A RISKY PROPOSITION?
RISK-BEARING AND SOLVENCY IN CALIFORNIA’S MEDICAL GROUPS

This policy brief is the product of background research and a discussion at the California Health Policy Roundtable on Medical Group Risk-Bearing and Solvency in Sacramento, California on July 20, 1999. The California Health Policy Roundtable is a non-partisan education and information forum on health policy issues in California. It is directed by Helen Schauffler and staffed by Juliette Cubanski, Center for Health and Public Policy Studies, University of California, Berkeley, School of Public Health; co-sponsored by the California Center for Health Improvement in Sacramento; and funded by the Kaiser Family Foundation.

The purpose of this Roundtable was to provide information about medical groups in California, including a discussion of risk-bearing, solvency, and proposed regulatory approaches, and perspectives on these issues from key stakeholders. Speakers at the Roundtable included Lori Hack, Board Member and Consultant, National IPA Coalition, Oakland, CA; Gary Hagen, Senior Vice President, Managed Care Resources, Inc., Yountville, CA; Brian Jeffrey, Vice President of Network Management, PacifiCare of California, Cypress, CA; James Robinson, Professor of Health Economics, School of Public Health, University of California, Berkeley, CA; Sam J. W. Romeo, President and CEO, University Affiliates IPA, Alhambra, CA; Shelley Rouillard, Program Director, Health Rights Hotline, Sacramento, CA; and Helen Schauffler, Associate Professor and Director, Center for Health and Public Policy Studies, School of Public Health, University of California, Berkeley, CA.

While recent efforts to establish consumer protections in managed care have dominated the health policy agenda in California and the nation over the last few years, policymakers and regulators are turning their attention to problems in another important sector of the health care industry — physicians and physician medical groups. Today’s managed care system in California consists of more than 300 medical groups and independent practice associations (IPAs) that negotiate contracts with health plans based on capitation payments — prepaid, fixed amounts per member per month (pmpm). These capitation contracts put the medical groups at direct financial risk for the delivery of medical care services to managed care patients; if physicians deliver services that cost more than the total capitation payment they receive, the medical group, not the health plan, bears the financial liability.

This transfer of financial risk from health plans to medical groups through capitation payments increasingly appears to disadvantage physicians and to threaten the solvency of medical groups in California. According to a report from Pricewaterhouse Coopers, commissioned by the California Medical Association (CMA), at least 34 — or almost 10% — of the state’s medical groups or IPAs may go bankrupt by the end of 1999.1 The problem affects not only physicians, but also consumers; the CMA estimates that more than 10 million Californians could experience interrup-
tions or delays in their medical care as a result of the financial difficulties experienced by the state’s medical groups.

The recent, well-publicized bankruptcies of two large physician practice management firms (PPMs) — MedPartners Provider Network, Inc. and FPA Medical Management, Inc. — have focused political, regulatory, and industry attention on the issue of medical group solvency. These bankruptcies have affected more than two million patients in California and have left thousands of physicians with over $100 million in unpaid medical bills. In 1999, 15 IPAs in California declared bankruptcy, bringing the total number since 1996 to 115.2

Focus on medical groups in California is also heightened by the interest of two of the state’s largest pension funds, the California Public Employees’ Retirement System (CalPERS) and the California State Teachers’ Retirement System (CalSTRS), in direct contracting with medical groups as an alternative to contracting with health plans for health insurance coverage.

The Rationale for Transferring Risk to Medical Groups

Initially, medical groups in California actively sought and negotiated contracts with health plans based on capitated payments. In a time of rising costs in the health care system, prepayment from health plans to medical groups in the form of a capitation payment served a number of functions, including:

• Providing a predictable cost structure for medical groups.

• Supporting medical decision-making at the patient/provider level by giving clinical autonomy to physicians and medical groups.

• Aligning incentives between health plans and medical groups to provide cost-effective care, improve collaboration and coordination, and emphasize prevention.

• Providing funding for infrastructure development at the provider level.3

In the past, capitation payments generated higher net revenues for many medical groups than what they had received under fee-for-service reimbursement, since larger medical groups could retain greater savings through economies of scale in their utilization management practices. In theory, larger groups and PPMs could also have enhanced bargaining power with health plans.

By transferring risk to the medical groups, health plans could reduce their own financial risk, and capitation payments encouraged more cost-conscious provider behavior, with the goal of controlling growth in health care costs. In addition, health plans delegated to medical groups specific managed care functions such as provider credentialing, utilization management, and claims payment. The rationale behind these contracts was to give medical groups a better ability to coordinate and manage care for their patient populations and to delegate responsibility for medical decision-making to the physician level, where treatment occurs.

