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Getting The Price Right: How Some Countries Control Spending In A Fee-For-Service System

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ABSTRACT Although the US has the highest health care prices in the world, the specific mechanisms commonly used by other countries to set and update prices are often overlooked, with a tendency to favor strategies such as reducing the use of fee-for-service reimbursement. Comparing policies in three high-income countries (France, Germany, and Japan), we describe how payers and physicians engage in structured fee negotiations and standardize prices in systems where fee-for-service is the main model of outpatient physician reimbursement. The parties involved, the frequency of fee schedule updates, and the scope of the negotiations vary, but all countries attempt to balance the interests of payers with those of physician associations. Instead of looking for policy importation, this analysis demonstrates the benefits of structuring negotiations and standardizing fee-for-service payments independent of any specific reform proposal, such as single-payer reform and public insurance buy-ins.

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The rising costs of US health care make affordability—for consumers, employers, and governments—an elusive goal. Studies show that these expenditures are higher in the US than other countries not because the volume of service is higher but because prices are higher.^{1–3} One reason for the higher prices in the US is that private insurers typically do not have sufficient market leverage to control them,^{4–6} and there are dramatic price variations in the private market.⁵ Medicare has done better at controlling prices than private insurers have, but Medicare is limited by Congress in the degree to which it can negotiate prices.

In most countries with universal health insurance, physicians are paid on a fee-for-service basis, yet prices there are lower than in the US. As Miriam Laugesen and Sherry Glied explain, “Higher fees, rather than higher practice costs, volumes, or tuition expenses, are the main driver of higher US spending.”²

Among US policy makers, the response has been to focus on market competition, managed care, price transparency, and performance measurement. This response is grounded in the view that fee-for-service private practice and third-party payment saddle the health system with perverse financial incentives.

Beginning in the 1970s, managed care emerged as a way to phase out fee-for-service physician payment and achieve greater efficiency.⁷ US health care policy has been on a fifty-year chase to develop innovative organizational forms of health care delivery and financing.⁸

The latest “fix” in response to the unhealthy combination of fee-for-service and third-party payment was included in the Medicare Access and CHIP Reauthorization Act of 2015: merit-based incentive payments and alternative payment systems. Similarly, accountable care organizations, value-based purchasing, and other pilot projects supported by the Center for Medicare and Medicaid Innovation are distinctly Ameri-

can responses to rising health care costs. But these models are overlaid on a fee-for-service health care system.

US health policy makers skipped a step in thinking through the role of fee-for-service and cost. Although there is evidence that fee-for-service allows for some supplier-induced demand, higher prices are distinct from incentives for physicians to provide more services. Few recent studies have investigated how systems with universal health insurance make the combination of fee-for-service and third-party payment work.^{9–11}

Representatives of systems with universal health insurance explain that their health systems reflect an enduring commitment to solidarity. Their position reflects the insistence that health care is a human right and a continuing affirmation of redistribution and reciprocity as a central element of social justice.

In this article we explore how three countries—France, Germany, and Japan—appear to achieve economic sustainability in a fee-for-service system. We then identify the institutional processes that influence the prices of physician services in universal health insurance systems. These countries have all attempted to contain rising health care costs by negotiating prices with physician associations and adapting fee-for-service to the evolution of health care provision.

France, Germany, and Japan are the three most populous high-income nations that combine universal health insurance with fee-for-service physician payment. Switzerland and the Netherlands are often compared with the US because they rely on insurance coverage mandates and incorporate some degree of competition among private health insurance plans. At the same time, their health systems combine a robust system of regulation with systemwide managed competition.^{12–14} In the US, in contrast, insurance regulation is less developed and has suffered from a lack of national uniformity. Because there is no universal health insurance, public programs including Medicare and Medicaid address the gaps in coverage.

The sizes of France, Germany, and Japan mean that their experiences regulating fees may be more applicable to the US. Lessons from these three Bismarckian health insurance systems are relevant for the US, particularly as the country considers further expansion of public insurance, most recently sparked by the coronavirus disease 2019 (COVID-19) pandemic.

We focus here on physician payment. As in the US, physician opposition historically has been a strong impediment to universal health insurance in France, Germany, and Japan—but one they nonetheless overcame. Understanding how

governments balance the needs of physicians, patients, and insurers is an important challenge for regulating prices once market leverage has been achieved.

