Fee-For-Service Is Not the Problem

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March 9, 2012

Word count for text: 2475 (2459 without titles)

There is a widespread assumption among health policy experts that the key problem with runaway health care costs is unnecessary care driven by the incentive to over-treat that is inherent in fee-for-service payment of doctors. Therefore, the argument goes, we need to improve financial incentives for care coordination and reorganize doctors into "Accountable Care Organizations," forcing primary care, specialist physicians, and hospitals into shared financial arrangements that shift at least some insurance risks onto providers, countering the fee-for-service incentive to over-treat.

While there are certainly some doctors providing unnecessary procedures due to fee-for-service financial incentives, it is extremely unlikely that this is the root of our health care cost problem. The argument that fee-for-service incentives are the driver of excess health care cost is based on a fundamental misdiagnosis of the reasons for unsustainable cost escalation in U.S. health care.

If one attempts to quantify the sources of excess U.S. health spending by looking at actual evidence, it is apparent that exorbitant and unnecessary administrative costs are the biggest driver (around 20-25% of National Health Expenditures[1,2]), followed by unnecessary care due to over-treatment[3,4] (perhaps 10% of NHE, of which only a fraction is attributable to fee-for-service incentives), and expensive complications of under-treatment due to lack of access (perhaps 5-10% of NHE, plus a lot of suffering and death that does not show up in health spending figures). About half of over-treatment is due to unreasonable demands for care by patients, most of which is actually driven by providers (direct-to-consumer advertising for drugs, ads by hospitals, and by the recommendations of doctors.) Malpractice costs and defensive medicine are only a few percent at most.[5]

There is a problem with lack of coordination of care for certain patients, but the far bigger problem is inadequate access to necessary care. There is a nation-wide shortage of doctors in primary care and also in many specialties. This is compounded by the problems of un-insurance and under-insurance, and the refusal of many doctors to accept patients with insurance plans that are onerous, pay low fees, or both. Care coordination is meaningless without access.

According to a recent CBO report[6], all 34 pilot care coordination projects funded by CMS either failed to save any Medicare spending at all, or if they did save on health care spending, they cost more in administrative expenses than they saved, for a net *increase* in total cost for all of them. Three of four payment reform demonstration projects that relied on pay-for-quality incentives failed to save money, and the only successful one negotiated a discounted, bundled fee for coronary bypass surgeries and did not use pay-for-performance incentives. After three years, the PROMETHEUS project on bundled payments for episodes of care has failed to implement any actual contracts due to the complexities of defining a “bundle.”[7] Just about all the "cost saving" initiatives in the Affordable Care Act (ACA) are along the same lines and will fail for the same reasons.

There are only a few U.S. health reform programs that have actually achieved significant cost savings without relying on “cherry picking” healthier populations and avoiding sicker ones. Major examples are Community Care of North Carolina[8] and Rocky Mountain Health Plans in Colorado[9]. The common denominator is not elimination of fee-for-service, which both still employ; it is physician leadership, high levels of physician participation and buy-in, significantly improved access to outpatient care for sicker high-risk patients, and a shared commitment to quality improvement.

Part of the problem is indeed the imbalance in pay between certain specialties and primary care, rooted in the flawed Medicare SGR physician fee schedule, and we do need to re-think how the money is distributed between "cognitive services" and procedures. Increased payment for primary care and care-coordination is part of the solution, but does not require shifting insurance risk onto doctors via HMO's or ACO's.

Administrative costs

If we want to "bend the cost curve," we should focus first and foremost on administrative simplification. The drivers of excess administrative costs are primarily due to use of competing insurance plans to finance health care. Insurance works fine for expensive, infrequent, and unpredictable risks like house fires. However, when insuring health care for a population, a large percentage of whom have known risks (pre-existing conditions and risk factors), then the overriding incentive for competing plans is not to offer a better plan; it is to identify higher risk (sicker) individuals and groups and avoid insuring them or avoid paying for their care if they get sick. The attempts in the ACA to counter the perverse incentives due to competition among insurance plans have been watered down and will fail to achieve adequate control of the problem, and are adding even more administrative costs. The only definitive way around these perverse incentives would be to establish a social insurance model with a single risk pool covering an entire population. This means eliminating competing private health insurance plans, at least for medically necessary health care. Competing private health plans also carry approximately six times the administrative cost of a social insurance system.

