# Fee for Service, Health Insurance, and the Family Physician

E. Harvey Estes, Jr., MD
Durham, North Carolina

The traditional, unmodified fee-for-service payment system for medical services may have been appropriate in a time in which these services were simple and inexpensive, but the development of complex, labor intensive, specialized services, such as those provided by hospitals, and the inevitable increased costs, have caused this system to be an unsuitable mechanism for many patients and their physicians.

These inadequacies were widely recognized during the Great Depression of the early 1930s. The combined stresses of a lowered income and an unexpected hospitalization reduced many families to bankruptcy. As a response to this state of affairs, two major modifications of the payment system were developed and tried in the 1930s. One, the hospital (or health) insurance system, has become the predominant payment system in the United States. The other, the prepayment or capitation system, has developed much more slowly, but continues to gain support.

The hospital insurance system was a less radical change from the established fee-for-service mechanism than the prepayment system; therefore, it is not surprising that this method found earlier acceptance. This paper will advance the proposition that this system, like the unmodified fee-for-service system, has become unsuitable for many patients and primary care physicians and that other options should be sought for the future.

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## The Hospital Insurance System

What are the concepts that were tested and validated in the early 1930s? The most fundamental one is that, while the need for hospital care cannot be accurately predicted for a single *individual*, the need for hospital care for a large *group* of individuals can be predicted with considerable accuracy. If the required number of days of care for a group can be predicted, and the average cost of a day of care is known, then the total cost of hospitalization for that group over a given period of time can also be predicted.

If a group of 1,000 people are predicted to require $240,000 per year, or $20,000 per month, for hospitalization, then each individual can pay $20 per month into an insurance fund, which should contain sufficient funds to allow each individual unfortunate enough to need hospital care to withdraw enough to pay for that care. Each person pays a moderate, predictable amount, and no one bears the full brunt of the cost of a hospital stay.

A second concept is that the plan should be used to cover rarely encountered but very expensive events. This ensures that the operation of the insurance plan consumes only a small fraction of the collected premiums, the rest being available for payment of subscriber benefits.

### *Problem 1: Increasing Overhead*

In the earliest hospital insurance plans, only hospital bed costs were covered. It soon became obvious that surgeon and/or physician professional charges could be predicted with approximately the same precision as hospital bed costs.

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These too were expensive, yet rarely encountered, and were suitable for inclusion in an insurance plan.

At this stage hospital insurance covered inpatient services, but it did not cover outpatient services. This proved to be a powerful incentive for both patient and physician to overuse the hospital. In response, demand gradually developed for insurance coverage for both inpatient and outpatient services. Over a course of about 50 years, insurance coverage has been gradually extended, first to outpatient services, then to more routine and predictable services which most subscribers could afford to pay out of pocket.

The cost of processing an insurance claim is largely independent of the size of the claim. If an insurance company is able to process its claims for an average of $2 per claim, the overhead would be 0.1 percent of a claim of $2,000, but 10 percent of a claim for $20. Thus, as health insurance is extended to cover smaller and smaller items of service, which might once have been paid out of pocket, the result is an increase in overhead costs in relation to benefits paid.

### *Problem 2: Community Rating vs Select Group Rating*

Hospital insurance developed as a system that would cover all persons in a given community. The predicted rate of utilization of hospital beds for the entire community was used to predict the monthly cost of coverage. This is termed the *community* rate.

However, it soon became apparent that an alert, enterprising insurance company could compete more successfully with other companies by selecting a group of healthier than average people and restricting the purchase of insurance to this group. This group might be college students or employees of a given company. The group might also be those who have passed a health examination.

Those eligible to purchase such insurance will be relatively healthy people, and since the risk is shared among this selected group, the coverage can be provided at a cost below that to the community at large.

As several such groups are formed by several competing insurance carriers, each removing from the population a relatively healthy segment of people, there remains an unavoidable residual group who are poor, disabled, sick, or unemployed, who are either not insured at all or who must pay an unacceptably high rate for coverage.

This movement from community rating to a series of selected groups, each rated independently of all others, has led to a system in which health insurance is not available to those who need it most.

### *Problem 3: Need for a Defined, Provable Event for Payment*

A successful insurance plan must evolve a series of defined services which qualify for payment. These must be standardized from one place to another, and there must be some means of verifying that the service was performed.

These requirements were not difficult to meet when insurance coverage was restricted to payment for hospital bed costs. A day of hospital care was approximately the same in Boston as in Atlanta, and the provision of the service could easily be verified. The same is true of charges for surgical services. A cholecystectomy is a fairly standard procedure, and it can be verified by the dozens of people who participate in its performance.

