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Health insurance, treatment plan, and delegation to altruistic physician

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ABSTRACT

We study delegating a consumer's treatment plan decisions to an altruistic physician. The physician's degree of altruism is his private information. The consumer's illness severity will be learned by the physician, and also will become his private information. Treatments are discrete choices, and can be combined to form treatment plans. We distinguish between two commitment regimes. In the first, the physician can commit to treatment decisions at the time a payment contract is accepted. In the second, the physician cannot commit to treatment decisions at that time, and will wait until he learns about the patient's illness to do so. In the commitment game, the first best is implemented by a single payment contract to all types of altruistic physician. In the noncommitment game, the first best is not achieved. All but the most altruistic physician earn positive profits, and treatment decisions are distorted from the first best.

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1. Introduction

Physicians have different practice styles. Patients with similar medical conditions often get treated differently. Practice-style variations are present across specialties such as obstetrics (Epstein and Nicholson (2009)), cardiology (Molitor (2012)), and primary care (Grytten and Sørensen (2003)). Practice variations can be very costly if physicians deviate from using cost-effective treatments. In fact, Phelps and Parente (1990) estimated an annual welfare loss valued at US $33 billions due to hospitalization rate variations.

Current theory explains practice variation by information diffusion and physician learning (Phelps (1992), Phelps and Mooney (1993)). Under this hypothesis, practice variation should be smaller within markets than between markets, and should diminish over time. However, Epstein and Nicholson (2009) find the opposite: for risk-adjusted cesarean-section rates, within-market variation is twice that of between-market variation; almost 30% of the variation is due to time-invariant, physician-specific factors other than experience, gender, race, and where a physician received residency training. This time-invariant, physician-specific factor likely reflects physicians' intrinsic preferences about the appropriate treatments for their patients.

In this paper, we model practice styles by physicians' heterogenous preferences towards their patients. Physicians are partially altruistic, their utilities being weighted sums of profits and patients' utilities. Physicians have multiple treatment options, and patients' illness severities differ. Physicians' tasks are to match patients with different severities to

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different treatment plans. However, physicians possess private information about patient's illness severity, and their treatment decisions are noncontractible.

We study the following questions. What is the efficient treatment plan when there are multiple treatment options? Under what conditions can payment contracts implement the efficient treatment plan? If the efficient treatment plan is not implemented, what are the distortions? Finally, how are insurance premiums affected?

Since Arrow (1963) observed the importance of altruistic physicians in the health market, the altruistic-physician assumption has been widely adopted.[2] While most papers in the literature have assumed that the degree of altruism is given and known, we go beyond the fixed-altruism assumption and allow the physician to be of many different types, this being his private information.[3]

An altruistic physician may trade off his own profit against the consumer's utility. This formal construct does permit an ultra altruistic physician to run a financial loss to subsidize treatments. This, however, is unrealistic. Being an economic agent, a physician must face some financial constraints, so we assume that a physician must on average earn a minimum profit. We do allow a physician to sustain some financial loss sometimes, but he must expect to earn a minimum profit on average. We normalize this minimum expected profit to zero.[4]

The physician practice-style issue rests on an environment in which many treatment options for an illness are available. We model multiple treatment options in the simplest way. A less costly treatment succeeds in eliminating a patient's illness disutility with a lower probability. A second treatment is more costly, but succeeds with a higher probability. In contrast to papers in the literature, we let physicians combine treatments. For example, a high-cost treatment may be used after a low-cost treatment fails to eradicate the illness. The physician decides on sequences of treatments, which we call treatment plans or protocols.

Our main findings are the following. First, the first-best treatment plan prescribes a conservative approach under a cost-convexity assumption, which says that the higher the success probability, the higher is the cost per unit success probability. If the severity is low, then no treatment is used; if it is of medium value, a low-cost treatment will be used; if it is high, then the low-cost treatment will be used, followed by the high-cost treatment if necessary. In other words, the consumer should never take the high-cost treatment before trying the low-cost treatment.

Second, the first best can be implemented by a *single* contract when the physician can commit to treatment plans before learning about patients' severities. This result is surprising both because in principal-agent models, information asymmetry often generates information rent and distortions, and because the first best is implemented without the use of any contract menu. Third, the first best is infeasible when the physician cannot commit to treatment plans; the physician earns excess profits, and treatment decisions are distorted from the first best.

To explain our results, we should first describe the extensive-form game. In Stage 1, an insurer offers an insurance contract to the consumer, and a payment contract to the physician, which consists of a capitation payment and the physician's share of treatment cost. In Stage 2, nature determines the physician's degree of altruism, which is privately known to the physician. In Stage 3, the physician and the consumer decide whether to accept the contract. The physician also decides on a practice style which is a rule for prescribing a treatment plan for any illness severity. In Stage 4, nature determines the patient's illness severity. The physician learns the illness severity and follows the treatment plan decided in Stage 3.

The commitment power manifests in Stage 3. At that time, the physician has not learned the patient's illness information (he already has the private information about the degree of altruism), but he does anticipate learning that in Stage 4. What he does in Stage 3 is to formulate a rule for how the patient is to be treated: if the severity turns out to be such and such in Stage 4, then this or that treatment will be used. Stage 3 is also the contract acceptance stage, and the physician must simultaneously assess whether the capitation payment and cost share can generate a minimum expected profit.

The first best can be implemented by a contract designed as if the physician were the least altruistic type. Suppose the least altruistic physician puts a 10% weight on consumer's utility. The insurer should offer a contract with a 10% cost share and a transfer equal to 10% of the expected first-best cost. The 10% altruistic physician will fully internalize the social costs and benefits when bearing 10% of the cost. A lump-sum transfer equal to 10% of the expected cost in the first best allows the least altruistic physician to break even.

Why can this contract still implement the first best when the physician puts, say, a 50% weight on the consumer's utility? If the physician accepts the contract and implements the first best, he also breaks even. The doctor would have liked to offer more generous treatments because he was more altruistic. But if he had done so, he would not break even. The transfer is so low—only 10% of the expected first-best cost—that more generous treatment plans would put the 50% physician in the red. The nonnegative expected profit constraint is so binding that the 50% physician must follow the strategy of the least altruistic physician. It follows that the 50% altruistic physician implements the first best.

[2] A sample of papers using the altruism assumption in the health literature includes Chalkley and Malcomson (1998), Choné and Ma (2011), Dranove and Spier (2003), Dusheiko et al. (2006), Ellis and McGuire (1986, 1990), Jack (2005), Ma (1998), Ma and Riordan (2002), Makris and Siciliani (2011), Newhouse (1970), Rochaix (1989), and Rogerson (1994).

[3] All the papers in footnote 2 use the known altruism assumption except Choné and Ma (2011) and Jack (2005).

[4] Our results remain the same if the minimum profit is strictly positive. The level of the premium will be adjusted accordingly, since any profits will be passed onto consumers.

Next, we study a game in which the physician does not have commitment power. The first two stages of the game remain the same. But now in Stage 3, the physician only decides on whether to accept the contract. He does anticipate learning the illness severity in Stage 4, but the treatment decision is postponed until then. The difference, therefore, is that any capitation payment specified in Stage 3 has been paid, and has no bearing on the physician's treatment decision in Stage 4.

Now, the single contract in the game with commitment fails to implement the first best. The 50% altruistic physician will reject a 10% cost-share contract. In Stage 4, bearing only 10% of costs, the physician now cannot resist offering treatments that are more generous than the first best. It is time inconsistent for the 50% altruistic physician to stick to the first best. However, the low transfer in the 10% cost-share contract would not allow him to break even. Anticipating the deficit in the continuation, the 50% altruistic physician rejects the contract in Stage 3.

If the insurer has to retain a physician with high degrees of altruism, contracts with higher cost shares must be offered. In fact, a menu of incentive-compatible payment contracts will be offered, and physicians may earn positive profits. Distortions from first-best treatment plans will result, and the insurance premium for the consumer will be higher.

Our results confirm the efficiency loss due to practice-style variations. However, our analysis also indicates how this loss can be avoided. If treatment plans can be finalized when the financial constraint is relevant, efficiency can be attained. A sort of "bottomline medicine" principle is being advocated whereby resources, including lump-sum payment, and medical treatments should always be considered together. The policy implication is that the insurer should encourage doctors to formulate their treatment plans at the point of contract acceptance, and give doctors incentives to carry out the plan when seeing patients. For example, when offering the single contract, the insurer also suggests the efficient treatment plan as a medical guideline. In addition, the insurer announces that he will only renew contracts with physicians whose total treatment cost (say in a year) is below a threshold.

In economic models, it has been shown time and again that commitment is powerful. Yet, it appears that here, a physician's commitment power is being exploited by the insurer. A physician earns a zero profit when he is able to commit to a treatment plan, but a positive profit otherwise. However, physicians in our model are altruistic and their preferences are *not* based on profits alone. In fact, a physician's total utility may be higher when he has commitment power and is very altruistic.

Although we analyze games in which physicians may or may not commit to treatment plans, commitment itself is taken to be exogenous. In the literature, many researchers have posited that commitment requires a player of a game to take a costly action, but others have assumed that a player may be a commitment type that can stick to a strategy.[5] We are agnostic about whether commitment must require a prior costly action or not. Our interest is to identify circumstances in which efficiency can be achieved. As it turns out, our researh points to the importance of medical practice style as a commitment that may be used for implementing efficienct treatments.

As Arrow (1963) has pointed out, physician altruism seems so natural, and important in the health care market. The economic analysis following such a hypothesis has only been studied quite recently. A contribution here is that altruism interacts with profit motives. The implementation of the first best depends on physicians caring about their patients, having to make a minimum expected profit, as well as being able to commit to treatment protocols.

In the literature, the idea that economic agents have nonmonetary motives has been studied intensively. Here is sample of such recent papers: Akerlof and Kranton (2005), Bénabou and Tirole (2003), Besley and Ghatak (2005), Delfgaauw and Dur (2007, 2008), Francois (2000), Makris (2009), Murdock (2002), and Prendergast (2007, 2008). Our paper differs from these works in that the physician's degree of altruism is unknown (see also footnotes 2 and 3 above). Unknown altruism generally brings in a second dimension of asymmetric information. Our paper contributes methodologically to the multi-dimensional asymmetric information problem.

A few papers in the literature use a limited liability constraint, which is identical to our minimum expected income constraint. Makris and Siciliani (2011) consider incentive schemes for altruistic providers who possess private information about production efficiency, but who must be able to break even. Makris (2009) uses a slightly different setup in which an agent must not be asked to use any of his own wealth. In these two papers, the degree of altruism is common knowledge. Choné and Ma (2011) also use a minimum income constraint. The requirement of minimum profit for altruistic agents appears to be both natural and necessary.

Unknown altruism in the health market has been considered before by Jack (2005) and Choné and Ma (2011). Nevertheless, our paper differs in many ways. In Jack (2005) and Choné and Ma (2011), risk aversion and insurance are not considered. Jack's model considers noncontractible quality choices by a provider, and lets the physician suffer some financial losses. We do not consider quality, and impose a nonnegative expected profit constraint. Choné and Ma study a more general agency problem in which the physician's preferences may not be altruistic. In addition, in Choné and Ma, health care quantities are contractible, and the physician possesses private information about patient illness severity and his degree of physician agency before accepting a contract, so commitment is irrelevant. Moreover, in Jack (2005) and Choné and Ma (2011), there are no equilibria in which the first best is implemented.

