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How Did We Get Here? A Historical Review of Payment Systems in the United States

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INTRODUCTION

With the emergence of health savings accounts (HSA), flexible spending accounts (FSA), high deductible plans and pay-for-performance (P4P) models, it gives a person pause to think about whether this “new frontier” of consumer-directed health plans in America is going to help solve the high cost of healthcare. When one reviews the physician payments system’s evolution over the past century here in the United States, one could easily say that we are headed towards a full circle in terms of patient responsibility. As the trend moves away from 100% employer sponsored health coverage and towards a greater financial obligation on the part of the patient, will Americans become more interested in and better informed consumers of their healthcare costs? Will consumer directed health plans be affordable for most Americans and, as patients become more responsible for higher portions of their healthcare bill, how will this impact the private practice economically?
Over the course of time American culture towards healthcare costs have become, for the most part, apathetic. To a great extent, the health industry was insulated from the competing demands of food, clothing, shelter and recreation on a family budget. Its cost was hidden in the products consumers bought from cars and radios to food, clothing and shelter. Families, blanketed in the rich first-dollar coverage plans, thought they never had to pay for doctors or hospitals (Califano, 1986). Prior to 1930, healthcare coverage was non-existent in the United States. Americans personally paid more than 90% of hospital and physician bills (Califano, 1986).

How did we get here? Through a search of the literature, the author will attempt to chronicle the evolution of major events shaping American physician payment systems and show how it has shaped the American attitudes towards the cost of healthcare. The paper will further attempt to discuss the financial impact of the emerging consumer directed healthcare plans on American families and the physicians who care for them.

**AMERICAN HEALTHCARE COVERAGE PRIOR TO 1930**

**The AMA and its Political Power**

In early American society medicine was relatively insignificant as an economic institution (Starr, 1982). Prior to the mid 1800’s, early American physicians were unable to support themselves solely by practicing medicine. They typically would support themselves by farming as a second occupation. Medical practice offered too small a financial return for many doctors to invest in a long professional education or for state legislatures to require one. Although there were some economic rewards based on competition, the more fundamental reason for the low income was the fact that most American families could not afford a doctor. Care of the sick generally remained within the family or community circle.
Prior to the late eighteenth century, the government played an active role in the economic life of medicine that included regulation of prices. However, after a physician sued for reasonable value of his services, price-setting shifted from law and custom to private contract. The states had nothing to do with private transactions between practitioners and their patients except in the case of malpractice. The federal government offered compulsory hospital insurance for merchant seamen; however, that was the extent of government involvement in the economics of medicine before the Civil War (Starr, 1982).

Medical societies tried to assume the functions of the government by establishing a fee table. As published in the *New England Journal of Medicine and Surgery* in 1825 “The law nowhere settles the precise value of professional opinion or advice…A fee table settles this”. However, the fee tables went unobserved and were of little importance as authorities (Starr, 1982).

Most physicians were paid by a fee per service or a fee per case. Some were retained for a fixed fee per year to provide all necessary care to a family, a plantation or the indigent members of a community called “contract price” (Starr, 1982). This sounds pretty much like early “capitation”. These physicians did not seem to care for it any more than our current day practitioners.

Physicians felt that they were being exploited under this system because of the unlimited services they might be asked to provide. The burden of risk was fully placed on the individual physicians; however, this spoke to the weak bargaining position of many doctors of that time.

In 1845, the American Medical Association was founded. Its aim was to primarily raise and standardize the requirements for medical degrees. It also enacted a code of ethics that denied fraternal courtesy to “irregular” practitioners (Starr, 1982). Up until this time, many practitioners were not formally educated. However, the AMA, with only 8000 members out of 100,000 doctors, had little impact during its first 25 years (Califano, 1986). By 1910, the AMA had
grown to 70,000, about half of the doctors in America. They began to create very potent political action groups alerting the public to false claims of patent medicines and becoming a force to be reckoned with in the legislative and regulatory process both locally and nationally. In 1905 the members of the association refused to accept ads in their medical journals for any therapeutic drug that was advertised directly to the public (Califano, 1986). The state and local governments, concerned about public safety and with the strong encouragement of the AMA, made the doctor’s prescription the key access to most drugs. Once pharmaceutical companies realized their market, doctors were perfectly positioned to hold exclusive power to prescribe.