Study Data And Methods

We reviewed and translated fee schedules, payment policy descriptions, reports, policy documents, and academic literature on health systems from sources in French, German, Japanese, and English. We identified stakeholders and health policy experts within each country from these documents. We approached health policy experts to assist us in identifying people involved in the process of setting fees for physicians, and we used a snowball technique to identify other potential interviewees via those key informants.¹⁵ We visited all three countries between 2016 and 2018 to meet with stakeholders in their offices and collect documentation. We also supplemented those visits with a small number of semistructured interviews via Skype. Our final sample of interviewees included representatives of the ministries of health, nonprofit foundations, physicians trade unions and associations, pharmaceutical companies, private and social insurance funds, and hospitals, as well as a national mission to the United Nations in New York and, in one country, an elected official.

We interviewed a total of thirty-seven people (fourteen in France, eleven in Germany, and twelve in Japan). In the course of our interviews (which lasted approximately sixty to ninety minutes and were recorded), we sought to understand the process for creating physician fee schedules and updates, learn about recent policy changes in physician payment, and identify the remaining challenges in the use of fee-for-service payment to physicians.

French, German, And Japanese Health Systems: A Brief Overview

All legal residents in France, Germany, and Japan are covered under universal health insurance by multiple insurers, which operate within a national statutory pricing framework for provider fees. In different ways, the three countries finance health care through social insurance that pools income-based health contributions across the entire population, and they rely on private-sector providers, particularly for community-based ambulatory care reimbursed by fee-for-service.

These countries have resisted insurance reform efforts based on competition.¹⁶ In France and Japan there is no consumer choice of public health insurance plans. Although reforms in fa-

vor of competitive insurance exist in Germany that allow people to change plans, interviewees told us that plans vary in marginal ways. In all three countries competition occurs among health care providers, not among insurers. Plan enrollment is determined by a person's occupation, although prefecture residency and age influence enrollments for some plans in Japan.

FRANCE France has more than 600 mostly private nonprofit and for-profit complementary insurers (similar to Medigap coverage in the US) that provide partial reimbursement for out-of-pocket expenses for the same benefit package covered under universal health insurance and for supplementary benefits, mostly dental and optician services. Employers are required to offer and finance half of the premium costs to provide a minimal level of complementary health insurance for their salaried employees. For those below a poverty income ceiling, a minimum package of complementary insurance benefits is available without premium charges; this covers all coinsurance payments for physicians who accept universal health insurance tariffs as payment in full. Unemployed people maintain their usual coverage, as there is no "job lock," and their complementary insurance is ensured for up to one year of unemployment.

The majority of French residents receive their primary health insurance coverage from the National Health Insurance Fund for Salaried Workers (Caisse Nationale de l'Assurance Maladie des travailleurs salariés, or CNAM) and its eleven affiliated funds for specific occupational categories and their dependents, which cover 86 percent of the population. Other health insurance funds cover farmers and agricultural workers and the self-employed. In 2004 these three principal funds were consolidated (Union Nationale des Caisses d'Assurance Maladie, or UNCAM) with reinforced powers for the director of this new entity in negotiating fees directly with physician representatives.

GERMANY In Germany 90 percent of the population enjoys statutory health insurance (gesetzliche Krankenversicherung, or GKV), and 10 percent (mainly the highly affluent, civil servants, and the self-employed) sign on with private health insurance (private Krankenversicherung, or PKV). Built on the principles of social insurance, the system is funded half by extractions from workers' paychecks and half by levies on the revenues of employers. Private insurance is financed by risk-related premiums. Interviewees said that premium differences were largest between social insurance plans and private insurers. Germans choose coverage from among roughly 120 sickness funds in statutory health insurance and 50 in private health insurance/

nonprofit insurance organizations that have a "public purpose" and are governed by an extensive set of government regulations.

JAPAN Japan's universal health insurance system has two different types of insurance: employer based (Kenkō-Hoken) and community based (Kokumin-Kenkō-Hoken). Employer-based insurance includes people working for firms who are assigned to funds on the basis of their occupation: They do not have a choice of funds. Municipalities operate the community health insurance funds that insure self-employed people, farmers, the unemployed, retirees, and their dependents. Public assistance delivers health services for the most socially vulnerable people, who receive them without charge. The full cost of insuring this this group is covered by taxes.

