Canaries In A Coal Mine: California Physician Groups And Competition

Struggles of physician groups signal flaws in public and private competition policies.

by Lawrence Casalino

ABSTRACT: Health care organizations may compete by developing organized processes to improve quality and increase efficiency, or may focus on growing to increase negotiating leverage and on controlling costs through withholding appropriate care and avoiding sick patients. This paper describes key ways in which public and private policy decisions create incentives that influence the competitive focus of physician groups in California, a state in which physician groups and health maintenance organizations are prevalent. These policies do not manage competition in optimal ways: They reward groups for market leverage and controlling costs while failing to fully reward quality and efficiency.

Dying canaries warned miners of invisible hazards. Such early warning signs are scarcely needed for U.S. health care, in which evidence of trouble is all too obvious. Yet it may be useful to think of California physician groups—some of which are dead and many of which are threatened with death—as canaries. California has more large physician groups than any other state and is notable for widespread use of the delegated model, in which health maintenance organizations (HMOs) give financial risk and utilization management responsibility to physician groups. Understanding the groups and the delegated model can yield insights into the pressures—many of which are not easily visible—that are shaping health care competition.

The evolution of California’s physician groups and the delegated model has been described elsewhere; the current crisis is described in this volume of Health Affairs. Because far fewer data are available on physician groups than on HMOs and hospitals, they are studied less often. But physician groups are important both as a way of understanding the competitive pressures actually existing in health care and because, flawed as they are, well-organized physician...
groups may be a way to increase health care quality while controlling costs.

For nearly seventy years medical reformers have suggested that prepaid group practice is desirable as a way to promote coordinated, population-based, high-quality, cost-effective care. During the 1970s and early 1980s proponents of managed competition envisioned it primarily as competition among Kaiser-like integrated systems, each with a health plan, hospitals, and one or more physician groups. Although few if any such systems have been created, many analysts continue to praise the virtues of competition; the nature of the organizations that should be competing—for example, HMOs, physician groups, or individual physicians—is often left unspecified.

HMOs can compete on premium levels, service to purchasers and patients, and, to some extent, quality. But physicians, not HMOs, actually provide medical care for patients; although HMOs can contribute to identifying patients who need care and educating them, they cannot fully substitute for organized processes developed at the physician-group level to improve care. Furthermore, issues of statistical power and risk adjustment for patients' health status make groups, rather than individual physicians, plausible units of analysis for cost and quality measurements and for competition and rewards based on those measurements.

Federal and state governments create public policy both as regulators and as purchasers of health care. Large corporations and corporate purchasing coalitions create policy, privately, through the decisions they make when purchasing health insurance. Public and private policies go a long way toward determining both what kinds of organizations can compete in health care and how they can compete. This paper focuses on the ways in which policies in California create incentives for physician groups to compete in ways that are desirable (by developing processes to become more efficient and to improve quality) or undesirable (by skimping on appropriate care, avoiding sick patients, and subordinating efficiency and quality to rapid growth in an attempt to gain negotiating leverage).

Efficiency

Physician group and HMO executives agree that efficiency in medical care should be defined as providing the right care, at the right time, in the right place, with the right use of resources, to the right people—that is, to all patients in a group who need care, not only those who just happen, for example, to appear for appropriate immunizations. The traditional fee-for-service system failed to provide incentives for this kind of care; capitation was proposed as a remedy. But capitation is simply a payment method, neither a panacea
nor the root of all evil. The degree to which capitation encourages organizations to compete on quality and efficiency depends on the market context within which it is used.

California has enacted a series of laws regulating risk contracting, specifying treatment parameters for specific medical conditions, mandating direct patient access to certain specialists, and facilitating lawsuits against HMOs.

- **Regulation of risk contracting.** California’s 1975 HMO Act (the Knox-Keene Act) created state oversight of HMO financial solvency. When the act passed, it was not anticipated that physician groups would bear financial risk, and regulations for group risk bearing were not included. But since their creation in the 1970s, California HMOs have primarily contracted with physicians using risk contracts in which an independent practice association (IPA) or a medical group of twenty or more physicians is financially responsible (capitated) for physician services, the group and the HMO share risk for the cost of hospital and ancillary services, and the group does most of the utilization management.7