**Supply and Demand Effect**

In 1910 the AMA supported an expose’ written by Abraham Flexner, an educator and reformer who devoted his life to the improvement of teaching and research in America ([www.bookrags.com](http://www.bookrags.com), 2006). Flexner exposed the false claims and shoddy curriculum, facilities and faculties of many medical schools. With the support of the AMA, states enacted stiffer licensing requirements for physicians. In the five years following Flexner’s report, 62 of the 131 medical schools in the country closed down and the number of new graduates fell 35 percent, from 5,440 to 3,536. The national supply of physicians in 1900, one for every 578 Americans, declined to one for every 730 Americans by 1920 (Califano, 1986). Over this same period of time, states passed laws to protect the public from untrained physicians, however, because it was taken for granted that doctors knew best about medicine and science, the laws delegated regulatory power to the state medical societies. Outside of the physician community, there was no oversight on the impact on the market place, hence, while overall consumer prices doubled between 1900 and 1928, the incomes of physicians quadrupled and doctors, whose average nineteenth-century income had put them in the lower middle class in America, began their climb up the ladder to status and money (Califano, 1986).
This was also a very exciting time in terms of medical breakthroughs. Up until the 20th century, hospitals were a place people went to die. Doctors could ease pain with morphine but otherwise, their role was to console the afflicted and get a priest to give last rites. In the early twentieth century, the leading causes of death were tuberculosis, diphtheria, influenza, pneumonia, cholera and gastrointestinal infections. Over the next few decades, public health strategies were developed with improved sewer and sanitation systems, pasteurization of milk, effective vaccines and mass immunization programs. In the early 1930’s the introduction of sulfa drugs and then penicillin, streptomycin and a host of others aseptic modalities dropped the death rate for these diseases by 43 percent (Califano, 1986). As death from infectious diseases plummeted, new killers such as heart disease, cancer and stroke emerged. With the success of major public health strategies and the growth of new killer diseases appearing, this was a prime backdrop for increased health care costs (Calafano, 2006).

**Opposition to National Health Care Coverage**

By the late 1920’s the core of the healthcare industry; physicians, hospitals, medical education, state licensing and some early medical research successes were in place and humming along. What was needed was funding to keep this business of medicine flourishing. From about 1913 to 1919 there was modest effort to promote national health insurance. The AMA originally supported it but they quickly realized that it could weaken their political stronghold and lower their fees. Samuel Gompers, president of the American Federation of Labor, saw a national health plan as a direct threat to union-sponsored insurance programs which helped build union membership. Together the AMA and the Federation of Labor opposed the development of national health insurance and the efforts failed.
Hospitals greatly improved their sanitary practices and found that many post-surgical patients were going home rather than to the graveyard. As the perception of hospitals and doctors improved, hospitals got more expensive as they shifted from housing the sick to healing the sick.

With the advent of research and improved medical care, hospital costs began to rise, particularly for extended hospital stays.

**The Great Depression**

By 1929, illnesses requiring hospitalization accounted for 50 percent of all medical expenditures (Califano, 1986). The stock market crash of 1929 sent the economy into a tailspin ushering in an economic crisis of unprecedented magnitude. As the Depression deepened, hospital occupancy rates dropped because most people had no way to pay for medical care. Some hospitals, seeking a way to develop a stable source of revenue, set up prepayment “service” plans where members would pay a monthly fee and then be eligible for free hospital services if they needed care (Quadagno, 2005). One such plan was established in Dallas, Texas. Baylor University Hospital initiated a plan for 1,250 schoolteachers where they paid fifty cents a month and received up to twenty-one days of hospital care each year. Other Dallas hospitals began to offer similar but competing plans and shortly thereafter, the model began to spread to other communities across America. (Raffel, 1994)

**BLUE CROSS/BLUE SHIELD PLANS EMERGE**

In 1932, three years after the development of the Baylor University Hospital Plan a community-wide plan was developed in California. Under this plan local area hospitals agreed to provide services to any subscribers who paid a premium to the plan instead of directly to the hospital. In this way, hospitals did not have to compete. Although the AMA lashed out against them, the American Hospital Association (AHA) helped hospitals establish these group plans and
succeeded in rescuing many floundering community hospitals. Prepayment plans became the precursor to what would become Blue Cross (Quadagno, 2005). As hospitals began to embrace these non-competitive plans, they began to market them on a non-for-profit basis. They became known as Blue Cross plans and by 1937, these plans had 800,000 subscribers while individual hospital plans had only 125,000. By 1940, with the help of the American Hospital Association, Blue Cross plans grew to six million (Califano, 1986).

Commercial carriers began to feel the pressure to underwrite health coverage. Once they saw that Blue Cross was successful, in 1934 they began to offer coverage for hospitalization, then in 1939 for surgery. Typically, commercial carriers would pay their subscribers. The cash payments received by the patients could be used to pay either the hospital or the doctor. By 1940, commercial insurers covered 3.7 million people (Califano, 1986). Blue Cross plans, which covered hospitalization only, looked for ways to compete with the commercial carriers. At the same time, the AMA was looking for ways to stop states like California from instituting mandatory government health insurance to cover doctors and hospitals. Working together in the late 1930’s and early 1940’s, the AMA and Blue Cross plans established Blue Shield plans to compliment Blue Cross. Initially, it covered doctors’ fees for hospitalizations only but eventually, services of all kinds were covered. Participating doctors of the Blue Shield plan had to accept the amounts the plans set as full payment only for low-income subscribers; they were free to balance bill to others. This acted as a minimum security income program for physicians. Those who chose not to be participating could charge Blue Shield subscribers whatever they wished for any income level patient. The patient would then have to make up the difference between the doctor’s charge and what Blue shield paid. Commercial carriers often contested the unfair advantage of Blue Cross and Blue Shield but soon realized that their alliance should be with the doctors and hospitals they pay rather than to the patients who bought their insurance (Quadagno, 2005).
Before anyone realized what was happening, the health insurance industry was positioned to minimize competition, control prices, direct usage and ease bill collections for doctors and hospitals. In the case of Blue Cross and Blue Shield, the hospitals and the doctors controlled rates, coverage and payment (Califano, 1986).