As hospital insurance becomes health insurance and payment is extended to a variety of outpatient services, problems soon emerge. Primary care is especially difficult, because the services cannot be precisely defined, and the delivery of these services often cannot be documented.

As a proxy measure of such services, the office visit is often used as a unit of service. This may be three minutes in length and a relatively trivial event, or it may be an hour in length and one of the most important events in the patient's life. Such services as counseling, advising, prevention, and caring, which are the backbone of primary care, are services that defy definition and usually cannot be verified.

It is easy to understand why insurance companies, when faced with the necessity for providing payment for such services, have adopted defensive tactics to avoid large financial losses. The first tactic is to exclude coverage for such services. This was the most common response of insurance

carriers over several decades, as these companies recognized the great potential for abuse and for financial disaster.

As external pressures forced consideration of such coverage, another tactic was employed. The lowest possible value was placed on such services. Most primary care physicians will recognize the wide use of this technique and its combination with the previously described tactic of noncoverage. For example, most insurance plans do not cover preventive or counseling visits. There must be a complaint and a medical diagnosis for the visit to be eligible for payment. Even when these requirements are met, the allowed fee is usually minimal in relation to those allowed for other services.

Accepting that there is a genuine need for standardization or definition of services and for a means of external validation of the delivery of these services, it is easy to understand the behavior of insurance carriers in using these techniques. However, the primary care physician faces an almost insoluble problem under this system. Those aspects of primary care that are of the greatest importance, the caring component and the preventive component, are either not covered at all or are covered at a minimal value.

At the same time, services that are easily defined and easily documented, such as technical and surgical procedures, are generally well rewarded. This has created a significant difference between the income level of primary care physicians and that of their colleagues in secondary and tertiary care.

These differences are not confined to large services such as a surgical procedure. Relatively small, yet easily defined and verifiable services, such as laboratory tests, are well covered under most insurance contracts.

### *Problem 4: Customary, Prevailing, and Reasonable Charges*

Insurance companies must develop a method for setting the maximum allowable payment for a given service. Some use a fee schedule in which a fixed price is paid for a given service regardless of the physician's charge. Others have allowed payment of charges that are in conformity with those of most physicians in the area (usual, customary, and reasonable charges).

In 1965, Title XVIII of the Social Security Act (the Medicare Act) specified that payments under the act would be in conformity with the customary charges for such services and the prevailing charges in the area. From this has evolved the customary, prevailing, and reasonable (CPR) system of determining allowable payments.

First, the physician cannot charge the Medicare patient more for a given service than would be charged a non-Medicare patient. Next, there must be a determination of the prevailing charge in the area. This is done by the fiscal intermediaries that administer this program for the federal government.

The intermediary receives all charges from various physicians in the area. For each defined service, the charges submitted by area physicians are arrayed in order of amount from lowest to highest. Medicare defines the 75th percentile level within this array as the upper level of the allowed payment. Other insurance companies might allow payment up to the 90th percentile.

All charges received by the intermediary or insurance company that are below the established level will be paid, and those above this level will be reduced to the established upper level. These lists are generally kept secret, but physicians can probe the system by submitting higher charges until the fiscal intermediary begins to reduce payments below the charged amount.

Delbanco et al[1] have documented that physicians performing less common services, who also perform a high percentage of these services in a given geographic area, can have a very prompt and large impact on the customary or prevailing rate for these services. In this study, two surgeons were able to cause a $500 increase in the allowance for coronary artery bypass surgery over a period of two years.

Contrast this ability of the cardiothoracic surgeon to modify his or her payment level with that of a family physician in the same community. The cardiothoracic surgeon is one of a small group of physicians performing bypass surgery and personally performs about one quarter of the procedures in the community. The family physician is one of several hundred performing the common service defined as office visit. He has negligible control over the level of payment for this service.

Those performing unusual procedures and serv-

ices have had a large impact in increasing their fees over time, while those performing common primary care procedures and services have had little or no control over their fees. This has produced a gradual widening of the income gap between primary care physicians and those performing more unusual procedures, especially complex surgical procedures.

### *Problem 5: Differential Payment Allowances Between Generalists and Specialists*

In most respects the current payment system affects family physicians, general internists, and general pediatricians alike, but in one respect the family physician is treated differently.