The growth of California physician groups and HMOs was fueled by their ability to profit from driving down the costs of hospital care through reducing the numbers of admissions, decreasing lengths-of-stay, and reducing payment rates to hospitals.8 During the 1990s many groups sought to take even more financial risk because they believed that there were further profits to be made, that the flow of prepaid dollars would make it possible and desirable for them to develop proactive processes to improve care, and that their ability to manage care would firmly establish them at the center of the health care system. In 1996 the prevailing view among group leaders was that “the goal for physicians in managed care is to get as much risk as possible and to be in charge of managing that risk themselves.”9

Many groups signed multiyear, percentage-of-premium contracts with HMOs, giving the groups responsibility for virtually all costs of patient care just as it became more difficult to further reduce the costs of hospital care.10 Capitation rates in California continued to fall below national levels, state “patient protection” mandates were raising costs, and labor and pharmaceutical costs were rising rapidly. The state took action after the bankruptcies of two giant, globally capitated physician practice management (PPM) firms, Med-Partners and FPA, which affected more than two million patients and left $100 million in unpaid claims, according to a California Medical Association (CMA) report.11 This report, although exaggerated in its details, accurately conveyed the sense of financial crisis among California physician groups.12 California law S.B. 260 (1999) created a Department of Managed Health Care (DMHC) with a
mandate to protect consumers and to regulate risk contracting.

In March 2001 the DMHC issued “emergency regulations” specifying the obligations of HMOs and physician groups engaged in risk contracting. The HMO must submit monthly reports to each group listing patients enrolled with the group and the amount of capitation to be paid for each patient. During contract negotiations the HMO must provide a matrix showing how responsibility for costs will be divided between the group and the HMO and must detail expected utilization rates, costs, and factors used for risk adjustment. The HMO must provide quarterly reports showing income and expenses for shared risk pools and must give the group its share of money remaining in risk pools (if any) within 180 days of the end of the contract year. Physician groups must submit annual audited financial statements to the DHMC and must provide it with quarterly status reports, including financial statements, a statement showing what percentage of claims the group has reimbursed or denied, and a statement of whether the group has maintained a positive level of working capital as well as positive tangible net equity of at least twice the amount owed by the group.

There are no good estimates of the percentage of groups that will be able to meet these requirements. The DMHC’s stated goal is to protect patients, not to choose a model of contracting. If few groups are able to meet the requirements, the delegated model may virtually disappear in California, but it appears more likely that the regulations will stabilize the model by eliminating weaker groups, thereby moving patients to the stronger groups and reducing the disruption caused by bankruptcies.

The DMHC has resisted calls from the CMA and consumer groups to force HMOs to pay outstanding claims when a risk-bearing physician group becomes insolvent. HMOs argue that this would amount to “paying twice,” they hope that the DMHC’s solvency requirements may shield them from legislative and legal initiatives aimed at forcing them to do so. Leaders of many groups support this view, fearing that if HMOs are required to “pay twice,” they will either abandon the delegated model or become overly intrusive in overseeing groups’ business.

The DMHC has also resisted calls to review all risk contracts between HMOs and physician groups to ensure that they are “actuarially adequate.” The larger groups and the DMHC argue that this would be a Herculean task, that it would be a form of rate setting, and that ultimately it would require the DMHC to decide how much physicians and their staffs should earn (since their earnings are an important factor in determining actuarial rates).

In retrospect, the idea that a large organization specializing in
insurance functions (an HMO) should pass virtually all financial risk to a smaller organization (a physician group) made little sense. Even before the DMHC rulings, California groups and HMOs had begun moving toward a more efficient allocation of risk, one that gives groups much responsibility for the costs they can affect but does not turn them into miniature insurance companies. During the past two years contracts have allocated less risk for hospital services and drug costs to groups and have sometimes included clauses that give groups the possibility of sharing in savings gained by controlling drug costs ("upside risk") without any "downside" risk.

- **Disease- and specialist-specific mandates.** California has passed a series of laws targeted at specific medical conditions. A.B. 38 (1997), for example, requires HMOs and capitated groups to offer a forty-eight hour hospital stay for mothers after vaginal delivery (ninety-six after cesarean section); A.B. 7 (1998) prohibits limiting a patient’s length-of-stay after mastectomy; and S.B. 64 (1999) requires coverage of diabetes supplies, patient education, and medication.

HMO executives and physician group leaders oppose “legislation by body part.” They argue that it has no scientific basis, raises costs unnecessarily, and diverts resources to well-organized interest groups. They make analogous arguments about laws mandating access to specialists, notably A.B. 2493 (1994), which requires that HMOs permit obstetrician-gynecologists to serve as primary care physicians. They suggest that government should intervene only in cases where the scientific benefit of a service is clear and the market is not supplying the service.