**UNION BENEFITS AND THE SLIPPERY SLOPE**

It all started innocently enough in 1941 when the Chrysler Corporation agreed to set up a group health plan under its recently recognized union. Initially the plan covered only hospitalization and the employees funded the plan 100% through payroll deductions. Nobody really thought that by covering hospitalization it would sway the medical services toward the most expensive level of healthcare. The initial thought was to protect workers from catastrophic hospitalization. Nothing really changed much until 1950 when Ford Motor Company, the “big daddy” of the auto industry, came up with a plan to pay 50% of the employee’s health plan and include coverage for doctor’s services for medical and surgical fees. Under competitive pressure, Chrysler followed suit and three years later, “upped the ante” to include retirees, although, retirees had to pay the full cost of the coverage. In 1961, following Ford Motor Company, Chrysler paid 100% for employees and their dependents coverage and 50% for retirees. In 1964, Chrysler, targeted for a strike by the United Auto Worker’s Union (UAW), agreed to first-dollar coverage (no deductibles) for outpatient psychiatric care as well as 100% paid coverage for its retirees and their dependents. The treasury door continued to open wider and wider not realizing the health care costs would constitute up to 40% of their healthcare cost. In 1967, a prescription drug program for employees and dependents was added. Company paid coverage for retirees came in 1971. Next came dental coverage in 1973 (Califano, 1986). Collective bargaining allowed all unions to extract not only higher wages for it workers but an array of other benefits, not the least of which was healthcare coverage. Soon non-union employers also began offering medical insurance to
lure employees (Roueche, 2005). First dollar coverage and 100% paid healthcare benefits began to insulate the American worker from any sense of what health care cost. (Califano, 1986) When the Supreme Court ruled that employee benefits, including health insurance, were a “legitimate part of the labor-management bargaining process” in 1949, the practice of offering health insurance to employees became firmly entrenched. (Roueche, 2005). Healthcare coverage became the “premier” fringe benefit of the 1960’s and 1970’s eliminating worker incentives to seek efficient care. Likewise, in 1967, plans agreeing to pay “usual, customary and reasonable” fees to physicians eliminated physician incentives to hold down fees and hospitalization (Califano, 1986).

**THE ADOPTION OF MEDICARE AND MEDICAID**

President Franklin Roosevelt wanted to include some form of medical coverage with the original social Security Act of 1935; however, worried about jeopardizing his entire bill, Roosevelt decided to put national health insurance on hold (Quadagno, 2005).

President John Kennedy had made health insurance for the elderly a major issue during his 1960 presidential campaign, however, his program was squelched by Republicans and southern Democrats (Califano, 1986). It was not until President Johnson made Medicare a priority in his first congressional speech in early 1964 where he said, “We are going to fight for medical care for the aged as long as we have breath in our bodies”. (Califano, 1964).

The Kerr-Mills legislation was constructed out of pressure from the increasing aged population and their working children. Under the Kerr-Mills legislation, the federal government would provide funds for hospitalization for the aged, limited to those in severe financial needs. Although President Johnson wanted more for the aged as well as the poor, he knew it would be a tough sell and that some compromises would have to be made with the physicians, hospitals and insurance companies. One provision already agreed upon was to pay hospitals their “reasonable
costs”. In August of 1964, Johnson added the Medicare bill onto a bill providing for increased Social Security benefits. The Senate tried to abandon the Medicare amendment but President Johnson would not give in so the bill died. Senator Mills promises to give Medicare first priority in the next session. In the next session, Mills proposed combining the Democrats’ hospitalization-insurance bill for the elderly with a Republican alternative that would create a voluntary program of surgical/medical insurance to be paid through individual premiums and general revenues (Medicare Part A & B). In addition, Mills suggested changing eligibility for the Kerr-Mills program to include most people on welfare and the medically indigent without regard to age, calling it Medicaid. Johnson agrees to the proposal. The compromise was to agree to “usual, customary and reasonable” fees for doctors as well. In 1965, the adoption of Medicare and Medicaid was passed (Califano, 1986).