Many insurance companies established separate payment schedules for general practitioners and specialists such as internists, pediatricians, surgeons, and obstetrician-gynecologists. As family physicians emerged from the new residency programs established in the late 1960s and 1970s, these physicians were grouped with the general practitioners, who traditionally had a lower fee structure than the specialist groups.

Thus two physicians performing the same service, such as a normal delivery, are frequently paid very different amounts. The obstetrician-gynecologist might be paid an amount twice that of the family physician. The same is true for many other services, such as setting a simple fracture, suturing a laceration, and so on. In each case, the "specialist" is paid more, even though the family physician is also a specialist and is very competent to perform the service.

This payment pattern has recently been challenged in the courts, and in one case a federal court has ruled that this practice is not legal and must be modified.

### *Problem 6: Loss-Leader Primary Care*

Most surgeons are consultant surgeons, receiving their patients by referral from their professional colleagues. However, there are some who for various reasons do not receive their patients by referral. Some of these perform primary care as a loss leader. This primary care can be done for very low fees because surgical cases are identified during the course of seeing primary care problems that can lead to relatively high surgical fees.

This pattern is not confined to surgical practice. Obstetrician-gynecologists also perform in this fashion. A number of women are seen for routine care, minor illnesses, and annual checkups, and some of these patients are found to need hysterectomies and pelvic repairs.

The same can be seen in internal medicine or family medicine, where the laboratory, the endoscope, and/or the electrocardiograph machine become the high-profit service, substituting for the surgical procedure.

### *The Impact on the Family Physician*

From the preceding discussion, it can be seen that the health insurance system, which has been the predominant payment system for the past several decades, has developed a number of flaws. These are of sufficient importance that family physicians might question whether the system should be extended into the future.

It should be emphasized that the above problems are almost specific in their impact on the primary care physician. The secondary and tertiary care physician, who traditionally performs highly technical services, tends to benefit from most of these problems.

The family physician suffers the following effects:

1. *Many of the services the family physician is taught to value highly and to provide to his/her patients cannot be paid for under most insurance plans.* The caring functions, the preventive functions, and the counseling functions that he/she has been trained to do are often specifically excluded from payment.

2. *Those services that can be paid are paid at a low level.*

3. *Having been locked into an unfairly low payment structure, the family physician is unable to escape.* This discrepancy is widening instead of improving.

4. *The family physician is competing with other practitioners who are able to use primary care as a*

*loss leader*. The family physician has no offsetting high profit services.

As young family physicians emerge from training programs and enter practice, they are faced with some unpleasant options relating to their location and their style of practice.

They can practice in affluent areas, in which Medicare and Medicaid patients are a small segment of the practice, and in which patients can afford to pay out of pocket for preventive and counseling services; or they can practice in areas of geographic or economic need, and face a much lower standard of living than most of their colleagues.

They can spend the time required for counseling, prevention, and the caring functions of medical care and suffer financially, or they can ignore their training and see large numbers of patients, allowing their behavioral and preventive skills to atrophy.

For the family physician, the above picture is bleak. It is critical that this relative financial picture of family practice be substantially improved or corrected, or the efforts of the past ten years will be for naught.[2,3] If family practice trainees are not able to survive in economically borderline areas, then one very important advantage of the specialty, its ability to disperse its practitioners into areas of social need, is threatened.

For the past ten years there has been heavy federal support of family medicine training programs. The model practice units associated with these programs are generally unable to recover more than one third to one half of the cost of their operation. This is related to inefficiencies associated with the educational process, but it is also related to the financial disadvantages described above. As federal subsidies for medical training programs are phased out, it is extremely important that model practice units become more self-sufficient.[4]

## Are There Alternatives?

Most physicians, including most family physicians, have defended the current payment system vigorously, seeing it as the only available alternative to a centrally controlled, highly regulated federal health system. Prepayment systems have also been viewed as highly centralized and regulated systems, only slightly more acceptable than a federal takeover of medical care.

Recent years have demonstrated that private enterprise can sponsor excellent, well-managed prepayment systems, that these can be highly decentralized, and that they can improve the income of the family physician/primary care physician in relation to that of the referral physicians while reducing overall health care costs.[5]

The newer procompetitive health insurance proposals, which have been popular with some health planners for several years, and which are now being introduced as proposed legislation, are especially favorable to the family physician.[6]

Family physicians should be active in supporting well-managed prepayment and competitive systems and should provide professional leadership in such programs, but also they should provide guidance and advice to the public and to legislators about these matters. Their help is needed in correcting the inequities inherent in the current system lest the ground gained over the past decade is lost.

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