“Body parts legislation” had the unintended consequence of exacerbating the financial crisis of California physician groups. While legislators (few of whom understand the delegated model) believed that HMOs pay the price of these mandates, in fact capitated groups paid much of the extra costs, at least in the short run. The cost to an eighty-physician group with 100,000 capitated patients, for example, can be calculated to be about $1.5 million a year for the mandate requiring a forty-eight-hour hospital stay after vaginal delivery.

- **Lawsuits against HMOs.** The United States has no generally accepted standard for health plan liability. An unintended consequence of the Employee Retirement Income Security Act (ERISA) of 1974 was to preempt lawsuits in state courts against health plans contracting with self-insured employers. ERISA-covered lawsuits in federal courts award only the cost of the denied service to patients and do not permit payments for pain and suffering and punitive damages, which are permitted in state courts and have generated judgments in excess of $100 million. Three states, including California (S.B. 21, 1999), have passed bills that attempt to circum-
vent the ERISA preemption and make HMOs liable for their own utilization management (UM) decisions and those of delegated physician groups.

Policies facilitating lawsuits against HMOs would have complex effects—probably raising costs both directly (cost of suits) and indirectly (costs of HMOs' backing off from appropriate utilization management)—while reducing the likelihood that appropriate medical services' would be withheld. Such policies may also have the unintended consequence of pushing HMOs away from the delegated model toward individual contracting with physicians, to protect themselves from being sued for decisions made by delegated groups.

Some California physician group leaders suggest that HMOs should be required to exercise due diligence in deciding to which groups they delegate utilization management and in ongoing general (not decision-by-decision) oversight of groups' UM processes. If they exercise such due diligence, they should be liable only for their own UM decisions, not for decisions made by delegated groups. This would preserve and even strengthen the delegated model, since plans would be less likely to delegate utilization management to groups that appear to lack the capacity to do it well. It would make health plans responsible for oversight but not for day-to-day interference with physicians' clinical decisions.

Efficient groups subsidize inefficient groups. In a truly competitive market, groups that efficiently manage their operational and patient care costs would gain more patients (assuming that their quality scores were adequate) because they would be able to offer patients a lower price. This is now impossible, because many patients make the same premium contribution regardless of which HMO they choose, and even those who pay more if they choose a higher-price HMO pay neither more nor less if they select a higher-or lower-price physician group. Thus, efficient groups subsidize inefficient groups, and patients are deprived of the opportunity to save money by selecting an efficient group. For this to change, employers would have to move toward defined-contribution health benefits, and employers, Medicare, and Medicaid would have to require that HMOs charge different premiums and/or different co-payments for different physician groups.

Efficiency versus size: market leverage. Negotiation of payment rates between organizations is standard procedure in competitive markets, but experience in California suggests that it may not be ideal for contracts between health plans, hospitals, and physician groups. It leads to public showdowns, to contract terminations affecting hundreds of thousands of patients (for example, the recent struggle between Sutter Health System and Blue Cross of
California), and to an inefficient race toward growth.

Economic theory suggests that an organization’s attempts to squeeze higher prices from purchasers by gaining market leverage are doomed to failure in competitive markets. In the long run, if an organization tries to maintain its prices at a level much higher than costs, other organizations will enter the market and attract that organization’s clients with lower prices. The California health care market, however, is far from perfectly competitive: It is very difficult for new competitors to emerge to compete with the dominant hospitals and HMOs, although physician groups in general lack this degree of dominance. Physician group, hospital, and HMO leaders, who are interested in surviving in the short run in an imperfect market rather than on theoretical predictions about the long run in a perfect market, strategize constantly about market leverage.

During the 1990s California’s largest health plans (Kaiser excepted), using a clause in the Knox-Keene Act, converted from non-profit to for-profit status and grew rapidly through mergers and acquisitions. The six largest plans now have 78 percent of the state’s twenty-one million HMO and PPO enrollees. Physician groups also engaged in a wave of mergers and acquisitions, and many sold their group to a hospital or PPM firm, partly to profit from the sale, but also in an attempt to avoid being weak in negotiations with ever-larger HMOs. The race to become large enough so that the other side must contract with you has resulted in organizations’ growing at rates that HMO and group leaders acknowledge have sometimes been unmanageable and to sizes that many believe may be larger than warranted by economies of scale.