The literature on physician payment is large. An earlier survey is McGuire (2000), and a more recent one is Léger (2008). Despite the prevalence of multiple treatment options, most existing works either do not model treatment plans (Pauly,

[5] For example, in the industrial organization literature, a firm may make an irreversible investment in order to commit to agressive pricing strategies against rivals. On the other hand, in the resolution of the chain-store paradox, and in many repeated games, some type of a player is assumed to always play a suboptimal strategy.

1968), Zeckhauser (1970), Choné and Ma (2011)), or allow patients to take only one treatment (Ma and Riordan (2002)). Several more recent papers (Chernew et al. (2000), Malcomson (2005), Siciliani (2006)) allow the patient to choose one treatment out of many options. However, they do not allow the patient to take a treatment sequence. Different from all these works, our model has multiple treatment options and examines optimal treatment sequences.

The rest of the paper is organized as follows. Section 2 presents the model and the first best. Section 3 studies the two delegation games. Section 4 discusses related issues and policy implications. Section 5 draws conclusions. Proofs are in the Appendix.

2. The model and the first best

A risk-averse consumer has income Y and suffers from an illness. The loss due to illness is described by a random variable ℓ on a support $[0, \bar{\ell}]$, with distribution and density functions $F(\ell)$ and $f(\ell)>0$, respectively.[6] We assume that the upper support of the illness loss, $\bar{\ell}$, is sufficiently large.[7] We let the consumer's utility function be separable in income and the loss from illness, and measure the disutility of illness by the loss, so the consumer's utility is $U(Y)-\ell$ when ℓ is the illness loss. The function U is strictly increasing, strictly concave, and the marginal utility at zero income is infinite ($U'(x)\to\infty$ as $x\to 0^+$).

The consumer's loss due to illness can be recovered by medical treatments. We assume that there are two treatments; in Section 4 we will discuss the case when more treatments are available. A treatment either recovers the loss ℓ or does not, and is defined by the probability of success and the cost. Treatment can be taken sequentially, so if a treatment does not succeed, a second treatment can be used. We assume that when a treatment fails once, it will fail again. In other words, the effectiveness of a treatment is perfectly correlated over trials. Given the binary structure, a treatment will never be used twice.

We call the two treatments, Treatment 1 and Treatment 2. Treatment 1 succeeds with probability θ_1 and costs c_1. Treatment 2 succeeds with probability θ_2 and costs c_2. These four parameters are strictly positive. Treatment 2 is more effective than Treatment 1 but also costs more, so we have $\theta_1<\theta_2$ and $c_1<c_2$. We make an assumption on the relative effectiveness of the treatments:

Assumption 1 *(Cost convexity).* $\frac{c_1}{\theta_1}<\frac{c_2}{\theta_2}$.

Assumption 1 says that the cost per unit of success probability of Treatment 2 is higher than Treatment 1. This is a convexity assumption on treatment costs; the cost per unit of success probability increases with the success probability. We will discuss what will happen if Assumption 1 is violated.

In this paper we consider *Treatment protocols*. A treatment protocol describes a sequence of treatments. There are five treatment protocols:

Protocol 0: Do not use any treatment.
Protocol 1: Use Treatment 1 only.
Protocol 2: Use Treatment 2 only.
Protocol 3: Use Treatment 1, and then Treatment 2 if Treatment 1 fails.
Protocol 4: Use Treatment 2, and then Treatment 1 if Treatment 2 fails.

Because we have assumed that a treatment outcome is perfectly correlated across trials, Treatment Protocols do not include multiple trials of the same treatment. The *ex ante* success probabilities of Protocols 3 and 4 are, respectively, $\theta_3\equiv\theta_1+(1-\theta_1)\theta_2$ and $\theta_4\equiv\theta_2+(1-\theta_2)\theta_1$. These *ex ante* success probabilities are the same because each of Protocols 3 and 4 allows the consumer to try both treatments, and offers a higher success probability than either Protocol 1 or Protocol 2. The expected costs of Protocols 3 and 4 are, respectively, $c_3\equiv c_1+(1-\theta_1)c_2$ and $c_4\equiv c_2+(1-\theta_2)c_1$. By Assumption 1, Protocol 4 costs more than Protocol 3: $c_4-c_3=c_2\theta_1-c_1\theta_2>0$.

Without any insurance, the consumer will decide on the treatment protocol after she learns her illness loss. For low values of ℓ, she may not get any treatment; for high values, she may. The consumer faces fluctuations in income since she has to bear treatment costs. The consumer can insure herself against income fluctuations due to illness by purchasing an insurance contract in a competitive insurance market. Insurers are risk neutral, and they offer insurance contracts to maximize the consumer's expected utility subject to a zero expected profit constraint.[8]

[6] Unlike most other models, we do not set up a probability of the consumer falling ill, upon which the loss occurs. Our model is slightly more general because we allow a large density around ℓ=0, so it can approximate models with a fixed probability of falling ill.

[7] If the upper support is not large enough, the consumer's benefit from Treatment 2 cannot be justified by the cost. Hence, Treatment 2 should never be used. See below.

[8] We can replace the perfectly competitive insurance market by a benevolent regulator who wishes to maximize a weighted average of the consumer's utility and the physician's payoff. Our results will continue to hold as long as the weight on the physician's payoff is not too high.

2.1. First best

In the first best, illness loss ℓ is verifiable. An insurance contract can be made contingent on the value of ℓ. Due to risk aversion, the first best shields the consumer from all risks due to treatment costs. A first-best contract specifies a premium P and four treatment protocol functions $\tau_i : [0, \overline{\ell}] \longrightarrow [0, 1]$, $i = 1, 2, 3, 4$. The consumer pays P before the realization of ℓ, and will not incur any payment after ℓ is realized and when treatment is used. The function τ_i, $i = 1, 2, 3, 4$, specifies the probability that Protocol i is to be used when the consumer's loss is ℓ. We have used the nontreatment Protocol 0 as default.

If the consumer suffers a loss ℓ and is treated by Protocol i, her expected payoff is $U(Y - P) - \ell + \theta_i \ell$. The first-best contract $(P, \tau_1, \tau_2, \tau_3, \tau_4)$ maximizes the consumer's expected utility

$$\int_0^{\overline{\ell}} \left[U(Y-P) - \ell + \sum_{i=1}^{4} \tau_i(\ell)\theta_i \ell \right] \mathrm{d}F(\ell) \tag{1}$$

subject to the breakeven constraint

$$P = \int_0^{\overline{\ell}} \sum_{i=1}^{4} \tau_i(\ell) c_i \mathrm{d}F(\ell) \tag{2}$$

and the boundary conditions

$$\sum_{i=1}^{4} \tau_i(\ell) \le 1 \quad \text{and} \quad 0 \le \tau_i(\ell) \le 1, \tag{3}$$

for each $\ell \in [0, \overline{\ell}]$ and $i = 1, 2, 3, 4$. The utility function in (1) consists of the utility from the income less the premium, the utility loss ℓ, as well as the recovery prospects from the four treatment protocols. The breakeven constraint (2) ensures that any insurance firm offering the contract will make zero expected profit. The remaining constraints in (3) make sure that the treatment protocol probabilities are consistent.

First, we rank the relative cost effectiveness of the treatment protocols:

Lemma 1. *Under Assumption 1,* $\frac{c_1}{\theta_1} < \frac{c_3}{\theta_3} < \frac{c_4}{\theta_4} < \frac{c_2}{\theta_2}$.

According to Lemma 1, in terms of cost per unit of success probability, the ranking, in ascending order, is Protocol 1, Protocol 3, Protocol 4, and Protocol 2. Now, $\theta_3 = \theta_4 > \theta_2$, so both in terms of success probability and cost per unit of success probability, Protocols 2 and 4 are dominated by Protocol 3. In other words, Protocols 2 and 4 are less efficient than Protocol 3.[9]

Proposition 1. *In the first best, the consumer pays a premium P^*, receives no treatment if her loss is lower than ℓ^*, Protocol 1 if her loss is between ℓ^* and ℓ^{**}, and Protocol 3 if her loss is higher than ℓ^{**}, where $\ell^* \equiv U'(Y - P^*)\frac{c_1}{\theta_1} < U'(Y - P^*)\frac{c_2}{\theta_2} \equiv \ell^{**}$. The premium is given by $P^* = c_1[1 - F(\ell^*)] + (1 - \theta_1)c_2[1 - F(\ell^{**})]$.*

Proposition 1 presents two principles in the first best. First, the consumer is risk averse, so financial risks due to illness will be borne by the insurer. Second, by basic cost-benefit consideration, the consumer should receive more treatment when her loss is higher. Basic cost-benefit consideration also eliminates inefficient treatments, so by Lemma 1, Protocols 2 and 4 are never used.

Consider consumer ℓ^*. His expected utility benefit from Treatment 1 is $\theta_1 \ell^*$, and this is equal to the cost of Treatment 1 measured in utility, $U'(Y - P^*)c_1$. While the benefit from Treatment 1 increases in illness loss, the cost remains constant. Therefore, the consumer should receive Treatment 1 if and only if his illness loss is at least ℓ^*.

As the illness loss continues to increase beyond ℓ^*, Treatment 2 should also be given if it is needed. At $\ell = \ell^{**}$, the cost of using Treatment 2 is $U'(Y - P^*)c_1$ which is equal to $\theta_2 \ell^{**}$. Therefore, a consumer with $\ell > \ell^{**}$ should receive Treatment 2 if and only if Treatment 1 has failed. This is Protocol 3.

3. Altruistic physician and delegation

Suppose now the consumer's illness loss is not observed by the insurer. Although treatments prescribed by the physician are verifiable *ex post*, they are *ex ante* noncontractible. The physician will observe the illness loss and be delegated to make the treatment decision. In the delegation regime, an insurance company establishes a payment contract with the physician,

[9] We briefly comment on the case when the Cost Convexity assumption is violated. In that case, we have $\frac{c_1}{\theta_1} > \frac{c_2}{\theta_2}$. The ranking of cost per unit of success probability becomes $\frac{c_2}{\theta_2} < \frac{c_4}{\theta_4} < \frac{c_3}{\theta_3} < \frac{c_1}{\theta_1}$, so that Protocols 3 and 1 will be inefficient. Proposition 1 will be modified: Protocol 2 will be used for intermediate values of ℓ, while Protocol 4 will be used for high values.

and an insurance contract with the consumer. The physician's decision on a treatment plan can be interpreted as his practice style.

The insurance contract for the consumer consists of a premium P. We focus on physician payment and delegation, so we assume that the patient does not bear any financial risks *ex post*. In fact, this is what the first best prescribes. The payment contract for the physician is a two-part tariff, (S, T), where S is the physician's share of the incurred treatment cost, and T is a lump-sum or capitation payment.

The physician is risk neutral, and partially altruistic to the consumer. The physician learns about the consumer's illness loss ℓ after the payment contract has been accepted. This is a natural assumption in an insurance model because at the time the insurer offers contracts, the consumer is not yet sick. When the physician treats the consumer with Protocol i, his expected payoff consists of profit and the consumer's utility: $T - Sc_i + \alpha[U(Y-P) - \ell + \theta_i \ell]$. Both S and T are nonnegative, but we do not restrict S to being less than 1. The profit from using Protocol i is $T - Sc_i$; he receives the transfer T, and bears a cost Sc_i, with the balance of the cost paid for by the insurer. The parameter α measures the strength of the consumer's utility in the physician's preferences.