With capitation generating a profit for some medical groups, they negotiated with health plans to receive additional capitation amounts for the pharmaceuticals, specialty care, and hospital services utilized by their patients. These arrangements are referred to as “full-risk” or “global” capitation. Some medical groups and PPMs have applied to the California Department of Corporations (DOC) for licensure to accept full-risk capitation — known as a “limited license.” As of July 1999, the DOC had issued 13 limited licenses to provider groups in California, with 12 pending applications.

Under a capitated system, medical groups are responsible for managing a wide range of services delivered to their patient populations. Sound business practice in a capitated environment requires that physicians provide services that cost no more than the total capitation payment they receive, and that medical groups actively monitor and manage their costs and level of capitalization.

The Evolution and Current Status of Risk Bearing Among California Medical Groups

In the 1990s, health maintenance organization (HMO) enrollment grew faster than most health care industry analysts predicted, challenging both health plan and medical group capabilities.4 Managed care had a stabilizing effect on health care costs for purchasers, with relatively little increase in HMO premiums from 1992-1997
in California, translating into relatively stable revenues for plans. However, the costs of providing care over this same period were continuing to rise, in part due to increased pharmaceutical utilization and prices. The combination of stable premium revenues and rising costs created financial problems in the health care system, and medical groups have not been the only organizations to feel these effects. All types of medical care providers in California have experienced financial problems, including PPMs, HMOs, hospital systems, and medical groups.

The Knox-Keene Health Care Service Plan Act of 1975 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. While the DOC has been responsible for licensing and regulating health plans in California, no state entity currently regulates risk-bearing arrangements between health plans and medical groups.

The Medical Group and Physician Perspective

While medical groups have been accepting capitation payments from health plans in California for some years, recent circumstances have caused some to question this contracting arrangement for many providers. Medical groups argue that:

• Health plans negotiated lower premium rates with purchasers (such as employers) in the early to mid-1990s, which in turn led plans to reduce capitation payments to providers.

• Health plans have passed on responsibility for claims payment and utilization management to medical groups, but have not subsequently increased payments to medical groups to cover the administrative costs associated with these functions.

• The health plan industry has consolidated in recent years, giving plans more bargaining power over medical groups.

• Premium increases negotiated between plans and purchasers in the last few years have not been passed down to provider groups.

Medical groups claim that capitation payments are increasingly inadequate to cover the services required by their patient populations. Capitation rates have fallen from an average of $45 per member per month (pmpm) during 1990-1993 to $29 pmpm during 1997-1999—a 35% decrease—while the cost of living has increased by 25.2%. Small provider groups face a higher probability of losses associated with “inadequate” capitation rates than larger groups, since they are less able to insulate themselves from surges in utilization by building large reserves for the “bad years.”

According to California Medical Association Chief Executive Officer, Dr. Jack Lewin, “Medical groups and independent physicians associations are going bankrupt across the state because HMOs are forcing doctors to do more with less. They have placed the burden of paying for patients’ health care on the physicians through capitation and then squeezed capitation rates down to the point where they are often insufficient to cover the costs of care.”

The CMA has served eight HMOs operating in California with a lawsuit accusing the health plans of abdicating their fundamental responsibility to reimburse physicians who care for the plans’ patients. The suit claims that these HMOs violated California’s Health & Safety Code §1371, which holds health plans ultimately responsible for such payment.

The Health Plan Perspective

Existing law requires health plans to reimburse claims, an obligation that cannot be waived when the health plan requires its contracting provider groups to pay claims for covered services. However, one health plan spokesman considers the CMA’s lawsuit invalid: “After we’ve paid the medical groups once, we aren’t obligated to provide duplicate payments to physicians.”

Because of this potential exposure to “paying twice,” some health plans have made solvency at the provider organization level an important contractual issue by inspecting the financial status of medical groups prior to contracting with them; other health plans routinely audit the medical groups with which they contract. Plans may also be more careful
to maintain financial reserves in case of insolvency at the provider group level.

Some in the managed care industry argue that medical groups are suffering financially because their management systems are “antiquated” and the groups are “unable to deal with the demands of medicine as a competitive business.” Health plans argue that the medical groups are responsible for failing to control the health services utilization of their patients, and that the medical groups assume ultimate financial responsibility for patient care when they sign capitation contracts with the plans. According to the California Association of Health Plans:

“HMOs are unwilling to shift full financial risk for variable costs to unregulated providers, yet bear the full risk for all losses, regulatory sanctions, and liability if contracted care is not provided as required under law.”