The CMA in California and the American Medical Association nationally are taking a different approach. They have been pushing bills to create an exception to antitrust law that would make it legal for physicians in completely independent practices to negotiate collectively with health plans. Debates on this legislation center on the degree to which it would increase premiums. It would also have an unintended consequence, of which its legislative sponsors appear to be unaware: It would remove a powerful incentive for physicians to create and to join medical groups and IPAs.

As long as negotiation over prices remains the modus operandi of California health care, it is difficult to see how there will be any end to recurrent threats to terminate contracts causing disruptions of patient care and to continued emphasis by HMOs and physician groups on market leverage, possibly at the expense of efficiency. One alternative to the negotiated price model would be for the government to set payment rates, a policy that does not enjoy great favor in the United States at present. Other alternatives—for example, per-
mitting groups to set their own rates and having patients pay more (through contribution to premium and/or copayments) if they select higher-price groups—may also be possible.19

**The Lack Of A Business Case For Quality**

Purchasers and regulators have failed to create a business case for quality. Quality failure in physician offices and hospitals, though profound, remains invisible. If it were more visible to the public, purchasers and regulators would be forced to make a much stronger case for quality improvement.20

Means for improving the quality of U.S. health care are not lacking. HMOs and physician groups could play complementary roles in providing disease management, continuous quality improvement, and patient education programs; in directing patients to high-quality specialists and hospitals; and in increasing the appropriate use of preventive services. Most of these methods are beyond the capacity of solo or small group practices (although not necessarily of the IPAs to which such practices may belong), but they could be created by HMOs and physician groups.

Proponents of prepaid group practice initially believed that capitation would provide a sufficient incentive for physician groups to invest in improving quality, arguing that groups that kept their patients healthy would be more profitable. Unlike physicians in fee-for-service practice, who are paid only for the services they provide, capitated physician groups would have an incentive to allocate the pool of capitation dollars they receive—a pool that approximates $15 million a month for a 100-physician, globally capitated group—to services that they believe would be most likely to improve their patients’ health.

But there are problems with this optimistic scenario: Any investment to improve quality may have one of three effects on the costs of patient care, and two of these result in a net financial loss to the organization making the investment. A quality investment may increase quality but also increase costs, may decrease patient care costs in the current year, or may increase them in the current year but decrease them in the distant future, when the investing organization is unlikely to reap the savings. Furthermore, organizations that gain a reputation for high quality may attract sicker patients but do not receive higher capitation rates to pay for the care of these patients.21 This is why we do not see billboards advertising that HMO A or Medical Group B provides outstanding care of diabetic patients. In the absence of adequate risk adjustment, capitated organizations with a reputation for high quality may suffer a double financial hit: a loss on their investment in quality, and a loss from attracting sicker-than-average patients.
Physician groups and HMOs will not exert themselves to develop organized processes to improve quality if they lose money by making this investment. However, public and private policies in California fail to provide incentives sufficient to create a “business case for quality,” although some efforts are being made. Many large employers will contract only with HMOs that are accredited by the National Committee for Quality Assurance (NCQA). HMOs that score well on the NCQA’s Health Plan Employer Data and Information Set (HEDIS) measures do not, however, generally receive higher premiums from purchasers, nor do such scores influence most patients’ or employers’ choice of HMOs. In California the Pacific Business Group on Health (PBGH), a large employer purchasing coalition, and the California Public Employees Retirement System (CalPERS) collect and publish quality data on health plans; the PBGH puts 2 percent of plan premiums at risk for performance on quality and customer service measures. It also collects and publishes limited quality data on physician groups.

Incentives for improving quality are scarcer for physician groups than for HMOs. For several years during the 1990s the Medical Quality Commission, which had been created by capitated West Coast physician groups, sought to accredit groups. Most groups saw no benefit in being accredited, and the organization closed. A few California HMO/group contracts put small amounts of money, in the range of 2 percent, at risk for a group’s performance on quality measures. These contracts remain uncommon, and group and HMO executives alike state that this is far too small an incentive to induce groups to invest greatly in quality. Despite the lack of incentives, many of the state’s well-established groups did institute disease management and other quality improvement programs during the 1990s, but as the financial disincentives become clearer, and as the groups struggled with the financial crisis of the late 1990s, these efforts have been scaled back.

