The purpose of this Roundtable is to provide information about medical groups in California, including a discussion of risk-bearing, solvency and current regulatory approaches, and perspectives on these issues from key stakeholders.

The growth of managed care has generated numerous changes in the American health care delivery system. Foremost of the changes affecting physicians in California has been the shift from practicing independently to affiliating with organized provider groups, such as medical groups and independent practice associations (IPAs). This reorganization has occurred in conjunction with the transfer of financial risk from health plans to provider groups through capitation payments. Capitating providers for the delivery of patient services means that providers receive a prepaid, fixed amount per managed care enrollee per month, regardless of the actual cost of delivering care. Capitated entities face the risk that if a patient requires services that cost more than the capitation amount, the provider is financially responsible for the difference. Conversely, capitated medical groups gain if they develop preventive, clinical, or administrative programs that reduce the cost of delivering care. The model for the capitated medical group is The Permanente Medical Group, which is paid on a per member per month basis by Kaiser Foundation Health Plan.

In the early days of managed care, provider groups in California actively sought and negotiated capitated contracts with health plans. The rationale behind such contracts was to delegate responsibility for utilization management and medical necessity decision making from plans to providers and to allow provider groups a greater ability to coordinate and manage utilization for their patient populations. Capitation payments also generated higher net revenue for many of these groups than what they received through fee-for-service reimbursement, since larger medical groups could retain greater savings from their utilization management practices. As capitation payments generated profit for medical groups, some contracted with health plans to assume responsibility for more aspects of patient care than just physician services, including institutional and pharmaceutical services. This practice is referred to as “global capitation” or “full-risk contracting.”

Under pressure in the early 1990s to curb rising health care costs, the majority of employers in California turned to managed care as one, if not the only, source of health insurance coverage for their employees. Meanwhile, large health insurance purchasing groups in California, such as the Pacific Business Group on Health (PBGH) and CalPERS, negotiated lower annual health plan premium increases. Health plans also negotiated stricter capitation rates with provider groups. With less money per enrollee coming from health plans and responsibility for managing a wider array of patient services and for performing utilization management, provider groups were in some cases agreeing to do more with less. The combination of...
increasing numbers of managed care enrollees and lower capitalization payments has made full-risk contracting a high-risk venture for many provider groups.

### How Could Medical Group Insolvency Affect Patients, Physicians, and Health Plans?

The recent, well-publicized bankruptcies of major physician practice management organizations such as MedPartners Provider Network and FPA, Medical Management have elevated concern that many provider groups in California are in similar financial difficulty.

Health plans contend that when provider groups sign capitation contracts, the plans effectively sign over responsibility for managing and providing care to the provider groups. Since the providers assume financial responsibility for patient services, plans claim they should not be held financially responsible if a provider group has insufficient funds to cover the actual cost of care for its patient population. Meanwhile, provider groups claim that capitation payments from health plans in California are increasingly inadequate to cover the services required to care for the patient population.

Regardless of which entity should be held financially accountable for patient care when the capitation amount runs dry, the insolvency of physician organizations may jeopardize the quality of care patients receive and threaten the stability of the health care system.

### How Does the Knox-Keene Act Regulate Medical Group Risk-Bearing Arrangements and Solvency?

The Knox-Keene Act regulates the financial stability of health plans, but does not regulate medical groups or other provider organizations, nor does the Act dictate solvency requirements for California’s medical groups or IPAs. The Knox-Keene Act does require that a health plan with capitation or risk-sharing contracts with providers must make certain each contracting provider has the administrative and financial capacity to meet its contractual obligations. However, some have suggested that regulation of this requirement should be enhanced.

The Knox-Keene Act did not envision, and thus makes no provision for, medical groups bearing partial or full risk in their contracts with health plans. There is some debate over whether the Act even permits full-risk contracts between health plans and provider groups. In the absence of standards regulating risk-bearing provider groups, a model known as the limited license plan has evolved. The California Department of Corporations (DOC) is using its regulatory authority to issue limited licenses to provider groups seeking to negotiate partial or full-capitation contracts with health plans for professional and/or institutional services. Limited licensees must have quality assurance and grievance systems and are held to the same financial viability standards as fully-licensed health plans, while DOC waives other requirements for plan licensure, such as marketing and access. However, the financial troubles of FPA and MedPartners, both limited licensees, call into question how well the limited license model is functioning.

### What Are the Current Proposals to Regulate Medical Groups in California?

Currently there is no commonly held understanding of the problem of medical group risk-bearing and solvency, nor agreement on potential solutions. Medical group regulation is addressed in AB 78 (Gallegos), which would establish a new state Department of Managed Care and would require that the new department prepare a report to the Governor and the Legislature by May 1, 2000 regarding legislation that may be necessary to expand the department’s existing jurisdiction over medical groups, IPAs and other provider groups that bear financial risk in the provision of medical care.

Another proposed approach to addressing medical group solvency is to establish a system of “actuarially-sound” capitation payments from health plans to medical groups. AB 918 (Keely) would require that a qualified actuary compute health plan capitation payments to providers, and would require a health plan to provide DOC with an annual update of its actuarial report. Another proposal is to prohibit health plans from transferring financial risk to medical groups. For example, AB 1053 (Thompson) would prohibit a health plan contract from including the cost of medically necessary prescription drugs in the capitation payment to a prescribing or providing health care provider, medical group or IPA.

AB 698 (Corbett) would more generally address the solvency issue by requiring the DOC commissioner to establish a system to enable a health care service plan contracting with a risk-bearing provider organization to meet the plan’s obligations under the Knox-Keene Act to ensure the financial soundness of its arrangements for health care services. The bill proposes that the commissioner authorize a uniform set of financial status assessment standards and that a uniform, annual, independent financial audit be conducted by certified public accounting firms.

Other possible approaches not yet formalized in proposed state legislation include requiring health plans to carry insolvency insurance for all reasonable associated risks of their subcontractors; requiring insolvency insurance for the default of a health plan and its subcontractors; risk-adjusting capitation payments to provider groups; and requiring health plans and/or provider groups to purchase stop-loss coverage (i.e., reinsurance for claims/losses over a certain amount).