

# Is “Fee For Service” A Reverse Incentive In The Health Care Market Of The United States

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## Abstract

### INTRODUCTION

The controversy over healthcare in United States never seems to pack its bags and leave for good. The debate has raged on for years, resulting in little more than divided and embittered factions, each with its own zealous mantle or outlook as to the best possible healthcare option. However, there is general agreement that many of the cost and quality problems associated with the delivery of health care in the United States are either caused by or exacerbated by the way payments are made for health care services. Physicians undeniably have an economic interest in providing more services, but payment mechanisms overshadow the former's effect in clinical decision making (Shen, Andersen et al. 2004).

The US health care market relies mainly on competition to control the rising cost. However, the unique status of physicians and to an extent that of health insurers has effectively removed some of the much needed competition from the market and tempered the effect of contestation on capping costs. The health care delivery system is driven by private and state owned insurers and therefore, its beneficiaries have too little incentive to be prudent buyers. On top of both practitioner and health care service decision making, the entire process is driven by a race forward in science, multiple treatment options, and enormous power on the side of suppliers.

### UNDERSTANDING THE FEE FOR SERVICE SYSTEM (FFS):

FFS occurs when doctors and other health care providers receive a fee for each service such as an office visit, a test, a procedure or any other health care service. This means that units of service are individually priced and paid, but the payments are issued retrospectively, after the services have

been provided. These payments are those made primarily to physicians by both private insurance companies and state run agencies like Medicare and Medicaid, in addition to provider groups acting like insurance companies such as the Independent Physician Association (IPA) or the Physician Hospital Organization (PHO). In the fee for service system, providers benefit when patients consume more as opposed to a different payment system operating independently of quantity e.g. capitation.

Capitation pays only a set benchmark fee for a patient regardless of sickness, giving physicians an incentive to avoid the most costly of patients. So whether a patient makes just one visit or multiple visits, requires simple tests or more complicated and invasive procedures, he or she is paid for by the set fee. Capitation theoretically corrects for the overreliance on face-to-face office visits that characterize the primary care FFS business model. In paying a per-person-per-month (PPPM) payment for an average amount of services for a population under a physician's care, theoretically the payer allows the practitioner to determine how to allocate her own time and efforts to care for assigned patients (Berenson and Rich 2010).

Another option is to pay physicians a monthly or yearly premium for their services in the form of a fixed salary. Although recent studies show a substantial increase in the number of physicians who are employees rather than practice owners (Casalino, November et al. 2008), neither Medicare nor most private payers have direct physician employment as a realistic payment option. Payment by salary neither offers overt incentives to withhold care (as with capitation) nor to over-provide (as with FFS).

The basic objective of pay for performance involves the use of marginal financial incentives that reward (or penalize)

clinicians and other providers for meeting (or failing to meet) predetermined performance goals as reflected in specific performance measures (Rosenthal and Dudley 2007). Med-Vantage lists 148 pay for performance programs through December 2007 (Med-Vantage 2008). This rapid growth is occurring despite a paucity of empirical evidence that pay-for-performance programs actually deliver on their promise to improve the quality and reduce the cost of health care (Dudley 2005).

### **MAGNITUDE OF THE PROBLEM:**

The question as to whether health systems will be financially sustainable in the future is frequently raised in health policy debates. As health care spending consumes an ever larger share of the nation’s economic output in the future, Americans will be faced with increasingly difficult choices with the delivery of health care. The United States spends 15% of its GDP on health care which is 60% more than what is spent in many European nations (table no: 1) with better health indices (Smith 2010). The fee for service system is one of the many reasons attributed to this increased risk. In a study comparing Medicare patients with FFS to Medicare patients with alternative plans, it was noted that the Medicare patients in alternative plans used fewer hospital resources than those in the FFS plan by averaging a shorter length of stay and a lower total cost per hospitalization (Friedman, Jiang et al. 2006). Therefore the most effective strategy for reducing health care expenditures is fundamental reform of the incentives provided to health care professionals, especially physicians.

There are a large number of reasons often attributed to this phenomenon as to why the Fee for Service system increases health care costs. These include physician’s practice behavior, associated administrative costs, waste in health care and costs associated with practicing defensive medicine.