While health plans do not feel responsible for “mis-management” at the provider group level, neither do they want to destabilize medical groups to the point that their members can no longer see physicians who are in groups experiencing financial troubles.

In California’s health care system, as currently configured, health plans depend on a financially sound provider network for the delivery of care to their enrollees. Health plans and medical groups are in a mutually dependent relationship, and the success of each depends on both maintaining fiscally sound organizations.

The Consumer Perspective

In the destabilization created by financial insolvency, consumers have been caught in the middle between health plans and medical groups. As medical groups experience financial constraints, they may place greater restrictions on provider behavior and alter their utilization management practices, essentially rationing patient care more tightly. Insolvent medical groups may create additional problems for their patients, many of whom have experienced disruptions of care such as being involuntarily transferred to a new medical group, having to find a new physician, or not getting their medical records transferred from the old group to a new one.

According to Peter Lee, Executive Director of the Center for Health Care Rights in Los Angeles:

“When a medical group is not doing very well financially, there is additional pressure on the doctors to look at cost instead of quality. When medical groups are at the edge financially, that is the point at which you’re going to see them denying elective surgery and being less apt to refer people for expensive diagnostic tests.”

The Policy Challenge

The policy challenge of whether to regulate medical group solvency, and if so how, can be framed as a question of appropriately allocating functions and payments between health plans and medical groups. These functions include risk-bearing, utilization management, and quality.

Appropriate allocation of insurance risk-bearing. Paying medical groups using the capitation payment system allows physicians to coordinate and control the process of care for their patients. However, capitation puts providers at insurance risk, and many medical groups have not maintained adequate reserves. Regulating the allocation of insurance risk-bearing could mean putting limits on capitation, including regulating the level of capitation payments and what services may be included in the capitation.

Appropriate allocation of health care utilization management. When health plans capitate medical groups, they typically also delegate clinical decision-making, which puts individual physicians in charge of the patient care process. However, many purchasers, regulators, and consumers want to establish uniform standards for utilization management processes across health plans and provider networks. The transfer of clinical decision-making from providers back to health plans could simplify oversight by regulators, purchasers, and accreditors, but it gives health plans, rather than doctors and hospitals, greater influence in medical care decision-making.

Appropriate allocation of quality improvement activities. Health plans are ultimately responsible for quality of care according to the Knox-Keene Act, and cannot dele-
To guard against provider insolvency, thus ensuring that patient care does not suffer, the relationship between plans and medical groups should be more closely regulated by the state. Existing law requires the DOC, until recently responsible for regulating the state’s managed care industry\(^\text{11}\), to oversee the financial solvency of health plans, including the financial soundness of health plan arrangements for health care services, which includes their contracts with provider groups. However, the DOC has lacked the ability to address many of the issues and problems associated with medical group insolvency.

In an attempt to improve the state’s role in regulating this environment, Governor Gray Davis signed Senate Bill 260 (Speier) in September 1999, which, among other provisions, establishes a Financial Solvency Standards Board within the newly created Department of Managed Care (DMC). This law is the first to address the fiscal solvency crisis facing medical groups in California by requiring the adoption of regulations and placing safeguards in contracts between health plans and risk-bearing provider organizations.

**SB 260:**

1. Creates a new advisory Financial Solvency Standards Board to:
   a. Advise the director of the DMC on matters of financial solvency;
   b. Develop financial solvency requirements and standards for plan operations, plan-affiliate operations and transactions, plan-provider contractual relationships, and provider-affiliate operations and transactions; and
   c. Monitor and report on the results of the financial solvency requirements.

2. Places a two-year moratorium on the issuance of limited licenses.

3. Requires contracts between health plans and risk-bearing provider organizations to include provisions concerning the risk-bearing organization’s administrative and financial capacity, including:
   a. Requiring risk-bearing organizations to furnish financial information to plans that assists plans in maintaining the financial viability of the risk-bearing organizations; and
   b. Requiring health plans to disclose information to risk-bearing organizations about the financial risk being assumed.

4. Requires the adoption of regulations to provide for the following:
   a. A process for grading risk-bearing provider organizations and a requirement that they provide information according to generally accepted accounting principles to an external party for such grading;
   b. Reporting by health plans to the DMC as to the risk arrangements with risk-bearing provider organizations; and
   c. A process for corrective action plans.

5. Prohibits contracts between health plans and risk-bearing organizations from requiring the risk-bearing organization to be at financial risk, or requiring providers to accept rates or methods of payment with affiliates, without negotiation.

