosure prior to enrollment in a health plan is preferable, as the structure of financial inducements could influence the patient's decision to purchase a specific form of coverage. Some obligation, however, exists on the part of the physician to provide this information if it has not already been provided.

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