Since the insurance industry does not want to be pushed out of health care, they have a strong incentive to blame providers and patients for rising health care costs, hence the focus on fee-for-service and unnecessary care, and on increasing cost sharing for patients to deter care. The result is ever rising administrative costs and ever decreasing access to care for sick people.

Over-treatment and fee-for-service

Perhaps10% of national health expenditures is attributable to unnecessary care (over-treatment). Some of this is not due to financial incentives at all, but rather to lack of effort or skill on the part of doctors to persuade patients that further care or the requested treatment is ineffective or would only prolong suffering. Major examples are futile end of life care and antibiotics for colds. Some unnecessary care is also driven by direct to consumer ads for drugs and specialized hospital services, which don't involve financial incentives for doctors. Only a fraction is attributable to fee-for-service incentives.

Fee-for-service physician payment cannot be a root cause of high US health care costs. Other countries with much less expensive health care systems pay doctors with fee-for-service and seem to have fewer problems with unnecessary care, and in studies of regional variation in Medicare spending, high and low cost areas use fee-for-service equally. It takes a combination of fee-for-service and other factors to generate a lot of unnecessary care,

such as for-profit hospitals pushing doctors to do unnecessary procedures, and doctors who start for-profit facilities and therefore have incentives beyond getting paid for professional services.

There are pro's and con's to paying physicians with either fee-for-service or salaried arrangements that need to be clearly understood in health care planning. Fee-for-service motivates doctors to work harder than they do under salaried arrangements, but can be an incentive to unnecessary care. Salaried arrangements have no incentive to over-treat, but do introduce an incentive to under-treat and may skimp on necessary care. Salaried doctors also tend to work less hard and have to be pushed to maintain high productivity. Where there is a shortage of doctors, fee-for-service can encourage higher productivity. In urban areas where there is an over-supply of doctors, salaried arrangements may be better. For patients with straightforward chronic diseases, integrated systems that can enforce protocols for best practice are probably superior. For “complex” patients (around 25% of a primary care doctor’s practice[10]) with unclear diagnoses, unusual or complex problems, or poor compliance, fee-for-service is probably superior because doctors will be more motivated to put in the extra time required if they can get paid more for it.

Integrated, capitated health plans such as Kaiser pay doctors on salary, so they have no financial incentive to over-treat. Kaiser does a good job of treating patients with established chronic diseases, but their system can be quite unfriendly to patients with unclear diagnoses, complex interacting problems, or complicating psychosocial problems. Kaiser in Hawaii limits their exposure to Medicare and Medicaid. They accept some Medicaid patients under General Assistance and Aid For Dependent Children, but they declined to bid on a plan for the higher risk Aged, Blind, Disabled population. Their ads are entirely targeted to healthy people. In other words, a good portion of their "success" in delivering cost-effective care is actually attributable to cherry picking healthier populations and avoiding sicker ones.

What does motivate doctors?

Doctors are indeed motivated by financial incentives, and they do expect to achieve an income commensurate with the rigors and expense of the training necessary to do what they do. However, they are also motivated by professionalism: putting the needs of their patients first, quality improvement, and individualizing care for complex and difficult patients.

There are two broad ethical paradigms in the world of economics: commercial ethics and "guardian" ethics.[11] The commercial paradigm assumes a seller and buyer of goods or services, whose power and interests are balanced through the marketplace and the laws of supply and demand, with financial incentives as a primary motivator. Guardian ethics are applicable to socially necessary services that require specialized training not available or achievable by the general public, so that there is an inherent imbalance of power between the provider and recipient of services. Classic examples are the military, medicine, and other specialized professions. In these cases, the interests of the public are protected by a tradition of professionalism and concern for the welfare of the public, or patient, or client, which is held to be a higher ethical value than financial considerations.