The altruism parameter α is a random variable, drawn on a strictly positive support $[\underline{\alpha}, \overline{\alpha}]$, with distribution and density functions, respectively, $G(\alpha)$ and $g(\alpha) > 0$. We assume that the hazard rate $\frac{G(\alpha)}{g(\alpha)}$ is increasing in α. The physician knows α, and this is his private information. We use the term "type-α physician" for a physician with altruism parameter α. We assume that F and G are independent.

A higher value of α indicates a physician who cares more about the patient's welfare. The strength of the physician's trade-off between profit and patient utility is captured by the altruism parameter α. In making a decision based on this trade-off, the physician must respect an *ex ante* nonnegative profit constraint. In practice, a physician treats many patients, and the likelihood that he makes a loss *ex post* out of the entire set of patients is negligible. Indeed, if we interpret the consumer as the representative in a mass, then *ex ante* nonnegative profit implies *ex post* nonnegative profit.

As in other agency models, we include a reservation utility constraint. If the altruistic physician does not accept the contract, he does not earn any profit, but does not treat the patient either, so his utility is $\alpha \int_0^{\overline{\ell}} [U(Y) - \ell] \mathrm{d}F(\ell)$, which is defined to be his reservation utility.[10]

To better understand the equilibria when the physician's degree of altruism is unknown, we first show, in the next subsection, that the first best can be implemented when the physician's degree of altruism is known.

3.1. Known altruism

In this subsection, we assume that the altruism parameter α is common knowledge. The physician, with known altruism parameter α, is paid a lump-sum $T(\alpha)$, and bears a cost $S(\alpha)c_i$ when he uses Protocol i for the patient. Subject to the payment scheme, the physician makes treatment decisions for the patient.

Suppose that, on observing the illness loss ℓ, the physician uses treatment Protocol i with probability $\tau_i(\ell)$. His expected utility is

$$\int_0^{\overline{\ell}} \left\{ T(\alpha) - S(\alpha) \sum_{i=1}^{4} \tau_i(\ell) c_i + \alpha [U(Y-P) - \ell + \sum_{i=1}^{4} \tau_i(\ell) \theta_i \ell] \right\} \mathrm{d}F(\ell). \tag{4}$$

He chooses τ_i to maximize (4) subject to a nonnegative expected profit constraint

$$\int_0^{\overline{\ell}} \left\{ T(\alpha) - S(\alpha) \sum_{i=1}^{4} \tau_i(\ell) c_i \right\} \mathrm{d}F(\ell) \geq 0, \tag{5}$$

and a participation constraint:

$$\int_0^{\overline{\ell}} \left\{ T(\alpha) - S(\alpha) \sum_{i=1}^{4} \tau_i(\ell) c_i + \alpha [U(Y-P) - \ell + \sum_{i=1}^{4} \tau_i(\ell) \theta_i \ell] \right\} \mathrm{d}F(\ell) \geq \alpha \int_0^{\overline{\ell}} [U(Y) - \ell] \mathrm{d}F(\ell)$$

[10] Alternatively, we can let the consumer be treated by some other physician, and the consumer obtains a higher expected utility. See footnote 9.

which says that the utility from accepting the contract is higher than from refusing it. Now, the participation constraint never binds. Rewrite it as

$$\int_0^{\bar{\ell}} \left\{ T(\alpha) - S(\alpha)\sum_{i=1}^{4}\tau_i(\ell)c_i \right\} \mathrm{d}F(\ell) \geq$$
$$\alpha \int_0^{\bar{\ell}} [U(Y) - \ell]\mathrm{d}F(\ell) - \alpha \int_0^{\bar{\ell}} \left\{ [U(Y-P) - \ell + \sum_{i=1}^{4}\tau_i(\ell)\theta_i\ell] \right\} \mathrm{d}F(\ell).$$

The right-hand side of this inequality is the patient's loss from the lack of insurance. Due to a competitive insurance market, this loss is never positive, so, in fact, minimum profit implies participation.[11] In the games with asymmetric information, given the minimum profit constraint, the participation constraint remains slack for each type of the altruistic physician, so from now on, we will ignore it.

For each $\alpha \in [\underline{\alpha}, \overline{\alpha}]$, define

$$S(\alpha) \equiv \lambda\alpha \tag{6}$$

$$T(\alpha) \equiv \lambda\alpha \left[\int_{\ell^*}^{\ell^{**}} c_1 \mathrm{d}F(\ell) + \int_{\ell^{**}}^{\bar{\ell}} c_3 \mathrm{d}F(\ell) \right], \tag{7}$$

where $\lambda = U'(Y - P^*)$, and P^*, ℓ^*, and ℓ^{**} are the first-best premium and threshold loss levels defined in Proposition 1.

Lemma 2. *Given $S(\alpha)$ and $T(\alpha)$ defined in (6) and (7), the delegation scheme implements the first best.*

The cost share $S(\alpha) \equiv \lambda\alpha$ in Lemma 2 makes the physician internalize the consumer's treatment cost and benefit. The partially altruistic physician values the patient's benefit at $\alpha\theta_i\ell$. To align his preferences with the first best, he should be made to bear the cost at $\lambda\alpha c_i$, where λ, the marginal utility of income at first best, adjusts for the difference in the measurement between benefits (in utility) and cost (in money). This is exactly what $S(\alpha) \equiv \lambda\alpha$ does. Under this cost share, the physician's expected utility in (4) becomes

$$\int_0^{\bar{\ell}} \left\{ T(\alpha) - S(\alpha)\sum_{i=1}^{4}\tau_i(\ell)c_i + \alpha[U(Y-P) - \ell + \sum_{i=1}^{4}\tau_i(\ell)\theta_i\ell] \right\} \mathrm{d}F(\ell)$$
$$= \int_0^{\bar{\ell}} \left\{ \alpha \left[\sum_{i=1}^{4}\tau_i(\ell)\{\theta_i\ell - \lambda c_i\} \right] + T(\alpha) + \alpha[U(Y-P) - \ell] \right\} \mathrm{d}F(\ell),$$

so the term inside the big square brackets is the consumer's benefit less cost. The transfer $T(\alpha)$ ensures that the physician makes a zero expected profit.

A more altruistic physician is asked to bear a larger share of the cost *ex post* because he has a greater incentive to overtreat the patient. The lump-sum transfer $T(\alpha)$ is proportional to the cost share $S(\alpha)$. Given that all types of physician will incur the first-best cost, a more altruistic physician should receive a larger transfer *ex ante*; otherwise, he will not be able to break even. These findings are consistent with Ellis and McGuire (1986) who show that the first best can be implemented in a mixed payment system when the physician's degree of altruism is common knowledge. While Ellis and McGuire focus on a single treatment, we show the same results for multiple treatments.

The physician's behavior for the maximization of (4) subject to (5) assumes that he chooses the treatment protocols at the time of contract acceptance and before he observes the illness severity. This assumption is only made for convenience. When $S(\alpha)$ and $T(\alpha)$ are given by (6) and (7), the physician can also make the treatment decision *after* he observes ℓ. The treatment decisions will be exactly the same. Hence, the timing for treatment decisions is unimportant when the physician's degree of altruism is common knowledge. This, however, is not true when the physician's degree of altruism is his private information.

3.2. Unknown altruism

In this subsection, we study delegation games with unknown altruism. We show that equilibria depend on the physician's timing of treatment decisions. In the case of commitment, the physician follows a predetermined treatment plan before he learns the patient's illness. In the case of noncommitment, the physicians decides on treatment after he learns the patient's illness. We first present the game with commitment; the game without commitment follows. In each game, the insurer

[11] We assume that if the consumer is not served by the physician, the illness remains untreated; this is the utility on the right-hand side of the participation constraint. We can alternatively assume that the consumer is served by another physician, so the right-hand side term is larger. However, we have assumed that the insurer aims to maximize the consumer's expected utility, so the participation constraint remains slack.

chooses contracts to maximize the consumer's expected utility, so we assume that the consumer will accept the contract. We assume that the consumer does not know the physician's degree of altruism, but still delegates treatment decisions to the physician. One might wonder if there would be an incentive for a consumer to seek out a more altruistic physician, and we will discuss this issue in Section 4.

3.2.1. Equilibria in delegation with treatment plan commitment

We show the first best can be implemented by a single contract when the physician can commit to a treatment plan made at the point of contract acceptance. The extensive form of the game has four stages.

Stage 1: An insurer offers an insurance contract to the consumer and a payment contract to the physician.
Stage 2: Nature draws α from the distribution G. The physician learns α.
Stage 3: The physician decides whether to accept the payment contract, and the consumer decides whether to accept the insurance contract. The game ends if either party refuses to accept; otherwise, the physician also decides on how he will prescribe treatment protocols depending on illness loss.
Stage 4: Nature draws ℓ from the distribution F. The physician learns ℓ, and carries out treatment protocols according to the prescription rule decided in Stage 3. The physician will be paid according to the payment contract.

When altruism is unknown, a type-α physician will mimic another type if the full menu of contracts defined in the regime of known altruism is offered. From Lemma 2, if a type-α physician selects $(S(\alpha), T(\alpha))$, he will choose the first-best treatment protocols and break even. However, the type-α physician can do better by exaggerating α and choosing a contract meant for type-α', $\alpha' > \alpha$. Under $(S(\alpha'), T(\alpha'))$, he can still implement the first best and break even, but will gain by being slightly less generous than offering first-best treatments. This deviation will result in a second-order loss in the consumer's expected utility but a first-order gain in the profit because $T(\alpha') > T(\alpha)$.

Our next result shows that, surprisingly, each type of physician can still be made to implement the first best even when the full menu of contracts defined in the regime of known altruism fails to do so. This is achieved by a very simple payment contract, namely $(S(\underline{\alpha}), T(\underline{\alpha}))$, defined in (6) and (7). This contract is designed as if the physician were the least altruistic type $\underline{\alpha}$.

A type-α physician's best response against $(S(\underline{\alpha}), T(\underline{\alpha}))$ is to select $\tau_i(\ell)$ to maximize

$$\int_0^{\bar{\ell}} \left\{ T(\underline{\alpha}) - S(\underline{\alpha}) \sum_{i=1}^{4} \tau_i(\ell) c_i + \alpha [U(Y-P) - l + \sum_{i=1}^{4} \tau_i(\ell)\theta_i \ell] \right\} \mathrm{d}F(\ell) \tag{8}$$

subject to

$$\int_0^{\bar{\ell}} \left\{ T(\underline{\alpha}) - S(\underline{\alpha}) \sum_{i=1}^{4} \tau_i(\ell) c_i \right\} \mathrm{d}F(\ell) \geq 0. \tag{9}$$

A type-α physician's choice of treatment decision in Stage 3 is made contingent on possible illness loss. Anticipating that he will follow this treatment plan after observing the illness severity in Stage 4, the physician decides whether to accept the payment contract.

Lemma 3. *When given contract $(S(\underline{\alpha}), T(\underline{\alpha}))$ defined in (6) and (7), a type-α physician, with $\alpha > \underline{\alpha}$, chooses the first-best treatment thresholds l^* and l^{**}.*

Lemma 3 reports a surprising result. Under the payment contract $(S(\underline{\alpha}), T(\underline{\alpha}))$, the best response of the type-$\underline{\alpha}$ physician is the first-best treatment protocol. His incentives have been aligned with the first best. Now consider a more altruistic, type-α physician. He cares more about the consumer's utility than type-$\underline{\alpha}$, so he would like to be more generous, offering Protocol 1 at $\ell < \ell^*$, and Protocol 3 at $\ell < \ell^{**}$. Indeed, the first-order derivative of (8) with respect to τ_i is $\alpha\theta_i \left[\ell - \lambda \frac{\underline{\alpha}}{\alpha} \frac{c_i}{\theta_i}\right]$, which is greater than $\alpha\theta_i \left[\ell - \lambda \frac{c_i}{\theta_i}\right]$, the corresponding first-order derivative in the first best.