**FEE-FOR-SERVICE**

As stated, the “Usual, Customary, and Reasonable” (UCR) fee screen system was used by Medicare and Medicaid programs as well as other third party insurers. Under UCR, the allowable rate of payment for a covered service was the minimum of the actual billed charge and the values of two fee screens. The first of these, called Level 1 screen or “usual” fee was the physician’s median or modal charge for the service, generally computed using charge data from the prior year. The second, called Level 2 screen or “customary” fee was a percentile of the distribution of Level 1 screens of all physicians in the same geographic area. In special cases, such as those requiring an unusually complex treatment, the insurer may have allowed a charge in excess of the fee screens calling it "reasonable" (Langwell, 1986).

A study investigating the inflationary impact of UCR, using physician pricing behavior, found that physicians engaged in inflationary pricing under UCR in order to increase future fee screens. The evidence suggested that unrestrained UCR systems encouraged physicians to increase actual
current charges in order to raise future allowances. (Yett, 1981) From 1965 to 1981, the percentage of expenditures on physician services covered by third parties increased from 39 to 62 percent (Gibson, 1982).

Since under fee-for-service doctors and hospitals made more money the more services they provided, they had an incentive to maximize the volume of services. Third-party fee-for-service payment was the central mechanism of medical inflation (Starr, 1982). Under such a system any institution or doctor that reduced costs would reduce income, possibly for years to come, since the record of past costs affected future reimbursement levels. Thus, hospitals and physicians were encouraged to solve financing problems not by minimizing costs but by maximizing reimbursement. What was individually a solution for hospitals and physicians was, in aggregate, a problem for society (Starr, 1982).

The alternative to UCR involved basing payment levels on a fee schedule. A fee schedule is a fixed set of dollar values that represents the insurer’s maximum allowable rate of payment for a specified set of services.

**EFFORTS AT COST CONTAINMENT**

Though overshadowed by the huge expansion of the Blues and commercial insurance, direct-service prepayment plans finally gained a stable and independent position in the decade after 1945 (Starr, 1982). Some of the old industrial plans began to decline. The workers began to feel that the “company” hospitals were too self-serving and not focused on quality care. The workers began to negotiate for direct cash payments so they could choose community hospitals if they wanted to.
Physician sponsored plans and cooperatives were also popping up but did not get much support. In 1946, 56 of the 368 medical groups with three or more doctors offered prepayment plans of some kind but they were not eager to expand them because of the financial risk (Quadagno, 2005).

The big breakthrough for HMO’s came in 1942 when Henry J. Kaiser formed two, one to provide medical services for Kaiser employees in Portland, Oregon, the other to serve workers in Richmond and Fontana, California (Califano, 1986). The program Dr. Sidney Garfield had set up for his workers at the Grand Coulee Dam in 1938 had impressed Kaiser (Starr, 1986). During World War II Kaiser decided to carry over the same practice of providing comprehensive health services to his shipyard and steel mills. The plan threatened to compete with private practitioners but because of the war, local hospitals and physicians were much overburdened and offered little opposition (Starr, 1986). Kaiser and Garfield then brought the concept to other work sites on the West Coast. As the war ended, the work forces declined and the plans had almost closed when late in 1945, the decision was made to open Kaiser-Permanente Health Plans to the public. Kaiser believed that he could reorganize medical care on a self-sufficient basis, independent of government, to provide millions of Americans with prepaid and comprehensive services at prices they could afford. (Califano, 1986)

Although Kaiser Permanente proved to be successful, until the 1970’s HMO’s were not able to shake the label of socialized medicine that the fee-for-service world continued to lament. Big business stayed away from HMO’s, especially during the anticomunist fever of the 1950’s and 1960’s (Calafano, 1986).

By the end of the 1960’s, the costs of the war in Vietnam and rising prices for energy and health care had created record budget deficits and inflation ending two decades of economic growth and
When Richard Nixon became president in 1968, he proclaimed that the healthcare system faced a “massive crisis”: “Unless action is taken to meet that crisis within the next two or three years, we will have a breakdown in our medical care system.” (Quadagno, 2005) However, the solution did not come from commercial insurance companies feeling that they must crack down on providers but simply that they must raise premiums and increase deductibles and co-insurance. The solutions were not going to come from Blue Cross either because they were interested in protecting the hospitals. In fact, when a Pennsylvania insurance commissioner held hearings to determine how hospital charges were calculated, Blue Cross officials refused to release their records. (Quadagno, 2005) Some concerted government response was required.

Between 1971 and 1974, Richard Nixon introduced his Economic Stabilization Policy. It would involve a mandatory wage-price freeze for 90 days followed by a 2-3 percent yearly limit on average price increases and a 5.5 percent cap on wage hikes. Medical care was singled out for special treatment with physicians’ fee increases capped at 2.5 percent annually and rises in hospital charges limited to 6 percent (Quadagno, 2005). The doctors responded to these fee controls by increasing volume, especially return visits and diagnostic tests (Starr, 1982). When the freeze was lifted for most goods and services, the controls remained on health care; however, when Congress lifted the controls on healthcare, an immediate, sharp increase in physician fees and hospital charges occurred. Nixon’s staff soon realized that some formal program had to be established to monitor health care costs permanently (Quadagno, 2005).