Working adults pay around 10 percent of their income for health insurance premiums in Japan. Both employer and community-based insurers receive tax subsidies. Those ages seventy-five and older are in a different plan, Medical Care System for Elderly in the Latter Stage of Life. Coinsurance for this group is 10 percent compared with 30 percent for working adults and 20 percent for children.¹⁷

Fee Negotiations With Physicians

All three countries engage in regular fee negotiations with physicians, but the parties involved, frequency of fee schedule updates, and scope of negotiations differ.

FRANCE In France fee-for-service physician payment occurs within budget constraints set by parliament and the Ministry of the Economy and Finance. UNCAM negotiates fees with representatives of the physicians unions. All physicians in the community and in private for-profit hospitals are reimbursed according to this fee schedule. Most public hospital physicians are paid on a part-time or full-time salaried basis. Although the state is not officially involved, it closely monitors the negotiations between UNCAM and the physicians unions.

The Ministry of Social Affairs and Health and UNCAM participate in a national commission with physicians union representatives to develop their own catalogue of procedure codes. This commission, originally inspired by Medicare's resource-based relative value scale, yielded a document known as the Classification Commune des Actes Médicaux (CCAM) with more than 7,000 procedure codes.¹⁸ UNCAM and physicians unions have gradually increased their reliance on technical studies that assess physicians' activities and procedures on the basis of complexity, time, and intensity of effort, but the relative values and conversion factors that deter-

mine physician fees remain a matter of political negotiation. Technical analysis serves as a guide, but the political power of physicians unions' acceptance of budget constraints shapes the final decisions. As one of our interviewees suggested, "The CCAM was designed to provide a scientific argument for negotiating with physicians, but it was never intended to replace the negotiations."

GERMANY The German approach is characterized by "an expansion of corporatist regulatory powers with the goal of enabling the collective organizations of sickness funds and service providers to urge their members to contain costs."^{19,20} For example, in 1977 Germany created a multisectoral, sixty-member "concerted action" body, charged with negotiating an annual national cap on the allowable increase in spending for physician services.

In Germany social insurance resources earmarked for health care are vested in a national association of sickness funds, which negotiates with a national association of physicians over allocating funds to their members for individual medical procedures. Each side is advised by regional counterparts. This approach to "health insurance bargaining,"¹⁰ known as "self-government" (by organizations representing providers and insured citizens), goes back to the origins of the German system in 1883. The national government sets the rules and leaves decisions about allocation of resources, management of coverage, and clinical care to the associations and their members.

Germany relies on structured bargaining around a fee schedule that specifies thousands of medical procedures for which a physician may bill. Associations of physicians and of sickness funds negotiate annually over the relative value of a subset of coded items. The schedule includes both a general component (standard expenses of medical practice) and one that takes account of specificities of treatments. In the private insurance sector, prices are not negotiated and are often higher than those in the public fee schedule. The government has been under pressure to create a single fee schedule, particularly from the leftist parties.

Negotiating positions are argued out first within regional associations of physicians and funds, then within the national associations of each side, and finally between the two national associations. The federal association is sometimes compelled, according to one of our interviewees, to cater to "loud extremists who make drastic demands for, say, a 10 percent increase. When 1.8 percent gets approved they are disappointed but they are isolated, and sometimes they even admit they have to push the extremes to satisfy their audience." Physician associations

in Germany (as elsewhere) face a delicate balancing act between looking tough to their members and appearing reasonable to government officials, whose main focus is the health care budget.

The expectation is that both sides will compromise. "Compromise," mused one of our interviewees, "is in our veins." Negotiations are often technocratic, but as in France, no one pretends that they can be merely technical. If compromise is elusive, disputes are resolved by a committee.

One source explained: "The idea is that both sides engage in collective bargaining. They may start with extreme positions.... But we try for balance, to keep both sides on track. Our role is scientific and political—that is the intent." Leaders of the associations may consult with officials in the Ministry of Social Affairs and Health or in Parliament, but the French federal government avoids direct involvement in these negotiations.