The capitation payment $T(\underline{\alpha})$ only compensates for the cost share $S(\underline{\alpha})$ when treatments are at the first best. The type-α suffers a loss if he follows a treatment plan more generous than the first best. The binding nonnegative profit constraint therefore stops the type-α physician from being more generous than a type-$\underline{\alpha}$ physician. Since he is able to commit to a treatment plan, it is a best response for the type-α physician to accept the contract $(S(\underline{\alpha}), T(\underline{\alpha}))$, and to implement the first best.[12] To summarize, we present

[12] We have assumed that the altruism parameter is in a strictly positive support $[\underline{\alpha}, \overline{\alpha}]$. If the support of α includes 0 (so that $\underline{\alpha} = 0$), our result will be modified slightly. Here, the first best can be approximated. Setting the payment contract at $(S(\alpha), T(\alpha))$, where $\alpha > 0$ and is arbitrarily close to 0, will implement the first best for all physician types higher than α. However, the contract $(S(0), T(0))$ will *not* implement the first best for any physician type.

Proposition 2. *In the equilibrium under delegation with treatment plan commitment, the insurer offers a single payment contract $(S(\underline{\alpha}), T(\underline{\alpha}))$. In equilibrium, each physician type accepts the contract and delivers the first-best treatment protocols to the consumer.*

The key to the first-best result stems from the requirement that treatment plans are made when the nonnegative expected profit consideration is still relevant. We could consider an alternative extensive form where the physician decides on treatment plans after he has accepted a contract, but before he observes ℓ (still fully anticipating that he will). This kind of commitment has no bite, and the equilibrium will be exactly the same as if commitment were impossible (as in the next subsection). This is because once the contract $(S(\underline{\alpha}), T(\underline{\alpha}))$ has been accepted, the treatment plan decision will be determined *only* by the cost share $S(\underline{\alpha})$ while the transfer $T(\underline{\alpha})$ is already received.

Proposition 2 highlights the social value of treatment plan commitment. If the physician determines his treatment plan when accepting the payment contract and sticks to it, the insurer can successfully induce all types of physicians to carry out the efficient treatment plan. Therefore, the unwarranted cost variation due to physicians' heterogeneous preferences can be reduced.

The next subsection discusses the scenario when the physician lacks the ability to commit to a predetermined treatment plan.

3.2.2. Equilibria in delegation without treatment plan commitment

The first two stages of the game without treatment plan commitment are the same as game with commitment, except that a payment contract is now a menu. The last two stages are as follows:

Stage 3: The physician decides whether to accept the payment menu, and the consumer decides whether to accept the insurance contract. The game ends if either party refuses to accept; otherwise, the physician picks an item from the menu.

Stage 4: Nature draws ℓ from the distribution F. The physician learns ℓ, and decides on treatment protocols. The physician will be paid according to the payment contract that he has selected in Stage 3.

The key difference between games with and without treatment plan commitment is the timing of treatment decisions. Under delegation without treatment plan commitment, the physician makes his treatment decision *after* he has accepted the contract. In other words, the physician makes the contract acceptance decision and treatment decisions sequentially. By contrast, in the game with treatment plan commitment, he makes the two decisions simultaneously. In both cases, however, the physician fully anticipates receiving the patient's severity information in Stage 4.

Clearly, the single contract $(S(\underline{\alpha}), T(\underline{\alpha}))$ can no longer implement the first best. Anticipating using treatment plans more generous than the first best, physician types more altruistic than $\underline{\alpha}$ will reject this contract. This is because the transfer $T(\underline{\alpha})$ is so low that they cannot break even.

We derive the menu of optimal contracts by examining the physician's treatment protocol decisions in Stage 4. Suppose that a type-α physician has accepted a payment contract $(S(\alpha'), T(\alpha'))$ in Stage 3, and learns that the consumer's illness loss is ℓ. His decision is only affected by the cost-share parameter $S(\alpha')$, not the transfer $T(\alpha')$. Given ℓ and $S(\alpha')$, his payoff from choosing Protocol i with probability τ_i is $-S(\alpha')\sum_{i=1}^{4}\tau_i c_i + \alpha\left[U(Y-P) - \ell + \sum_{i=1}^{4}\tau_i\theta_i\ell\right]$. The first-order derivative with respect to τ_i is $\alpha\theta_i\ell - S(\alpha')c_i$. As in the earlier analysis, the equilibrium treatment is characterized by two thresholds $\widehat{l}(\alpha';\alpha)$ and $\widehat{\widehat{l}}(\alpha';\alpha)$. The physician will never use the inefficient protocols. A consumer with ℓ smaller than $\widehat{l}(\alpha';\alpha)$ receives no treatment; with ℓ between $\widehat{l}(\alpha';\alpha)$ and $\widehat{\widehat{l}}(\alpha';\alpha)$, Protocol 1; with ℓ larger than $\widehat{\widehat{l}}(\alpha';\alpha)$, Protocol 3. The equilibrium in Stage 4 is completely characterized by the thresholds

$$\widehat{l}(\alpha';\alpha) = \frac{S(\alpha')}{\alpha}\frac{c_1}{\theta_1} \quad \text{and} \quad \widehat{\widehat{l}}(\alpha';\alpha) = \frac{S(\alpha')}{\alpha}\frac{c_2}{\theta_2}. \tag{10}$$

To save on notation, we write $\widehat{l}(\alpha;\alpha)$ and $\widehat{\widehat{l}}(\alpha;\alpha)$ as $\widehat{l}(\alpha)$ and $\widehat{\widehat{l}}(\alpha)$, respectively.

In contrast to delegation with treatment plan commitment, the equilibrium treatment decisions are to be made without any reference to the nonnegative profit requirement. In Stage 4, the physician does not have the option of rejecting a payment contract. The requirement of making a nonnegative expected profit has no bite here.

Next we study the physician's equilibrium choice of a payment contract in Stage 3. Suppose that the menu $\{(S(\alpha), T(\alpha))\}$ has been offered to the physician in Stage 2. We use a generalized version of the revelation principle (Myerson (1982)). Define a type-α physician's expected payoff from selecting contract $(S(\alpha'), T(\alpha'))$ and the thresholds l' and l'' by

$$\begin{aligned} V(\alpha', l', l''; \alpha) \equiv T(\alpha') - S(\alpha')\left[\int_{l'}^{l''} c_1 \mathrm{d}F(l) + \int_{l''}^{\bar{l}} c_3 \mathrm{d}F(l)\right] \\ + \alpha\left[U(Y-P) - \mathrm{E}(l) + \int_{l'}^{l''} \theta_1 l \mathrm{d}F(l) + \int_{l''}^{\bar{l}} \theta_3 l \mathrm{d}F(l)\right]. \end{aligned}$$

We consider equilibria in which a type-α physician selects contract $(S(\alpha), T(\alpha))$, and adopts the thresholds $\widehat{l}(\alpha)$ and $\widehat{\widehat{l}}(\alpha)$. Clearly, for any choice of $(S(\alpha'), T(\alpha'))$ the thresholds that maximize V are $\widehat{l}(\alpha', \alpha)$ and $\widehat{\widehat{l}}(\alpha'; \alpha)$, as in the continuation equilibrium (10). A menu of contracts is said to be incentive compatible if $V(\alpha, \widehat{l}(\alpha), \widehat{\widehat{l}}(\alpha); \alpha) \geq V(\alpha', l', l''; \alpha)$ for all α' and α, and all l' and l''. Given a menu $(S(\alpha), T(\alpha))$, define the type-α physician's maximum payoff by $W(\alpha) \equiv \max_{\alpha', l', l''} V(\alpha', l', l''; \alpha)$.

Lemma 4. *A menu of contracts $\{(S(\alpha), T(\alpha))\}$, $\alpha \in [\underline{\alpha}, \overline{\alpha}]$, is incentive compatible only if W is convex,*

$$W'(\alpha) = U(Y-P) - \mathrm{E}(l) + \int_{\widehat{l}(\alpha)}^{\widehat{\widehat{l}}(\alpha)} \theta_1 l \mathrm{d}F(l) + \int_{\widehat{\widehat{l}}(\alpha)}^{\bar{l}} \theta_3 l \mathrm{d}F(l), \tag{11}$$

and both $\widehat{l}(\alpha)$ and $\widehat{\widehat{l}}(\alpha)$ are decreasing in α.

Incentive compatibility requires that the physician's equilibrium utility be convex in the altruism parameter. In other words, the change of the physician's equilibrium payoff, $W(\alpha)$, must be increasing. Because U is a utility function of income, its sign can be positive or negative; hence, W and W' can be positive or negative. Indeed, signs of W and W' are irrelevant for incentive compatibility. Furthermore, Lemma 4 says that the equilibrium thresholds must be decreasing so that a more altruistic physician prescribes more treatments. We write the continuation equilibrium condition (10) as

$$\widehat{l}(\alpha) = \frac{S(\alpha)}{\alpha}\frac{c_1}{\theta_1} \quad \text{and} \quad \widehat{\widehat{l}}(\alpha) = \frac{S(\alpha)}{\alpha}\frac{c_2}{\theta_2}, \tag{12}$$

so incentive compatibility requires the cost share to altruism parameter ratio, $\frac{S(\alpha)}{\alpha}$, to be decreasing. This is in contrast with the known α case where $\frac{S(\alpha)}{\alpha}$ is a constant.

To see the intuition, suppose $S(\alpha)$ increases proportionally to α. Because the more altruistic physician will prescribe more treatments but has to bear a larger share of the cost, the lump-sum transfer must increase more than proportionally. Otherwise, the physician cannot break even. However, a disproportionately large lump-sum transfer would provide the physician a greater incentive to exaggerate his degree of altruism because he can gain a larger profit by withholding treatments. Hence, with constant $\frac{S(\alpha)}{\alpha}$, the insurer has to give up too much information rent to induce truth telling. The insurer can do better by reducing the cost share borne by the physician to trade off efficiency for information rent.

Next, we analyze the physician's nonnegative profit constraint. By selecting $(S(\alpha), T(\alpha))$, a type-α physician's expected profit is

$$\pi(\alpha) \equiv T(\alpha) - S(\alpha)\left[\int_{\widehat{l}(\alpha)}^{\widehat{\widehat{l}}(\alpha)} c_1 \mathrm{d}F(l) + \int_{\widehat{\widehat{l}}(\alpha)}^{\bar{l}} c_3 \mathrm{d}F(l)\right].$$

Substituting this expression into $W(\alpha) = V(\alpha, \widehat{l}(\alpha), \widehat{\widehat{l}}(\alpha); \alpha)$, we have $W(\alpha) = \pi(\alpha) + \alpha\, W'(\alpha)$, or

$$\pi(\alpha) = W(\alpha) - \alpha W'(\alpha). \tag{13}$$

Differentiating both sides of this equation, we have $\pi'(\alpha) = -\alpha W''(\alpha)$. The convexity of $W(\alpha)$ implies that $\pi(\alpha)$ is decreasing. The physician's nonnegative profit constraints are therefore simplified to $\pi(\overline{\alpha}) \geq 0$. In other words, if the most altruistic physician breaks even, so do all other physician types. Although the physician's profit is decreasing in α, his equilibrium payoff is increasing due to the altruistic benefit.