### **PHYSICIAN’S PRACTICE BEHAVIOR:**

The health care system has long been accused of emphasizing the quantity rather than the quality of care, giving doctors and other health providers incentive to order extra tests and procedures when they have a limited effect on the outcome. Physicians within this system have no incentive to avoid more costly tests and procedures as opposed to physicians paid under capitation. Hence Physicians reimbursed by an FFS basis have the opposite incentives and face much less financial risk than physicians paid by capitation. In addition, when patients are shielded from paying (cost sharing) by health insurance coverage,

they are incentivized to welcome any medical service that might do some good. Hence when bills are paid under FFS by a third party – patients along with doctors have no incentive to consider the cost of the treatment (Kralewski, Rich et al. 2000). On the other hand, physicians paid by capitation have incentives to contain costs and financial risk because of the fixed budget. If no health plan enrollees seek care, physicians under capitation face no financial risk; they simply receive the monthly payment for each enrollee. However, if all health plan enrollees seek care and their actual costs are greater than the monthly payments (which are based on estimated costs), then the physician must cover the cost of care that exceeds the monthly payment. Physicians are not allowed to ask the health plan for extra payments to cover the additional costs of care. This itself is an incentive for the physicians paid by capitation to manage and provide appropriate care to their patients. They have an incentive to provide more preventive care that catches illnesses early (e.g., mammograms). Preventive and primary care intends to keep patients healthy so they need fewer tests and procedures when they do see the physician. Physicians under capitation also have an incentive to contain costs by providing more preventive care that limits the number of additional office visits that patients need. So it’s clear that payment systems do have a substantial influence on the physician practice behavior.

Although there is limited research on the influence of payment systems on physician behavior, (Robinson 2001) what does exist supports the presumption that payment incentives do affect behavior in predictable norms (Gosden, Forland et al. 2001). Fee for service payment encourages consumption of resources while Capitation discourages it.

### **ADMINISTRATIVE COSTS:**

This is the cost incurred from the work hours devoted to coding, billing and collecting reimbursements and related payments. Physicians, nurses and other clinical employees in the doctor’s offices are involved in this process. In the United States, the administrative cost for health care delivery was \$1,059 per capita, as compared with \$307 per capita in Canada (Woolhandler, Campbell et al. 2003). Under the FFS system, each service is billed, which can be very time consuming since it requires the knowledge of the various types of billing codes and its proper usage. Also a system with multiple insurers is intrinsically costlier than a single-payer system. In general, providers’ administrative costs were far lower in Canada. Between 1969 and 1999, the share of the U.S. health care labor force accounted for by

administrative workers grew from 18.2 percent to 27.3 percent. In Canada, it grew from 16.0 percent in 1971 to 19.1 percent in 1996 (Both nations' figures exclude insurance-industry personnel.) (Woolhandler, Campbell et al. 2003). Internationally, administrative expenditures show little relation to overall growth in costs or to life expectancy or other health indicators. The existence of global budgets in Canada has eliminated most billing and minimized internal cost accounting, since charges do not need to be attributed to individual patients and insurers.

### **WASTE IN HEALTH CARE SPENDING**

Half of the one trillion dollar waste in health care is related to clinical causes, where medical care itself is considered inappropriate entailing overuse, misuse or under-use of particular interventions, missed opportunities for earlier interventions, and overt errors leading to quality problems for the patient. Prominent experts have estimated that at least 30% of U.S. health care spending represents waste or pays for poor-quality care that doesn't benefit patients (Reid PP 2005). In the model created by the RAND health experiment, it was noted that pre-paid global payments to physicians reduced the cost by 28% compared to the fee for service plans (Enthoven 2011). Global payment systems will also eliminate the burden of large paperwork and back-logged records that most physicians inevitably face at some point in time. Physicians and physicians groups have always argued that they could reduce costs without harming patients and would do so if the fee-for-service system didn't punish them with reduced revenue.

### **DEFENSIVE MEDICINE AND FEE FOR SERVICE:**

Determining the costs of defensive medicine may be impossible. In a fee-for-service system that rewards overutilization, it is difficult to separate defensive medicine from medical providers' profit incentives. A survey of physicians revealed that medico-legal concerns are an important factor in ordering pre-operative tests when patients are not benefitted from those tests (Brown and Brown 2011). Overall annual medical liability system costs, including defensive medicine, are estimated to be \$55.6 billion in 2008 dollars, or 2.4 percent of total health care spending (Mello, Chandra et al. 2010).

### **TRENDS AND RECENT DEVELOPMENTS:**

According to the 2011 Segal Health Plan Cost Trend Survey (Segal 2010), The Segal Co. consultancy's 14th annual survey of health plan cost trends, all 2011 medical plans types will experience cost trends that are more than eight

times higher than the consumer price index (CPI) for all urban consumers. Compared to 2010, cost trend rates for high-deductible health plans (HDHPs) are expected to decrease (that is, grow slower) in 2011. Also, trend rates for preferred-provider organizations and point of service plans will be slightly higher than in 2010. One of the cost containing step that they have mentioned is Investing in controlled preventive/wellness services and on-site clinics that move away from fee-for-service contracts.

