Family Physicians and the Future of Fee-For-Service Payment Plans

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The mechanisms by which health care providers in the United States are reimbursed for their services are undergoing dynamic and rapid changes. Traditional fee-for-service payment schemes as the predominant reimbursement methods are declining and are being supplanted by a plethora of different schemes that incorporate prepayment as the mode of compensation for service. A number of trends over the past decade predict that this transference to prepayment will continue in the future and will have a profound impact on the future practice of family medicine. It is important for family medicine educators and practicing family physicians to understand these market forces and trends so they will be better able to alter their training programs and future practices to meet future needs.

Today's family practice residency graduates can expect to be in practice for an average of 35 years. Thus, family physicians who are currently entering practice must prepare themselves for the changes that can be expected to occur in the field of health care through the year 2020. An increasing rate of change in health care delivery has been well documented.[1] It is astonishing how much change has occurred in the past 35 years.

In 1950, penicillin had just become available for regular civilian use following World War II. Sulfa drugs were the only other antibiotic in common use. Digitalis and quinidine were the only commonly prescribed cardiac medications, and diuretics were not yet in common usage for treatment of hypertension.[2] Another significant event was occurring at about the same time. A group of physicians providing medical services to shipyard workers in the San Francisco Bay Area on a prepaid basis during World War II liked this form of practice and became the nucleus for what is now known as the Kaiser-Permanente Medical Care System.[3] Changes of even greater magnitude in medical knowledge, delivery systems, and payment mechanisms can be expected in the next 35 years.

Submitted, revised, August 26, 1985.

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CURRENT TRENDS IN US HEALTH CARE

To predict more accurately the future of fee for service for family physicians, it is important to review current trends in US health care. Six major trends are having a substantial impact on the delivery system.

COST

The cost of health care in the United States is the most important collective concern in shaping future changes in health care delivery. With a 1983 total health cost of $355.4 billion, the average expenditure per person in the United States was $1,459.[4] Between 1982 and 1983 the consumer price index for all goods and products increased 3.2 percent, while medical care costs increased at three times this rate (8.7 percent).[4] American business is becoming increasingly concerned and involved with efforts to trim their overhead costs for health and welfare benefits for employees.[5] American companies such as automobile manufacturers now compete with automobile manufacturers from other countries whose cost for health benefits for their labor force is significantly less than American companies.[6] Ford Motor Company reports that its health care costs have doubled every five years for the last 15 years and averaged $3,350 per active employee in 1980. This amounts to about $290 per car manufactured in 1980.[6]

The federal government's total expense for personal health care services has continued to increase rapidly since the mid-1960s, totaling $105.5 billion for fiscal

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year 1983.[4] With increasing pressure to reduce the federal budget deficit, attempts by government to control health care costs can be expected to increase in the future.

MANPOWER

The issue of manpower was brought to the attention of the nation in the 1979 report of the Graduate Medical Education National Advisory Committee (GMENAC).[7] The report predicted an oversupply of physicians by the year 1990 with an increasing oversupply beyond that. Although this report did not project a surplus of family physicians, it seems inevitable that the law of supply and demand will dictate a relative reduction in physician bargaining power and income over the next two decades. The average number of patient visits per physician per year has dropped for the past two years, an indication that the manpower competition effect is already being felt.[4]

OWNERSHIP

A relatively recent phenomenon that shows little sign of abating is the rise of multihospital systems, particularly investor-owned (for-profit) hospital systems.[8] In California, there was a 400 percent increase in investor-owned hospitals from 1972 to 1982. During this same time 23 county hospitals in California have closed. The not-for-profit hospitals that are surviving are becoming equally aggressive in forming multihospital chains. Both types of hospital systems are investing in areas of the delivery system not traditionally part of a hospital. Ambulatory care centers sponsored by hospital chains are a rapidly growing California phenomenon.

The investor-owned sector of the medical care system is even showing evidence of evolving into the research and new product development arena, which traditionally has been the domain of universities on federal and foundation dollars. The recent artificial heart trials by the Humana Hospital Corporation provide an example of this activity.

PROFIT

The concept of profit as a driving force in decisions about health care delivery is a frightening but real issue. That physicians have been "paid well" has been accepted as a fact of life. The United States is a capitalistic, free-enterprise country, however, and corporate America sees profits to be made in health care. The pharmaceutical industry has been one of the most stable and highest profit-margin industries on Wall Street. Hospital Corporation of America, the largest investor-owned hospital company, showed 1983 revenues of almost $4 billion with pre-tax earnings (profit) of $391.7 million.[9] Maxicare Health Plans, Inc, one of the six largest and fastest growing publicly owned health maintenance organization companies, experienced 1984 revenues of $317 million with an $11 million net income.[10] It is safe to predict that profit will be a major motivating force shaping the future US health care delivery system.

PRICE

Economists have traditionally held that the US health care system does not respond with predictable economic behavior to market forces.[11] Fuchs[12] argues that the absence of price as a major determining factor in consumer behavior is a major reason why market forces have been unable to affect the spiraling cost of US health care. Historically, health care in the United States has been reimbursed by insurance programs, and price has not been an important factor in consumer (patient) decisions. Current research suggests that patient behavior does change when out-of-pocket money is a factor in determining where to receive care and how much care to buy.[13] It appears that consumers follow traditional economic behavior when decisions about competing delivery systems directly affect their pocketbooks.

REGULATION AND COMPETITION

During the 1970s a number of efforts were instituted to control costs by regulating health expenditures. The National Health Planning and Resources Development Act of 1974 (PL93-641) exemplified this effort to control costs by regulatory means through a mandated certificate of need (CON) program. Hospitals were required to apply to their respective state for a certificate of need before they were permitted any capital development or major equipment purchases.[14]

The current administration in Washington has successfully fought against regulation as a cost-control strategy. Instead, a number of federal initiatives have promoted competition as the answer to health care cost containment. Enthoven,[15] who is widely viewed as a key administration advisor on health policy, has presented the case for competition. This strategy holds that traditional free-market forces will hold costs down as they have in other industries.