Who is to blame? Purchasers, physicians, and plans blame each other for the lack of emphasis on quality. Physicians and health plans argue that purchasers care mainly about price and are unwilling to pay for quality. Large purchasers like the PBGH insist that they want to put more money at risk for quality in their contracts with HMOs, and that they try to persuade HMOs to put more money at risk for quality in their contracts with physicians, but that the plans reply that it is not possible to create such arrangements for some purchasers and not others, that data systems are not adequate, and that in any case physician groups are unwilling to accept such contracts. The groups argue that health plans do not make capitation payments accurately now so cannot be expected to pay accu-
rately for quality, and that in any case capitation rates in California are so low compared with rates in the rest of the country that putting these payments at risk for quality would be unacceptable. Quality incentives, they argue, must come from new money, which purchasers are unwilling to provide. Looming behind these arguments is the failure to adjust capitation payments for the health of patients who enroll with HMOs and groups. Although models of risk adjustment in purchaser-plan contracting do exist, purchasers in general have not pushed risk adjustment, and physicians are reluctant to trust health plans to administer what remain admittedly imperfect risk adjustment methods.22

A way out of the quality stalemate? The current lack of a business case for quality results from a profound failure of public and private policies to shape a market in which groups and HMOs compete by providing value. Is there a way out of the quality stalemate? The federal government could have an enormous impact if it created quality incentives at the plan level and required plans to create incentives at the group level, but the Health Care Financing Administration (HCFA) has no statutory authority to pay differentially based on quality. State governments could require that purchasers put a minimum percentage of the premium paid to health plans at risk for quality, and that plans do so for groups. The NCQA could make it a requirement for accreditation that health plans place a large percentage of their capitation payments to physician groups at risk for quality. Both the plans and the groups would resist such requirements, unless premiums were greatly increased.

Without such policy interventions, care will continue to be of lower quality than it could be, and competition will fail to select for higher-quality organizations. If, to take an unproven but plausible example, physician groups are better able to develop processes to improve quality than solo or small group practices are, and if HMOs are more capable of doing so than PPOs are, then the lack of competition over quality eliminates a competitive advantage of these organizational forms. Lacking this advantage, these canaries may die.

Creative Destruction?

Current public and private policies reward controlling costs and growing to gain negotiating leverage more than improving quality and efficiency.23 This is perhaps more clearly seen in California than in states where the individual physician–HMO contracting model is prevalent. Groups have the potential to develop organized processes to improve quality than solo or small group practices are, and if HMOs are more capable of doing so than PPOs are, then the lack of competition over quality eliminates a competitive advantage of these organizational forms. Lacking this advantage, these canaries may die.
flawed set of incentives affecting California physician groups suggests that policymakers should consider moving beyond ad hoc “patient protection” regulations to a more deliberate, coordinated approach to creating incentives for competition.

At a minimum, this would require that policymakers understand the delegated model and the possible unintended consequences of policies on physician groups and on HMO/group contracting. Such an understanding might, for example, lead to laws that permit legal action against HMOs for denying approval for appropriate medical services but do not hold them liable for services denied by a delegated physician group, if the HMO has used due diligence in selecting the group and in overseeing the group’s UM processes. It might lead to intervention by federal and state governments and by organizations like the NCQA to break the quality stalemate and introduce incentives sufficient to create a business case for quality. It might mean exploring ways to move beyond the negotiating model for determining payment rates to a model in which groups name their price and patients who choose higher-cost groups pay more.

Public and private policies will be critical in determining whether the turmoil in California results in “creative destruction”—the emergence of new forms of organization and better ways of providing a service—or simply in destruction.

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NOTES

1. Physician groups include both independent practice associations (IPAs) and medical groups.


4. Committee on the Costs of Medical Care, Medical Care for the American People (Chicago: University of Chicago Press, 1932); and F.W. Wasserman and M.C. Miller, Building a Group Practice (Springfield, Ill.: Charles C. Thomas, 1973).


6. HMOs are also good units for measurement; both should compete.

7. See Casalino and Robinson, The Evolution of Medical Groups.

8. Ibid.

9. A prominent health care attorney, speaking at the Unified Medical Groups annual meeting in California in 1996.

10. It proved to be harder to reduce hospital days per thousand from 180 to 140 than from 300 to 180, which many groups had already done. Furthermore, consolidation gave many hospitals the ability to demand higher payment rates.


16. The groups are currently liable to malpractice suits for their UM decisions and would remain so, a fact that the leaders accept.

17. Physician groups could, for example, be placed into high, medium, and low cost categories, with patients paying more to enroll with the higher-cost groups. This is being tried by the Buyers Health Care Action Group (BHCAG) in Minneapolis. See D. Knutson, “Case Study: The Minneapolis Buyers Health Care Action Group,” Inquiry (Summer 1998): 171–177.


19. See Knutson, “Case Study.”