A second stab at monitoring costs was included in the 1972 amendments to the Social Security Act. The most notable change was to extend Medicare to people who were eligible for disability insurance and it was incorporated into the 1972 amendments after strong opposition from the AMA. The amendment also allowed Medicare beneficiaries to choose coverage through a health
maintenance organization. In it was an unnoticed provision which called for professional
standards review organizations (PSROs) to be created to review hospital admissions and develop
“standard practices” (Law, 1976). When the AMA got wind of the proposal, they countered that
the monitoring should be done by state medical societies. The Senate Finance Committee
rejected it as “totally self-serving” (Quadagno, 2005). “It would, in effect, turn responsibility for
review over to state medical societies with virtually no accountability” (Iacocca, 1988). The
Finance Committee proposed a stricter method of ensuring accountability through PSRO’s and
would be responsible for all medical care provided to Medicare patients to ensure that only
medically necessary services were provided (Quadagno, 2005). Persistent opposition from
physicians caused the PSROs to flounder, and five years later no statistical profiles on length of
stay for various diagnoses had been established and no sanctions against hospitals that deviated
from national standards had been applied (Tuohy, 1999)

The fight for national health insurance continued to surface. In 1968 Walter Reuther, President of
the UAW, made a speech before the American Public Health Association. He charged that the
existing health care system was disjointed, antiquated, and obsolete. The only way to remove
economic barriers to care and contain health care costs was through national health insurance
(www.time.com, 2006) In 1969 he pulled the UAW out of the AFL-CIO and had to show
what the UAW could achieve on its own. He opened an office in Washington, DC and
organized the Committee of 100 for National Health Insurance. The committee consisted of trade
unionists, social activists, college professors, physicians, and liberal politicians. Among them was
Senator Ted Kennedy (Lippman, 1976). In 1969, the committee drafted their first model bill that
would fold public and private health plans into a single federal program. There were concerns
that the plan may be labeled as socialized medicine so the committee promised to reorganize the
health care system “in an American way” without taking over hospitals or turning physicians into
government employees (Quadagno, 2005). When Kennedy assumed the chairmanship of the
Senate Health Subcommittee in 1971, he introduced his Health Security bill. Unfortunately, his grand plan was thwarted by the Chappaquiddick Island scandal. Kennedy lost on every key issue during the next ten months (Quadagno, 2005).

Kennedy’s fall from grace was short lived and Nixon perceived Kennedy as a formidable political opponent despite his personal troubles so Nixon announced his own health program. Nixon’s National Health Insurance Partnership Act took a regulatory approach that encouraged the private insurance market. It centered on an employer mandate where employers would either provide health insurance for their employees directly or pay taxes to insure them through a government program (Quadagno, 2005).

The employer mandate won the endorsement of the Washington Business Group on Health, an organization whose primary mission was to bring together top-level executives to exchange ideas on cost-management techniques and help firms design benefits packages that could reduce health expenses (Starr, 1982). Nixon’s plan would also provide planning grants and loan guarantees for prepaid group practices called health maintenance organizations (HMOs) (Starr, 1982).

David Ellwood, a Minneapolis physician who directed the American Rehabilitation Foundation, proposed the original HMO idea. (Brown, 1983). Ellwood argued that the current health care cost crisis was caused by perverse incentives that encouraged costly treatment and penalized physicians who returned patients to health. He envisioned a system where primary care doctors would serve as gatekeepers who would evaluate patients before they saw specialists or received costly tests and high-technology care. Ellwood cleverly repackaged the prepaid health plans that had been in existence since the 1940’s, called them HMOs, and sold them as a pro-market solution. HMO’s would be non-profit and would use any revenues saved to improve health care or increase the number of insured patients (Bennehum, 1999).
National health insurance was an important issue in the next election; therefore, Nixon needed an alternative to Kennedy’s proposal. Ellwood’s plan didn’t require an immediate expenditure of large sums, and it involved the private sector. The White House approved the initiative, and in a special health message to Congress in February of 1971, Nixon made HMO’s the centerpiece of his health policy (Brown, 1983). HMO’s had the support of corporate employers who were disturbed by rising health care costs, therefore, the Health Maintenance Organization and Resources Development Act of 1973 was enacted. The HMO act authorized $375 million in planning grants and loans to encourage the development of new HMOs. It also required companies that had 25 or more employees and that provided health insurance to offer an HMO option (Quadagno, 2005). HMO’s that received federal support would have to offer comprehensive benefits, charge their enrollees the same “community rate,” and allow open enrollment at least once a year, regardless of an individual’s health. These regulations made HMO’s the most heavily regulated part of the health insurance system placing them at a competitive disadvantage with other insurance plans dampening their growth. A provision allowed Medicare beneficiaries to enroll in HMO’s, but only two chose to participate (Quadagno, 2005).

