

■ Applications

The Basis of Pay

25. In a health maintenance organization (HMO), subscribers pay a fixed annual fee to the organization. In return, the member is entitled to comprehensive care through the organization's network of physicians. Some HMOs contract with physicians who also have private practices (i.e., serve non-HMO patients as well). In such instances, patients go to the physician's private office for care. Other HMOs maintain their own staff of physicians who are located at a few central locations. According to an article in *The Wall Street Journal*, January 25, 1993 (p. B1, B4), doctors employed by HMOs typically receive a flat fee (e.g., \$10) for every HMO member they see. Such fees are easier to administer than other systems where doctors are compensated on the basis of the services actually performed. In order to improve the quality of care patients receive, some HMOs have been experimenting with individual incentive-pay plans.
- 25a. Why might the quality of care be a concern under a system where doctors are paid a flat fee for each patient served?
- 25b. Besides being easier to administer, why do you suppose organizations might use such a flat fee system instead of paying for each service rendered?
- 25c. What determines how low the fee can go? What role do doctor's preferences toward risk play in the setting of the rate?

- 25d. One individual incentive-pay plan gives doctors bonuses of between 5% and 15% of their base pay depending on how they score on patient satisfaction questionnaires and a review of office records. What are the advantages of such a pay plan? What are the disadvantages? What kinds of questions should be asked in the questionnaires?
- 25e. Are such incentive pay plans likely to work better with staff doctors who are private practitioners or with the doctors who work exclusively for the HMO at a central location?
- 25f. Other organizations have moved away from the flat fee method to a merit-pay system. Under these plans, doctors receive bonuses if they are rated as “exemplary” or “commendable” by their section chiefs. What problems might occur in such a system?
- 25g. Would it make sense to tie the doctors’ pay to the overall success of the HMO? If so, what would be an appropriate measure of group success? What problems might you expect from such a group incentive-pay plan?
- 25h. Given all the problems associated with performance-based pay, why do HMOs not just compensate doctors for their time?

The Level of Pay

26. An article on the career paths of top executives contained the following quote.
- “Forget about the straight climb to the top of the company you started with. Increasingly, the fast track up will be a zigzag through different companies. Whoever wants to run General Motors in the future should leave it now.” [*The Wall Street Journal*, March 15, 1993 (p. B1)]
- 26a. Assuming this statement is true, what are its implications for the use of efficiency wage strategies?
- 26b. One explanation for why large firms pay more is that large firms are more likely to utilize an efficiency wage strategy. What is the reasoning behind this assertion? Is the reasoning consistent with the above quote?

The Sequencing of Pay

27. Faced with pressures to employ a diverse workforce, some firms have abandoned seniority-based layoff policies (“last hired, first fired”) for ones that favor the retention of women and minorities (who tend to be the newest workers). What affect would such a change have on the likelihood of a firm successfully using a deferred compensation scheme?