JAPAN In Japan the government is more directly involved in negotiations. In 1958, in anticipation of universal health insurance, Japan combined several different fee schedules into a single schedule. Before 1958 there were inequities in access deriving from disparities in prices paid to physicians by different insurers. According to one interviewee, the consensus in Japan is that universal access depends on uniform prices for equivalent services.

The Ministry of Health, Labour, and Welfare sets prices and regulates the medical profession.²¹ Although Japan's centralized system gives the ministry considerable power, the health budget is set by the prime minister. As one interviewee explained, the ministry's main concern is cost control. The global budget relies on input from "the ministers and top bureaucrats of the two ministries [the Ministry of Health, Labour, and Welfare and the Ministry of the Economy and Finance]. The person in charge of the [Ministry of Health, Labour, and Welfare] budget and the [Ministry of the Economy and Finance] stays in office from two to three years, so if he points his finger up, then [the global budget] goes up. If it's down, [the global budget] doesn't go [any higher]."

The second stage is taken up by the Central Social Insurance Medical Council, or Chuikyoku, housed inside the ministry's Health Insurance Bureau.¹¹ The Central Social Insurance Medical Council revises the fee schedule every two years. This council is part of the Ministry of Health, Labour, and Welfare, not independent as is the American Medical Association's Relative Value Scale Update Committee. Increases in payments to physicians in Japan are often financed by price decreases in the pharmaceutical budget. Essentially, pharmaceutical companies pay for higher

physician fees.

Meetings of Japan's Central Social Insurance Medical Council are open to the public and attended by members of the media, the pharmaceutical industry, and other stakeholders.²² The council includes dentists, pharmacists, and physicians,²³ plus members of the public. Although the council and its members play a significant role, the key relationship is between the ministry and the Japan Medical Association.

In Japan, as is the case also in Germany and France, the bureaucracy is happy to delegate some authority to physician representatives. Conflict revolves around the extent of delegation and the budget constraint. All three nations have a stronger government purchaser or stewardship role than in the US. However, there are differences in the relationships between providers and elected officials. The close relationship between the Japan Medical Association and the Liberal Democratic Party of Japan, which has dominated Japanese politics for most of the post-World War II era, makes Japan unique, but there is still a nationally determined health budget.

Primary care physicians dominate the Japan Medical Association and are better compensated than specialists. In most countries specialty societies engage in vigorous advocacy on economic issues, but in Japan specialists are less politically active because of their employment in hospitals and university clinical departments.^{23,24} Although the Japan Medical Association can circumvent the bureaucracy via allies in the legislature during negotiations over the global budget, in Japan, as in France and Germany, fee negotiations within the context of expenditure targets or budget caps have given rise to contentious negotiations.

Impact Of Expenditure Targets And Budget Constraints

As a result of fee negotiations within expenditure targets, physicians in all three countries earn lower incomes than their US counterparts. For example, in 2016 generalist physicians in the US earned an average of \$218,173. In comparison, generalists in France and Germany earned \$111,769 and \$154,126, respectively. Similarly, specialist physicians in the US earned an average of \$316,000 in 2016, compared with \$153,180 in France and \$181,253 in Germany.³ Japanese physicians earned, on average, \$124,558 in 2016; however, this is an average of generalist and specialist incomes.

Policy makers in the US have been concerned that fee-for-service payment results in an excessive volume of services. The French response was to impose expenditure targets in 1996 and 2010,

but France exceeded its budget targets frequently.^{12,25} Within the past decade physician fee increases and total annual spending have been held in line. This success reflects tighter political control by parliament, the Ministry of the Economy and Finance, and the Ministry of Social Affairs and Health, which has made budget constraints explicit for UNCAM in negotiations with physicians unions.

In Germany there is a global budget for payments to physicians, first created in the Health Care Structural Reform Act of 1993. It places a limit on the amount that the associations of statutory insurance physicians can allocate to their regional affiliates, which decide how much to pay individual physicians.

The outpatient fee-for-service physician fee schedule also falls under a budget cap in Japan.²⁶ The Japanese Ministry of Finance establishes targets for expenditure, thus essentially capping the physician budget.