Lemma 5. *Incentive compatibility is equivalent to $S(\alpha)/\alpha$ being decreasing, and hence $\widehat{l}(\alpha)$ and $\widehat{\widehat{l}}(\alpha)$ decreasing. Nonnegative expected profit for the physician is equivalent to $\pi(\overline{\alpha}) \geq 0$.*

We continue with the derivation of the equilibrium contract menu. Following the standard method in the literature, we replace $\pi(\alpha)$ by $W(\overline{\alpha})$ to simplify the maximization problem. The insurer must break even given the continuation equilibrium after Stage 1. The total expected expenditure by the insurer equals the expected profit and treatment cost, averaged over all physician types. Hence, the premium P satisfies

$$P = \int_{\underline{\alpha}}^{\overline{\alpha}} \pi(\alpha)\mathrm{d}G(\alpha) + \int_{\underline{\alpha}}^{\overline{\alpha}} \left[\int_{\widehat{l}(\alpha)}^{\widehat{\widehat{l}}(\alpha)} c_1 \mathrm{d}F(l) + \int_{\widehat{\widehat{l}}(\alpha)}^{\bar{l}} c_3 \mathrm{d}F(l)\right] \mathrm{d}G(\alpha). \tag{14}$$

From $W(\alpha) \equiv W(\overline{\alpha}) - \int_{\alpha}^{\overline{\alpha}} W'(x)\mathrm{d}x$, we can substitute for W in the expression for π in (13):

$$\pi(\alpha) = W(\overline{\alpha}) - \int_{\alpha}^{\overline{\alpha}} W'(x)dx - \alpha W'(\alpha).$$

Then we use (11) in Lemma 4 to replace $W'(x)$. After integration by parts, we can substitute for $\pi(\alpha)$ and rewrite (14) as

$$\begin{aligned} P &= \int_{\underline{\alpha}}^{\overline{\alpha}} \left[\int_{\widehat{l}(\alpha)}^{\widehat{\widehat{l}}(\alpha)} c_1 \mathrm{d}F(l) + \int_{\widehat{\widehat{l}}(\alpha)}^{\bar{l}} c_3 \mathrm{d}F(l) \right] \mathrm{d}G(\alpha) + W(\overline{\alpha}) \\ &\quad - \int_{\underline{\alpha}}^{\overline{\alpha}} \left\{ \left(\frac{G(\alpha)}{g(\alpha)} + \alpha \right) \left(U(Y-P) - \mathrm{E}(l) + \int_{\widehat{l}(\alpha)}^{\widehat{\widehat{l}}(\alpha)} \theta_1 l \mathrm{d}F(l) + \int_{\widehat{\widehat{l}}(\alpha)}^{\bar{l}} \theta_3 l \mathrm{d}F(l) \right) \right\} \mathrm{d}G(\alpha). \end{aligned} \tag{15}$$

The premium for the patient includes treatment costs and the physician's utility, which consists of the base utility $W(\overline{\alpha})$ less the consumer's utility multiplied by the physician's altruism parameter adjusted by the hazard rate $(G(\alpha)/g(\alpha)+\alpha)$.

From (13), we have

$$\begin{aligned} \pi(\overline{\alpha}) &= W(\overline{\alpha}) - \overline{\alpha} W'(\overline{\alpha}) \\ &= W(\overline{\alpha}) - \overline{\alpha} \left[U(Y-P) - \mathrm{E}(l) + \int_{\widehat{l}(\overline{\alpha})}^{\widehat{\widehat{l}}(\overline{\alpha})} \theta_1 l \mathrm{d}F(l) + \int_{\widehat{\widehat{l}}(\overline{\alpha})}^{\bar{l}} \theta_3 l \mathrm{d}F(l) \right], \end{aligned}$$

so $\pi(\overline{\alpha}) \geq 0$ if and only if

$$W(\overline{\alpha}) \geq \overline{\alpha} \left[U(Y-P) - \mathrm{E}(l) + \int_{\widehat{l}(\overline{\alpha})}^{\widehat{\widehat{l}}(\overline{\alpha})} \theta_1 l \mathrm{d}F(l) + \int_{\widehat{\widehat{l}}(\overline{\alpha})}^{\bar{l}} \theta_3 l \mathrm{d}F(l) \right]. \tag{16}$$

The equilibrium in Stage 4 also requires (12), which says that $\widehat{l}(\alpha)$ and $\widehat{\widehat{l}}(\alpha)$ follow a fixed ratio; this will be shown to be satisfied, so we will ignore this requirement for now.

The equilibrium allocation implemented by the insurer is the solution to the following program: choose P, $W(\overline{\alpha})$, $\widehat{l}(\alpha)$, and $\widehat{\widehat{l}}(\alpha)$ to maximize the consumer's expected utility

$$U(Y-P) - \mathrm{E}(l) + \int_{\underline{\alpha}}^{\overline{\alpha}} \left(\int_{\widehat{l}(\alpha)}^{\widehat{\widehat{l}}(\alpha)} \theta_1 l \mathrm{d}F(l) + \int_{\widehat{\widehat{l}}(\alpha)}^{\bar{l}} \theta_3 l \mathrm{d}F(l) \right) \mathrm{d}G(\alpha)$$

subject to the breakeven constraint (15), the physician nonnegative profit constraint (16), and $\widehat{l}(\alpha)$, $\widehat{\widehat{l}}(\alpha)$ both decreasing. Let μ denote the multiplier for the insurer's breakeven constraint (15). We present the characterization of the solution:

Proposition 3. *Under treatment plan noncommitment, the equilibrium thresholds and premium, $\widehat{l}(\alpha)$, $\widehat{\widehat{l}}(\alpha)$, and P are given by*

$$\widehat{l}(\alpha) = \mu \frac{c_1}{\theta_1} \left[1 + \left(\frac{G(\alpha)}{g(\alpha)} + \alpha \right) \mu \right]^{-1} \tag{17}$$

$$\widehat{\widehat{l}}(\alpha) = \mu \frac{c_2}{\theta_2} \left[1 + \left(\frac{G(\alpha)}{g(\alpha)} + \alpha \right) \mu \right]^{-1} \tag{18}$$

$$U'(Y-P) = \mu. \tag{19}$$

The type-$\overline{\alpha}$ physician earns zero profit, and $W(\overline{\alpha})$ is given by (16) as an equality; all other physician types earn strictly positive profits.

From the equilibrium thresholds in Proposition 3 and equation (12), we can find the cost share and transfer functions for the implementation. The cost share function is

$$S(\alpha) = \alpha\mu \left[1 + \mu \left(\frac{G(\alpha)}{g(\alpha)} + \alpha \right) \right]^{-1} \tag{20}$$

and the transfer function is

$$T(\alpha) = W(\alpha) - \alpha W'(\alpha) + S(\alpha) \left[\int_{\widehat{l}(\alpha)}^{\widehat{\widehat{l}}(\alpha)} c_1 dF(l) + \int_{\widehat{\widehat{l}}(\alpha)}^{\bar{l}} c_3 dF(l) \right], \tag{21}$$

where $W'(\alpha)$ is determined by equation (11) and $W(\alpha)$ is obtained by integrating $W'(\alpha)$. The physician's implementation of Protocol 3 is time consistent. If $\ell > \widehat{\widehat{l}}(\alpha)$, his utility from continuing with Treatment 2 for the consumer is $\alpha\,\ell\,\theta_2 - S(\alpha)c_2$. From (20), this is $\alpha\ell\theta_2 - \alpha\mu\left[1+\mu\left(\frac{G(\alpha)}{g(\alpha)}+\alpha\right)\right]^{-1}c_2$, which is strictly positive by Proposition 3.

The determination of the equilibrium thresholds includes the term $\frac{G(\alpha)}{g(\alpha)}+\alpha$, the key difference from Proposition 1. The first-best thresholds are determined by a straightforward cost-effectiveness principle. This has to be modified due to the missing information about the physician's degree of altruism. The equilibrium cost shares and transfers involve the hazard rate, $\frac{G(\alpha)}{g(\alpha)}$, a standard, Myerson "virtual" adjustment due to private information. Furthermore, treatment benefits are valued by physicians, so the adjustment also includes the term α in addition to the virtual component.

Because the physician's profit is passed on to consumers, we have the following corollary:

Corollary 1. *The equilibrium premium P is higher than the first best premium P^*.*

The comparison between equilibrium thresholds in Proposition 3 and the first best is not straightforward. The first best is independent of the distribution of α, but the functions $\widehat{l}$ and $\widehat{\widehat{l}}$ have ranges that depend on the distribution as well as the support of α. We suspect that for low values of α, equilibrium thresholds will be higher than first best, while for high values of α, they will be lower. That is, less altruistic physicians provide treatments less than the first best, and the opposite for more altruistic physicians. The following example agrees with our conjecture. Let the utility function be $U(Y) = \ln Y$, so $U'(Y) = 1/Y$. Suppose that l is uniformly distributed on [0, 1] while α is uniformly distributed on $[\underline{\alpha}, \underline{\alpha}+1]$, $\underline{\alpha} > 0$. By Proposition 1, the first-best thresholds are

$$l^* = \frac{1}{Y-P^*}\frac{c_1}{\theta_1} \quad \text{and} \quad l^{**} = \frac{1}{Y-P^*}\frac{c_2}{\theta_2}. \tag{22}$$

Equation (19) reduces to $\mu = 1/(Y-P)$. The equilibrium thresholds in Proposition 3 are

$$\widehat{l}(\alpha) = \frac{1}{Y-P}\frac{c_1}{\theta_1}\left[1+\frac{2\alpha-\underline{\alpha}}{Y-P}\right]^{-1} \quad \text{and} \quad \widehat{\widehat{l}}(\alpha) = \frac{1}{Y-P}\frac{c_2}{\theta_2}\left[1+\frac{2\alpha-\underline{\alpha}}{Y-P}\right]^{-1}. \tag{23}$$

By Corollary 1, the premium P is larger than the first-best premium P^*. From (22) and (23), $\widehat{l}(\alpha)$ and $\widehat{\widehat{l}}(\alpha)$ are larger than the first-best thresholds for $\alpha < \frac{P-P^*+\underline{\alpha}}{2}$, and are smaller than or equal to the first-best thresholds otherwise. If the difference $P - P^*$ is between $\underline{\alpha}$ and $\underline{\alpha}+2$, there exists a type-$\widetilde{\alpha}$ physician delivering first-best treatments. Physicians less altruistic than type-$\widetilde{\alpha}$ will provide less treatment than the first best, whereas physicians more altruistic than type-$\widetilde{\alpha}$ will provide more.

Proposition 3 and Corollary 1 can explain the wide variations of medical costs. Differences in physician practice styles are here captured by differences in physician altruism. The same illness will be treated differently depending on the attending physician's preferences. Such variations, however, can be avoided if altruistic physicians make treatment decisions when the full financial consequences are respected, as Proposition 2 shows.