In July 2011, the Center for Medicare and Medicaid Services (CMS) announced the results of the Physician Group Practice (PGP) Demonstration project (Wilensky 2011). The demo resulted from a directive by Congress in 2000 to test ways to encourage physicians who were part of traditional (fee-for-service) Medicare to provide higher-quality care at lower cost and to be rewarded for doing so with a share of the savings they produced. The PGPs did very well on the quality metrics during all 5 years of the demo. Even with all their experience, only two of the PGP participants were able to exceed a 2% savings threshold the first year of the demo, and only half managed to surpass that threshold after 3 years. The PGPs have suggested that some of the challenges they faced derived from design issues — the way the comparator groups were constructed, the ways patients were attributed to PGPs, and the risk-adjustment mechanism used.

In 2009, the Massachusetts Special Commission on the Health Care Payment System said that fee for service “rewards overuse of services, does not encourage consideration of resource use, and thus cannot build in limitations on cost growth.” The commission concluded that “risk-adjusted prospective global payment models that provide appropriate incentives for efficiency should serve as the direction for payment reform.” (Kirwan 2009).

### **DISCUSSION**

The increased health care expenditure in United States is not solely from the current system of payment to providers. Greater quantities of high-priced innovative technologies in the United States also contribute to higher expenditures in the United States compared with other nations. The potential for practice and system disruptions from payment reform cause some to argue for no immediate changes in the current system (Davis, Schoenbaum et al. 2005). Undoubtedly access of care is better with fee for service system. Fewer hospital admissions will ensue, as access to care will be inversely associated with hospitalization rates for these chronic medical conditions.

Applying incentives in the context of medical care may not be appropriate. Patients should have substantial say in the decision making process of their health care. Patient’s ability to choose their own physicians is the hallmark of fee for service system.

Price et al conducted a study by dividing subjects into the types of insurance they had: capitated, fee for service, or Medicaid insurance (Price, Norris et al. 1999). The Medicaid group had more emergency room visits than the other two groups. Fee for service group had the least number of ER visits.

One of the main concerns with FFS is that it fails to contain the rise in the cost of health care delivery. CMS carried out a demo project in which physician groups received their regular Medicare payments for services provided to beneficiaries but could also share in the savings generated as long as they met certain quality metrics and exceeded a savings threshold of 2%. Per capita expenditures for a comparator group in the same geographic area was used to calculate the savings (Iglehart 2011). The published findings showed that most physician groups failed to achieve the 2% saving requirement (Wilensky 2011). Incentivizing physicians to save while maintaining the quality of care is harder to achieve than many had thought. In another study to compare Medicare patients and patients enrolled in alternate plans with capitated payments, revealed no actual savings in using the alternate plans. In addition, the preventable admission rates were also same in both groups indicating no difference in the quality of care provided between the plans (Friedman, Jiang et al. 2006).

Patient satisfaction has always been higher with FFS models. A John Hopkins study (Kasper and Riley 1992) investigated satisfaction with care among Medicare beneficiaries enrolled in a health maintenance organization (HMO) and beneficiaries in fee-for-service (FFS) care in the same geographic area. Results indicate higher satisfaction with access/quality of care among those in FFS. Number of other studies showed HMO enrollees expressed less satisfaction compared with fee-for-service beneficiaries regarding the professional competence of their health care providers and the willingness of the HMO staff to discuss problems (Rossiter, Langwell et al. 1989) (Adler 1995). Higher satisfaction with the quality of interaction with their physicians were seen in patients enrolled in fee for service models compared to other models (Tudor, Riley et al. 1998). FFS was also found to be better in many aspects of care related to access and beneficiary experiences (Landon,

Zaslavsky et al. 2004). Membership in a managed care organization is associated with a delay in receiving definitive surgical care for benign gynecologic diseases compared to those enrolled in FFS (Chin and Harrigill 1999).

There are many other reasons why health care is so expensive in United States. Nations in which a greater proportion of physicians practice primary care medicine tend to have lower per capita health expenditures than does the United States, in which a greater proportion of physicians practice specialty care. The price of hospital care is far higher in the United States than in other nations. Even though the United States has fewer physician visits and hospital beds than do other nations, it has a greater supply of expensive new technologies and uses them more intensively (Bodenheimer and Fernandez 2005).

### **SUMMARY**

The only way universal health care can adequately address rising health care costs is by limiting available care. Rationing of care is not an acceptable health care delivery principle, nor is it an appropriate way to contain health care costs. Fee for service models may contribute to rising health care cost, but on analyzing the alternatives proposed, the FFS is still the most acceptable payment system for health care delivery.

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