There has been a movement in this country for the past 50 years to de-professionalize

medicine, with an underlying assumption that commercial ethics are the only valid and trustworthy ethics. This justifies increasing interference in health care decisions by insurance plans and government, and a reliance on financial incentives to "fix" problems in health care, and especially its high cost. However, if doctors are stripped of their professional autonomy and treated as if financial considerations are paramount, they actually do start to abandon professional ethics for commercial ones. They start responding to financial considerations above patient needs; they select patients according to their insurance status; and they look for ways to game the system and make more money from things other than professional services. They begin to try to maximize income by any available means, helping drive the cost of health care higher. Sometimes this leads to outright fraud.

My opinion is that the real cause of much of the physician-controlled unnecessary care in the U.S. is abandonment of traditional professional ethics for commercial ethics - "medicine as a business, patients as consumers" - that when combined with fee-for-service leads to excessive and unnecessary care. If my diagnosis is correct, then the further commercialization of medical practices into competing corporate entities will only make the problem worse.

On the other hand, promotion of professionalism among doctors and harnessing it to make care more cost effective through quality improvement programs is the antidote to both the incentive to over-treat under fee-for-service and to under-treat under salaried arrangements.

Quality Improvement

Payment reform initiatives that rely on financial incentives tied to individual quality and performance ratings of doctors and hospitals carry a serious risk of unintended adverse consequences. Much of health care is too complex to be amenable to valid quality ratings anyhow. Rating individual providers will quickly induce them to game the ratings by up-coding diagnoses or avoiding sicker, atypical, and more complex patients, or it will drive them to refuse plans that impose such ratings. Attempts to correct for these problems require complex information from computerized health records and are fraught with problems. Many older, less tech-savvy physicians are likely to retire rather than accept enforced computerization, and with our nation-wide physician shortage we cannot afford to drive a large number of physicians out of practice.

Instead of rating individual doctors for pay-for-performance, quality improvement efforts should be based on the Continuous Quality Improvement (CQI) model, as exemplified by Intermountain Healthcare in Utah.[12] This model defines problems as systems problems, not problems with individual doctors, and engages all doctors cooperatively in improving care. It means focusing on processes of care and transitions between care settings. It encourages reduced variation in practice patterns without punishing doctors for deviating from guidelines when there are good clinical reasons to do so. It means health IT is not focused on measuring for selection, but on measuring for relative improvement. It does not require all doctors to have an EHR, and it requires less disruption in physician workflow. CQI harnesses physician professionalism to improve care and make it more cost effective, rather than relying primarily on financial incentives.

Achieving cost-effective, sustainable health care

We must abandon the idea that competition among health plans can make care more cost-effective. Competition adds administrative complexity and cost for both plans and providers, and interferes with efficient delivery of health care. It does not reduce total health care costs, but does push plans to try to exclude the sick from coverage, reduce benefits, and increase administrative burdens, all of which are destructive to health care. Fragmentation in health care financing also impairs quality improvement efforts, which work best in a universal system. We need *consolidation* of health plans under an administrative structure that is accountable to effective delivery of health care.

Universal access to care is crucial to ensuring that health care is delivered in the most cost effective setting, minimizing use of emergency rooms and hospitals. Significant savings from administrative simplification depend on universal access, and quality improvement is much more effective when everyone in a community is included.

Solving our physician workforce problems will require improved pay for care coordination and cognitive services, and correcting the imbalance in pay between procedural specialties and primary care. With a universal system, CPT procedure codes could be replaced with a simplified time-based system, with multipliers for training and overhead costs needed to practice a given specialty. An expanded program like the National Health Service, with government subsidies for medical education in exchange for a commitment to practice in under-served specialties and under-served areas, could remove medical education debt as a deterrent to entering less lucrative specialties such as primary care, psychiatry, and general surgery.

We need to promote professionalism among doctors. I am in favor of requiring all physicians to be members of a professional organization, tied to licensure, to ensure their participation in system-wide quality improvement, peer review, and continuing education. Physician professionalism, not pay-for-performance, should be the primary driver of quality improvement and cost containment efforts. It is more effective and costs less than managed care administered by an insurance plan.[8,9,12]

Cost-effective, sustainable health care will require a much simpler administrative structure, universal access to necessary care, and organization of doctors to promote quality improvement. Accountability must always be to the health care needs of the population served.

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