It is difficult to predict what the long term may show in regulation vs free-market competition as competing strategies for cost containment. The remaining years of the Reagan administration will, however, continue to see the reduction of regulatory efforts and a stimulation of competition.

MECHANISMS FOR PAYMENT

These six trends, as well as others not described, will profoundly affect the future of fee-for-service

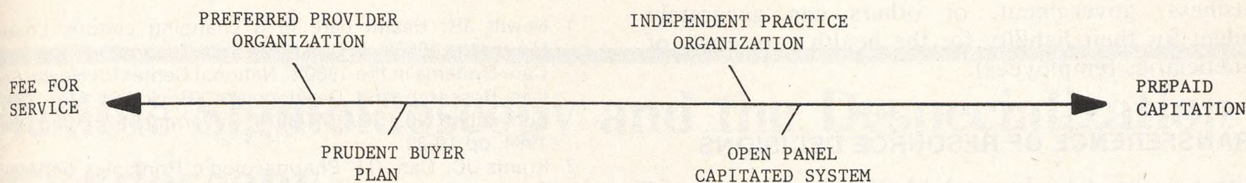

Figure 1. Spectrum of payment mechanisms

medicine. Fee for service is not equated with solo or private physician practice; rather, it is a mechanism of payment for a service. Fee for service will be judged over time for its viability according to its cost, overhead, and acceptability to buyers compared with other forms of payment with which it must compete. The most prominent alternative in the United States today is a prepaid, capitated health care payment mechanism as typified by a health maintenance organization. Prepayment for health services has multiple variations as does fee for service. It might be best to understand the options by envisioning a spectrum of payment mechanisms with a number of easily identifiable options displaying some of the characteristics of both types of payment mechanisms (Figure 1).

Being closest to pure fee-for-service reimbursement, preferred provider organizations and prudent buyer plans negotiate discounted provider fees. Providers then bill on a fee-for-service basis but at the reduced level. Independent practice organizations (IPAs) are a step further away from fee for service. The IPA is the organizational entity and is reimbursed on a capitation basis. Participating physicians, however, are usually reimbursed on a reduced fee-for-service basis. Any surplus or deficit at the end of the year is usually shared between the plan and the individual providers. An open-panel capitation system comes closer to a prepaid system in that the physicians are not directly employed by the organization but contract with the organization to participate on a capitated basis. There are more variations not described here, and it is becoming increasingly common in California for family physicians in private practice to be participating in several of these options at the same time.

FACTORS SUPPORTING SHIFT TO PREPAYMENT

With the trends previously described, it is predictable that there will be a shift toward prepayment. Four major characteristics of prepayment help explain its future dominance.

COST EFFECTIVENESS

The literature is replete with studies regarding the cost effectiveness of prepayment.[16,17] The basic issue that will prevail is that prepayment offers providers a strong economic incentive to reduce costs and services. In contrast, the economic incentive in fee for service is to provide the maximum number and most expensive types of service.

PREDICTABILITY

Under the fee-for-service payment mechanism, the payer, be it an individual, third party, or government, has great difficulty predicting the amount of the total bill for health care services. An example of this difficulty occurred in California during the state's fiscal crisis in 1981-82. At a time when the state faced "running out of money," the Medicaid (MediCal) program was identified as a major cause. The program's costs were exceeding projections despite potent cost-containment controls.

In contrast, use of a prepayment mechanism allows the payer to predict expenditures much more precisely. In exchange for a set prepaid amount, the provider agrees to provide all services required by a patient. This is the direction in which the State of California is moving for its public assistance patients. A prepaid capitated program allows the legislature to set a cap on program costs and eliminates the need for a reserve fund to protect against an overrun of costs. There are currently four options in California to provide MediCal services under prepayment, and the last legislative session saw several bills introduced to push the system further toward prepayment.

TRANSFERENCE OF RISK

A corollary to the predictability of budget to payers of health care is the transference of economic risk from the payer to providers. This assumption of the economic risk by providers is the essence of prepayment. In accepting prepayment, the provider is agreeing to provide all necessary services regardless of costs. Because the payer is no longer responsible for any cost

overruns, the need for payer reserve is eliminated. Business, government, or others can accurately budget for their liability for the health care costs of beneficiaries (employees).

TRANSFERENCE OF RESOURCE DECISIONS

With pressure to reduce total health costs, increased rationing of services will inevitably occur. Providing the best available care to every person is difficult now and will be more so in the future. Some rationing by ability to pay will occur, but pressure to limit the use of available resources for the majority of patients will increase. Government, business, and other payers of health costs will not be willing to make these decisions. By capitation and prepayment, these ethical and economic decisions will lie with the providers. Capitated plans will be forced to survive within a budget and will need to allocate resources within that budget.

SUMMARY

Considering these trends it seems inevitable that fee for service will continue to decline as the reimbursement mechanism for health services in the United States. Concern over cost containment alone has pushed the federal government and many states to try prepayment programs for Medicare and Medicaid. The private sector is also seriously reexamining the fee-for-service reimbursement system. Despite these rapid changes, it is important to realize that small practices can survive very well under prepayment if they are part of a larger system, such as an independent practice association. By participating in a larger organizational model, family physicians can take advantage of a larger financial risk pool and the marketing and management capabilities of the organization while still maintaining a small practice. By recognizing the trends described here and realizing their implications, family physicians can begin planning to practice family medicine in an organizational setting dramatically different from the traditional fee-for-service practice.

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