



Two Wrongs Do Not Make a Right: Flaws in Alternatives to Fee-for-Service Payment Plans Do Not Mean Fee-for-Service Is a Good Solution to Rising Prices

Comment on “Fee-for-Service Payment - An Evil Practice That Must Be Stamped Out?”

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Abstract

Professor Naoki Ikegami’s “*Fee-for-service payment – an evil practice that must be stamped out*” summarizes many of the failings of alternatives to fee-for-service (FFS) payment systems. His article also offers several suggestions for improving FFS systems. However, even powerful arguments against many of the alternatives to FFS, does not make a convincing argument for FFS systems. In addition, there are significant misunderstandings in Professor Ikegami’s presentation of and use of United States payment methods, the role of private vs. public insurance systems, and the increasing role of “accountable care organizations.”

Keywords: Cost, Fee-for-Service (FFS), Accountable Care Organizations

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Citation: Koppel R. Two wrongs do not make a right: flaws in alternatives to fee-for-service payment plans do not mean fee-for-service is a good solution to rising prices: Comment on “Fee-for-service payment - an evil practice that must be stamped out?”. *Int J Health Policy Manag.* 2015;4(9):611–612. doi: 10.15171/ijhpm.2015.94

Article History:

Received: 25 April 2015

Accepted: 9 May 2015

ePublished: 11 May 2015

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Professor Ikegami provides a careful and wide-ranging critique of the *alternatives* to fee-for-service (FFS) payment systems.¹ Excellent arguments *against* the several alternatives to FFS, however, is not a necessarily a good defense of FFS, especially if the pro-FFS arguments are marred with several inaccuracies as applied to the United States, which is a key player in Professor Ikegami’s Editorial. Equally disconcerting, I see notable weaknesses in his proposals to improve FFS payment plans.

He starts with an excellent summary of the problems with FFS. Then, however, his presentation of the facts suggests lack of familiarity with the United States system, which he uses as a touchstone case. He says that “*cost escalations, inequality and high administrative costs*” are associated with each player “*seeking to game (I think he means “gain”) at the expense of the other.*” And he says that prices are set by the private health insurance plans.

Let’s look at these statements: It is true that each discipline seeks to increase its reimbursements, but it is not a zero sum game, and costs continue to increase across the board. “My specialty is more deserving than your specialty” is not the cause of escalation.^{2,3} Also, and more important, while private insurance companies are active in setting some rates, they act to bring prices *down*, not *up*. They want to pay as little as possible for as few services as possible. Even more directly, the majority of medical cost prices—and usually the determination of what will be “covered”—are not set by private insurance companies, but rather covered services are primarily set by agencies of the federal government: Medicare and Medicaid.^{4,5} Professor Ikegami appears to neither comprehend nor incorporate the rule-setting

functions of Medicare and Medicaid. Worse, he misses the overwhelming role of the big pharmacy industry—which has successfully lobbied congress to prevent many federal agencies from buying drugs at lower prices, and which also prevents importation of drugs from nations without captured regulatory processes, eg, most of the world except the United States. The cost of medications is a significant part of healthcare inflation, and is not a part of FFS.

We shall not review his superb critiques of the alternative payment systems: health maintenance organizations (HMOs), pay-for-performance, diagnosis-related groups (DRGs), etc. But we single out his argument against pay-for-performance as especially cogent.

We turn now to his recommendations for improving FFS. Alas, many of his recommendations have been tried and most have failed.

1. He says that public service doctors or doctors in capitated fee systems use sometimes use FFS as an alternative income source, eg, some doctors have dual appointments and see FFS patients who receive faster service; others doctors avoid the public health system entirely. While true, that is not proof that FFS is a solution. Rather it shows that some public systems underpay their doctors, some public systems are poorly supported, some doctors are greedy, some want a higher-paying clientele, and some dislike bureaucracies. But FFS is a workaround to poor policy, not a solution for better care. Also, there are many big systems, like Kaiser, that pay doctors a fine wage and do not allow outside FFS services.⁶
2. He says that FFS would improve if: (1) doctors were

obliged to mutually arrive at reasonable cost rates, perhaps assisted in their negotiations by experts, specialists, and proactive management; and, (2) we carefully defined each item and set clear standards for consultations, acuity levels, staffing levels, follow up care, etc. Unfortunately, the United States has tried this repeatedly, and the outcome is still a mess. It remains a political and financial conflict zone (as Professor Ikegami correctly notes). The Lutheran minister and sociologist Peter Berger once suggested that if cannibals and antivivisectionists were in a room together for a while, they would arrive at a compromise, such as it is not right to eat one's relatives. Medical specialties have been at that negotiation room for decades and no compromise appears imminent.⁶

3. Professor Ikegami suggests that the cost of medical devices will be driven down by competition. That is simply not true in the United States, at least. Regulatory capture, restrictions on entry into the market, and other factors have had the opposite effect.
4. Professor Ikegami writes that the introduction of new technologies will drive down prices. In the United States, the opposite has occurred. For large hospital systems, electronic health records (EHRs) cost hundreds of millions of dollars to purchase and billions of dollars to install.⁷ For ambulatory care and smaller hospitals the prices are of course lower, but still massively expensive. Magnetic resonance imagines (MRIs) are now common and cost many millions.