4. Discussions and policies

4.1. Policy implication

Our analysis suggests that the insurer should help a physician with some commitment mechanism when offering the single contract $(S(\underline{\alpha}), T(\underline{\alpha}))$ to implement the first best. The patient's illness severity is unobservable to the insurer, but perhaps medical trainings can partially address this issue. When doctors have been trained to perform treatments according to certain (first-best) protocols, these protocols become established professional practices, and physicians may subscribe to them out of habit. An insurer therefore has a vested interest in promoting some protocols. Nevertheless, our model also suggests another way. When offering $(S(\underline{\alpha}), T(\underline{\alpha}))$, the insurer can propose the first best as medical guidelines, and renew physicians' contracts when they can maintain a minimum profit, say, at the end of an accounting period. Contract termination punishes the physician for overtreatment. Contract nonrenewal is an effective threat because in equilibrium physicians earn more than their reservation utility. This is a kind of "efficiency wage" mechanism to provide incentives for the first best.

4.2. More than two treatments

We have assumed that there are only two treatments available. Proposition 1 can be extended to an arbitrary number of treatments under Cost Convexity. Suppose that there is also Treatment 3. We can construct many treatment protocols by various treatment sequences. However, only three are efficient. These three are (i) use Treatment 1 only; (ii) use Treatment 1, and if it fails use Treatment 2; and (iii) begin with Treatment 1, if it fails use Treatment 2, and if that also fails, use Treatment 3. The intuition behind the inefficiency of protocols other than those in (i), (ii), and (iii) mimics that in Lemma 1. For example, the protocol of Treatment 2 and then Treatment 3 upon failure of Treatment 2 is dominated by the protocol in (iii). Adding Treatment 1 before Treatment 2 raises the total probability of success, and reduces the expected cost due to Cost Convexity, because Treatment 1 has the lowest cost-success probability ratio. Retaining the two-treatment assumption saves on notation, while relaxing it would not lead to qualitatively new results.

4.3. Searching for altruistic physicians

In Proposition 3, a physician provides more treatments when he is more altruistic. Therefore, *ex post*, a consumer prefers to be treated by a more altruistic physician. In Lemma 5, a physician reveals his type by selecting an item from the full cost-share-transfer menu. Typically, however, consumers may not be aware of the financial arrangement between the insurer and the physician, so a physician's altruism information may not be inferred.

In repeated interactions, without treatment plan commitment, consumers' incentive to search must exist. In our setup, after an initial treatment episode, if a consumer knows the illness severity, then she can update her belief about the physician's altruism. For example, suppose that the severity is moderate, but the physician does not recommend Treatment 2 after Treatment 1 has failed. Then the consumer will infer that the physician is not very altruistic.

Searching for more altruistic physicians is irrelevant when treatment plan commitment is possible. In the first-best equilibrium in Proposition 2, all physician types provide the same treatment. When search is relevant, it is associated with inefficiency and higher premium due to the lack of commitment in Proposition 3. Search exacerbates inefficiency. To attract consumers, physicians may offer more treatments even when their own degree of altruism is low. Clustering of consumers among altruistic physicians may likely increase the premium, too. A policy implication is that inefficient search can be avoided if treatment plan commitment is possible.

4.4. Selecting physicians

Physicians earn profits when there is a lack of treatment plan commitment. A way to limit profit is to reject some physician types. We have assumed that all types in $[\underline{\alpha}, \overline{\alpha}]$ must earn nonnegative profits. It is possible to relax this by allowing the insurer to retain only those with α between $\underline{\alpha}$ and $\overline{\alpha}' < \overline{\alpha}$. This can be implemented by reducing the transfer function T in (21) (say, by a constant). Those physicians with α larger than $\overline{\alpha}'$ will not accept any contract. All those who accept will make less profits, and the distortion can be reduced.

The cost of rejecting highly altruistic physician types comes in the form of rationing. We have considered contracts for one consumer and one physician. We implicitly have assumed that the aggregate supply equals aggregate demand. Rejecting some physician types reduces the physician supply. Even in a competitive insurance market, the premium may have to increase; otherwise, nonprice rationing results.

5. Concluding remarks

We study how an insurer can reduce the unnecessary cost due to practice-style variations by designing payment contracts for heterogenous physicians. Our model consists of two new elements. Treatments can be combined, and physicians are altruistic, with different degrees of altruism. We develop new principles from this setup. First, we show that the first-best treatment plan follows a conservative pattern. Second, we consider delegating treatment decisions to physicians, and show that the first best can be implemented only when a physician can commit to treatment plans at the time of contract acceptance. We offer various policy implications.

Treatment plans involve a time dimension, and it is natural that commitment plays a role in the analysis. The physician committing to using particular plans may result in time-inconsistent decisions. But such commitment has social value; it reduces premium and inefficient search.

The treatment technology is richer than the usual health care quantity approach. This lets us rule out some treatment combinations as inefficient. However, our main results for delegation under treatment plan commitment and noncommitment should hold without any modification if the physician is choosing a quantity of services.

We acknowledge that our model abstracts from learning. Two issues naturally arise when learning is important. First, the likelihood of treatment success may itself be uncertain. A first treatment is often an experimentation for the physician to learn about treatment efficacy. The failure of a treatment may then update the likelihood that other treatments may be successful. Second, illness severity may be uncertain. A first treatment may reveal that the illness is more or less severe than initially thought. This new information will impact subsequent treatments.

We have focused on payment contracts based only on the physician's reported type and on full insurance contracts for consumers. In general, the physician's cost shares can depend on the chosen treatments, and consumers may incur copayments. These more general contracts are unnecessary under treatment plan commitment. We already can implement the first best with the restricted contracts. More general contracts can potentially improve outcomes when treatment plan commitment is invalid. However, the trade-off between efficiency, risk sharing, and incentives is complicated. We have found the characterization under such general contracts intractable. Apparently, separate analyses of demand-side and supply-side incentives are common in the literature, and we have chosen to study supply-side incentives. It is clear, however, that adding demand-side incentives would not permit the implementation of the first best because full insurance of financial risks cannot be achieved.

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Appendix A.

Proof of Lemma 1: Let $k_1 \equiv \frac{c_1}{\theta_1}$and $k_2 \equiv \frac{c_2}{\theta_2}$. By Assumption 1, $k_1 < k_2$. From the definitions of θ_3 and c_3, we substitute c_1 and c_2 by $k_1\theta_1$ and $k_2\theta_2$, respectively, and obtain

$$\frac{c_3}{\theta_3} = \left[\frac{\theta_1}{\theta_1 + (1-\theta_1)\theta_2}\right] k_1 + \left[\frac{(1-\theta_1)\theta_2}{\theta_1 + (1-\theta_1)\theta_2}\right] k_2,$$

which is a weighted average of k_1 and k_2, so $\frac{c_1}{\theta_1} < \frac{c_3}{\theta_3} < \frac{c_2}{\theta_2}$.

Because $\theta_3 = \theta_4$ and $c_3 < c_4$ by Assumption 1, we have $\frac{c_3}{\theta_3} < \frac{c_4}{\theta_4}$. It remains to show that $\frac{c_4}{\theta_4} < \frac{c_2}{\theta_2}$. By Assumption 1, $c_1\theta_2 < c_2\theta_1$. To both sides of this inequality we multiply by $(1-\theta_2)$ and then add $c_2\theta_2$. This results in $(c_2 + (1-\theta_2)c_1)\theta_2 < c_2(\theta_2 + (1-\theta_2)\theta_1)$. Since $c_4 = c_2 + (1-\theta_2)c_1$ and $\theta_4 = \theta_2 + (1-\theta_2)\theta_1$, we have $c_4\theta_2 < c_2\theta_4$, so $\frac{c_4}{\theta_4} < \frac{c_2}{\theta_2}$.

Proof of Proposition 1: Omit the boundary conditions. Use pointwise optimization, and form the Lagrangian for ℓ:

$$L = \int_0^{\bar{\ell}} [U(Y-P) - \ell + \sum_{i=1}^{4} \tau_i(\ell)\theta_i\ell]\mathrm{d}F(\ell) + \lambda\left(P - \int_0^{\bar{\ell}} \sum_{i=1}^{4} \tau_i(\ell)c_i \mathrm{d}F(\ell)\right)$$

where $\lambda > 0$ is the multiplier of the premium constraint. The first-order derivatives are

$$\frac{\partial L}{\partial P} = -U'(Y-P) + \lambda \tag{24}$$

$$\frac{\partial L}{\partial \tau_i} = f(\ell)\left(\theta_i\ell - \lambda c_i\right) = f(\ell)\theta_i\left(\ell - \lambda\frac{c_i}{\theta_i}\right), i = 1, 2, 3, 4. \tag{25}$$

The derivatives in (25) are independent of τ_i, so at each ℓ, the Protocol with the highest positive value of $\frac{\partial L}{\partial \tau_i}$ among $i = 1, 2, 3, 4$ will be used. If all the derivatives are negative, then no treatment will be used.

First, $\tau_2(\ell) = \tau_4(\ell) = 0$ for all ℓ; the consumer never uses Protocols 2 and 4. Because $\frac{c_3}{\theta_3} < \frac{c_2}{\theta_2}$ by Lemma 1 and $\theta_2 < \theta_3$, $\frac{\partial L}{\partial \tau_2} < \frac{\partial L}{\partial \tau_3}$, $\forall\ell$. Therefore, we must have $\tau_2(\ell) = 0$, $\forall\ell$. Because $\frac{c_3}{\theta_3} < \frac{c_4}{\theta_4}$ by Lemma 1 and $\theta_3 = \theta_4$, $\frac{\partial L}{\partial \tau_4} < \frac{\partial L}{\partial \tau_3}$, $\forall\ell$. Therefore, we must have $\tau_4(\ell) = 0$, $\forall\ell$.

By Lemma 1, when $\ell < \lambda\frac{c_1}{\theta_1}$, the first-order derivatives $\frac{\partial L}{\partial \tau_i}$ are all negative. Define $\ell^* \equiv \lambda\frac{c_1}{\theta_1}$. From Lemma 1, when $\ell < \ell^*$, $\tau_i(\ell) = 0$, $i = 1, 2, 3, 4$. Hence, the consumer does not use any treatment when $\ell < \ell^*$.

Next, from (25), we have

$$\begin{aligned} &\frac{\partial L}{\partial \tau_3} - \frac{\partial L}{\partial \tau_1} \\ &= \left[(\theta_3 - \theta_1)\ell - \lambda(c_3 - c_1)\right] f(l) \\ &= (1-\theta_1)[\theta_2\ell - \lambda c_2]f(l) \end{aligned} \tag{26}$$

Now define $\ell^{**} \equiv \frac{\lambda c_2}{\theta_2}$. (Because we assume that $\bar{\ell}$ is sufficiently large, we have $\ell^{**} < \bar{\ell}$, and it is well-defined.) The expression in (26) is positive if and only if $\ell > \ell^{**}$. Both $\frac{\partial L}{\partial \tau_3}$ and $\frac{\partial L}{\partial \tau_1}$are positive when $\ell > \ell^*$. Together, we have $\tau_1(\ell) = 1$ when $\ell^* \le \ell < \ell^{**}$, and $\tau_3(\ell) = 1$ when $\ell^{**} < \ell < \bar{\ell}$.