SB 260 also requires the Financial Solvency Standards Board to report to the director of the DMC by January 1, 2001, regarding the feasibility of requiring risk-bearing provider organizations to purchase insurance coverage commensurate with the financial risk they assume to protect against financial losses (i.e., reinsurance policies), and on the appropriateness of different risk-bearing arrangements between health care service plans and risk-bearing organizations.

**Additional Reform Proposals**

A number of legislative proposals were introduced in the 1999 legislative session that address some additional aspects of the medical group solvency and risk-bearing issue. These bills remain in committee. They include proposals to:

- Prohibit the transfer of pharmacy risk to medical groups (AB 691 – Gallegos; AB 1053 – Thompson).
Establish financial monitoring standards for medical groups and require health plans to submit timely financial information to medical groups (AB 698 – Corbett).

Establish administrative cost limits on health plans; health plans would be required to report their actual or expected loss ratios to the state (AB 888 – Wayne).

Require health plans to update annually the actuarial report originally submitted at the time of licensure; the report must substantiate that the capitation rates between a health plan and its contracting providers are adequate to assure the continuance of the relationship between the plan and the provider (AB 918 – Keeley).

Conclusion

California is often considered a bellwether for change in the health care system at the state level. The state’s system is now organized around a few very large health plans and hundreds of medical groups and IPAs. Whether for good or bad, health plans have shifted a large amount of financial risk to medical groups over the last decade. These groups have assumed responsibility for managing and delivering more comprehensive care to health plan members, while at the same time receiving diminishing capitation payments from the plans.15

Given the inability of many provider groups to continue to bear risk and remain solvent, policymakers in California have intervened with passage of SB 260, the first attempt to address this issue through legislation. Since the law did not take effect until January 2000, its outcome is unknown. However, it is likely that some problems associated with medical group risk-bearing and solvency will not go away.

What does the future hold for provider organizations?

Some health care industry observers have suggested that the dominance of the medical group model in California is waning, in light of the financial instability of many of these groups. Others predict that as insolvent groups dissolve, the ones that remain will consolidate, and like consolidation in the health plan industry, the marketplace will stabilize.16 This stabilization could also result from the growth of “mixed model HMOs,” in which some patients receive care through large medical groups and others see doctors who contract directly with health plans and assume less financial risk.

It is likely that most plans will become more actively involved in assessing and monitoring the financial health of their provider group subcontractors.17 In a more extreme scenario, some health plans could move away from the capitation model of medical group payment, and revert to a discounted fee-for-service payment structure for individual physicians. Another option is for purchasers (employers, Medicaid, Medicare) to contract directly with large medical groups and hospital systems for the provision of health care services, bypassing the health plans altogether.18

All of these possibilities create a great deal of uncertainty for health plans, physicians, and consumers. Moreover, the new arrangements and financial accountability standards at both the health plan and provider group level could come with a high price tag, since less risk-sharing between health plans and medical groups could erode provider incentives for cost-controlling behavior. Rising premiums have obvious negative implications for affordability, already a major concern for patients in today’s health care system, particularly in California where the rates of uninsured are among the highest in the nation.

Intervention through law/regulation to deal with California’s medical group insolvency problems could reduce the ability of health plans to “manage” the provision of health care (affecting both cost and service delivery), or alternatively could increase health plans’ role in medical decision-making. Policymakers, regulators, and industry stakeholders all have roles to play in the evolution of California’s health care system, while treading carefully in these uncharted waters, since change will affect health plans, physicians, and consumers alike. California’s efforts to deal with the problems of capitation and to oversee the financial solvency of providers in its health care system may be a useful guide to the rest of the nation.
For more information about the California Health Policy Roundtable, please contact:

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Endnotes


4 Based on the discussion of James Robinson at the California Health Policy Roundtable on Medical Group Risk-Bearing and Solvency; July 20, 1999.

5 For a fuller discussion of these issues, refer to the CMA report, The Coming Medical Group Failure Epidemic; September 2, 1999.


10 California Association of Health Plans, Issue Brief on Full Risk Capitation; August 1998.


12 Sharon Bernstein, “2 Dozen Doctor Groups In State Near Failure,” Los Angeles Times; September 2, 1999.

13 Based on the discussion of James Robinson at the California Health Policy Roundtable on Medical Group Risk-Bearing and Solvency; July 20, 1999.

14 The passage of Assembly Bill 78 (Gallegos) on September 27, 1999 requires the creation of a new Department of Managed Care to assume this regulatory role.