In 1979 the number of doctors in America grew from 8,000 to 16,000 per year. Thinking that the supply of doctors would be needed due to the increase in the elderly population, the government created amendments to the Health Professions Educational Assistance Act to provide funds to encourage medical schools to double the number of physicians graduating. The supply and demand philosophy that more doctors means more competition, hence, lower fees was not how it played out. What was not expected was the impact on physician control of prices and services and the explosion of specialization. The combined force of both those elements was huge. More doctors meant higher costs and more specialists meant a richer mix of medical services, a combination that sent the cost of health care through the roof (Califano, 1986).
### Capitation

Under the capitation system, which still exists today in some markets, primary care physicians are often paid a pre-agreed upon rate for all physician services required by contracted patient per month. (PMPM). This system was aimed at lowering medical costs by making the primary care physician responsible for all costs incurred for the patient. The PCP’s or “gatekeeper” role was to order tests and refer to specialists on an as needed basis. The cost of all services given to the patient by specialists and testing facilities were directly deducted from the per member per month fee. This was surely going to hold down costs, so it was believed, but at what price to the patient in terms of quality of care? This was the looming question among the public at large. To address this issue, preferred provider organizations (PPO) shortly developed as another offering.

### Preferred Providers Organizations (PPO) and Discounted Fee-for-Service

Preferred Provider Organizations were developed to contract with hospitals and doctors for deep discounts in exchange for listing them in their preferred provider directory. Why would physicians accept a discounted fee schedule when it usually implies lower net revenue (Sloan, 1978)? “The empirical evidence seemed clear that direct payment to physicians reduced bad debt and collection costs in many cases and that this warrants, in the minds of physicians, making the decision to discount their usual charges in order to receive direct payment “ (Langwell, 1986). Many physicians were under the impression that they could make up the discounts by increasing volume accomplished by being published in the preferred provider directories.

To decrease utilization significant controls were placed on both the patient and the doctor. Most procedures required pre-authorization in order for the services to be paid. Patients were obligated to use the physician panel contracted by the health maintenance organization. If they went outside the network of preferred providers, the out-of-pocket costs were higher to the patient.
Freedom of Choice Debate

Most patients choose their family doctor. Beyond that, the family doctor chooses all the specialists and surgeons, who in turn select the anesthesiologists, radiologists, pathologists, hospitals, etc. The debate, however, became whether the choice of the family doctor was an informed choice. Consumers, both patient and employers, were unable to make an intelligent choice because it required information that was strongly denied to them. The consumer had no information about quality or price. There was no information about individual doctor’s practices, morbidity and mortality rates for different disease and methods of treatment as compared to other doctors. There was no information on which doctors performed a sufficient number of surgical cases for a particular disease or what the costs and outcomes would be at the hospitals in which they perform their surgery (Califano, 1986).

In April of 1985, the Department of Health and Human Services issued a regulation requiring public access to statistics showing how well hospitals perform including admission rates, lengths of stay, infection rates and death rates for different illnesses. The information is made available by peer review organizations created by Congress to monitor hospital’s service to Medicare patients. In 1990, Massachusetts was the first state to offer a comprehensive program to give patients access to information about the education, training, and experience of all licensed physicians. The “Physician Profiles” program is one tool patients can use to make the right health care decisions. The physician specific information available on the Physician Profiles site are education, training, medical specialty, professional demographics, research or publications, malpractice claims paid in the past ten years, hospital discipline in the past ten years, criminal convictions in the past ten years and disciplinary actions of the Board of Registration in Medicine in the past ten years. Additionally, credentials such as license number, license renewal date and
date renewal was received can also be accessed. (www.profiles.massmedboards.org) This is where we are as of today, 2006

THE NEW FRONTIER

Here in 2006, Federal law requires Medicare payments to physicians to be modified annually using a formula known as the sustainable growth rate (SGR) (Clemens, CMS 2005). Because of flaws in its methodology, the formula has mandated physician fee cuts in recent years. Absent additional congressional action, the SGR will continue to mandate physician fee cuts for the foreseeable future (www.texmed.org, 2006).

Medicare payments to physicians cover only about 65% of the actual cost of providing patient care. The SGR links physician payment updates to the gross domestic product (GDP), however, fluctuations in the economic conditions as measured by GDP have very little relationship to the cost of providing patient services. This is the recognized flaw in the SGR formula (www.texmed.org, 2006).

The SGR formula was originally designed to control utilization by reducing physician fees. The primary drivers of utilization, however, are new or improved technologies, increased beneficiary awareness of potential treatment options, and a general shift from inpatient to outpatient care. Physician behavior controls none of these factors (www.texmed.org, 2006).

Pay-for-Performance (P4P)

Physician pay-for-performance programs for the federal government and the private sector are in various stages of proposal, development and implementation. The Centers for Medicare & Medicaid Services (CMS), the Medicare Payment Advisory Commission (MedPAC), members of
leading congressional committees, health plans and large employers are supporting pay-for-performance programs (MGMA position paper, 2005).