Budget constraints in all three systems create a zero-sum game of resources, so one might expect conflict among physician groups. In Germany there are conflicts between general practitioners and specialists, as well as among specialists, and these fights may be more intense than those between physicians and the funds. As a policy maker explained during their interview: "The doctors are under more pressure from their boards than the sickness funds. The regional associations put pressure on the national body if they're not seeing big increases in pay."

In Japan the Japan Medical Association's power and the global budget have restrained higher fees for specialist services. Unlike in France and Germany, the fortunes of physicians and their compensation are more closely tied to a single political party (the Liberal Democratic Party of Japan), and as long as this party is in power, community-based physicians represented by the Japan Medical Association have an advantage. One of our interviewees explained that during a brief period between 2009 and 2011, when the Liberal Democratic Party of Japan was out of power, the ministry used a decrease in office visit fees to "finance the surgical fees, because there's a huge number of consultation fees, but not so many surgical," one interviewee explained.

Summary Of The Approaches

The three countries we examined all negotiate fees in the context of expenditure constraints, but they have contrasting institutional processes to address health care prices and volumes. France has negotiated prices aggressively but has few controls over the volume of care. Germany controls service volume indirectly by im-

posing budget caps on sickness funds and physician associations and putting them in charge of enforcing volume controls.

Japan's approach is more centralized, with a complex set of conditions that govern how and where health care services can be provided. These conditions are specified in the same document that lists the negotiated fees for each service. The aim is to constrain volume by limiting the volume of services billable for each item and by limiting the number and types of hospitals, clinics, and physicians that are allowed to provide particular services.

Although France and Germany hold physician fees at lower levels than in the US, both countries pay specialists more than primary care physicians. These fee schedules reflect a bias for more technical or procedural services over services such as office visits in primary care. In contrast, Japan, uniquely, pays private office-based generalist physicians, represented by the Japan Medical Association, more than academic hospital-based specialists.

Discussion

The health systems we studied focus on controlling prices in the context of fee-for-service medical practice and national expenditure constraints that do not result in withholding health care from the population.^{27–29} The use of fee-for-service physician payment does create problems, but marking fee-for-service as the major cause of high health care spending in the US is problematic, especially as countries with lower prices and expenditures use fee-for-service systems. France, Germany, and Japan limit the incomes of physicians by standardizing and adjusting the fees they are paid while using a variety of approaches to limit the volume of services provided.

The diversity of payment arrangements in the US acts as a constraint on unified approaches while also creating growing pressure to change and standardize fees. Although some Democratic leaders in Congress emphasize the buying power and leverage of a single-payer health care system to contain prices, extending Medicare to all legal residents would introduce challenges in negotiating prices with hospitals, pharmaceutical manufacturers, and physicians within the context of US institutions. Perhaps the most important implication of our study is that regardless of whether either fundamental changes such as Medicare for All or incremental expansion of the Affordable Care Act are proposed, both would oblige policy makers to think hard about how to set prices and oversee service volume.

Although France, Germany, and Japan vary in

their approaches to regulating prices and service volume, all three rely on centralized fee negotiations. This general approach is evident in some Democratic health reform proposals, some of which have proposed empowering the secretary of health and human services to create a national fee schedule for payers and providers within a public option or Medicare for All design.³⁰ The Democratic Party presidential nominee for the 2020 election, former Vice President Joseph Biden, proposes creating a public option that would lower prices via negotiations with hospitals and other providers.³¹

Medicare prices are used as the baseline price in a wide range of plans released by Democratic presidential candidates in early 2020. Whether part of a public option (in a plan proposed by Sen. Elizabeth Warren [D-MA]) or as a benchmark for reining in egregious out-of-network charges (in plans proposed by Michael Bloomberg and Pete Buttigieg), both reform approaches pegged prices at Medicare rates. This suggests that even among more centrist Democrats, who do not support a significant expansion of coverage, there is increasingly an understanding of the need to address the way in which the US sets prices for medical services, as well as health care more generally. Based on our review of fee-for-service payment practices in France, Germany, and Japan, the key challenge for the federal government would be to create processes and institutions to bring together representatives of the private insurance industry, providers, and government into a system of structured negotiations.