Setting the first-order derivative (24) to 0, we have $\lambda = U'(Y-P)$, so the values of ℓ^* and ℓ^{**} are those in the Proposition. Finally, the premium P^* is $[F(\ell^{**}) - F(\ell^*)]c_1 + [1 - F(\ell^{**})]c_3$, which simplifies to

$$P^* = c_1[1 - F(\ell^*)] + (1-\theta_1)c_2[1 - F(\ell^{**})]. \tag{27}$$

There is a unique solution for P between 0 and Y. Let $g(P)$ denote the right-hand side of (27), where ℓ^* and ℓ^{**} are now regarded as functions of P. Since $U'(Y-P)$ increases in P, ℓ^* and ℓ^{**} increase in P. The function $g(P)$ is decreasing in P. The function $g(P)$ reaches the maximum at $P = 0$, and $g(0) = c_1\left[1 - F(\frac{U'(Y)c_1}{\theta_1})\right] + (1-\theta_1)c_2\left[1 - F(\frac{U'(Y)c_2}{\theta_2})\right] > 0$. The function $g(P)$ reaches the minimum at $P = Y$, and $g(Y) = 0$ because $U'(0) = +\infty$. We conclude that there is a unique solution for $P = g(P)$.

Proof of Lemma 2: First, given the contract $(S(\alpha), T(\alpha))$, the type-α physician chooses treatment protocols $\tau_i(\ell)$, $i = 1, 2, 3, 4$, to maximize his expected utility

$$\int_0^{\bar{\ell}} \left\{ T(\alpha) - S(\alpha)\sum_{i=1}^{4}\tau_i(\ell)c_i + \alpha[U(Y-P) - \ell + \sum_{i=1}^{4}\tau_i(\ell)\theta_i\ell] \right\} \mathrm{d}F(\ell). \tag{28}$$

The first-order derivative of (28) with respect to $\tau_i(\ell)$ is

$$\begin{aligned} &\alpha f(l)\theta_i\left[\ell - \frac{S(\alpha)c_i}{\alpha\theta_i}\right] \\ &= \alpha f(l)\theta_i\left(\ell - \frac{\lambda c_i}{\theta_i}\right) \end{aligned} \tag{29}$$

upon substitution $S(\alpha)$ by $\lambda\alpha$. The first-order derivative (29) is the first-order derivative (25) for the first best multiplied by α, a constant. We conclude that the type-α physician's optimal treatment decision is first best.

Given the contract, the physician's expected profit from his optimal, first-best treatment decision is

$$\begin{aligned} &T(\alpha) - S(\alpha)\left[\int_{\ell^*}^{\ell^{**}} c_1\mathrm{d}F(\ell) + \int_{\ell^{**}}^{\bar{\ell}} c_3\mathrm{d}F(\ell)\right] \\ &= \lambda\alpha\left[\int_{\ell^*}^{\ell^{**}} c_1\mathrm{d}F(\ell) + \int_{\ell^{**}}^{\bar{\ell}} c_3\mathrm{d}F(\ell)\right] - \lambda\alpha\left[\int_{\ell^*}^{\ell^{**}} c_1\mathrm{d}F(\ell) + \int_{\ell^{**}}^{\bar{\ell}} c_3\mathrm{d}F(\ell)\right] = 0, \end{aligned}$$

so constraint (5) is satisfied.

It remains to show that the insurer breaks even. The insurer receives the first-best premium P^* from the consumer. He pays the physician the transfer $T(\alpha)$, and $1 - S(\alpha)$ share of the cost to the physician. The insurer's expected profit is therefore

$$\begin{aligned} &P^* - T(\alpha) - (1 - S(\alpha))\left[\int_{\ell^*}^{\ell^{**}} c_1\mathrm{d}F(\ell) + \int_{\ell^{**}}^{\bar{\ell}} c_3\mathrm{d}F(\ell)\right] \\ &= P^* - \left[\int_{\ell^*}^{\ell^{**}} c_1\mathrm{d}F(\ell) + \int_{\ell^{**}}^{\bar{\ell}} c_3\mathrm{d}F(\ell)\right] - \left\{T(\alpha) - S(\alpha)\left[\int_{\ell^*}^{\ell^{**}} c_1\mathrm{d}F(\ell) + \int_{\ell^{**}}^{\bar{\ell}} c_3\mathrm{d}F(\ell)\right]\right\}. \end{aligned} \tag{30}$$

The insurer breaks even in the first-best contract, so $P^* - \left[\int_{\ell^*}^{\ell^{**}} c_1\mathrm{d}F(\ell) + \int_{\ell^{**}}^{\bar{\ell}} c_3\mathrm{d}F(\ell)\right] = 0$. The term inside the big curly brackets in (30) is the physician's profit and has been shown be to zero. Hence, the insurer makes zero expected profit.

Proof of Lemma 3: The Lagrangian for the constraint optimization program maximizing (8) subject to (9) is

$$L = \int_0^{\bar{\ell}} \left\{ (1+\varphi)\left[T(\underline{\alpha}) - S(\underline{\alpha})\sum_{i=1}^{4}\tau_i(\ell)c_i\right] + \alpha\left(U(Y-P) - \ell + \sum_{i=1}^{4}\tau_i(\ell)\theta_i\ell\right)\right\}\mathrm{d}F(\ell),$$

where $\varphi \geq 0$ is the multiplier for the nonnegative expected profit constraint. From pointwise optimization, the first-order derivative with respect to $\tau_i(\ell)$ is:

$$\frac{\partial L}{\partial \tau_i} = \alpha f(l)\theta_i\left[l - \frac{\lambda\underline{\alpha}(1+\varphi)c_i}{\alpha\theta_i}\right]. \tag{31}$$

after substitution by $S(\underline{\alpha}) = \lambda\underline{\alpha}$. Define $l' \equiv \lambda\frac{c_1}{\theta_1}\left[\frac{\underline{\alpha}(1+\varphi)}{\alpha}\right]$ and $l'' = \lambda\frac{c_2}{\theta_2}\left[\frac{\underline{\alpha}(1+\varphi)}{\alpha}\right]$. From the proof of Proposition 1, the physician will not prescribe any treatment if $l \leq l'$, will use treatment Protocol 1 if $l' < l < l''$ and treatment Protocol 3 for $l'' < l$.

Next, we show that the Lagrangian multiplier φ must equal $\frac{\alpha}{\underline{\alpha}} - 1$ for a type-α physician. When $\varphi = \frac{\alpha}{\underline{\alpha}} - 1$, the loss thresholds l' and l'' are identical to the first-best levels, l^* and l^{**}, respectively, so the first best is optimal. It remains to show that $\varphi = \frac{\alpha}{\underline{\alpha}} - 1$, and we do that by contradiction.

Suppose that $\varphi < \frac{\alpha}{\underline{\alpha}} - 1$. Then the loss thresholds satisfy $l' < l^*$ and $l'' < l^{**}$. The difference between the physician's expected profit from choosing thresholds l' and l'' and that from choosing the first-best thresholds l^* and l^{**} is

$$\left\{T(\underline{\alpha})-S(\underline{\alpha})\left[\int_{l'}^{l''} c_1\,\mathrm{d}F(l)+\int_{l''}^{\bar{l}} c_3\,\mathrm{d}F(l)\right]\right\}-\left\{T(\underline{\alpha})-S(\underline{\alpha})\left[\int_{l^*}^{l^{**}} c_1\,\mathrm{d}F(l)+\int_{l^{**}}^{\bar{l}} c_3\,\mathrm{d}F(l)\right]\right\}$$

$$=-S(\underline{\alpha})\left\{\int_{l''}^{l^{**}}(1-\theta_1)c_2\,\mathrm{d}F(l)+\int_{l'}^{l^*} c_1\,\mathrm{d}F(l)\right\}<0.$$

Given that under $(S(\underline{\alpha}), T(\underline{\alpha}))$ the expected profit from the first-best treatments (the second term, in curly brackets, on the first line) is 0, the physician's expected profit from choosing thresholds l' and l'' is negative. This violates the nonnegative expected profit constraint, and contradicts the assumption that $\varphi < \frac{\alpha}{\underline{\alpha}}-1$. Hence, we conclude that $\varphi \geq \frac{\alpha}{\underline{\alpha}}-1$.

Next, suppose that $\varphi > \frac{\alpha}{\underline{\alpha}}-1$. Then the loss thresholds satisfy $l' > l^*$ and $l'' > l^{**}$. The difference between the physician's expected profit from choosing thresholds l' and l'' and that from choosing the first-best thresholds is

$$\left\{T(\underline{\alpha})-S(\underline{\alpha})\left[\int_{l'}^{l''} c_1\,\mathrm{d}F(l)+\int_{l''}^{\bar{l}} c_3\,\mathrm{d}F(l)\right]\right\}-\left\{T(\underline{\alpha})-S(\underline{\alpha})\left[\int_{l^*}^{l^{**}} c_1\,\mathrm{d}F(l)+\int_{l^{**}}^{\bar{l}} c_3\,\mathrm{d}F(l)\right]\right\}$$

$$=S(\underline{\alpha})\left\{\int_{l^*}^{l''}(1-\theta_1)c_2\,\mathrm{d}F(l)+\int_{l^*}^{l'} c_1\,\mathrm{d}F(l)\right\}>0.$$

Again, given that under $(S(\underline{\alpha}), T(\underline{\alpha}))$ the expected profit from the first-best treatments is 0, the physician earns a strictly positive expected profit. Hence, the nonnegative expected profit constraint does not bind, and the multiplier φ must be zero. This contradicts the assumption that $\varphi > \frac{\alpha}{\underline{\alpha}}-1>0$. Hence we conclude that $\varphi \leq \frac{\alpha}{\underline{\alpha}}-1$. In sum, we have $\varphi = \frac{\alpha}{\underline{\alpha}}-1$.

Proof of Proposition 2: First, Lemma 2 has shown that a type-$\underline{\alpha}$ physician will accept $(S(\underline{\alpha}), T(\underline{\alpha}))$ and implement the first best. Next, consider a type-α physician, with $\alpha > \underline{\alpha}$. According to Lemma 3, he will implement the first-best treatment thresholds l^* and l^{**} given contract $(S(\underline{\alpha}), T(\underline{\alpha}))$. Because the contract allows the physician to just break even on the first best, the type-α physician's payoff is

$$\alpha[U(Y-P^*)-E(\ell)+\int_{l^*}^{l^{**}}\theta_1\ell dl+\int_{l^{**}}^{\bar{l}}\theta_3\ell dl].$$

If the type-α physician rejects the contract, he receives the reservation utility $\alpha[U(Y)-E(l)]$. Because the insurer maximizes the consumer's expected payoff,

$$U(Y-P^*)-E(\ell)+\int_{l^*}^{l^{**}}\theta_1\ell dl+\int_{l^{**}}^{\bar{l}}\theta_3\ell dl>U(Y)-E(l).$$

Given $\alpha > 0$, a type-α physician strictly prefers to accept $(S(\underline{\alpha}), T(\underline{\alpha}))$.

Proof of Lemma 4: Because $W(\alpha)$ is the upper bound of affine functions of α, it is convex (Rockafellar, 1972, Theorem 5.5), and therefore almost everywhere differentiable (Rockafellar, 1972, Theorem 25.5). Incentive compatibility implies $V(\alpha, \widehat{l}(\alpha), \widehat{\widehat{l}}(\alpha); \alpha)=W(\alpha)$. By the envelope theorem,

$$W'(\alpha)=\frac{\partial V}{\partial\alpha}=U(Y-P)-\mathrm{E}(l)+\int_{\widehat{l}(\alpha)}^{\widehat{\widehat{l}}(\alpha)}\theta_1 l\mathrm{d}F(l)+\int_{\widehat{\widehat{l}}(\alpha)}^{\bar{l}}\theta_3 l\mathrm{d}F(l),$$

with the partial derivative being evaluated at $\alpha'=\alpha$, $\ell'=\widehat{l}(\alpha)$, and $\ell''=\widehat{\widehat{l}}(\alpha)$, and we obtain the expression in the Lemma.