Health Plan Pay-for-Performance (P4P) programs are designed to reward physicians for meeting specific quality measurements. Quality improvement programs have been incorporated into many health plan contract models and typically follow one of two common designs: 1) bonus payments or 2) tied to future payment increases. According to the *Massachusetts Physician Incentives Guide 2005*, plans use a variety of methods to measure quality, including: patient satisfaction, use of preventive care screening, and patient-safety related indicators. While many of the programs include patient experience, it is typically weighted less than clinical quality measures (Rosenthal, 2004). The Health Plan Employer Data and Information Set (HEDIS) preventive measures are typically used in incentive programs, for example: mammography, immunization, and secondary prevention for chronic illnesses. Implementation and use of information technology (IT) such as electronic health records and electronic prescribing are some measures aimed at improving patient safety (Massachusetts Medical Society Lecture, 2006).

Nationally, the Centers for Medicare and Medicaid Services (CMS) are conducting a pay-for-performance (P4P) demonstration project with ten large group practices. The groups will continue to be paid on a fee-for-service basis, but will be eligible for rewards based on their performance in improving patient outcomes by coordinating care for chronically ill and high cost beneficiaries in an efficient manner. The P4P initiatives CMS is conducting are being watched carefully by experts who note the need for a single set of measures (Managed Care Week, 2005).

CMS launched the Physician Voluntary Reporting Program (PVRP) on January 1, 2006. In October 2005, CMS announced the PVRP, consisting of 36 evidence-based, clinically valid measures that were part of numerous guidelines endorsed by physicians and medical specialty
societies. The core starter set consists of 16 measures, which will significantly reduce the number of measures applicable to any individual physician practice specialty. These 16 core starter set measures are a subset of the initial 36 measures. It is anticipated that participating physician practices will begin to receive data feedback on the 16 core measures in December of 2006. CMS intends to further pursue development and refinement of the remaining 20 measures within the 36 measures. As other measures are developed by medical specialty societies, it is anticipated that the PVRP will be expanded to include these consensus measures after they are endorsed and implemented (Massachusetts Medical Society Lecture, 2006).

There is speculation that legislation introduced in Congress will eventually tie P4P into the sustainable growth rate (SGR) formula that could increase reimbursements for providers who meet the desired standard for patient outcomes. Under such a system, providers not meeting the standard could see reimbursements drop (Peterson, 2005).

The American Medical Association (AMA) has developed five P4P principles that attempt to ensure P4P programs are positively structured and appropriately applied:

1. Ensure quality of care
2. Foster the relationship between patient and physician
3. Offer voluntary physician participation
4. Use accurate data and fair reporting
5. Provide fair and equitable program incentives.

Solid evidence is needed to establish that P4P actually contributes to higher quality and more cost-effective health care. Evidence supporting the value of such incentives in health care is, at present, limited (Massachusetts Medical Society Lecture, 2006).
New Product Designs

Employers have endured five consecutive years of double-digit premium hikes for standard health insurance for their employees (Rowland, 2006). New insurance models are being welcomed and appear to be very attractive to employers. More transparency about the true costs of health care and quality information is a consumer’s desire. New product designs include: high deductible plans, tiered co-payment structures and consumer directed healthcare plans. How these will work economically for the work force is still to be determined.

High Deductible Plans

The high deductible products merely represent a cost shifting to employees. Employers pay lower premiums and employees are expected to pay more costs up front when the service is actually delivered, giving employees a better understanding of the true costs of their health care service (www.massmed.org, 2006). Similar to non-deductible health maintenance organizations (HMOs), the primary care physician (PCP) will provide or arrange for health services. Referrals are usually required for most specialty care. Generally, this type of plan offers in-network preventive care benefits that are not subject to calendar year deductibles. Currently, high deductible plans can range in deductibles from $500 to $3000.

Tiered Co-Payments

Tiered co-payment structures were built on the philosophy that specialty care is more expensive than primary care; therefore, a higher co-payment for specialists will deter patients from bypassing primary care services when patients have a problem. The Massachusetts Medical Society (MMS) notes concerns about potential unintended consequences of access to care and the quality of care if patients seek care at inappropriate settings for their condition.

(www.massmed.org 2006)
Consumer-Directed Health Plans

The increase in product designs that attempt to empower consumers to make decisions about quality and costs of care are referred to as consumer-directed health plans. Innovative strategies such as reward points and personal health accounts, tax sheltered health savings accounts funded through payroll deductions are a key component of the new generation of plans (Rand, 2005).

**Health Savings Account (HSA):** Federal law requires HSAs to be combined with a health plan that has a minimum deductible of $1,000 for individuals and $2,000 for families. Employers may fund some or all of the employees’ HSA with employees having an option to also contribute with pre-tax payroll deductions. The HSA can be used to pay any federally defined healthcare expense and the pool of funds rolls over from year to year. The member retains full ownership of the account, even if they switch employers.