The experiences of these countries suggest that changes in physician reimbursement policy need not presuppose widespread changes to coverage and vice versa. Both become more interdependent when governments are committed to providing universal and affordable health insurance coverage. Health care pricing is an important pillar supporting and upholding universal coverage. Even without universal coverage, the US can and should regulate how much discretion providers of health care services have in setting their own prices. Standardization of prices can reduce treatment and administrative costs alike.

Americans should work within their institutional framework to allow for greater standardization of prices based on negotiation. Such an approach would be a shift away from the current system, in which payment negotiations lack transparency. The absence of arrangements similar to those in the three countries we have studied leaves payers fragmented and gives providers too much control over their own prices. Policies such as all-payer regulation would also address these issues.³²

The purpose of international comparisons for policy learning is not to transplant or import foreign systems into domestic institutions. The US lacks a solidaristic vision—the population is distributed across separately regulated private insurance plans, and programs designed for different groups remove a shared identification, balkanizing the system of health care. Our approach to understanding physician payment policy across nations acknowledges the absence of solidarity in the United States. Price negotiations reflect the history and distinct character-

istics of each country.

Cross-national comparisons, however, offer perspective on the challenges that Americans confront and the ways in which experience abroad might be adapted to the specificities of other national institutions. The ways and means by which France, Germany, and Japan are “getting the price right” should not be ignored by US policy makers concerned with universal health insurance or with the incremental extension of affordable health insurance coverage. ■

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Queries

1. In author bios, the chief copy editor, Andrea Zuercher, is pleased to work with you and your coauthors again. I have been editing the work especially of Rodwin and Brown for many years. Please give them my greetings.
2. In abstract, sentence beginning “The parties,” the chief copy editor added “those of” before “physician associations.” Please verify and amend if needed.
3. Paragraph beginning “The latest,” the chief copy editor added “-based” to “value purchasing.” Please verify and amend if needed.
4. Paragraph beginning “In this,” the chief copy editor made some changes for better flow and less repetition, in this and the following paragraphs.
5. Paragraph beginning “The sizes,” please explain how size makes these systems a good comparison for the US. Also, when you say “more applicable,” what is the point of comparison? More applicable than what, or more applicable to the US than to what?
6. Paragraph beginning with subhead “Germany,” the chief copy editor added the German names of the insurance schemes.
7. Paragraph beginning “Working,” the chief copy editor could not find the Japanese name for “Medical Care System for Elderly in the Latter Stage of Life.” Please provide if you can, for consistency.
8. Paragraph beginning “The German,” there are two issues. First, although the other copy editor pointed out the existence of two separate sources for the first sentence, the chief copy editor questions whether two citations attached to a direct quote are as useful as they could be. Presumably only one source is being quoted directly. Since note 18 (now note 19) is a source in German, it would appear that the quote comes from note 20. Please advise on accurate endnote placement. Second, as the chief copy editor added subheads identifying subsections, she notes that this paragraph on Germany appeared between two paragraphs on France, after which Germany was mentioned again, in order. The paragraphs have been grouped by country. Please verify and amend if needed.
9. Paragraph beginning “One source,” please verify which country you are talking about here. The chief copy editor thought it was Germany, but you mention the French federal government in the last sentence.
10. Paragraph beginning “Policy makers,” second sentence, the French response to what? Not clear from context.
11. Paragraph beginning “Medicare prices,” the chief copy editor amended the copy editor’s changes regarding Bloomberg and Buttigieg.
12. Paragraph beginning “The experiences,” and subsequent paragraphs, the chief copy editor changed the use of first person plural pronouns. Confusion can arise if those pronouns are used for anything but direct reference to the authors and their work.
13. Paragraph beginning “The purpose,” thank you for clarifying the last sentence. Would adding the word “must” help convey your meaning more clearly? (Price negotiations must reflect)
14. Note 18, the chief copy editor filled in publication details along with a URL. Please verify and amend if needed.
15. Note 21, the chief copy editor changed the author from “Ministry of Health Law” to “Ministry of Health, Labour, and Welfare.” Please verify and amend if needed.
16. Note 26, thank you for verifying the link suggested by the copy editor. The chief copy editor has opted to keep the citation as it was. It satisfies what is required

for documentation purposes.

17. Note 30, thank you for providing a URL. The chief copy editor shortened it to remove the string characters; it connects to the source without the extra characters, which can cause problems in typesetting.