Next, rewrite $W'(\alpha)$ as

$$U(Y-P)-\mathrm{E}(l)+\int_{\widehat{l}(\alpha)}^{\bar{\ell}}\theta_1 l\mathrm{d}F(l)+\int_{\widehat{\widehat{l}}(\alpha)}^{\bar{l}}(1-\theta_1)\theta_2 l\mathrm{d}F(l). \tag{32}$$

Because $\frac{\mathrm{d}\widehat{l}(\alpha)}{\mathrm{d}\alpha}=\frac{\mathrm{d}(\frac{S(\alpha)}{\alpha})}{\mathrm{d}\alpha}\frac{c_1}{\theta_1}$ and $\frac{\mathrm{d}\widehat{\widehat{l}}(\alpha)}{\mathrm{d}\alpha}=\frac{\mathrm{d}(\frac{S(\alpha)}{\alpha})}{\mathrm{d}\alpha}\frac{c_2}{\theta_2}$, $\frac{\mathrm{d}\widehat{l}(\alpha)}{\mathrm{d}\alpha}$ and $\frac{\mathrm{d}\widehat{\widehat{l}}(\alpha)}{\mathrm{d}\alpha}$ share the same sign as that of $\frac{\mathrm{d}(\frac{S(\alpha)}{\alpha})}{\mathrm{d}\alpha}$. If $\widehat{l}(\alpha)$ and $\widehat{\widehat{l}}(\alpha)$ were increasing at some α, then from (32) $W'(\alpha)$ would be decreasing at α. This contradicts incentive compatibility. We conclude that $\widehat{l}(\alpha)$ and $\widehat{\widehat{l}}(\alpha)$ must be decreasing.

Proof of Lemma 5: We only need to show that any menu satisfying $S(\alpha)/\alpha$ decreasing and $\pi(\overline{\alpha}) \geq 0$ implies incentive compatibility and nonnegative expected profit. We start with a given cost-share rule $S(\alpha)$ with $S(\alpha)/\alpha$ decreasing. From Lemma 4 and the equilibrium condition for Stage 4 in (12), we have the thresholds $\widehat{l}(\alpha)$ and $\widehat{\widehat{l}}(\alpha)$ being decreasing. We can construct $T(\alpha)$ so that $(S(\alpha), T(\alpha))$, $\alpha \in [\underline{\alpha}, \overline{\alpha}]$, is incentive compatible. First, we set $\widehat{l}(\alpha)$ and $\widehat{\widehat{l}}(\alpha)$ by (12) for the continuation equilibrium in Stage 4. Second, we use (11) to construct a function $W'(\alpha)$. Setting a value for $W(\overline{\alpha})$, we integrate $W'(\alpha)$ to obtain $W(\alpha)$. Third, we set

$$T(\alpha)=W(\alpha)-\alpha W'(\alpha)+S(\alpha)\left[\int_{\widehat{l}(\alpha)}^{\widehat{\widehat{l}}(\alpha)} c_1 \mathrm{d}F(l)+\int_{\widehat{\widehat{l}}(\alpha)}^{\bar{l}} c_3 \mathrm{d}F(l)\right]. \tag{33}$$

It is straightforward to check that $S(\alpha)$ and the $T(\alpha)$ in (33) satisfy incentive compatibility. Finally, we can choose $W(\overline{\alpha})$ so that $\pi(\overline{\alpha})\geq 0$.

Proof of Proposition 3: From the Lagrangian function L, where μ and γ are the multipliers for constraint (15) and (16), respectively.

$$\begin{aligned} L \;&= U(Y-P)-E(l)+\int_{\widehat{l}(\alpha)}^{\widehat{\widehat{l}}(\alpha)} \theta_1 l dF(l)+\int_{\widehat{\widehat{l}}(\alpha)}^{\bar{l}} \theta_3 l dF(l)+\mu\left\{P-W(\overline{\alpha})-\int_{\widehat{l}(\alpha)}^{\widehat{\widehat{l}}(\alpha)} c_1 dF(l)-\int_{\widehat{\widehat{l}}(\alpha)}^{\bar{l}} c_3 dF(l)\right\}\\ &+\mu\left(\frac{G(\alpha)}{g(\alpha)}+\alpha\right)\left(U(Y-P)-E(l)+\int_{\widehat{l}(\alpha)}^{\widehat{\widehat{l}}(\alpha)} \theta_1 l dF(l)+\int_{\widehat{\widehat{l}}(\alpha)}^{\bar{l}} \theta_3 l dF(l)\right)\\ &+\gamma\left\{W(\overline{\alpha})-\overline{\alpha}\left[U(Y-P)-E(l)+\int_{\widehat{l}(\overline{\alpha})}^{\widehat{\widehat{l}}(\overline{\alpha})} \theta_1 l dF(l)+\int_{\widehat{\widehat{l}}(\overline{\alpha})}^{\bar{l}} \theta_3 l dF(l)\right]\right\}. \end{aligned}$$

We use pointwise optimization for $\widehat{l}(\alpha)$, $\widehat{\widehat{l}}(\alpha)$, and take the derivatives of the Lagrangian function with respect to them at α. To simplify, we drop constant terms in the derivatives $\frac{\partial L}{\partial \widehat{l}}$ and $\frac{\partial L}{\partial \widehat{\widehat{l}}}$. These (simplified) derivatives are in expressions (34) - (37). The derivatives of the Lagrangian function with respect to P and $W(\overline{\alpha})$ are in (38) and (39).

$$\left.\frac{\partial L}{\partial \widehat{l}}\right|_{\alpha<\overline{\alpha}}=-\theta_1\widehat{l}+\mu c_1-\mu\left(\frac{G(\alpha)}{g(\alpha)}+\alpha\right)\theta_1\widehat{l} \tag{34}$$

$$\left.\frac{\partial L}{\partial \widehat{l}}\right|_{\alpha=\overline{\alpha}}=-\theta_1\widehat{l}+\mu c_1-\mu\left(\frac{G(\overline{\alpha})}{g(\overline{\alpha})}+\overline{\alpha}\right)\theta_1\widehat{l}+\gamma\overline{\alpha}\theta_1\widehat{l} \tag{35}$$

$$\left.\frac{\partial L}{\partial \widehat{\widehat{l}}}\right|_{\alpha<\overline{\alpha}}=-\theta_2\widehat{\widehat{l}}+\mu c_2-\mu\left(\frac{G(\alpha)}{g(\alpha)}+\alpha\right)\theta_2\widehat{\widehat{l}} \tag{36}$$

$$\left.\frac{\partial L}{\partial \widehat{\widehat{l}}}\right|_{\alpha=\overline{\alpha}}=-\theta_2\widehat{\widehat{l}}+\mu c_2-\mu\left(\frac{G(\overline{\alpha})}{g(\overline{\alpha})}+\overline{\alpha}\right)\theta_2\widehat{\widehat{l}}+\gamma\overline{\alpha}\theta_2\widehat{\widehat{l}} \tag{37}$$

$$\frac{\partial L}{\partial P}=-U'(Y-P)+\mu\left[1-U'(Y-P)\int_{\underline{\alpha}}^{\overline{\alpha}}\left(\frac{G(\alpha)}{g(\alpha)}+\alpha\right)\mathrm{d}G(\alpha)\right]+\gamma\overline{\alpha}U'(Y-P) \tag{38}$$

$$\frac{\partial L}{\partial W(\overline{\alpha})}=-\mu+\gamma \tag{39}$$

We obtain (17) and (18) in the Proposition by setting (34), (36) to zero. From (39), we have $\mu=\gamma$. We then substitute γ by μ in and (38), set it to zero, and then apply integration by parts to obtain (19).

The first-order conditions for $\widehat{l}$ and $\widehat{\widehat{l}}$ at $\alpha=\overline{\alpha}$ are

$$\widehat{l}(\overline{\alpha})=\mu\frac{c_1}{\theta_1}\left[1+\frac{G(\overline{\alpha})}{g(\overline{\alpha})}\mu\right]^{-1} \tag{40}$$

$$\widehat{\widehat{l}}(\overline{\alpha})=\mu\frac{c_2}{\theta_2}\left[1+\frac{G(\overline{\alpha})}{g(\overline{\alpha})}\mu\right]^{-1}. \tag{41}$$

The limit of $\widehat{l}(\alpha)$ as α converges to $\overline{\alpha}$ from below is $\frac{c_1}{\theta_1}\left[\frac{1}{\mu}+\left(\frac{G(\overline{\alpha})}{g(\overline{\alpha})}+\overline{\alpha}\right)\right]^{-1}$. Clearly, $\lim_{\alpha\to\overline{\alpha}}\widehat{l}(\alpha)<\widehat{l}(\overline{\alpha})$. Because incentive compatibility requires $\widehat{l}(\alpha)$ to be decreasing, the monotonicity constraint must bind at $\widehat{l}(\overline{\alpha})$, so $\widehat{l}(\overline{\alpha})=\lim_{\alpha\to\overline{\alpha}}\widehat{l}(\alpha)$. By the same argument, we have $\widehat{\widehat{l}}(\overline{\alpha})=\lim_{\alpha\to\overline{\alpha}}\widehat{\widehat{l}}(\alpha)$.

By assumption, the hazard rate $\frac{G(\alpha)}{g(\alpha)}$ is increasing, so $\frac{G(\alpha)}{g(\alpha)} + \alpha$ is increasing. Hence, $\widehat{l}(\alpha)$ and $\widehat{\widehat{l}}(\alpha)$ are decreasing in α. Finally, from (17) and (18), the ratio of $\widehat{l}(\alpha)$ to $\widehat{\widehat{l}}(\alpha)$ is a constant, so the equilibrium condition in Stage 4, (12), is satisfied.

Proof of Corollary 1: Suppose $P \le P^*$. Then

$$\frac{1}{U'(Y-P)} \ge \frac{1}{U'(Y-P^*)} = \frac{c_1}{\theta_1}\frac{1}{\ell^*},$$

where the equality follows from Proposition 1. From (19), we have

$$\frac{1}{\mu} = \frac{1}{U'(Y-P)} \ge \frac{1}{U'(Y-P^*)} = \frac{c_1}{\theta_1}\frac{1}{\ell^*},$$

so

$$\frac{1}{\mu} \ge \frac{c_1}{\theta_1}\frac{1}{\ell^*}. \tag{42}$$

By (17), we have

$$\begin{aligned} \frac{c_1}{\theta_1}\frac{1}{\widehat{\ell}(\alpha)} &= \frac{1}{\mu}\left[1 + \left(\frac{G(\alpha)}{g(\alpha)} + \alpha\right)\mu\right] \\ &\ge \frac{c_1}{\theta_1}\frac{1}{\ell^*}\left[1 + \left(\frac{G(\alpha)}{g(\alpha)} + \alpha\right)\mu\right] > \frac{c_1}{\theta_1}\frac{1}{\ell^*}, \end{aligned} \tag{43}$$

where the weak inequality is due to (42), and the strict inequality follows from the term inside the square brackets of (43) being strictly positive. Therefore, $\widehat{\ell}(\alpha) < \ell^*$ for all α. Repeating the same argument, we have $\widehat{\widehat{\ell}}(\alpha) < \ell^{**}$ for all α. The consumer receives more treatments and the physician receives profits. This therefore implies that $P > P^*$, which is a contradiction.

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