**Health Reimbursement Arrangements (HRA):** These accounts are available to any size group with contributions and maximum reimbursement defined by the employer who retains ownership of the account. It is not portable with the employee.

**Flexible Spending Account (FSA):** Employees contribute to the account based on the maximum dollar limit set by the employer. This option, which is pre-taxed, is not portable and ownership of the account resides with the employer. Generally, any money left in the account at the end of the year is forfeited.

Proponents of these plans argue that the cost containment value is that they give you an incentive not to use health care you don’t really need and to shop carefully for the care you do need. This new found cost-consciousness, as the theory goes, puts downward pressure on prices throughout the system. (Crenshaw, 2006) The concept does make the patient more of a consumer of health services and they may likely limit visits to the doctor and ask for generic drugs but there may be...
more who may decline preventive care (mammograms, cholesterol test, etc.), which may ultimately result in a sicker population (Fuchs, 2002).

In an article entitled “Collecting just got harder” from *Medical Economics* in May of 2005, author Robert Lowes published tips for physician offices in collecting from high deductible plan and consumer driven plan patients:

1. Scope out insurance coverage before the visit (pin down the deductibles)
2. Scrutinize that ID card. The card looks like a regular PPO but the giveaway is the absence of information.
3. Read your health-plan newsletters. New plans and explanations of the rules are usually found there.
4. Get the patient’s debit card number on file. At check-out, ask for the card number and explain that you’ll punch it into the card terminal at a later date once the explanation of benefits form (EOB) indicates the charge liability.
5. Move claims out the door within 24 hours. Since you have to wait for the EOB to bill the patient, don’t make you’re A/R problem any worse by delaying the billing process.
6. Collect past-due amount in the office.
7. Issue ultimatums. For elective visits, practices are starting to tell patients, “We can’t schedule your next appointment until you pay for the last visit.”
8. Consider letting somebody else collect. Rather than hiring an extra billing clerk to handle increased collection work, consider an outside agency.

**Conclusion**

It seems that the more things change, the more they stay the same. When one reviews the evolution of the health care delivery system in the United States, it could be concerning to realize...
that many solutions have been tried in some form or another and we continue to be in a healthcare crisis. It is difficult to determine at this stage of the game, if Americans are better informed or more discerning consumers of health services.

As compared to the insulation created during the post-war boom of unionized benefits, one could safely say that there is certainly a heightened awareness today. In a study conducted by benefits consultants at Watson Wyatt Worldwide, Watson found that among a group of large employers, seventy-two percent of the insured workers and their families accounted for only eleven percent of the employers healthcare expenditures and that four percent accounted for almost half, 49%, of the employer costs. Therefore, while a large share of the population, the low-cost group, could be influenced by economic incentives to curb healthcare spending, it would only affect a small portion of the overall costs. Meanwhile, the high-consuming 4 percent are really sick people and a $1000, or $2,000 deduction is not going to change their behavior very much. (Crenshaw, 2006)

What about affordability? The high deductibles and tax-sheltered options are great for those in the upper-middle class and higher who are savvy investors and have disposable income, however, it is going to be a stretch to believe that minimum wage workers and low to moderate-income families will be dishing out $1000 - $2000 a year for healthcare. A majority of American families are so focused on surviving day to day, paying the mortgage, buying food and making the car payment; it is not realistic to believe that they will have the energy or the inclination to capitalize on these types of plans. The basis of our health-care system is still employer focused and therefore, does not address the issues of the unemployed, underemployed, disabled and elderly consumers.

The new wave of insurance products is not enough to rein in healthcare costs and yet, the federal government still allows the healthcare crisis to sit squarely on the shoulders of society.
As consumers begin to carry the larger burden of healthcare costs, what will this mean for the private practice in terms of overhead costs and soaring accounts receivable? Well, more patients with high deductibles means more time spent trying to collect fees. While it would seem easy enough to swipe an HSA card at the front desk and call it a day, think again. How will your staff know what the patient’s deductible is? How will they know when the deductible has been met? Chances are you will have to wait for claim adjudication before you can bill your patient. Expect your days in AR to increase as well as your accounts over 60 days (Woodcock, 2006).

There will be a greater demand among physicians and administrators to simplify the health care payment system in order to hold down operating costs. Even with the availability of technological improvements in electronic medical records, automated appointment scheduling and e-mail communications, the labor-intensive aspects of insurance verification, credentialing, privileging, prescription management, referral authorization and more collection efforts, are taking its economic toll on the practice (Gans, 2006).

Establishing a single protocol for credentialing and privileging would substantially diminish staff time spent in this area. Having a single formulary and one set of disease management protocols, along with standardized communication practices would further reduce time. Other opportunities for cost savings could result from a standardized referral process, common medical record coding and documentation policies and a single methodology to submit insurance claims (Gans, 2006). It is not quite yet appropriate to determine that we have come full circle in terms of patient responsibility as compared to our ancestors back in the 1800’s but then again, I guess it depends on where you stand.

And the beat goes on.
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