He says that electronic billing will make the process more efficient and transparent. In the United States, it is absolutely not true. First, because of the interplay of government regulators, insurance companies, and several (often conflicting laws) the prices are completely non-transparent.⁸ For example, a hospital might have a listed charge for a service (say, inserting an artificial knee) of \$35 000, but the various insurance companies will actually pay \$4000, and the copays from individual patients will vary from \$100 to \$31 000.^{8,9} Moreover, there will be additional fees from the anesthesiologist (with the same range of costs and payments), for operating room time, etc. In fact, most hospital bills are incomprehensible even to experts, and many are often flat out wrong.^{8,9}

Professor Ikegami raises many excellent points and is undoubtedly well-intended and knowledgeable about many national health systems. His critique of non-FFS systems is spot on. But his use of the United States as an example and as a source of lessons is problematic. In fact, the United States is moving increasingly toward "accountable care organization" payment plans, where the hospital or medical system assumes the cost and risk for all care. It is the exact opposite of FFS payment systems.¹⁰⁻¹³

In sum, his argument and hope for FFS as a solution to rising prices is not a convincing position.

Ethical issues

Not applicable.

Competing interests

Author declares that he has no competing interests.

Author's contribution

RK is the single author of the manuscript.

References

1. Ikegami N. Fee-for-service payment - an evil practice that must be stamped out? *Int J Health Policy Manag.* 2015;4(2):57-59. doi:10.15171/ijhpm.2015.26
2. Adams JL, Mehrotra A, William WT, McGlynn EA. Physician cost profiling — reliability and risk of misclassification. *N Engl J Med.* 2010;362:1014-1021. doi:10.1056/NEJMSa0906323
3. Weinberger SE. Providing high-value, cost-conscious care: a critical seventh general competency for physicians. *Ann Intern Med.* 2011;155(6):386-388. doi:10.7326/0003-4819-155-6-201109200-00007
4. US Government Accountability Office. Medicaid payment: comparisons of selected services under fee-for service, managed care, and private insurance. <http://www.gao.gov/assets/670/664782.pdf>. Accessed July, 2014.
5. Evans M, Demko P. Medicare's payment reform push draws praise and fears. *Modern Healthcare.* January 26, 2015. <http://www.modernhealthcare.com/article/20150126/NEWS/301269813>
6. Diane R. Rittenhouse DR, Shortell SM, Fisher ES Primary care and accountable care — two essential elements of delivery-system reform. *N Engl J Med.* 2009;361:2301-2303. doi:10.1056/NEJMp0909327
7. Koppel R, Lehmann CU. Implications of an emerging EHR monoculture for hospitals and healthcare systems. *J Am Med Inform Assoc.* 2015;22(2):465-471. doi:10.1136/amiajnl-2014-003023
8. Caldwell N, Srebotnjak T, Wang T, Hsia R. "How much will i get charged for this?" Patient charges for top ten diagnoses in the emergency department. *PLoS One.* 2013;8(2):e55491. doi:10.1371/journal.pone.0055491
9. Rosenthal E. The medical bill mystery. *New York Times.* May 2, 2015. http://www.nytimes.com/2015/05/03/sunday-review/the-medical-bill-mystery.html?_r=0
10. Sinaiko AD, Rosenthal MB. Increased price transparency in health care — challenges and potential effects. *N Engl J Med.* 2011;364:891-894. doi:10.1056/NEJMp1100041
11. Demko P. If fee-for-service is a problem, what's the solution? *Modern Healthcare.* February 25, 2015. <http://www.modernhealthcare.com/article/20150225/NEWS/150229939>
12. Japsen B. White house plans to shift Medicare away from fee-for-service; 50% of payments tied to quality by 2018. *Forbes.* January 26, 2015. <http://www.forbes.com/sites/brucejapsen/2015/01/26/medicares-bolt-from-fee-for-service-means-50-percent-value-based-pay-by-2018/>
13. Colbert J, Kocot SL, Brenner R, Monterastelli M, Seidman J, White R. Adopting accountable care: an implementation guide for physician practices. Engelberg Center for Health Care Reform at Brookings, Brookings Institute. November 19, 2014. http://www.brookings.edu/research/papers/2014/11/19-accountable-care-toolkit-physician-aco#recent_rr/